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Involving residents in quality specification

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ABSTRACT

The extension of user involvement in different aspects of service delivery in health and social care has been a central element of care in the community policy. Purchasers and providers of such services for older people have been exploring ways of tailoring services to meet individual need and ensure that the quality of the service reflects user preference rather than service-provider requirements. This article describes a project involving residents from a random proportionate sample of nursing homes and residential homes for older people in the City of Manchester. The project was designed to bring user views about quality into the service contract specification for the purchase of residential and nursing home care. The process and the outcomes are described. Factors which appear to promote the movement of user involvement into the mainstream of service specification and service development are identified. The role of small-scale initiatives is discussed.

KEY WORDS – User involvement, service contract specification.

Introduction

In the White Paper, *Community Care in the Next Decade and Beyond*, the then UK government's proposals for improving community care were described. At the heart of these proposals were two key concepts. The first emphasised the provision of services which people needed to enable them to live as independently as possible in their own homes or in 'homely' settings in the community (Department of Health 1989: 3). Social and health care services for those people who needed them should thus be designed to 'provide the right amount of care and support to help people achieve maximum possible independence and…help them achieve their full potential'. The second key concept was to 'give people a greater individual say in how they live their lives and the services they need to help them do so' (Department of Health 1989: 4). This, it has been argued, may be seen as the development of

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consumerism in the health and social care quasi-markets (Pollit 1988).

Much of the discussion about choice focuses on alternative forms of care (Department of Health 1992). There is, however, the issue of choice within a type of care and at the micro level of service delivered to the service user (Willcocks, Peace and Kellaher 1987). The project described focuses on facilitating the involvement of residents in nursing and residential homes in contract specification. Their views were used to inform the review of the contract used by a local authority to purchase services for older people in nursing and residential homes.

The work, carried out in the Metropolitan Borough of Manchester, contributes to the exploration of ways in which the new enabling authorities can seriously address the views of those on whose behalf they purchase services. The involvement of service users and carers in planning, managing, and delivering services and improving the quality of the care they receive in the community, has not been a central tenet of the delivery of either health or social care in England. Goss and Miller (1995) describe a Joseph Rowntree Foundation project which was designed to encourage the development of user and carer centred community care. Each of the four local authorities involved had already piloted user and carer involvement projects. The purpose of the Rowntree project was to assist the movement of these initiatives, as Goss and Miller put it, 'from being a new development on the margins to be a mainstream part of community care' (Goss and Miller 1995: 4). The project identified the diversity of arrangements to facilitate this. It also identified some of the features across the initiatives which appear to help projects to become part of mainstream provision.

Other recent work (Wistow and Barnes 1993; Hoyes *et al.* 1994; Bewley and Glendinning 1994) has described the attempts of different local authorities' social service departments and health care purchasers and providers to involve service users in the planning and running of services. Most of this work has focused on services for people living in their own homes. The lessons from this work and that of Goss and Miller, however, are pertinent to the provision of residential services. Goss and Miller have argued that even where there is goodwill and commitment on all sides, moving the clients' views into the arena of debate, and recognition on a permanent basis, needs more than these essential prerequisites. Identifying some of the prerequisites will assist in the movement from needs-led to client-led services.

Purchasers of services have to find ways of ensuring the provision of a homely environment for those who do not live in their own homes and on whose behalf they purchase places in residential or nursing homes.

One of the means at their disposal is the contract they enter into with providers. In the contract, detailed specification of the aspects of the service to be provided can be laid down. Service contracts contain specifications that relate to the quality of the service to be provided, as well as other matters. People who are residents in such homes may well have views about the service to be provided. This involvement of service users in contract specification to influence the quality of the service at the point at which they receive it, may be one of the small ways in which user involvement can lead to improvements in existing services. This study describes one attempt by a service purchaser to enable service users to influence the quality of the services they received.

The project methods are described, then the outcomes. The lessons learned and the factors linked to sustaining client/patient participation in such a process are discussed. Factors which appear to be specific to this type of service user involvement and those which are of more general application to the development of user views in services are identified.

Background to the project

In 1991 the Contracts and Purchasing Unit of Manchester Social Services Department included quality standards in its contract specification for the purchase of residential and nursing home care (Department of Health 1991; Manchester 1991). The original quality specifications had been professionally driven and did not involve consultation with service users in their developments. The Social Services Department was concerned to find ways of accessing the views of residents in the review of existing contract specifications relating to quality. The contract was subject to review every three years in this local authority. In 1994 the Social Services Department funded a research and development project. This had, as one of its objectives, informing the contracting and purchasing review process with residents' views which were to be obtained from data gathered in focus groups.

The sample

In the City of Manchester there are 100 homes within the geographical boundaries of the City registered under the 1984 Registered Homes Act (Department of Health 1984). At the time of the study, three types

TABLE 1. *Sample of Residential, Nursing and Dual Registered Homes*

| | Type of registered home | | | |
Locality	Residential	Nursing	Dual	All
1	8	4	3	15
2	5	2	0	7
3	9	3	1	13
4	4	5	1	10
5	4	1	0	5
Total	30	15	5	50

of registered homes: residential, nursing and dual registered homes existed within the City boundaries. The City is divided for administrative purposes into five localities. A sampling design to generate a random proportional sample was used. The sample drawn from the 100 homes is representative of both the different types of homes and the administrative localities into which the City is divided. A sample of 50 homes was drawn. Table 1 shows the composition of the sample.

The method

Before the sample was drawn a letter was sent to all home owners inviting them, and any residents they might wish to bring, to a meeting. Details of the research were described at this meeting. The residents' right not to participate was stated. Confidentiality of the information obtained in this study, relating to both homes and residents, was guaranteed. Following this meeting the sample was drawn. All homes in the sample were written to. A request was made in the letter to visit the home to seek two residents from each home to participate in the focus group meetings. It was explained that these would be held in local venues away from the homes.

Two of the 50 homes refused to participate in the project. In addition, one was found to be located outside the City boundaries and one was not primarily for older people. Thus 46 homes were visited. In some homes all residents were spoken to. In other homes, staff selected residents to participate or be introduced to the researcher to discuss their possible participation in the study. The visits produced 45 homes in which at least one resident agreed to participate in a focus group meeting. Eighty-six residents in 45 homes were sent invitations to the meetings.

TABLE 2. *Reasons for Residents' Non-attendance at Meetings*

	Type of registration of home		
Reason	Residential	Nursing	Dual
Changed their minds	9	1	2
Too ill on the day	6	7	1
Died	0	1	0
Other reasons	2	0	2
No reason given	3	0	0
Total	20	9	5

TABLE 3. *Special Needs of Residents Attending the Focus Group Meetings*

Physical special need	Number in original sample	Number attending at least one meeting
Wheelchair only	18	13
Wheelchair, stroke	2	1
Wheelchair, partially sighted	1	0
Wheelchair, voice box	1	0
Frame/stick only	16	12
Frame, deaf/hard of hearing	2	1
Tripod, use of one hand	1	0
Deaf/hard of hearing only	3	3
Deaf/hard of hearing, diabetic	1	1
Hard of hearing and sight	1	1
Blind/partially sighted	3	2
Physically handicapped, no details	2	0
Total	51	34

The meetings were held in the evening. Residents from 70 per cent of the homes in the sample attended the meetings. Table 2 gives the reasons for residents' non-attendance at the meetings.

The maximum size of the focus groups was 10 residents. The group meetings were held at a number of different locations. All of these were unconnected with the providers or purchasers of services. Transport was provided for participants in taxis or minibuses and arranged by the research team. The cost of this transport was borne as part of the research project. Of the 52 residents who attended the ten meetings, 39 had special needs (Table 3). No residential care staff were allowed to attend any of the meetings. Escorts were provided by the research staff when these were requested by residents and/or the home.

The focus group meetings

The meetings were divided into two sessions with a break between each. Refreshments were served on arrival and during the break. Each group had a facilitator and secretary. In the first session the participants were asked what they thought made a good home. Residents' responses to the questions were recorded on a flipchart by the secretary. The record of what was said was checked with group members to establish its accuracy before the end of the first session. In the second session of the meeting this process continued. Participants were also asked to identify one thing which could improve their residential or nursing home. Finally, they were asked if they wanted a report of the outcome of the meeting and if they wished to participate in a further stage of the research. Once the residents had left the building all assistants were debriefed. A briefing session was held prior to each focus group meeting for all of the research assistants involved.

The data from the groups were compared with the 1991 service specification. Areas of overlap and discrepancies were identified.

Outcomes

1. *Residents' views*

In response to the question 'What makes a good residential care or nursing home?' residents discussed many aspects of their care. Their key concerns to ensure good quality care are listed in Table 4 below.

Residents' views about the characteristics of a good home, covering such matters as going out, having things to do within the home and food in the home, are illustrated below, with some of their verbatim comments about those features of residential care.

The residents said a good home was one where there was a variety of things to do, because there were different types of residents in a home; there was a variety of resources available for residents to use *e.g.* games, wool, plants; there were art classes or other such organised activities within the home, or outside it, so residents could maintain or develop a skill or interest; there were library books brought into the home; and where the residents' hobbies were identified as they arrived and the possibility of continuing these was explored, *e.g.* gardening or knitting.

The residents were also keen to be allowed to do jobs around the house if they wished. They identified a range of such activities which

T ABLE 4. *The Characteristics of Good-Quality Care in Residential and Nursing Homes*

Characteristic	Number of meetings at which this was discussed
Activities in the home	10
Provision of opportunities to get out of the home	10
Provision of good food, choice in relation to it and the opportunity to make a drink	10
Provision of kind and knowledgeable staff	9
Access to one's bedroom	9
Pleasant company and friendship of other residents	8
Continuity of staffing	7
The physical comfort of the home	7
The availability of support services	6
Personal safety in the home	5
The availability of aids and adaptation to promote self-care	5
The size of the home	5

included watering the plants; setting the table; washing up; dusting; cleaning and polishing; feeding the birds; helping with the laundry; peeling potatoes; and making a cup of tea for other residents less able than themselves.

The residents had a great deal to say about what it was like to spend the day with nothing to do. They said, for example, that 'Sitting there looking at each other all day long is boring'; 'The day drags, you are not tired when you go to bed, so you don't sleep'; 'I have never been in the kitchen'; and 'They should use all the resources they have which includes the residents of the home'.

Perhaps the most telling critical comment about the effect of the lack of activity during the day was expressed by one resident who said:

You get up and get dressed and have breakfast. You sit. You get up and go to the toilet. You come back. You sit. You get up and have lunch. You sit. You get up and go to the toilet. You come back. You sit. You get up and have tea. You sit, you go to the toilet. You sit. You go to bed. You can't sleep because you are not tired.

Some residents commented on the availability of activities in the homes in which they lived, and the pleasure they derived from this. One for example said that 'They asked me what my hobbies were and I have been able to garden'; 'I go to other people's rooms to listen to opera', and 'I go to an art class outside the home and they provide transport for me'.

The residents said a good home was one where they could go out to get a change of scene; go down the street to a shop, pub or park; go out for a walk around the block, or out for a walk to get some exercise; or go out to a class.

The residents' illustrated their views about the importance of getting out of the home with such comments as 'I would give the world to go out and I don't know the rules about this'; 'It is especially important for those who cannot walk because they get in a stupor and it gets hard to move them'; 'I am in a chair, I can go out if I get help'; and 'You don't need to go far. It is really important to go out even if it is just to the corner of the street.'

One of the residents who was encouraged to go out and was escorted to a local park and allowed to remain there, said 'You are with normal people in the real world then. I meet people and play with the dogs'.

In a good home the residents described the food as central in a number of different ways. There was some choice at meals; an alternative was available if a resident did not like the food being served; there was opportunity for a resident to get a drink; there was good wholesome food which did not need to be cooked by a qualified cook or chef but was cooked by someone who had the ability to cook; supper was not an endless succession of sandwiches; and breakfast was a flexible mealtime.

They referred to the food with such comments as 'I am happy to eat everything but tuna, but they don't give an alternative if they serve this'; 'For some people a cup of tea in the morning is important because you get dry throats because of the medication you are on'; 'Condiments ought to be available in addition to salt and pepper and they should be on the table'; 'Being told to leave what you don't want is wasteful – it would be better to get a choice and for them to leave things off the plate before you are given it'; and 'A good idea is to have regular meal times for main meals, for instance tea and dinner, but to have more flexible times for breakfast'.

2. *Comparison of the quality of standards in the service specification for residential and nursing home care for older people*

The analysis of the qualitative data obtained from the focus groups was used to generate a commentary on the original standards and outcome indicators. The residents' views were on the attributes of a good home compared with the quality specifications written in 1991. Many of the 1991 specifications and outcome indicators reflected current residents' concerns. When the 1991 standards and linked outcome indicators did

not reflect these concerns, recommendations to change them to reflect residents' views were made to the Purchasing and Contracting Unit (Raynes 1996*a*).

Standards and outcome indicators on which residents did not spontaneously make comments were those which related to administrative, managerial or legislative procedures. These procedures are assumed to generate the quality of care which residents would value and which are experienced on a day-to-day basis by residents. Some exploration of this assumption would be reasonable.

Certain issues raised by the residents were recommended for consideration in any review of standards. These were: the provision of opportunities to participate in the home's household and other activities within it; the provision of opportunities to go out of the home; staff attitudes to independence and self-care by the residents; the management of disturbed residents to reduce the stress for other residents.

3. *Developments affecting service contracting*

The following changes were observed. First, Contracting and Purchasing Unit staff did note and retain in the revised contract those aspects of the original specifications that reflected the concerns of residents in the focus groups. Thus, the quality standards were revised by the Contracting and Purchasing Unit to reflect recommended changes reflecting residents' views. The revisions were included in the new contract and circulated as part of the consultation process undertaken by the Contracting and Purchasing Unit. Following this consultation, a paper went to the Social Services Committee recommending adoption of the new service contract specifications. The Social Services Committee voted to adopt the new contract and service specifications in 1997. Also, the research report was sent to all participating homes and residents who were members of the focus groups. The Purchasing and Contracting Unit sent an executive summary of the report to all 100 homes registered within the City boundaries. Whilst this meant that some homes got more than one copy it ensured that we maintained the confidentiality of the homes participating in the project.

4. *Unplanned outcomes*

Following receipt of the report, one of the private homes purchased a minibus for transporting residents and employed 'leisure therapists' to promote activities for residents during the day. A group of homes asked for in-service training for staff members to explore ways of involving

residents in activities during the day. Another interesting outcome was that the authority received a request for the report from a group of homes which specialised in services for people with sensory disabilities.

Discussion

Many of the 1991 Manchester specifications were found to reflect the views expressed by residents about the attributes of good homes in the focus group discussions. This finding is encouraging since some of the professionally written specifications and related outcome indicators can be seen to be independently validated by the data obtained in the focus groups. However, the study demonstrates that there were some aspects of care, thought by residents to be important, which were not reflected in the original service specification written without their involvement. It would seem essential to ensure that ways are found to involve residents in developing service specifications since these services are being purchased on their behalf. This is especially important since it is at the micro level that most service users experience care. The quality of that care is important.

It may be said that the kind of user involvement which this study describes exemplifies that 'which seeks to improve the quality of services by making them more sensitive or responsive to the needs and preferences of those who use them' (Wistow and Barnes 1993: 285). However, it is arguable that it also appears to have as its purpose the empowerment of users in decision making about the design, delivery and review of services. The process described in this paper suggests that rigid demarcation between the two sets of objectives is not analytically helpful in understanding some of the user involvement initiatives in health and social care. These initiatives are better seen as a continuum along which an initiative itself may develop or generate others, either in linear fashion, or as a series of small movements back and forth in empowering users and extending their involvement.

The 'public service orientation', developed in the British local government context, places an emphasis on the serving of consumers' needs, not the convenience of the providers of services. The process in which the City of Manchester became involved was a way of improving management awareness of client needs and preferences. It was also a way in which the local authority managers could import the public service orientation into the providers' domain of the independent section. Thus, these providers were made more aware of their clients' preferences. The concept of establishing a partnership in decision

making between client and purchasers and providers at the level of service delivery was modified in the use made of the data from the focus groups. For this process to move towards increased and sustained user involvement, it is suggested that two further developments are necessary. The first of these, establishing a permanent forum for residents' views to be fed into the purchasing process, was addressed in a subsequent phase of the work. Recommendations were made by residents to establish a permanent city-wide residents' group representing all types of homes for older people in the city (Raynes 1996*b*). Its establishment remains to be achieved. The second development needed is the monitoring of the implementation of new service specifications into which residents had input.

Initiating carer involvement in service purchasing and definition of quality has to start somewhere. There is the hope, not necessarily realizable, that it may develop into an extension of user involvement in decision making or in further empowerment. User involvement is more likely to be successful in exerting influence if it has a reasonable chance of succeeding. In this study it is possible to identify factors which were critical in enabling the views of users to become incorporated into the service specification of the Contract and Purchasing Unit. These are:

- The allocation of a substantial amount of time and energy.
- Attention to detail.
- Some risk taking.
- Sense of humour.
- Food.
- Accessible and pleasant venues.
- Good and reliable transport.
- A phone.
- Ensuring all relevant stakeholders participate in a steering group.
- Continuous communication.
- A focus on outcomes.
- Partnership between equals.

A number of these attributes were also noted by Goss and Miller (1995) as key in moving projects from margin to mainstream. A focus on outcomes and a sense of partnership between equals, time and energy, as well as risk taking, were identified by them as key factors in effecting progress. In the Manchester study, outcomes were clearly the primary focus of the exercise. The process produced the comments made by residents in the review of existing service specifications. The residents and the home owners, as well as the Contracting and Purchasing Unit, were aware of these outcomes, which subsequently became part of the political process.

A sense of partnership existed at a number of levels in this study but at others was clearly not evident. The existence of the steering group with all relevant stakeholders was a key element in the partnership approach. The partnership that emerged in the focus groups between the researchers and the residents reflected mutual respect. Whilst the researchers could facilitate the meetings, only the residents had the knowledge to make the commentary on the City's service specification possible. The expenditure of time and energy by residents, researchers and service officers was needed to get the groups organised, and for the commentary to emerge and be incorporated into the revised contract. Risk taking was involved throughout the project, and by different parties involved in it. The City took a considerable risk in funding the project. The home owners who agreed to participate showed a willingness to take risks by allowing the residents to travel by taxi to venues without them. The facilitators and the residents also took risks. At each meeting no one knew what would happen either en route, during the meetings or after these meetings as residents returned to their homes.

There is no doubt that these elements – focus on outcomes; partnerships between equals; time, energy and risk taking – were crucial to the completion of the project, as was the communication which was involved at all stages and at every level. All participants were kept informed of developments and outcomes. Additionally, in the project, the need to pay attention to detail if progress was to be made, was repeatedly underlined. The planning had to be meticulous, and the need for a phone in dealing with the delays surrounding arrivals and departures, and other surprises which characterised some of the focus groups, should not be underestimated. Several venues were used. Those which are accessible, comfortable and pleasant are hard to find but are essential in the promotion of respect and a sense of equality. Linked to the comfort of the residents is good and reliable transport. This was discovered, like the matters of venues, to be not always available. Residents sometimes arrived at meetings after an unpleasant though thankfully short journey. Cab drivers trained in the use of ramps and licensed on this basis did not use them. Nor did they necessarily strap wheelchairs in so the residents could be secure on their journey. Checking this level of detail and listening to what the focus group members had to say about their journey was important. Equally important was taking action so that different transport providers were used.

The provision of refreshments to create a relaxed atmosphere, one in which sharing amongst equals took place, was important. Refreshments

were made to the individual group members' liking because they were prepared on the premises. Doing business with the focus groups was a pleasure and was designed so to be. A sense of humour was manifested by most members of the focus groups. This did seem to make work and progress easier. Goss and Miller (1995) mentioned this as contributing to what they described as the solid progress they saw in their four local authority case study sites. It did undoubtedly contribute to progress in this project.

Scepticism about service users' involvement in the development of policy standards is prevalent (Goss and Miller 1993). Criticism of their views is inevitable but partnership that enables the voices of service users to be heard and listened to, and then acted upon, can contribute to making the services purchased on their behalf more user than provider centred. That this goal is achieved in practice, requires a follow up research project to ascertain how the care that is provided looks to users. Service users have a direct interest in the quality and sensitivity of the interactions staff have with them. The contribution of users in specifying the quality of the services they receive is a first, if small, step towards improving those services that are purchased for them and which only they experience. Small beginnings are arguably more likely to succeed than grand plans in complex cultures in the new health and social care quasi-market economies. These contain the cultures of both small businesses and the new social services structures. Small changes, which can be cumulative, may be the only way to effect more user involvement. It is the case that the extension of the involvement of older people who use health and social care services in specifying standards, requires changes in processes as well as outcomes. This study described some of the attributes of the processes necessary to involve older people in influencing improvements to existing services. Going beyond that outcome to others such as the generation of new services, the redefinition of what older people's needs are or the establishment of a continuing mechanism to enable older people to exert influence on services purchased on their behalf, needs more work.

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