

Older people's definitions of quality services

Hazel Qureshi and Melanie Henwood

The **Joseph Rowntree Foundation** has supported this project as part of its programme of research and innovative development projects, which it hopes will be of value to policy makers, practitioners and service users. The facts presented and views expressed in this report are, however, those of the authors and not necessarily those of the Foundation.

Hazel Qureshi, Professor of Social Care, University of York
Melanie Henwood, Independent Health and Social Care Analyst

Acknowledgement

The authors would like to thank Mrs Nancy Spratt for her useful comments on the style and content of a draft of this paper.

© Joseph Rowntree Foundation 2000

All rights reserved.

Published for the Joseph Rowntree Foundation by YPS

ISBN 1 902633 82 2

Cover design by Adkins Design

Prepared and printed by:

York Publishing Services Ltd

64 Hallfield Road

Layerthorpe

York

YO31 7ZQ

Tel: 01904 430033 Fax: 01904 430868 E-mail: orders@yps.ymn.co.uk

OLDER PEOPLE'S DEFINITIONS OF QUALITY SERVICES

The Social Care and Disability Committee of the Joseph Rowntree Foundation (JRF) is developing an Older People's Programme, focusing on the support that older people would value in order to continue to live independently, comfortably and with a sense of dignity and freedom. This overview paper has been commissioned by JRF to address three tasks.

- Review what is known about definitions of quality from the perspective of older people.
- Seek out evidence about the outcomes older people wish to achieve and the extent to which services address these.
- Highlight possible avenues for future work that the Committee might take forward.

Introducing quality

Before turning to review older people's perspectives, it is worth briefly considering the concept of quality. The dictionary defines quality as 'degree of worth' or 'degree of excellence'. From the point of view of people using services, different aspects of a service may be of relevance to overall quality, for example, the quality of:

- the staff (are they well trained and competent, friendly and courteous?)
- the building in which the service is given (is it in a good state of decoration and cleanliness, is it accessible and well-signposted?)
- organisational arrangements (how long do people have to wait, how good is the information provided?)
- any help or treatment given (is it effective, is it state of the art, does it achieve what is wanted or expected?)

From the point of view of citizens in general, including those who are using services, the quality of public services is related to other issues, such as fairness and cost. For example:

- are services fairly distributed? (can all groups who need a service get an equal opportunity to access it, are the available resources going to some services or some groups of people rather than others?)
- do services represent good value for money? (is there unnecessary waste, could it be done more cheaply, should we spend more now to prevent future needs arising?)

Who should define quality?

Since there are these various aspects to quality in public services, there are a number of different groups with something to say about how it should be defined. Because there is this range of interested parties, forms of participation and involvement in the public sector are quite different from those in the private sector (Pfeffer and Coote, 1991). The overall limit to resources available

is one important issue that affects the extent to which all those who receive services can be satisfied, but, even if the resources existed to satisfy all service users, the resulting distribution of services or resources might well be regarded by many as unfair. Individual satisfaction with services may relate strongly to expectations (and the information that users have about services), therefore those who expect little may be satisfied with services which others may judge to be below the standards which should be expected. 'Others' might include professionals, relatives, users collectively, or the public in general. In short, there are other groups with a legitimate interest in the quality of public services apart from those who are immediately using them and thus other people to be satisfied.

An understanding of quality in this context recognises that it is likely to be a contested issue, with different stakeholders (or interested groups) having different ideas (Stewart and Walsh, 1990). This does not mean it becomes impossible to talk about quality, indeed it makes open discussion and negotiation all the more important. The emphasis on accountability of public sector managers means that description and assessment of the quality of services is essential information for public debate and for learning (Ranson and Stewart, 1994). Some definitions and ideas about quality may enjoy greater agreement than others. Indeed, we may all agree on what a good quality service might be, but not that it should be provided. All this suggests that our accepted ideas of what constitutes quality per se, and the acceptable quality for public services, will be subject to negotiation and change over time.

The remainder of this briefing will draw together the findings of studies that have investigated what outcomes older people want and receive from services. We will begin with the aspects of quality of life that have been identified as important in a range of studies, and the kinds of improvement in personal functioning,

resources or the immediate environment which tackle some of the barriers to achieving acceptable quality of life. Secondly, we will consider the separate outcomes that are not about changing or maintaining quality of life (which could occur whether or not people are getting services), but instead are the psychological results or impacts of the way in which services are delivered. Finally, we will consider what characteristics of services older people have identified as being likely to contribute to achieving the quality of life outcomes and the service process outcomes which they consider important. This drawing together of evidence will provide a basis for considering possible ways forward for research and development.

Quality of life outcomes identified by older people

Much of the research conducted around outcomes and quality has examined the experience of various groups of users of community care services. Improving the quality of life for people with long-term care needs was an explicit objective of the 1993 community care reforms (Secretaries of State, 1989). Similarly, services were to be developed which supported independence and which gave people a 'greater say in how they lived their lives'. Such objectives remain central to current community care policy and have been reinforced – for example – in the 1998 White Paper on *Modernising Social Services* (Secretary of State for Health, 1998), which emphasised the need to 'promote people's independence while treating them with dignity and respect at all times, and protecting their safety' (para 2.4).

We can distinguish between aspirations that are associated with particular circumstances (such as living in a residential home, or using home-care services), and those which relate to a broader concept of quality of life. Harding (1997) has highlighted issues

around the importance of retaining independence and autonomy; being in control of one's life; having choices about how one lives; and having one's priorities respected. Henwood and Waddington (1998) found reinforcement of such themes with groups of both older and middle-aged people who identified the prerequisites for maintaining independence and keeping control of their lives in terms of: financial security; appropriate and timely information; and keeping a healthy body and mind.

Moreover, Harding also argues that such aspirations are in some sense universal:

... these aspirations are common to all older people, not just those who are relatively active and healthy ... the evidence from older people themselves is that inclusion and quality of life are just as important to those whose health or mobility are impaired as it is to more active older people.

(Harding, 1999, p. 44)

Other research has also looked at outcome definition by different groups of service users and found a powerful consensus that links the views of different types of service user. *Shaping our Lives* was a project funded by the Department of Health from 1997 as part of the Community Care Development Programme. Based at the National Institute for Social Work, the project established a National User Group that brought together people with physical and sensory impairments, older people, people with learning disabilities and users/survivors of mental health services. The Group's statement on the outcomes users want to attain highlighted the themes of equality, empowerment and independence:

We want to be empowered as citizens and members of society and to achieve meaningful equality. Meaningful equality means having the same choices, opportunities, rights and responsibilities as all other members of society. It includes being enabled to live independently with the support that we require as a result of our impairments. Being empowered and independent means having full choice and control over the way we live. It is particularly important in relation to the provision of support services.
(*Shaping our Lives*, 1997)

Choice and Control are major themes which underlie much of our discussion, and which run throughout the research literature. Above all, older people want control over their daily lives. As the SPRU (Social Policy Research Unit) research on outcomes observed:

People wanted to be able to plan and organise their days, and enjoy a normal pattern of life. They wanted to maintain their own standards of cleanliness and tidiness in their own homes, to feel securely connected to the world, and to avoid boredom and isolation. They wanted to be able to have and deploy resources to achieve these outcomes, including having access to the maximum levels of benefit to which they were entitled, having sufficient information about services and entitlements to make choices, and being able to choose whether or not, and when, to draw on family assistance, or to give care to others.

(Qureshi *et al.*, 1998, p. 9)

Outcome dimensions

There is a growing volume of research on outcomes, driven in part by the Department of Health's emphasis on promoting an

evidence-based approach to policy and practice (reflected, for example, in its Outcomes of Social Care for Adults research programme). In this section, we identify the quality of life outcomes and themes that have been identified in a number of pieces of recent work with older people. The framework for analysing this material is derived from Qureshi *et al.* (1998), and draws a distinction between quality of life outcomes and service process outcomes. In addition to control over daily life, the five dimensions identified below can be seen as the core aspects of quality of life for older people, *whether or not* they require specific services or support to help them attain this life quality.

Keeping clean and comfortable

This includes being personally clean and presentable in appearance, having suitable arrangements for using the toilet or managing incontinence, having clean clothes and bed clothes, eating and drinking normally as far as one's health allows. The meeting of basic physical needs may not be mentioned as an important outcome by groups of older people, especially if the groups do not include people receiving personal care. When we do not experience illness or disability, we may take the meeting of such needs for granted. For providers of social care, these areas have assumed increasing importance over the past few years, often to the detriment of other needs which were previously met.

Enjoying a clean and orderly environment

The research literature indicates clearly the importance of this to many older people, particularly, but not exclusively, older women, not just because people value a clean environment in itself but also because a dusty home or an untidy garden can be experienced as a reflection on their reduced capacity to manage their own affairs. Services have progressively withdrawn from

this area of provision, for a range of reasons. Sometimes it has been argued that it is an area which is not a priority compared with others, unless someone's health is at risk. Often it has been argued that the introduction of charging for services means that a cleaning service is available elsewhere more cheaply. However, concerns about safety mean that older people have expressed a wish for some form of regulation or accreditation of commercial suppliers. Health and safety restrictions on what staff are allowed to do have led to difficulties for older people in getting assistance with practical tasks such as changing light bulbs or hanging curtains (Barnes and Bennett-Emslie, 1997; Henwood and Waddington, 1998; Henwood *et al.*, 1998). There is now an increasing recognition within Department of Health policy of the importance of 'lower levels of support' and the need to invest in preventive services in order to promote independence (Secretary of State for Health, 1998).

Being safe

This relates to confidence in the accessibility of help in any emergency as well as to generally feeling secure and protected from possible harm. Of course, people have different levels of tolerance of risk in their lives. Fears about safety can be a factor influencing people's decisions to enter residential care, but, equally, there are occasions when people wish to accept risks that give concern to their relatives or to staff of services. Safety is identified as an important outcome of being in residential care (Raynes, 1998) but, even within residential services, there may still be quality issues in relation to personal safety, for example the adequacy of fire precautions (Willcocks *et al.*, 1987).

Access to social contact and company

At its most basic, this is about the avoidance of severe social isolation that can follow upon difficulty in leaving the home. People

may find themselves unable to maintain contact with special friends or relatives (particularly if they too are sick or disabled), or they may wish for opportunities to meet new people and make new relationships. Research indicates the high value which service users attach to visits by care staff, particularly when their social network is minimal (Henwood *et al.*, 1998). At its most positive, social integration and inclusion may be sought, involving the achievement of social participation at levels similar to those of other older people. Again, this is an area that has at times been regarded by service providers as of relatively low importance, although it has been recognised that severe isolation may have negative effects on people's mental health. For some people, the company of other residents can be a positive outcome of living in residential care, although a failure to manage the behaviour of residents who are confused or disturbed can have negative impacts on others (Raynes, 1998; Willcocks *et al.*, 1987).

Keeping active and alert – having something interesting to do

No matter what their physical capacities may be, this remains important to people. In general, they may seek opportunities to preserve their mental and physical health, but people whose health has declined seek at least to keep their minds active and pass their time in an interesting way. It was one of the outcomes most frequently identified by groups of older people in Raynes' work with people living in residential care homes. Taking part in interesting activities, perhaps including making a contribution by doing jobs around the home if they wished, but also pursuing hobbies and interests, and getting a change of scene: these issues were raised in all groups consulted. Similarly, Henwood and Waddington (1998) reported older people emphasising the importance of remaining active and engaged, both as an end in itself, but also as a means of achieving social interaction. The

perceived lack of meaningful activity within residential homes was viewed critically by some, particularly by younger cohorts who saw nothing relevant to their own lifestyles or preferences.

The contribution of different services to older people's quality of life

The quality of life outcomes listed in the last section are rather global and general, and not obviously the responsibility of any particular service. In terms of the population as a whole, the achievement of these outcomes is perhaps the responsibility of Government and people together. For an individual, the quality of life outcomes we have mentioned can be reached in various ways. If people are fit and healthy, they may well be able to achieve them using their own resources with no other help. If people experience ill health, material deprivation, social exclusion or disability, then a service, or a number of services in combination, may be needed. These services may help to achieve the quality of life outcomes directly, or may tackle problems that stand in the way of doing so. Some of the specific changes that services might try to bring about include the following.

- Improve ability to get around, inside and outside the home: there are many ways to achieve this, such as adaptations to the building, alternative housing, equipment, physiotherapy, mobility training for people who are blind, accessible transport.
- Reduce (or manage) symptoms of ill health: e.g. pain, or lack of sleep, or 'nerves', or incontinence. A whole range of ways exists to achieve this, depending on the condition or illness the person is experiencing. Often people know quite well what they would like and there is no conflict with

professionals or relatives about the desired outcomes. The position can be more complicated when people cannot express their wishes (for example, in the later stages of dementia) or where there are disagreements about what should be done.

- Improve communication: where communication between the person and others is hindered, this may be improved by a range of methods, depending on the cause; for example, availability of interpreters, training staff to use sign language, using audio tapes or braille, reading letters for people who are blind, hearing aids, speech therapy.
- Regain skills and confidence: after illness or accident, recover capacity to look after self. This may happen as a result of natural recovery, and/or may involve assistance in the form of emotional support and counselling, training, physiotherapy and other rehabilitation services.
- Improve benefit income: maximising available income increases people's control over their lives and their capacity to make choices.

Different services may tackle different barriers to an acceptable quality of life and particular services can act only within their responsibilities. The NHS cannot give people a higher income, social services staff cannot prescribe appropriate medicines. Social services, in their role of providing an overall 'safety net', explicitly see it as part of their role to assist people to obtain other services, and it is users of social services (residential and community-based services, or direct payments) who have most clearly identified the general quality of life outcomes listed earlier as being actual, or potential, results of services. Using this list of

outcomes, Qureshi (1998) has suggested that some useful questions for investigating the impact of social services would be the following. Is the person clean and comfortable, and in a clean and comfortable environment? Do they have sufficient company, stimulation and activity? Do they feel safe and in control of their daily lives? If so, to what extent has the service (as opposed to other sources of assistance) helped with this? And if not, why not? Asking why not will be important, in case the remedy for any particular problem is one that social services cannot supply. Perhaps better health input, transport or housing is required. At least, however, it will be clear whether social services are doing the best they can and evidence will be being built up about the consequences of failures in quality in other services. Equally, this illustrates that quality of life may be useful as a concept for investigating the results of agencies working together.

Quality and the process of service delivery

As well as the outcomes of the kind we have described above, the experience of receiving a service has a number of other impacts on service users and these also reflect quality. Impacts of the way in which services are delivered are important in all services, but assume particular importance in social care. The work with service users carried out by the *Shaping our Lives* project found that, when people were asked about outcomes, discussion about the *process* of service delivery (or the process of trying to access services) tended to dominate. In their view, this reflected both failure to achieve outcomes using conventional services and the fact that the impacts of the way in which services were delivered (or denied) could be as important as other outcomes.

In relation to social services, users have argued that the way something is done can completely undermine the value of achieving some of the quality of life outcomes we have already described.

So often it is the style of the way services are delivered rather than the service itself which produces a quality service ... the home carer who gets you up in the morning can do this in an empowering way which enables you to face the efforts of the day positively or in a way which means that you are dressed and ready but not psychologically ready.

(Quoted in Harding and Beresford, 1996, p. 5)

Qureshi *et al.* (1998) have coined the term 'service process outcomes' to describe these impacts of the process of service delivery and older people in their study distinguished the following dimensions.

- 1 Satisfaction with the way help 'fits' with other life choices:
 - fits with care giving and receiving within the family
 - fits with cultural and religious preferences.

- 2 Having control over personal and domestic assistance:
 - tasks undertaken
 - timing of help
 - who helps
 - making a contribution wherever possible – this may be more important to women than men (particularly in relation to housework), although it is possible this may be less true of later generations. People in residential care have also expressed this wish.

- 3 Feeling valued and treated with respect:
- acceptance despite symptoms or difficulties
 - treated as someone with legitimate right to services
 - treated as a fellow human being (with some warmth and friendliness)
 - treated as someone different from others, with individual needs
 - feeling that privacy and confidentiality are respected.

The quality of life and service process issues identified by older people in community services differ little from those identified by people in residential homes. For example, in a study led by Raynes (1998), residents identified the following characteristics of good quality care:

- activities in the home
- provision of opportunities to get out of the home
- good food, choice of food, able to make a drink
- kind and knowledgeable staff
- access to one's bedroom
- pleasant company and friendship of other residents
- continuity of staffing
- physical comfort
- availability of support services
- personal safety
- availability of equipment and adaptations to promote self-care.

Issues that were recommended for consideration in review of standards were: participation in household and other activities; opportunities to go out; staff attitudes to resident self-sufficiency; and managing disturbed behaviour. The report of what was meant by 'activities' makes it clear that personal choice of activity was important, not just activity per se. People valued (or would have liked) a variety of resources to use individually, chances to help with tasks or other activities in the home, and organised group activities which they could choose whether to join or not. In a quality home, 'resident's hobbies were identified as they arrived and the possibility of continuing these was explored' (Raynes, 1998, p. 70).

Achieving quality

What are the characteristics of services that are likely to be able to deliver such outcomes? Henwood *et al.* (1998) explored the perceptions of older people using domiciliary care services. Judgements about service quality were typically a reflection of two components: the nature of the relationship with the home-care staff and the way in which care was delivered. A quality home-care service, according to service users, was one characterised by the following features:

- staff reliability
- continuity of care and of staff
- kindness and understanding of care workers
- cheerfulness and demeanour of care staff
- competence in undertaking specific tasks
- flexibility to respond to changing needs and requirements

- knowledge and experience of the needs and wishes of the service user.

Such features have been identified in other work, suggesting a degree of consensus among home-care service users over definitions of quality (Harding and Beresford, 1996; Qureshi *et al.*, 1998). A sample of 125 older people using community nursing services identified some similar issues which caused dissatisfaction, in particular, lack of reliability and staff being rushed. There were, however, no mentions of staff competence or flexibility, although friendliness of staff was valued. This suggests there may be more taking for granted of professional expertise and more clarity about the specific limits to the role in relation to community nurses (Reed and Gilleard, 1995).

These attributes of services can be seen as *likely to contribute to the attainment of process and quality of life outcomes* identified above. These issues of staff competence and manner, service organisation and management, and user-focused assessment all need to be addressed if the likelihood of delivering quality outcomes is to be improved for older (and other) service users.

We would caution against over-concentration on developing and using standards relating to organisational activities, at the expense of exploring the extent to which quality can be individualised. In other words, while there is evidence that *on average* certain characteristics of services are highly valued, this will not be true for all service users, and – for some people – other quite different features may be of more importance. For example, in Sweden, 180 older people (who used services) were asked to rank-order different dimensions of quality in home care. Some interesting results were that people in general rated the competence of staff as more important than their disposition and having plenty of time was rated more highly than time keeping

(Edebalk *et al.*, 1995). Continuity was generally the most highly ranked dimension, and, not surprisingly, it was of particular importance to the oldest older people and those with the highest needs for assistance. Indeed, the Swedish study demonstrated quite clearly that there were important differences in ranking between different groups: specifically between different age groups and those with different levels of service use.

The SPRU study (Qureshi *et al.*, 1998) also found variations in the features of service delivery which mattered most to individuals and was thus led to argue that a possible way forward to improve quality might be to ask service users whether they had any preferences or priorities which related to the way in which services were delivered, and to try and implement these, rather than to try and deliver punctuality or continuity of staff to everyone. With finite resources available, an over-concentration on providing services that meet certain quality standards, without reference to the importance of these dimensions to individuals, may limit the capacity of services to respond flexibly to individual requirements. Service users may be prepared to 'trade-off' different aspects of quality and to accept less of some dimensions if it allows them greater control over others that are of more importance to them. We simply do not know yet what range of preferences people might have, and to what extent they would be achievable, although a pilot study in one authority has included asking people for quality preferences and an important finding was that sometimes people were better able to do so after they had received services for a while, rather than before (Colhoun *et al.*, 1998).

We return to these issues below in considering the possible agenda for further research and development.

Assessing and ensuring quality of specific services

While older people (and other service users) talk about the quality of life they want to be able to attain, these objectives are often absent from the ways in which service objectives are specified. In part, this reflects the fact that the attainment of independence or autonomy has implications for services and structures that typically go beyond the remit of health or social care services. For example, the key to independence and being able to get about (inside and outside the home) requires strategies that address accessible transport, the nature of the built environment and the establishment of safe public areas. Similarly, the capacity of people to participate in society and to engage in normal patterns of social interaction can be substantially limited by low income.

The way in which people are treated, the ease of access to the service and the degree to which the service tries to fit in with people's needs and preferences are always likely to be important aspects of quality from the point of view of service users. Feedback from service users provides an important way of assessing these aspects.

For some services, or particular interventions, such as, say, a course of physiotherapy or surgery, the more specific 'change' outcomes such as improving mobility or reducing symptoms may be an appropriate level at which to initially consider outcome-related quality. Sometimes, particularly in health, quite technical issues will be involved in deciding whether such outcomes are as good as they should be, although there may be reservations about leaving these decisions to professionals alone: health professionals have sometimes been criticised for a narrow focus on symptom relief instead of broader effects on the patient's life. There is a continuing debate within the health sector about the extent to which service users and professionals give different

priorities to different outcomes (and the possibility of different side-effects) and about how to ensure the proper level of user influence on decisions which affect their lives (Donabedian, 1992). There is some evidence that widely used health status measures, when applied in community services, do not pick up impacts which older people consider important (Hill and Harries, 1993). Even where expert knowledge is important, there remains a role for the views of older people.

Checking quality by asking people who use services about outcomes and service processes can be very expensive. If we know for sure that a particular way of organising services is likely to deliver the outcomes older people are looking for, then it may be quicker and cheaper to assess quality by checking whether services are working in that way. For example, are there interpreters if people need them? Can people get help outside normal working hours and how many do? Are there waiting lists for services that people may feel they need urgently? Is information about services readily available and helpful to older people? Answers to these questions may reflect on quality, but, to frame the questions, we need knowledge (of the kind we have outlined earlier) about what aspects of services will be likely to deliver the outcomes that are sought. We really do need to be sure that the right things are being checked.

Assessing quality

Assessing quality is a process of making judgements about the quality of a given service.

- This can be done comprehensively, collecting information about what is being attempted, what is done, what is achieved, and involving staff, service users and external experts.

- It can be done on a day-to-day basis in a whole range of more partial ways such as analysing information from records, asking staff what they think, surveying service users, inspecting service settings.

There are various tools that have been developed to assess the quality of different services. In the field of residential care, for example, inspection documents, such as *Home Life* (Centre for Policy of Ageing, 1984) and *Homes are for Living In* (Department of Health, 1989), have been used to evaluate the quality of services by exploring dimensions which it is believed provide indicators of the quality of life available to residents and which move beyond a quantitative approach focused more on simply measuring the physical environment.

However, attempts to use these dimensions to assess quality in a consistent way for purposes of inspection have had limited success. Gibbs and Sinclair (1992a, 1992b) conducted a reliability study and found that it appeared to be very difficult to make reliable judgements on the quality of care in local authority homes using checklists based on *Homes are for Living In* (Gibbs and Sinclair, 1992a, p. 547). This may reflect general problems with standard indicators of quality. In a Norwegian study, Slagsvold (1997) compared quality ratings made using standard indicators (completed by staff) with the results of periods of direct observation within homes. She found worrying differences: for example, in relation to the exercise of autonomy and choice, observation showed more autonomy in smaller homes, but larger homes scored better on a standard indicator. Such disparities certainly do matter if decisions are to be taken on the basis of measurement against standard indicators.

Observations ... revealed that having autonomy (being offered influence, choices and control) really did seem to be of *great* importance to residents' well-being. But the kind of autonomy and influence important to them was to decide *what* to decide, *whether* to decide and *when* ... Relevant autonomy was an autonomy that was individualised, flexible, and contextual. The standard indicators ... did not catch the kind of autonomy that was relevant to the residents' well-being.

(Slagsvold, 1998, p. 298)

Slagsvold thus emphasised that good quality is that which contributes most to the well-being of residents, and argued that indicators which seem plausible should be tested to see if they really are related to the outcomes which matter to older people, before being used.

Some approaches to measuring service quality involve service users as evaluators. On the face of it, this would seem to be a good way to ensure that areas which really matter to older people are included in an evaluation. The Hampshire Consumer Audit Project is one such example. The project was established with Department of Health funding under the Community Care Development Programme. 'Consumer auditors' were recruited (either current users of community care services or carers) and trained by Southampton Centre for Independent Living. Audits of services involved a range of methodologies including interviews and informal discussions with service users; use of questionnaires; visits to services; time spent in observation of services; and review of service records. Each audit report highlights findings and makes recommendations. Drawing upon an explicit focus on the social model of disability, audits address the extent to which equal opportunities, choice, control and independence are increased or decreased for people using the service.

However quality assessment is done, and whatever tools are used, there has to be some expectation or understanding about what the service aims to achieve, for whom and the standards expected.

Assuring quality

Assuring quality means building into the service those ways of working which we know are likely to produce good quality.

- For an existing service, this has to start with assessing quality and should follow up by improving services or activities where aims are not being met (and by maintaining those where results and processes are good).
- It requires knowledge about what works, or would work, to deliver the aims of the service.
- At its best, it includes ways of continually checking out people's ideas about what gets in the way of achieving good quality and then acting to change things if possible; for example, quality circles, action learning sets (Taylor, 1995).

In principle, older people can be involved at every stage, either with the special expertise of service users or as citizens with particular expectations of the outcomes to be expected. Older people could be actively involved in collecting and analysing information and/or in deciding what information to collect, or in making judgements about information collected by others, or in deciding what should be done next.

An example of an attempt to develop quality monitoring and quality assurance mechanisms for domiciliary care was developed by Henwood *et al.* (1998). A series of frameworks was developed for service commissioners, care managers, providers and those responsible for accreditation and inspection. In each case, the frameworks suggest a process for engaging with the quality concerns identified by users and carers, and for addressing what this means for services in practice and how to ensure that such a service is delivered.

Developing an agenda for further work

In reviewing the core literature on quality, we would conclude that the broad definitions of quality from the viewpoint of older people can be seen to be well established and robust.

- The quality of a service is the degree to which it is effective, fairly distributed and delivered without unnecessary waste of resources.
- Effective services from the perspective of older people are those which: directly maintain, *or* remove barriers to achieving, quality of life (keeping clean and comfortable, living in a clean and orderly environment, being safe, having access to social contact and company, being able to keep active and alert, and having control over one's life) *and* which do so *in a way* which ensures that people are treated as fellow citizens with respect for their individual priorities and circumstances.

It is probable that further work may be required to refine the detail of these definitions in relation to specific life situations, or

with people from black and minority ethnic groups where cultural diversity might have an effect on expectations and requirements of services (indeed, one of the shortcomings acknowledged in much of the literature is the predominant focus on the perspectives of white older people). In addition to such further work as may be necessary to improve definition and understanding of the concept of quality, we would suggest that other areas in which development is required include the following.

- The development and testing of a range of different ways of assessing and assuring quality which would involve older people as partners with others. (This could include the quality of policy, as well as the quality of services, and might build on the experience of models such as the Hampshire Consumer Audit.)
- Supporting ways to test out further whether individual older people can define their own quality preferences and priorities, and to what extent services can respond to these.
- The further extension, and/or dissemination, of knowledge about which service characteristics help to ensure the achievement of quality of life or service process outcomes which older people have identified as important.
- Investigation of older people's views on the way in which indicators of quality in current use (such as checklists for residential care homes or performance indicators) reflect their conceptions of quality, or could be changed to do so more closely.

REFERENCES

- Barnes, M. and Bennett-Emslie, G. (1997) *'If They Would Listen ...' an Evaluation of the Fife User Panels Project*. Edinburgh: Age Concern Scotland
- Centre for Policy on Ageing (1984) *Home Life: a Code of Practice for Residential Care*. Report of a Working Party sponsored by the Department of Health and Social Security and convened by the Centre for Policy on Ageing. London: Centre for Policy on Ageing
- Colhoun, A. (1998) 'Improving the quality of purchasing in home care'. Unpublished report to Kensington and Chelsea Social Services Department
- Department of Health (1989) *Homes are for Living In: a Model for Evaluating Quality of Care Provided and Quality of Life Experienced in Residential Care Homes for Older People*. Social Services Inspectorate. London: HMSO
- Donabedian, A. (1992) 'Quality assurance in health care: consumer's role', *Quality in Health Care*, Vol. 1, No. 4, pp. 247–51
- Edebalk, P., Samuelsson, G. and Ingvad, B. (1995) 'How elderly people rank-order the quality characteristics of home services', *Ageing and Society*, Vol. 15, No. 1, pp. 83–102
- Gibbs, I. and Sinclair, I. (1992a) Consistency: a pre-requisite for inspecting old people's homes?', *British Journal of Social Work*, Vol. 22, No. 5, pp. 535–50
- Gibbs, I. and Sinclair, I. (1992b) 'Checklists: their possible contribution to inspection and quality assurance in elderly people's homes', in D. Kelly and B. Warr (eds) *Quality Counts*. London: Whiting and Birch
- Harding, T. (1997), *A Life Worth Living: the Independence and Inclusion of Older People*. London: Help the Aged
- Harding, T. (1999) 'Enabling older people to live in their own homes', in *With Respect to Old Age*, Research Volume 3. Report by the Royal Commission on Long Term Care. London: The Stationery Office, Chapter 3

Older people's definitions of quality services

- Harding, T. and Beresford, P. (1996) *The Standards we Expect: what Service Users and Carers want from Social Services Workers*. London: National Institute for Social Work
- Henwood, M. and Waddington, E. (1998) *Expecting the Worst? Views of the Future of Long-term Care*. Help the Aged Research Report. London: Help the Aged
- Henwood, M., Lewis, H. and Waddington, E. (1998) *Listening to Users of Domiciliary Care Services: Developing and Monitoring Quality Standards*. Leeds: Nuffield Institute for Health
- Hill, S. and Harries, U. (1993) 'The outcomes process: some reflections from research with people in their 60s and 70s', *Critical Public Health*, Vol. 4, No. 4, pp. 21–8
- Pfeffer, N. and Coote, A. (1991) *Is Quality Good for You? A Critical Review of Quality Assurance in Welfare Services*. Social Policy Paper No. 5. London: Institute for Public Policy Research
- Qureshi, H. (1998) 'Outcomes and local authorities', in S. Balloch (ed.) *Outcomes of Social Care: a Question of Quality?* Social Services Policy Forum Paper No. 6. London: National Institute for Social Work, pp. 15–23
- Qureshi, H., Patmore, C., Nicholas, E. and Bamford, C. (1998) *Overview: Outcomes of Social Care for Older People and Carers*. Outcomes in Community Care Practice Series No. 5. York: Social Policy Research Unit
- Ranson, S. and Stewart, J. (1994) *Management for the Public Domain: Enabling the Learning Society*. Basingstoke: Macmillan
- Raynes, N. (1998) 'Involving residents in quality specification', *Ageing and Society*, Vol. 18, No. 1, pp. 65–78
- Reed, R. and Gilleard, C. (1995) 'Elderly patients' satisfaction with a community nursing service', in G. Wilson (ed.) *Community Care: Asking the Users*. London: Chapman and Hall, pp. 113–25
- Secretaries of State (1989) *Caring for People: Community Care in the Next Decade and Beyond*. Cm. 849. London: HMSO
- Secretary of State for Health (1998) *Modernising Social Services*. Cm. 4169. London: The Stationery Office
- Shaping our Lives: Interim Report* (1997) London: National Institute for Social Work
- Slagsvold, B. (1997) 'Quality measures and some unintended consequences', in A. Evers, R. Haverinen, K. Leichsenring and G. Wistow (eds) *Developing Quality in Personal Social Services*. Aldershot: Ashgate, pp. 291–310
- Stewart, J. and Walsh, K. (1990) 'Performance management when performance can never finally be defined', *Public Money and Management*, Vol. 14, No. 2, pp. 45–9

Taylor, P. (1995) 'Learning in action', *Soundtrack*, No. 6, p. 10

Willcocks, D., Peace, S. and Kellaheer, L. (1987) *Private Lives in Public Places*.
London: Tavistock

