Moving on from Quality Assurance: Exploring Systems that Measure both Process and Personal Outcomes in Disability Services

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Abstract

Systems that measure service quality in disability organizations commonly review service delivery processes, rather than quality of life outcomes for service users. Disadvantages of measuring processes rather than outcomes are that funders and regulators may fail to identify poor quality support until major crises occur. One solution has been the development of quality systems that combine measuring processes and the personal outcomes of service users, though the efficacy of such systems has not been explored. The aim of this article was to identify quality systems that combine measurement of processes and personal outcomes, and explore the advantages and limitations of these to inform future development of quality assurance systems. The study used an internationally accepted eight domain quality of life framework and a qualitative content analysis to map and evaluate the characteristics of three combined quality systems currently used in the disability sector; the Care Quality Commission framework for community adult social care services, the adult social care outcomes framework and personal outcome measures. The three systems were unbalanced, focusing more on procedure than personal outcomes. None of the systems measured personal outcomes comprehensively against all eight quality of life domains and the rigor applied to such measurement varied markedly. Combined systems have potential to compensate for limitations of systems that measure either processes or outcomes, but could be improved by a greater focus on measuring service user outcomes, including all quality of life domains and use of mixed methods such as interviews and observation of the support people receive.

Keywords: intellectual disabilities, personal outcomes, quality assurance, service design

Background

Quality assurance systems are used in disability services across the world to measure service quality. Originally designed for use in manufacturing and engineering sectors, quality assurance systems primarily focus on measuring the efficiency, reliability, and accuracy of organizational processes (Gardner & Nudler, 1999). Processes are the actions or tasks performed within an organization to achieve a particular result, for example, assessment processes are designed to identify the type of support a person requires and planning processes are designed to help staff map the support to be delivered to a person. Quality assurance systems are used in disability services to review the policies and procedures that describe organizational processes against service standards developed by governments, independent regulators or funding bodies. The primary purpose of these quality assurance systems is to allow these stakeholders to determine which services to endorse or fund, based on their ability to

comply with the standards. Whilst quality assurance systems are cost effective and efficient, they are based on the assumption that organizational policies and procedures reflect staff practices. As a consequence of this assumption, very few quality assurance systems focus on measuring the quality of the supports that people with disabilities receive. Furthermore, few systems measure whether staff complete all the steps necessary to carry out a policy or procedure correctly, or if these are achieving their intended purpose. Research suggests that service policies and procedures do not necessarily represent staff actions, including how support is provided to people with disabilities (Department of Social Services, 2015). For example, services with excellent policies and procedures may provide poor quality support to people with disabilities, and services with poorly written policies and procedures may provide excellent support. The only way for governments, regulators and funders to know if the policies and procedures of service providers reflect their practice, is to measure the quality of the support they provide to people with disabilities. By failing to do so, they may inadvertently be endorsing or funding services where poor practice and abuse occurs. For example, allegations of abuse against staff from several disability services were released in 2016 during a parliamentary inquiry in the state of Victoria, Australia. In some

cases, the abuse had occurred over many years and across multiple service locations (Parliament of Victoria, 2016). At the times when abuses had occurred, it is highly likely that these services and others like them became or continued to be certified as compliant with the Victorian government's quality assurance standards. Further examples include Winterbourne View Hospital in Gloucestershire, England, where people with disabilities were abused at the hands of staff for several years. Despite this abuse, Winterbourne View continued to pass quality inspections that were conducted by England's national quality regulator, the Care Quality Commission (CQC). Following the uncovering of the abuse, whistle-blowers from Winterbourne View reported that CQC inspectors had been more interested in the services' I.T and administration systems than staff practices (Daily Mail, 2011).

It remains to be seen if the abuse and neglect that has occurred in disability services will instigate real and lasting change in the way that governments, regulators and funders understand and measure service quality. However, it is clear that in order to better identify poor quality support and abuse where it exists, more attention needs to be paid to measuring the quality of the support that people with disabilities receive (McEwen, Bigby, & Douglas, 2014). Specifically, systems are needed which review the way that staff interact with the people they support, including whether they enact appropriate values, attitudes and beliefs, such as respect and empathy toward people with disabilities. Research suggests a link between staff who hold negative values, beliefs and attitudes toward people with disabilities and their likelihood of committing acts of abuse, neglect and exploitation (Marsland, Oakes, & White, 2007). In particular, staff who believe that people with disabilities are "not like them" are likely to deliver poor quality support (Bigby, Knox, Beadle Brown, Clement, & Mansell, 2012). Observing staff practice and actively collecting feedback from people with disabilities about the way staff support them, could help services to identify undesirable staff behaviors and attitudes that lead to poor support, abuse or neglect.

A variety of systems aim to measure the quality of the support provided to people with disabilities. Some are referred to as "personal outcome measures," with the primary aim of measuring the "outcomes" of the support that individuals receive. Personal outcome measures are an increasingly popular way of evaluating the effectiveness of services and interventions in the fields of education, health, and social care (Gómez, Verdugo, Arias, Navas, & Schalock, 2013). They have also proven to be useful in providing services with knowledge that can be used to enhance service users' quality of life (Claes, Van Hove, Vandevelde, Van Loon, & Schalock, 2012). Typically, personal outcomes are referenced to eight core quality of life domains, which reflect people's self-determination, emotional well-being, interpersonal relationships, material well-being, personal development, physical well-being, social inclusion and rights (Verdugo, Navas, Gomez, & Schalock, 2012). Personal outcomes can improve or deteriorate on each of the eight domains and when summed together give an overall indication of an individual's quality of life (Schalock, 2001).

However, there is still a place for process orientated quality assurance systems within disability services, which allow approaches to service delivery to be tracked in a systematic way to support the replication of positive outcomes, or instigate the improvement of poor outcomes (Dykstra, 1995). Consequently, combined quality systems that measure both process and personal outcomes have been designed to provide a more adequate understanding about service quality within disability services, by measuring both the quality of the support provided to people with disabilities and the processes that underpin it (Dykstra, 1995).

With these issues in mind, relevant questions for disability services, governments, regulators and funders include; what systems exist that measure both process and personal outcomes; how do they work and what are the potential advantages and limitations associated with their use?

Specific Aims

The aim of this article is to identify quality systems that measure both processes and personal outcomes in disability services, and explore their content to determine any possible advantages and limitations that may be associated with using them.

Method

A review of the academic and publicly available literature written in English in the last 5 years was undertaken, with the aim of identifying quality systems currently being used to measure both process and personal outcomes in disability services. Initially, keyword searches were used to identify relevant literature, including "quality systems used in disability services" and "measuring quality in disability organisations." Literature identified was reviewed against the previously mentioned inclusion criteria and where it was not met, it was excluded. The remaining literature was further scrutinized, and decisions were made about which systems should be included in this study based on the degree to which they met the inclusion criteria and purported measuring both process and personal outcomes.

Three contemporary systems were identified: the Care Quality Commissions (CQC's) current regulatory framework for community adult social care services, the adult social care outcomes framework (ASCOF) (Department of Health, 2017), which is used by councils across England to measure and compare service outcomes; and personal outcome measures (POMS), a tool developed in the U.S. by the Council on Quality and Leadership (CQL, 2017) to help services measure personal and service related outcomes.

The characteristics of these three systems were identified and are summarized in Table 1. System characteristics were then compared and contrasted to identify differences or similarities between them.

System indicators were compared against the eight internationally accepted quality of life domains and their corresponding exemplary indicators set out in Table 2, to understand the types of personal outcomes they measure and to what extent they do so. Indicators for each system were coded and similar codes were categorized according to which quality of life domain they most closely aligned with. Decisions about alignment were guided by the exemplary indicators developed by Verdugo et al. (2012), which detail the sorts of issues and practices one might expect to be measured under each domain.

TABLE 1
Overview of quality systems

System	Care quality commission (CQC) regulatory framework for community adult social care services	Adult social care outcomes framework (ASCOF)	Personal outcome measures (POMS)
Purpose	To ensure that health and social care services in England provide safe, effective, high-quality and compassionate services. The CQC regulatory framework is the primary mechanism used to regulate all health and social care organizations within the UK (Care Quality Commission, CQL, 2017).	ASCOF aims to help local governments in England to improve the quality of care and support they provide. (Department of Health, 2017, p. 6).	To measure whether planned supports are achieving desired results or outcomes for service users. (CQL, 2017).
Domains & Indicators	Service quality is measured against the following five domains: Safe: People are protected from abuse and avoidable harm. (CQC, 2015, p. 6). Effective: People's care, treatment and support achieves good outcomes, promotes a good quality of life and is evidence-based where possible. (CQC, 2015, p. 13). Caring: Staff involve and treat people with compassion, kindness, dignity and respect. (CQC, 2015, p. 18). Responsive: Services are organized so that they meet people's needs. (CQC, 2015, p. 22). Well led: Leadership, management and governance of the organization assures the delivery of high-quality person-centered care, supports learning and innovation, and promotes an open and fair culture. (CQC, 2015, p. 26). Decisions about service quality are guided by prompts listed within each domain (called Kloe's or "Key Lines of Enquiry"). For example, the following prompt is listed in the domain "Effective": "People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence" (CQC, 2015, pp. 3–4).	Service quality is measured against the following four domains: Domain One: Enhancing quality of life for people with care and support needs Domain Two: Delaying and reducing the need for care and support Domain Three: Ensuring that people have a positive experience of care and support. Domain four: Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm. (Department of Health, 2017, p. 73). Decisions about service quality are made against indicators that describe the best possible outcomes services can achieve operationally, for service users and their carers. For example, the following indicator can be found within domain three, "Carers feel that they are respected as equal partners throughout the care process". (Department of Health, 2017, p. 73).	Outcomes are measured against the following five domains: My Human Security My Community My relationships My choices My goals (CQL, 2017, p. 9). Indicators that describe the best possible outcomes that could be achieved for service users can be found within each domain. Indicators guide decision-making about the presence of outcomes. The following indicators can be found within the domain "My human security": • People are safe • People are free from abuse and neglect • People have the best possible health • People experience continuity and security • People exercise rights • People are treated fairly • People are respected (CQL, 2017, p. 14) Positive personal outcomes and good service quality are believed to be intrinsically linked.

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TABLE 1
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System	Care quality commission (CQC) regulatory framework for community adult social care services	Adult social care outcomes framework (ASCOF)	Personal outcome measures (POMS)
Evidence	Self-assessments completed by services prior to inspections against CQC domains. Potential sources of evidence that may be used by inspectors when making decisions about service quality against each domain include: • Records such as incident reports, complaints, staff hand over logs, support plans and risk assessments. • Documents such as policies and procedures. • Feedback obtained from staff and service users during inspections. • Comments and feedback the CQC have received since the last inspection from people who use services, their relatives and carers and members of the public. These may be from phone calls, letters and emails or through the "share your experience" page on the CQC website. • Comments and feedback from stakeholders involved in the care of service users, such as commissioners of services, local authority teams and health professionals. • Observations of staff and service user interactions. (CQC, 2015, pp. 6–30).	Data provided by council's with adult social services related to service provision including the proportion of people using social care who receive self-directed support and those receiving direct payments. Demographic data provided by council's, service users and carers including: "the proportion of adults in contact with secondary mental health services in paid employment, the proportion of adults with learning disabilities in paid employment and the proportion of adults with learning disabilities who live in their own home or with family" (Department of Health, 2017, p. 73). Survey feedback from carers who were assessed or reviewed by their council. Annual survey feedback from service users related to their perceived quality of life, before and after receiving support from their council.	• Interview feedback from service users/proxies • observations of the way staff interact with service users • Documentation such as policies and procedures related to service provision

(Continues)

TABLE 1
Continued

System	Care quality commission (CQC) regulatory framework for community adult social care services	Adult social care outcomes framework (ASCOF)	Personal outcome measures (POMS)
Methods	Inspectors choose the methods they used to gather and analyze evidence at each inspection. However, Key lines of enquiry (or KLOE's) and potential sources of evidence listed in the CQC handbook's aim to guide inspectors' decision-making about the methods they use to measure service quality within each domain. Methods include: • Reviewing the content of records and documents. • Undertaking interviews with service users, staff and other relevant stakeholders (e.g., local authority teams and health professionals) to gather information about the way that support is both experienced and delivered. For example, under the domain "effective," inspectors are encouraged to "ask people and/or their relatives about their experiences and views on whether staff are sufficiently skilled and experienced to care and support them to have a good quality of life." The "effective" domain also encourages inspectors to "discuss with staff their induction, support and training and whether they feel this enabled them to care and support people effectively when they started work and on an ongoing basis" (CQC, 2015, p. 13) • Observing interactions between staff and service users. For example, under the domain "caring," inspectors are encouraged to observe "how staff and people interact with each other, and listen to the decision-making process to see if people are actively involved and given choice and independence" (CQC, 2015, p. 19).	Data related to service provision is entered into online statutory reporting systems at regular intervals (e.g., monthly, annually) by council's with adult social services. Once a year, council's select a proportion of service users and their carers using random stratified sampling methods. Selected service users and carers are issued surveys aimed at collecting information about the quality of the support they receive. All data from statutory reporting systems and surveys is extracted and analyzed by an independent organization (The Health and Social Care Information Centre) on an annual basis. Findings are used to create an overall ASCOF score for each council with adult social services, which is believed to reflect the overall quality of the services they provide. ASCOF scores for each council are reviewed against previous years scores at a local and national level.	Service users are asked a series of questions, related to each of the POMS indicators. For example, under the domain "My human security," questions for the indicator "People are safe" include "What kinds of safety risks are you concerned about In your home? In your community?" "Do you feel safe at home? At work?" CQL, 2017, p. 16 Participant responses guide decision-making about the presence of outcomes. Where participant responses indicate that they are experiencing negative outcomes related to particular indicators, goals are set to improve them. Where participants are unable to express their views easily, proxies are encouraged (McCormack & Farrell, 2009). POMS operational procedures suggest that facilitators observe practice where more information about participant outcomes is required. Facilitators are also encouraged to review the content of records pertaining to the support participants have received, as an additional source of information upon which decisions about outcomes can be made. (CQL, 2017, p. 89).

The proportion of indicators within each category were calculated against the total number of indicators within each system and set out in Table 4. The first author refined the categories in discussion with the second and third authors, until consensus was reached via agreement. Findings were reviewed against relevant peer reviewed literature to identify each system's possible advantages and limitations, including how adequately constructs were measured by examining the validity of the methods and evidence they prescribe.

Findings

System Characteristics

Purpose. All three systems share a common purpose, to identify the outcomes of service provision and the effectiveness of the processes that underpin it. However, ASCOF has an additional purpose, which is to compare service outcomes between councils in order to drive continuous improvement both locally and nationally. ASCOF's national focus on continuous improvement is intended to support changes in practice and social policy.

Domains and indicators. All the three systems consist of domains (dimensions that make up personal well-being) and indicators (perceptions, behaviors and conditions that give an indication of a person's well-being) (Schalock, Bonham, & Verdugo, 2008). The CQC's domains and indicators measure outcomes from an organizational perspective, describing the actions that staff should take to facilitate "good" outcomes for the people they support. For example, "services are organised so that they meet people's needs" (CQC, 2015, p. 22) and "how are people's medicines managed so that they receive them safely?" (CQC, 2015, p. 10).

ASCOF's domains and indicators have a greater focus on the perspectives of service users and their carers than the CQC framework. However, a small proportion of the ASCOF indicators measure service quality from an organizational perspective, for example, "people are protected as far as possible from avoidable harm, disease and injuries" and "earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive service" (Department of Health, 2017). In contrast to the CQC framework and ASCOF, the POMS domains and indicators focus entirely on the perspective of service users, and reflect the principles of self-determination. For example, "people perform different social roles, people choose services and people choose personal goals" (CQL, 2017).

Closer analysis of each system's indicators revealed that many of them relate to Schalock's eight quality of life domains (Schalock, 2001). System indicators and the quality of life domains they relate to are summarized in Tables 2 and 3.

The CQC's indicators measure issues pertaining to service users' interpersonal relations (30%), rights (30%), physical well-being (25%), self-determination (10%) and social inclusion (5%). However, it fails to measure issues pertaining to service user's personal development, material and emotional well-being. Furthermore, indicators measuring interpersonal relationships focus on the interactions between staff and service users, but do not appear to specify how positive interactions present characteristically. For example, an indicator under the CQC domain

TABLE 2

Quality of life domains and exemplary indicators

Quality of Life Domains	Exemplary Indicators
Personal development	Activities of daily living
Self-development	Choices, decisions, personal goals
Interpersonal relations	Social networks, friendships
Participation	Social inclusion/community involvement
Rights	Human and legal
Emotional well-being	Safety and security
Physical well-being	Health and nutrition status
Material well-being	Financial status, employment

Verdugo et al. (2012).

"be caring" includes; "are people treated with kindness and compassion in their day-to-day care?" (CQC, 2015, p. 18). No further information is provided by the CQC about how "kind" or "compassionate" interactions might present.

Analysis of the ASCOF indicators against the eight quality of life domains revealed some similarities to the CQC framework. ASCOF's indicators measure issues pertaining to service user's self-determination (31%), rights (31%), physical well-being (23%) emotional well-being (7.5%) and interpersonal relations (7.5%). As with the CQC framework, ASCOF indicators do not measure issues pertaining to the material well-being and personal development of service users. However, unlike the CQC framework, ASCOF does measure the emotional well-being of service users, but only to a small degree (7.5%). ASCOF does not measure the social inclusion of service users, which the CQC framework does, although social inclusion makes up a very small proportion of the CQC's indicators (5%).

Analysis of the POMS indicators against the eight quality of life domains revealed similar findings to the CQC and ASCOF frameworks. The POMS indicators measure service user's self-determination (33%), rights (28.5%), social inclusion (24%) interpersonal relations (9.5%) and physical well-being (5%). POMS indicators do not measure issues pertaining to service user's emotional well-being, material well-being, and personal development.

Evidence. The types of evidence required by each system to demonstrate conformity with its indicators differs substantially. For example, in some systems some indicators are very prescriptive about the evidence that must be used to measure service quality, while others allow for more flexibility. The CQC framework is by far the more flexible of the three systems, allowing inspectors to choose from a variety of evidence including data collected from interviews, observations and document review processes. Inspectors are expected to use their professional judgment to determine the type of evidence that constitutes conformity with system indicators. However, they are encouraged to consider using the "potential sources of evidence" listed in CQC handbooks, when making determinations about service quality (CQC, 2015). For example, under the domain "safe," the following "potential source of evidence" is listed for consideration, "review the details of statutory notifications for safeguarding, incidents and concerns/complaints" (CQC, 2015, p. 6). However,

TABLE 3
Quality system indicators categorized according to the quality of life domains they relate to

Quality of life domains	Emotional well-being	Interpersonal relations	Material well-being	Personal development	Physical well-being	Self-determination	Social inclusion	Rights
CQC indicators (CQC, 2015, p. 6-30).		How do people receive effective care, which is based on best practice, from staff who have the knowledge and skills they need to carry out their roles and responsibilities?			How does the service make sure that there are sufficient numbers of suitable staff to keep people safe and meet their needs?	How does the service support people to express their views and be actively involved in making decisions about their care, treatment and support?	How does the service promote a positive culture that is person-centered, open, inclusive and empowering?	How are people protected from bullying, harassment, avoidable harm and abuse that may breach their human rights?
		How are positive caring relationships developed with people using the service?			How are people's medicines managed so that they receive them safely?	How do people receive personalized care that is responsive to their needs?		How are risks to individuals and the service managed so that people are protected and their freedom is supported and respected?
		How does the service routinely listen and learn from people's experiences, concerns and complaints?			How well are people protected by the prevention and control of infection?			Is consent to care and treatment always sought in line with legislation and guidance?
					How are people supported to eat and drink enough and maintain a balanced diet?			How is people's privacy and dignity respected and promoted?
		How does the service demonstrate good management and leadership?			How are people supported to maintain good health, have access to healthcare services and receive ongoing healthcare support?			How people are supported at the end of their life to have a comfortable, dignified and pain free death?
		How does the service deliver high quality care?						How are people assured they will receive consistent coordinated, person-centered care when they use, or move between, different services?
		How does the service work in partnership with other agencies?						

(Continues)

TABLE 3
Continued

Quality of life domains	Emotional well-being	Interpersonal relations	Material well-being	Personal development	Physical well-being	Self-determination	Social inclusion	Rights
ASCOF indicators (Department of Health, 2017, p. 73).	Carers feel that they are respected as equal partners throughout the care process.	Carers can balance their caring roles and maintain their desired quality of life.			Everybody has the opportunity to have the best health and well-being throughout their life, and can access support and information to help them manage their care needs.	People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to match their needs.		People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.
					Earlier diagnosis, intervention and reablement mean that people and their carers are less dependent on intensive services.	People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.		People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.
					Everyone enjoys physical activity and feels secure.	When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence.		People are free from physical and emotional abuse, harassment, neglect, and self-harm.
						People are supported to plan ahead and have the freedom to manage risks the way that they wish.		People are protected as far as possible from avoidable harm, disease and injuries.

POMS indicators (CQL, 2017).

- People exercise rights.
- People are treated fairly.
- People are free from abuse and neglect.
- People experience continuity and security.
- People are safe.
- People are respected.
- People decide when to share personal information.
- People are connected to natural support networks.
- People choose where and with whom they live.
- People use their environments.
- People choose where they work.
- People live in integrated environments.
- People perform different social roles.
- People interact with other members of the community.
- People choose services.
- People participate in the life of the community.
- People choose personal goals.
- People realize personal goals.
- People have the best possible health.
- People have intimate relationships.
- People have friends.

TABLE 4

System indicators proportioned according to the quality of life domains they relate to

	CQC Indicators (%)	ASCOF indicators (%)	POMS indicators (%)
Emotional well-being	0	7.5	0
Interpersonal relationships	30	7.5	9.5
Material well-being	0	0	0
Personal development	0	0	0
Physical well-being	25	23	5
Self-determination	10	31	33
Social inclusion	5	0	24
Rights	30	31	28.5
Total	100	100	100

CQC inspection reports are more likely to contain information about the conclusions drawn by inspectors, than the evidence they used to make determinations about service quality. For example, "Staff worked in innovative and creative ways to provide people, their families and carers with support, care and treatment that made a positive difference to people's lives" (CQC, 2016). Furthermore, inspection reports lack important details about how and from whom or what evidence was collected.

In contrast to the CQC framework, ASCOF, and POMS require specific evidence to be collected and analyzed. ASCOF primarily requires the collection of data by councils throughout England. Data usually relates to the processes that underpin support including the "proportion of people using social care who receive self-directed support and direct payments," and the "proportion of adults in contact with secondary mental health services who are living independently" (Department of Health, 2017, p. 13). Personal outcome data is collected using the adult social care survey, which is sent to service users and carers who use council services, and provides an average score of the quality of life they experience in relation to the support they receive (Rand & Malley, 2017a). Survey questions include, "thinking about the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole?" and "Do care and support services help you in having control over your daily life?" (NHS Digital, 2017, p. 54). Questions allow participants to choose from a variety of scaled responses such as "so good it could not be better," "very good," "good," "alright," "bad," "very bad" and "so bad it could not be worse" (NHS Digital, 2017). Little scope exists for participants to provide further comments within the surveys about their quality of life or the support they receive. Furthermore, there appears to be no mechanism for verifying the accuracy of the feedback obtained from the adult social care survey, or the statistical data provided by councils. There is also no way of knowing whether surveys have been completed by service users or proxies (e.g., support staff or family members), or the extent to which others may have influenced participant responses.

Data obtained from semi-structured interviews are the primary source of evidence used to measure service quality under

POMS. Service users and the "those who know them best" are asked a series of questions related to the support they receive and how it has impacted their quality of life (CQL, 2017, p. 10). Responses provided determine the existence of personal outcomes, which may have improved, maintained or had a negative impact on participant's quality of life. The POMS operational literature also suggests that "if needed," services use other methods to verify the existence of outcomes such as document review processes and observation. However, it is not mandatory for POMS facilitators to perform document review processes and observations, and no methods for doing so are prescribed within the frameworks operational literature.

Data collection methods. The CQC framework is the only system of the three that requires evidence be collected and analyzed by people independent of the services under review. In contrast to the CQC framework, ASCOF evidence (or data) is predominantly supplied by councils for the purpose of reviewing the supports they provide. ASCOF data is then analyzed by staff within an independent nondepartmental body, the Health and Social Care Information Centre (HSCIC), who are ultimately responsible for determining each council's level of service quality. Unlike the CQC framework and ASCOF, POMS data can be both collected and analyzed by staff within services under review.

The CQC does not specify the knowledge inspectors must possess in relation to the methods they use, making it difficult to gauge how reliably they are applied. However, CQC inspectors must have experience with the services they inspect. Some inspectors who have professional experience are referred to as "specialist inspectors." For example, pediatricians, midwives and surgeons (Behan, Beebee, & Dodds, 2016, p. 147). Others have experience as service users, and are referred to as "experts by experience" (Behan et al., 2016, p. 148). ASCOF does not appear to require that council staff possess any particular skills or knowledge in relation to the data collection tasks they perform. However, staff within the HSCIC (who analyze the data provided by council staff and service users) appear to be highly skilled. POMS facilitators must be familiar with its processes and the domains and indicators around which interview questions are framed, however, it is not common for staff within disability services to possess knowledge about facilitating semi structured interviews. Consequently, it is likely that many staff facilitating POMS within services may be doing so based solely on the knowledge they have acquired through operational documentation supplied by the Council on Quality and Leadership or short training courses.

Discussion

The findings highlight the advantages and limitations of using combined systems to measure service quality in the disability sector. They stem from the analysis of three combined systems currently used within England (ASCOF and the CQC framework), and across the U.S., Ireland, Australia and New Zealand (POMS), but are not necessarily bound by geography as these systems are likely to be applicable to disability services in western countries.

The overall key finding from this study is that there may be significant limitations in the combined quality systems that are currently being used in the disability sector to measure service quality. One of these limitations is that there appears to be too greater a focus on procedural aspects of service quality, and not enough on service users, making it impossible to know if organizational processes are leading to positive personal outcomes for people or not (Dykstra, 1995). The CQC framework is a good example of a system that places too much emphasis on procedure, as its indicators predominantly focus on the processes staff should enact to achieve desired outcomes. For example, "how does the service make sure that there are sufficient numbers of suitable staff to keep people safe and meet their needs" (CQC, 2015, p. 9) and "how are risks to individuals and the service managed so that people are protected and their freedom is supported and respected" (CQC, 2015, p. 7). CQC indicators are not framed around service user's experience of support, but around the way services plan, enact and manage it.

There are also limiting aspects associated with the methods that are used to collect evidence of service quality under combined quality systems, which affect the reliability and accuracy of results. For example, ASCOF's adult social care survey offers participants little scope to provide further information that does not fit within the confines of survey response options and the reliability of feedback received from people with intellectual disabilities via survey may be questionable, as it does not allow participants to verify their understanding of the topics covered and ensure a considered response. ASCOF also has some limitations related to impartiality, as councils provide most of the data used to review the quality of the services they provide. However, unlikely, there is a risk that information received from councils could be inaccurate or exaggerated in order to produce more favorable outcomes.

Limitations related to the skills and knowledge of the people who collect and analyze evidence of service quality was also present in the systems analyzed. For example, staff facilitating POMS within services may interpret data obtained from the people they usually support inaccurately, by making assumptions about what service users may be "trying" to say, or by taking their feedback on "face value." Furthermore, when staff interpret information from service users during interview processes and do not use other methods to verify its accuracy, it is likely that inaccurate outcomes may be recorded given the high proportion of acquiescence experienced by people with disabilities (Williams, 2011). For example, when using a system that primarily uses feedback from service users to make determinations about personal outcomes such as POMS, one must consider the ability of service users to understand and respond to questions about their experiences of support reliably (Rand & Malley, 2017b).

Limitations were identified across all three systems related to the way in which personal outcomes are measured. For example, personal outcomes were measured against only some of the eight quality of life domains, and the rigor of measurement varied markedly, with the proportion of evidence required to demonstrate compliance against some domains far exceeding others. Consequently, all systems failed to adequately measure the impact of service provision on individuals quality of life (e.g., if it improved, maintained it or declined in some way), and therefore are likely to miss valuable information about the quality of the support they receive. For example, none of the indicators within the CQC framework could be aligned with the personal development

quality of life domain. This may suggest that boredom and frustration experienced by service users could be undetected, and that staff may be failing to engage with service users in ways that allow them to pursue their interests and goals. Research conducted by Bigby, Knox, Beadle Brown, and Bould (2014) revealed that high levels of boredom are experienced by service users in residential group homes where staff fail to actively support them to pursue their interests and desired activities.

ASCOF domains and indicators fail to measure personal outcomes against interpersonal relations, social inclusion, material well-being, and physical well-being quality of life domains. Research shows that social isolation and a lack of basic resources like housing, clothing and food can have a dramatic effect on the quality of life a person experiences (Chartered Institute of Environmental Health, 2017). Furthermore, a person's physical well-being can influence outcomes related to other quality of life domains such as their emotional well-being. For example, if a person is unwell or physically injured for a long time and they are unable to interact socially with others or practice self-determination, they may begin to feel socially isolated and decline emotionally. If the individuals emotional state is measured in isolation (rather than in conjunction with their physical health), the connection between their emotional and physical state may not be drawn. Consequently, measuring a quality of life domain in isolation may instigate a trajectory of inquiry that is misleading and inaccurate (Schalock, 2001).

Analysis of POMS domains and indicators revealed a failure to measure outcomes against the emotional well-being, material well-being and personal development quality of life domains. The lack of measures against material well-being and personal development domains suggests that service user's dissatisfaction with available resources (furnishings, clothing, and entertainment) and boredom and frustration could be undetected. Furthermore, by not exploring people's emotional well-being using semi structured interview processes, services may assume that people are happy with the support they receive, when they may not be. For example, it is often assumed that if an individual is exercising choice, that they are happy. However, the choices offered to that person may be limited and may not reflect their individual preferences.

Despite their limitations, the systems analyzed in this article do suggest positive changes in the way that quality is both understood and measured in the disability sector. They demonstrate a move beyond simple quality assurance measures, to new ways of understanding service quality that attempt to consider the way that individuals experience support. However, they also highlight the need for a system that measures processes and personal outcomes more adequately. In order to create such a system, the impact of support on service users quality of life must be measured across all the eight quality of life domains, using a variety of methods such as interviews and observation of the support people receive (Schalock, 2001). Consideration could also be given to measuring personal outcomes against the quality of life domain "rights" using indicators derived from the human rights listed in the UN Convention on the Rights of Persons with Disabilities, in order to better identify poor support, neglect or abuse where it exists. Furthermore, staff practices need to be reviewed using observation methods and findings aligned with the processes they used to achieve outcomes for

service users. In doing so, positive outcomes could be replicated and poor outcomes improved through targeted quality enhancement strategies (Dykstra, 1995). Such a system has the potential to provide authentic information about the quality of the support that people with disabilities receive, while helping services understand the link between the quality of their processes and the outcomes they achieve for the individuals they serve. For example, personal outcome data resulting from the processes staff enact, may help them understand how the individuals they serve experience and perceive the support they receive (Robinson & Chenoweth, 2011). It is possible that this understanding could positively influence the quality of the support that staff provide, as they become increasingly aware of how their actions contribute to personal outcomes. Furthermore, managers in services could use data generated by combined systems to make decisions about employee and organizational performance, as they use it to draw a link between how effectively processes are enacted by staff, and the types of outcomes that have been achieved for service users. This information has the potential to highlight issues related to staff competence which have been identified as a critical aspect of organizational culture, that can either protect against or promote abuse (White, Holland, Marsland, & Oakes, 2003). Consequently, the adoption of such systems could prove immensely positive for people with disabilities who are far more vulnerable to abuse and neglect than the "average citizen."

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