STUDY ON

Service Provider's **Implementation of Quality Approaches**

EASPD

European Association of Service providers for Persons with Disabilities

List of contents

Acknowledgements 5

Executive summary 6

Aims, objectives and design 8

Landscape analysis 9

Methods 10

Findings 11

- What approaches and methodologies are disability service providers currently using to measure service quality? 11
- Type of services in which the approaches or methods were used 11
- The legal status of the approaches/methods identified 11
- Frequency of evaluation and links to day-to-day practice 12
- What elements of quality are monitored? 12
- Quality monitoring and quality improvement 14
- Consistency with UN CRPD 14
- Conclusions 14

Proposed framework for quality measurement and improvement 16

Consultation on proposed framework for quality measurement and improvement 18

Introduction 18

Methods 18

Findings 18

Methods of collecting quality data 24

Conclusion 25

Overall summary, conclusions, and recommendations 26

Findings 27

Conclusions and recommendations 28

List of references 34

Annexes 35

Annex 1: Summary of Approaches and methods used to monitor quality 35

Annex 2: Areas of quality 40

Annex 3: Consistency of the approaches and methodologies used be providers with the UN CRPD 42

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Executive summary

In March 2021, the European Commission adopted the European Strategy for the Rights of Persons with Disabilities 2021-2030. The new strategy comprises ambitious actions and flagship initiatives underlining the importance of people with disabilities having a good quality of life and being able to live independently on an equal basis with others. Among these initiatives, the Strategy set out the intention to develop a European Framework for Social Services of Excellence for Persons with Disabilities by 2024. The aim of this study was to provide an overview of how service providers are monitoring and ensuring quality in their day-to-day operations and to identify the most useful and valid approaches to measure quality.

What approaches were service providing organisations using to monitor quality?

- Two main overarching approaches to quality monitoring were identified: Internal Audit or Quality Assurance (QA) and External Evaluation and Validation. In many organisations consulted both were used.
- Methods used, often in combination, included surveys and interviews, self-assessment/evaluation, visits to services by senior managers, auditors and/or external evaluators.
- The most common approach used in all countries was self-evaluation against a set of agreed standards conducted by services managers, sometimes involving staff teams and people who received services.
- In general quality monitoring and review was not part of day-to-day practice but was conducted on an annual basis. However, in some countries (e.g., Ireland and the UK) managers were required to visit and check at least compliance with standards on a monthly basis.
- Outcomes such as the quality of life of people supported were rarely assessed other than in terms of health, safety, complaints and satisfaction with services.
- In general, the approaches and methodologies used by service providers had limitations in their usefulness for a detailed monitoring of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD)[1] , often focusing only on certain human rights such as freedom from harm.
- Overall, the attention of monitoring and service improvement was related to ensuring that services were not "bad" rather than on what is going well or how "good" services are.
- Responses to issues of quality or lack of compliance was usually in the form of an action plan to rectify those issues. Rarely was good practice and positive outcomes formally recognised.

What approaches and methods were viewed by providers and stakeholders as useful and feasible going forward.

- Using a Quality-of-Life Framework (QoL) to review outcomes using any method (e.g., as part of daily recording, surveys, or observations) was seen as useful and a potentially reliable measure of outcomes and quality. However, feasibility was rated lower due to the apparent complexity and a general lack of awareness of the QoL.
- Indicators and methods that involved observations in practice, in particular structured observations, were seen as less feasible, although recognised as useful.
- Qualitative methods of collecting information were preferred although surveys were acknowledged as easier to use to collect the views and experiences of people supported, families and staff.
- Reviewing individual person-centred, or individuals plans and reviewing staff training and the support they receive were rated as very useful and feasible.
- To use daily recording as a source of data on quality, the focus of these and the way used to record information need to be changed so that individuals supported are involved and recording does not take time away from direct support.
- Structures such as team meetings, supervision and person-centred planning meetings were seen

1 United Nations Convention on the Rights of Persons with Disabilities, December 13, 2006, https://www.ohchr.org/en/hrbodies/crpd/pages/conventionrightspersonswithdisabilities.aspx

as useful venues to review and focus on quality improvement, although were hard to organise in some settings.

- Senior manager interest in evaluation and presence in services was noted as important to ensuring quality; visits by senior managers and/or a quality assurance team to observe practice were rated as less useful and less feasible.
- Internal audit processes were noted as needing to be properly resourced and part of the organisational culture.
- External evaluation was seen as useful, especially if it involved Experts by Experience. However, these were not without challenges and attention needs to be paid to ensuring that quality is not reduced to simple "ticking forms".

Conclusions and recommendations

- The approach to monitoring quality should be a multi-element and a multi-methods approach to ensure that the experience and views of people supported are captured and a holistic view of service quality is obtained.
- Everyday practices and processes such as daily recording, team meetings, supervision and manager visits can be streamlined with audit processes. This allows services to gather data and review service quality on an ongoing basis and encourages continual improvement.
- The focus of any quality monitoring approach should be primarily on Quality-of-Life outcomes at both service provider and quality inspectorate levels. This will need to be supported and incentivised by the European Commission but would allow elucidation of how well the UN CRPD[2] is being implemented.
- Observations are recommended for a valid picture of service quality. This requires managers to be present in services and is particularly important when those receiving services are not able to respond to surveys or interviews.
- Quality monitoring should also include the availability and quality of staff training, supervision, and support.
- Time and structures for reflection and quality improvement are essential. Any information gathered must be reviewed and used to improve services.

[2] United Nations Convention on the Rights of Persons with Disabilities

Aims, objectives and design

The overarching objective of the study is to provide an overview of how service providers are implementing quality approaches in their day-to-day operations and to identifying the most useful and valid approaches that services providers are using to measure quality.

Specific objectives of the study:

1. Identify the most useful and valid approaches that services providers are using to measure quality.
2. Explore similarities and differences between approaches used within common and different European welfare regimes.
3. Identify challenges and opportunities that these approaches bring in the improvement of services within common and different European welfare regimes.
4. Explore the feasibility and sustainability of these approaches, as well as their scalability in different contexts.

The study has been undertaken through four phases leading to the production of this report:

Phase 1.
Landscape analysis – identifying approaches to quality monitoring used by service providers.

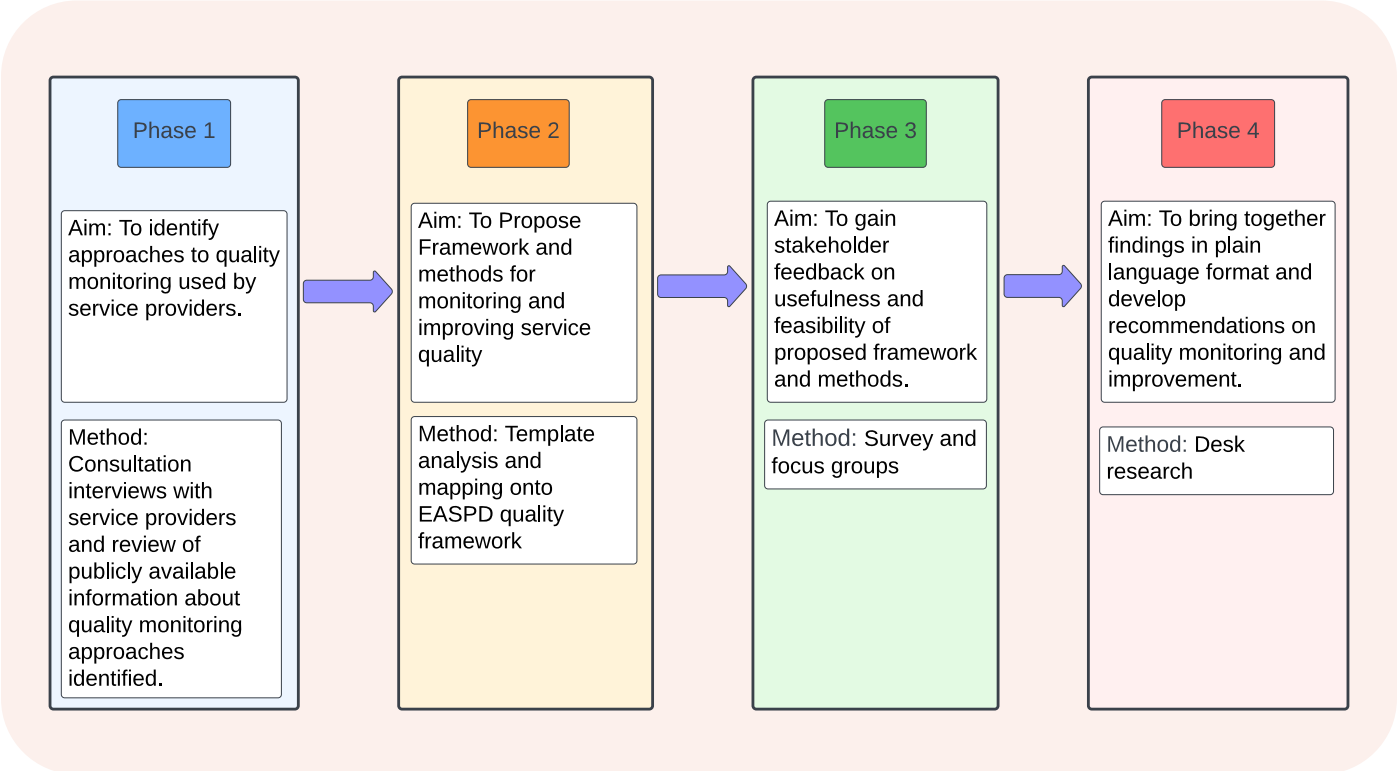
Phase 2:
Development of proposed framework for quality measurement and improvement quality.

Phase 3:
Consultation with stakeholders on proposed framework.

Phase 4:
Analysis, recommendations, and report writing.

The phases are summarised in Figure 1 below.

Figure 1: Summary of methods and phases



Landscape analysis

As identified in previous work (e.g., Šiška and Beadle-Brown, 2021)[3], different EU member states have different approaches to how they define and measure the quality of disability support services. In law and policy, quality is often formulated broadly with reference to human rights. At the same time, in many countries, there are quality assurance systems in place with relatively detailed descriptions of what is important to measure, how quality can be measured and who should be involved. In other cases, the precise meaning of quality is open to interpretation by service providers with some level of choice in determining the approach to be used for quality assessment. Šiška and Beadle-Brown (2021) identified a range of innovative frameworks for conceptualising and/or measuring service quality from desk research and consultation with local experts in a range of countries. However, there is very little documentation about the approaches and measures used by disability service providers, either as part of day-to-day practice or as part of organisational auditing.

The aim of this phase was to find out directly from a range of different service providers, in different countries, how they conceptualised and monitored the quality of their services and how quality monitoring was linked to quality improvement.

3 Šiška, J., Beadle-Brown, J. (2021) *Innovative Frameworks for measuring the Quality of services for Persons with Disabilities*. (n.d.). EASPD. https://www.easpd.eu/publications-detail/report-on-innovative-frameworks-for-measuring-the-quality-of-services-for-persons-with-disabilities/

Methods

The landscape analyses focused on the identification of quality assurance approaches used by service providers in 5 European regions in different countries and in different social service systems. Subject experts in the countries identified via interviews with representatives of services providers a range of different approaches being used by service providers to monitor quality. The interviews with representatives of service providers were focused on topics including: In which types of services is the approach or method used, Is the approach/method mandated or voluntary? How is quality defined (explicitly or implicitly) in this approach or method? If the focus includes outcomes of people receiving services, what outcomes are monitored? Whose perspectives of quality are gathered as part of quality monitoring? What methods are used to gather information on quality? Are people with disabilities involved in the process of monitoring quality in any way? Is the approach embedded in the day-to-day operation of services? How does the approach contribute to quality improvement? In addition, the approaches or methods were systematically analysed with aim to understand their consistency with the UN CRPD.

A template (in a form of Word document and as an on-line survey) was prepared to gather responses to the questions for each framework/method. Almost all templates were completed by an online or phone interview with one or more representatives from an organisation. In some cases, the interviews were supplemented by online research (e.g., organisation's website) or analysing provided documents.

Table 1 illustrates the regions and respective countries for the 25 templates completed. It was not possible to obtain completed templates for France and Portugal despite numerous attempts.

Table 1: European regions and countries

Geographical area	Country	Number of templates completed (n)
North-western Europe	Ireland, the UK, Scotland	6
Central and south-eastern European	Czech Republic and Romania	6
Nordic	Norway and Finland	5
Southern Europe	Spain	5
Western Europe	Germany	3

Findings

What approaches and methodologies are disability service providers currently using to measure service quality?

Analysis of the templates identified two overarching approaches to quality monitoring: Internal Audit or Quality Assurance (QA) and External evaluation and validation. Internal audit/QA included several different methodologies:

- Survey (sometimes completed with the person directly like an interview) – person receiving services.
- Survey of family members – satisfaction with services received.
- Survey of others such as guardians and funders.
- Self-assessment/evaluation by managers, sometimes involving staff and people supported to:
  - Rate service against externally set standards and criteria.
  - Reflect on user outcomes and service quality, with a focus on service improvement.
- Observation for staff development and feedback.
- Visits by senior managers or other organisational staff, such as a quality insurance or practice development team, to:
  - Check accuracy of self-assessment and/or compliance with standards
  - Observe staff working practices and interactions with the people they support and the accessibility and quality of the environment.

External evaluation and validation generally involved one of two methods:

- External evaluation to check for compliance with standards set by policy or external agency, sometimes involving observation. This usually involved visits by external agencies.
- External validation focused on good practice indicators with quality usually defined by an external agency. This sometimes-involved people with disabilities doing observations and talking to people who accessed the service.

However, it is important to note that rarely were organisations using just one of these approaches. In many cases there were both internal and external evaluations being used.

Annex 1 lists the approaches and summarises which countries they were used in, which types of services they were used in, who collected the data etc.

The most used methodologies were self-assessment by managers and internal audits primarily focused on health, safety, and service satisfaction.

Type of services in which the approaches or methods were used

Data gathered through the templates ranged in terms of what the approaches or methods focused on and the nature of the organisations using each approach or technique. Some of the templates represented approaches or methods used by a range of different providers. Other templates were a detailed description of how one organisation monitored quality. Service providers served a wide range of individuals (children, adults, and older adults and with a range of different types of disabilities) and provided a range of service types (residential care, supported living, day services, employment services, respite/short breaks, family support, skill development, behavioural services etc.). Finally, completed templates represented a range of sectors – statutory/publicly run services, voluntary/not for profit and private/for profit.

The legal status of the approaches/methods identified

The approaches to monitoring quality used by organisations were a mixture of voluntary and mandated. This was true in almost all countries. Where specific approaches described in the templates were mandated,

this was often in law (e.g., in Scotland, Czech Republic, Germany and Romania) and required and oversee by either the national, regional, or local government or by an agency given the task of registering services and/or monitoring quality – e.g., the Care Inspectorate in Scotland. In a few cases, the organisation responsible for ensuring quality of services provided was a professional body or training organisation – e.g.

However, even where the exact approach used by organisations was described as "voluntary", there was a requirement in policy or as part of registration or inspection processes for organisations to monitor the quality of their services. For example, in Norway and the UK, quality monitoring was seen as an indicator of a "well-led" organisation. Sometimes this requirement to regularly monitor quality came with recommendations about what should be included in the process – the most common example of this was that the views of stakeholders, in particular the people who use services. This views on quality of service provided is often collated in the form of survey for the clients and/or family members. However, legislation or guidance does not set out how this should be done or even how quality should be conceptualised, thus giving providers quite a lot of control over how they met the requirement to monitor the quality of their services. The disadvantage of this is that it is very difficult to then make comparisons or summarise data by approach or outcome.

Frequency of evaluation and links to day-to-day practice

Most organisations that conducted some form of internal audit using self-evaluation, surveys or visits did so on an annual basis, but with a few doing so once every six months.

However, in the Irish and UK based organisations, compliance with standards was usually checked every month by managers during their regular monthly visits (required by the regulation and inspection bodies) – this was partly to ensure that they would pass an inspection should there be an unannounced inspection.

Information on some elements of quality was collected as part of daily practice and then reviewed by the management and sometimes Trustee or Directors boards on, for example, a quarterly basis. The information collected as part of daily practice tended to relate to the physical well-being and safety of individuals supported and staff – for example, incidents of challenging behaviour, use of restraint, health and safety issues, mortality, medication errors. Complaints were also gathered on an ongoing basis and then collated and reviewed on a regular basis as part of quality monitoring processes.

In Romania there were examples of quality evaluation being related to training for new therapists/staff in family support services, rather than regularly done for all services. In Germany evaluation of how well services were responding if people showed challenging behaviour primarily used interviews and review of paperwork after an incident happened (so on an as needed basis) in combination with an annual survey.

What elements of quality are monitored?

For the most part, monitoring in all countries focused at least to some extent on compliance with standards set out in law/policy or with professional standards. The content of those standards varied from country to country and therefore so did the focus of monitoring. However, across all countries, the most common focus was on whether services were keeping individuals and staff safe and on whether policies, processes and systems considered to be important to produce good outcomes were in place.

In all countries, at least some of the approaches included asking people who use services to complete a survey giving their views on the services they receive and whether they are helped to do some of the things they want. In some countries, families or other stakeholders were also asked about their views on organisations. However, apart from physical well-being/safety and choice and control/self-determination, very few approaches assessed the Quality-of-Life outcomes for people using their services. Where they did it was usually limited to one or two domains/life areas – e.g., whether they had found a job if being supported to look for work; whether they had achieved any of the goals they identified in their planning meeting.

Annex 2 outlines the different areas of quality that were measured across the different approaches.

A second important finding was that overall, there appears to be very little focus on what is going well or how "good" services were, although in Scotland, for example, services do get a rating from excellent through to inadequate on each standard. However, the main focus of organisations policies was on making sure that they weren't "bad" – so a primary focus was on complaints, incidents of challenging behaviour, accidents, injuries other health and safety issues, errors made (e.g., in giving medication), staffing issues etc. Some approaches also looked at whether planning (in particular, care planning or person-centred planning) and appropriate or required assessments had been done and documented. But organisations did not appear, in general, to collect information about how good people's lives are and how good the support is.

Table 2 below summarizes the areas on which each approach to quality monitoring focused across the different countries, where detailed descriptions were available.

Table 2: Mapping the areas of focus for each approach/method identified.

Method	Outcomes of people using services	Satisfaction with services and support	Quality of support and interactions	Technical aspects of care	Physical environment	Management / leadership	Staffing/staff training	Person-centred Planning/ processes	Incidents/crises/complaints and documentation
Internal audit or evaluation									
Survey or structured interview with people receiving services	✓	✓							✓
Survey or structured interview with family/friends of people receiving services		✓							
Survey or structured interview with other stakeholders (e.g., funders, guardians)		✓							
Self-assessment by managers and/or staff team against a set of criteria or indicators.	✓			✓	✓	✓	✓	✓	✓
On-site visits by senior managers or a Quality assurance team to check compliance/validate self-assessment		✓		✓	✓	✓	✓	✓	✓
On-site visits by managers or QA team to conduct observations and gather information of service quality or user experiences (goes beyond compliance). Could include informal conversations with people living there and staff.	✓	✓	✓		✓		✓		
Self-evaluation and reflection by staff focused on outcomes and quality improvement	✓	✓	✓	✓	✓			✓	
External evaluation									
External evaluation focused on compliance with standards set in policy or by external agency.		✓		✓	✓	✓			
External evaluation, focused on good practice indicators or Quality Frameworks or conducted by Experts by Experience	✓	✓	✓		✓		✓	✓	✓

Quality monitoring and quality improvement

All approaches to monitoring in some way fed into quality improvement processes. In a few cases, the mechanism was direct feedback to the staff and/or managers and discussion of what could be improved. In Finland there were examples of where the staff team with their leadership reflected on the outcomes people were receiving and on the quality of the support they provided and then focused on what might be needed in terms of processes and structures to improve outcomes in most arears.

However, in most cases where the approach described was part of a wider quality monitoring system results were passed up the organisation to senior managers. Sometimes feedback on the evaluation or audit was fed back to services from senior managers in summary form (for example, findings from the survey used in the Norwegian organisation was summarised by department and fed back to managers at an annual conference of all managers across the organisation). Sometimes staff and managers could access the results for their service directly within an online dashboard (Ireland).

In most approaches, when a service was found to not be meeting all the required standards or quality indicators, the manager (and sometimes the staff team) had to develop an action plan to rectify the issues/shortcomings that had been identified in the evaluation process. Senior managers were then responsible for ensuring the actions were implemented, usually within set deadlines.

In Scotland the Care Inspectorate recently changed their whole system to put the evidence on increasing capacity for service improvement. In doing their self-assessment, providers are required to provide evidence (e.g., from surveys or observations) as to how they are meeting each of the standards. If they identify that there are shortcomings, then they have to show how they are going to respond to this and what changes they will make. They are provided with a large selection of resources by the Care Inspectorate as well as examples of good and poor practices on each indicator, plus training events. The ability to reflect on what is working and not working and come up with a plan is taken as an indicator of good quality - in particular leadership - therefore providers are more likely to be honest in their self-evaluations rather than try to make things look better than they might actually be.

The templates also included a question about what happened when services were found to be providing good services and where outcomes were particularly good. In almost all cases, the answer to this was that nothing happened. There were generally only consequences if things were wrong or bad. In one or two cases it was noted that services received recognition in terms of receiving feedback that they were good and in Finland one organisation was described as celebrating their annual results and recognising the good work they were doing – so as a community effort. In the case of Parent support/ therapy in Romania, therapists could get a pay rise if they received really good feedback from families. In one case, it was noted that a service would be likely commissioned to provide services to new clients if they were rated more highly on quality.

Consistency with the UN CRPD

As indicated above, the focus of quality monitoring was much more likely to be on compliance with standards that often were generic across different service types and were focused more on processes and the technical aspects of care rather than on the outcomes and on the quality of support received by individuals. In terms of outcome domains, most of the methods identified focused more on human rights, physical well-being, satisfaction with services (an element of emotional well-being) and choice and control than any other domain.

Annex 3 summarises 1) the key articles of the UN CRPD which service providers, not just States, can directly influence and 2) how these articles were reflected in the methods and approaches identified in the templates. The main finding from this mapping is that very few of the approaches and methodologies currently used by providers would provide assurance that the rights of persons with disabilities under the UN CRPD were being achieved.

Conclusions

The analysis of the templates highlighted that service providers took the task of monitoring quality seriously and often used well designed and detailed systems to

do this. However, several limitations to the approaches and methodologies currently used were also identified:

- Many of the methodologies used focused on compliance with standards and improving compliance more than quality.
- Few of the approaches summarised in the templates really explored outcomes experienced by individuals and, where this was the case, the most common focus was on physical well-being, in particular safety and choice and control.
- Few approaches collected information about how good people's lives were or focused on how people's lives were improving or being maintained over time (although some did ask people using services to say if their lives had improved because of receiving support from the service). For the most part, information collected was focused on ensuring that bad things did not happen rather than whether people using services were experiencing good quality of life outcomes.
- Connected to the above point, none of the approaches (or even a combination of approaches) would allow ascertainment of whether people's rights under the UN CRPD were being achieved.
- Satisfaction with services was more commonly assessed – usually with a survey or interview. The latter was more commonly used for people using services and surveys were more commonly used with families or other stakeholders. Most of these tools were kept very short to maximise participation and thus only asked very global questions or a small selection of service-specific questions.
- In most cases, organisations used a mixture of approaches – e.g., self-assessment, survey, interview and less commonly, visits to services.
- Visits mostly focused on checking compliance with standards, required paperwork, etc. or checked the validity of self-assessments.
- Although structured observation has been identified as particularly important to assess the quality of services, particularly for people with intellectual and developmental disabilities (Mansell, 2010), this was rarely used by even providers of services to people with intellectual disabilities.

In order to seek the views of stakeholders on approaches and methodologies that might be useful and feasible and respond to the above limitations, a proposed framework to guide the monitoring and improvement of quality was developed and this is outlined in the next section.

Proposed framework for quality measurement and improvement

The methods and approaches identified in the consultation with providers and completed templates were mapped onto the elements of the EASPD Service quality Framework (Šiška and Beadle-Brown, 2021[4]). The aim was to find ways of conceptualising and measuring quality that would promote robust quality monitoring and improvement and which would promote consistency in measurement and, therefore, potentially allow comparison between services. It was also important to identify measures that would potentially allow assessment of whether people are progressively realising their rights under the UN CPRD.

Drawing on that framework and the approaches currently used by providers and on the research in this field, it was identified that several elements were important in designing any framework for the monitoring and measurement of service quality:

- Quality should be evaluated at a range of different levels, involve different perspectives, and use a range of different tools to ensure the experiences of as many people as possible are included.
- The focus of quality monitoring is critical and the most holistic and comprehensive framework for doing this is the Quality-of-Life Framework.
- Attention should be paid to ensure that measure of quality and outcomes are as valid and reliable as possible.
- Streamlining of the process for gathering and reviewing data, so that information are collected as part of everyday systems and processes that have to happen anyway, would reduce the burden of and review for staff and managers.
- To create a strong motivational context, monitoring and review should focus on positive outcomes and elements of service quality, not just what has gone wrong or on whether people are safe and well.
  To have a good quality of life, it is essential that positive risk-taking is supported – at the very least, people need to have the opportunity and support for new activities and interactions that expand their experiences and support informed decision-making.
- Whilst outcomes of people supported is paramount, monitoring quality needs to include the structures and processes that are known to impact on user outcomes and on staff motivation and skills.
- Regular opportunities for reviewing the quality of services and reflecting on what is needed to improve outcomes and the quality of services should be embedded within everyday processes to allow issues to be picked up quickly and solved (as well as good practice recognised).

As such, we set out the following:

- A range of potential quality indicators that had been identified in the landscape analysis and previous research. These included indicators at the level of structures, processes, and outcomes. The individual items can be found in Table 3 below.
- Opportunities for collecting and reviewing data as part of everyday practices:
  - Daily recording
  - Team meetings
  - Frontline management observations of staff practice
  - Supervision with staff
  - Person-centred or individual planning processes

Further details of each item included at this level of can be found in Tables 4 to 7.

- Self-evaluation by front line managers and involving staff and service users in this (see Table 7 for individual items)
- Visits by senior managers and/or an internal quality assurance or improvement team – required in some countries by registration and inspection agencies (see Table 8 for individual items)
- Formal organisational audits (Table 9)
- External audit/evaluation including involving people with disabilities in it (Table 10).

4 Šiška, J., Beadle-Brown, J. (2021) *Innovative Frameworks for measuring the Quality of services for Persons with Disabilities*. (n.d.). EASPD. https://www.easpd.eu/publications-detail/report-on-innovative-frameworks-for-measuring-the-quality-of-services-for-persons-with-disabilities/

Finally, we set out a range of proposed methodologies for collecting qualitative data that were consistent with our Service Quality Framework (Šiška and Beadle-Brown, 2021)[5] and which were already being used by at least one or two providers consulted in Phase 1, indicating that the methods were in principle feasible. The items included were:

- People are supported to complete surveys by someone connected to the services.
- If using interviews, the questions are asked by someone not involved in the person's support.
- Surveys and interviews with people using services include questions that related to the domains of quality of life and not just about service satisfaction.
- During visits, evaluators look at calendars, schedules, weekly plans etc. to get a feel for what opportunities people have.
- During visits, evaluators explore whether the plans they have seen actually happen.
- Staff surveys include questions about how they are supported by the organisation to do their job well.
- Family surveys ask about their experiences and how they feel about the services their family member receives – not asked to say how they think the person themselves would feel.
- Visits to evaluate quality always include at least a short period of formal observation (except where consent and assent are not given).

5 Šiška, J., Beadle-Brown, J. (2021) *Innovative Frameworks for measuring the Quality of services for Persons with Disabilities*. (n.d.). EASPD. https://www.easpd.eu/publications-detail/report-on-innovative-frameworks-for-measuring-the-quality-of-services-for-persons-with-disabilities/

Consultation on proposed framework for quality measurement and improvement

Introduction

The overall aim of this phase was to seek the views of a wider range of stakeholders on the proposed framework and on each of the individual elements described above. We were particularly interested in the elements of the proposed framework that stakeholders felt would be most useful, identify any elements that they felt were less feasible and explore potential solutions that would increase the ability of organisations to engaged with those elements.

Methods

Survey

A group of stakeholders and experts including service providers were recruited in advance by EASPD from the members of their taskforce focusing on service quality. In addition, stakeholders who had been involved in completing the templates during Phase 1 were also invited to participate.

The evaluation of each element of the proposed framework was conducted using an online survey to explore:

- the usefulness of the approach or methodology in the context in which their work;
- the feasibility of each element if to be used more widely.

The background to the proposed framework was described at the beginning of the survey and participants were asked to complete ratings of each of the above dimensions for each element of the framework. At the end of each section, participants were encouraged to provide more qualitative feedback to explain their ratings or to make additional comments on the relevance, usefulness, or feasibility of the different elements.

The survey was administered through Google Forms and was available in English, German, Spanish and Czech.

The survey was completed by 17 stakeholders, representing Disability Service Providers, Disabled Peoples Organisations and several other associations and training providers. Respondents were from Spain, Germany, the Czech Republic, Romania, the UK, and Finland, with one person noting that they represented a European organisation.

Focus groups

At the end of the online survey, there was an invitation to an online focus group. In addition, invitations were also sent out to members of the EASPD Taskforce on Service Quality.

The focus group was held on two alternative dates (4-6 October 2023) to give the participants some flexibility. In total, seven people participated in the focus groups, which lasted between an hour and 1.5 hours.

During the focus groups, a summary of the key findings from the survey was presented. They were asked to comment from their experience and talk about the barriers to using the different methods set out above and potential solutions for those areas identified as less feasible.

Findings

Quality Indicators

Table 3 below shows the results from the survey for the different indicators of quality identified in Phase 1 and in the literature. As can be seen, most items were rated as useful or very useful and for the most part were also seen as at least somewhat feasible. The indicator rated as least useful was: reviewing equipment/resources and external sources of expertise.

The QoL was reported to be complex and challenging to assess objectively. Nevertheless, QoL was suggested to be useful for quality assessment. “Quality of Life domains are complex and not always objectively assessable, but if it were done well, it would be a

reliable indicator of the quality of a service. The QoL approach should be both embedded in services and inspectorates and properly supported by the EU. It is important to balance the controlling part with the supportive part of the quality assessment system." (UK/ training provider).

Limited knowledge about QoL framework amongst stakeholders and a dominant focus on processes rather than on outcomes hinders the broader implementation of QoL in practice. "I fear that the little experience with this area and the overestimation of evaluation procedures and rules limit the applicability of evaluation by results in our country." (CZ/Umbrella organisation of service providers).

In the focus groups discussion ISO 9001 was also mentioned as a frequently used instrument for assessing quality. However, it was considered too formal.

Table 3: Mean ratings (and range) on usefulness and feasibility of each potential indicator of quality.

	Mean Usefulness rating (max = 4)	% useful or very useful	Mean Feasibility rating (max = 4)	% at least somewhat feasible
Measuring outcomes using the Quality-of-Life domains	3.53 (1-4)	93	3.18 (1-4)	80
Measuring family outcomes and experiences	3.47 (3-4)	100	3.18 (2-4)	87
Measuring staff outcomes and experiences	3.53 (2-4)	87	3.54 (3-4)	100
Measuring the quality of interactions and working practices of direct support staff	3.65 (3-4)	100	3.47 (2-4)	87
Reviewing staff training and the support they receive	3.71 (3-4)	100	3.59 (1-4)	93
Assessing the environment and equipment available	3.29 (2-4)	93	3.53 (1-4)	87
Reviewing individual/person-centred plans	3.71 (3-4)	100	3.76 (2-4)	93
Assessing staff attitudes and the culture of a staff team	3.71 (2-4)	93	3.24 (2-4)	93
reviewing errors made and complaints	3.59 (3-4)	100	3.53 (2-4)	93
Reviewing policies and procedures at organisational level	3.31 (2-4)	86	3.82 (2-4)	93
Reviewing staffing, absences, and sickness	3.18 (1-4)	87	3.71 (2-4)	93
Reviewing equipment/resources and external sources of expertise	2.94 (1-4)	80	3.45 (2-4)	80

Data collection opportunities and processes

One aspect of quality monitoring in which we were particularly interested was whether quality is monitored, and service improvement considered as part of everyday practices and processes. This was not found to be the case in many organisations consulted in Phase 1 but doing so offers many opportunities for streamlining processes and for a continuous quality improvement approach. Table 4 shows that respondents felt that using daily recording as part of quality monitoring would be useful, as would including outcomes and quality of life as part of daily recording. However, they were a little less sure about how feasible this would be.

Table 4: Mean (and range) for usefulness and feasibility scores related to the use of daily recording as part of quality monitoring.

	Mean Usefulness rating (max = 4)	% useful or very useful	Mean Feasibility rating (max = 4)	% at least somewhat feasible
Using information that is recorded on a daily basis as part of ongoing quality monitoring	3.69 (2-4)	93	3.19 (1-4)	79
Daily recording gathers information related to outcomes and quality of life	3.75 (1-4)	93	2.75 (1-4)	71

Participants of the focus group reported on their duties to record all everyday activities. Reporting was considered to be often based on medical model, time consuming, administrative and with no or limited engagement of the clients. However, some were lobbying to change the reporting regulations with the participation of clients and using various channels to do so. "We want to do recording with the clients via, for example, mobile devices". (FG2/Fi). It was also suggested that it was important to use easy-to-understand language in daily recording tools.

Table 5: Mean ratings (and range) for usefulness and feasibility of using team meetings and person-centred planning processes as part of quality monitoring and improvement.

	Mean Usefulness rating (max = 4)	% useful or very useful	Mean Feasibility rating (max = 4)	% at least somewhat feasible
Holding team meetings every 4-6 weeks	3.94 (3-4)	67	3.65 (2-4)	93
Collating information from daily notes once a month (roughly) to review as a team	3.18 (2-4)	71	2.88 (1-4)	65
Focusing team meetings on documenting and celebrating success for those supported and discussing and problem-solving issues impacting on outcomes of people supported	3.71 (2-4)	80	3.29 (1-4)	60
Collating and reviewing data on outcomes achieved as part of individual or person-centred planning meetings	3.94 (3-4)	100	3.24 (1-4)	87
Using information on activities, experiences, and preferences to inform goal planning	3.71 (1-4)	93	3.41 (1-4)	87

Survey respondents commented that using day-to-day records were a useful instrument for making organisations stronger in quality improvement and for demonstration of compliance with regulations. It was suggested that this is an effective way of sharing information amongst staff and strengthening positive work climate. In contrast, daily recording can become counterproductive, bureaucratic, and taking time from direct work with people using services. Finding a balance between administration and support was suggested as key. It was felt that if measurement of quality directly involving people using services was conducted too frequently, this could potentially have a negative impact on their quality of life and lead to frustration. Data /records/ protection and respect of rights is important. Online/electronic information systems were seen to have great potential.

It was also noted that the positive impact of day-to-day recording on quality depends on how staff perceive its importance and value and whether recording is person-centred.

Table 5 above illustrates that people reported that holding team meetings regularly and collating daily recordings to review as a team was less useful than some other methods. They also felt that collating and reviewing as a team was less feasible. More felt that focusing team meetings whenever they happened on documenting success and problem solving related to outcomes of people supported was a useful approach but rated this as less feasible.

Meetings were reported to be demanding in terms of time and staff resources and therefore costly. They need to be organised effectively to promote the flow of information between management and staff: "There have to be different ways of delivering them than holding the whole staff group in a meeting to discuss someone who some staff might rarely interact with." (UK/training provider). Working together and sharing information was highlighted as a key element of social service during the focus groups: "It is not possible to run a service without working together and team meetings" (FG1). Focusing on positive rather than negative elements was recommended for meetings during focus groups.

Managers' observations and staff supervision were generally rated as useful and feasible (Table 6 above), although feasibility was rated slightly lower for supervision being conducted every 1-2 months as well as for the use of a tool to record observations and provide feedback to staff.

Comments from the survey illustrate that supervision can identify potential problems and address these early on. Supervision was seen as supporting teamwork and a positive working environment.

Observation requires sufficient time: "The question is the periodicity of the observations - whether there will be enough time to do it and often enough."

As noted in section 4 above, self-evaluation is a common approach to monitoring quality in many countries and organisations. It is not surprising therefore that such an approach was rated as very useful and quite feasible, including involving people with disabilities in self-evaluation processes (see Table 7).

Table 6: Mean ratings (and range) for usefulness and feasibility of front-line managers observations and staff supervision to be part of quality monitoring.

	Mean Usefulness rating (max = 4)	% useful or very useful	Mean Feasibility rating (max = 4)	% at least somewhat feasible
Front-line managers conduct observations on a regular basis	3.76 (1-4)	93	3.38 (2-4)	86
Individual supervision with staff every 4-8 weeks.	3.71 (1-4)	93	3.06 (1-4)	73
Using a tool to conduct structured observations and feedback to staff	3.47 (1-4)	80	2.94 (1-4)	73

Table 7: Mean ratings (and range) for usefulness and feasibility of self-evaluation

	Mean Usefulness rating (max = 4)	% useful or very useful	Mean Feasibility rating (max = 4)	% at least somewhat feasible
Managers involve staff in service self-evaluation process	3.94 (3-4)	100	3.5 (2-4)	91
Staff teams reflect on service quality quarterly as part of self-evaluation process.	3.88 (3-4)	100	3.29 (1-4)	87
Tool to guide these reflections to ensure consistency with service quality framework	3.88 (3-4)	100	3.29 (1-4)	80
Staff teams identify an action plan related to improving outcomes of the people they support	3.82 (2-4)	93	3.29 (1-4	80
People with disabilities are involved in self-evaluation where possible	4 (4-4)	100	3.59 (2-4)	93

In practice, self-evaluation and reflection are useful but usually performed spontaneously rather than intentionally. Effectiveness of intentional self-evaluation and reflection depends on how staff perceive its importance. "There are also challenges to consider in the process of self-evaluation. These include possible resistance within organisation, as change can often be met with opposition. Organisational development processes must be designed and implemented in such a way that employees are involved from the very beginning." (GE/service provider representative)

Often senior managers are required to regularly visit services. In some organisations there is also a quality assurance team or practice development team who may visit services. There was more variability in scores for this domain, with some people less convinced about the usefulness of these elements, also rating them as less feasible. In particular, senior managers spending at least an hour observing was rated as less feasible and checking the accuracy of frontline manager/team self-evaluations was seen as less useful (Table 8 below).

Table 8: Mean ratings (and range) for usefulness and feasibility of visits to services by senior managers or an internal quality assurance team

	Mean Usefulness rating (max = 4)	% useful or very useful	Mean Feasibility rating (max = 4)	% at least somewhat feasible
Senior managers or quality assurance (QA)team members visit every service once every six months.	3.38 (1-4)	75	3 (1-4)	67
Visits by senior managers or QA team include at least one hour spent formally observing.	3 (1-4)	73	2.76 (1-4)	60
Visits by senior managers or QA team include conversations with staff	3.59 (1-4)	80	3.12 (1-4)	80
Visits by senior managers or QA team include conversations with people supported wherever possible	3.53 (1-4)	87	3.06 (1-4)	80
During visits, senior managers or QA team check compliance with standards every time	3.06 (1-4)	73	2.53 (1-4)	60

	Mean Usefulness rating (max = 4)	% useful or very useful	Mean Feasibility rating (max = 4)	% at least somewhat feasible
During visits, senior managers or QA team check the accuracy and validity of manager/staff team self-evaluation for a representative sample of services	3.06 (1-4)	57	2.59 (1-4)	53
Findings from the visits are shared with the staff team to promote service improvement	3.76 (1-4)	87	3.29 (1-4)	80
Findings from the visits are fed into annual internal audit processes	3.76 (1-4)	93	3.41 (1-4)	80

Both success and failure in terms of quality was viewed as depending on leadership. Senior managers and service managers must be in the service and be part of the team (as leader, partner, and collaborator). The issue raised was how this can be feasible due to the time limitations and competing priorities of senior managers: "If the management is not interested in evaluation activities, it cannot be implemented" (CZ/ service provider representative).

All proposed elements of internal audits and external evaluations were rated by most respondents as useful and at least somewhat feasible (Table 9 and 10 below).

Table 9: Mean ratings (and range) for usefulness and feasibility of internal audits

	Mean Usefulness rating (max = 4)	% useful or very useful	Mean Feasibility rating (max = 4)	% At least somewhat feasible
Internal audits collate data collected during the year as part of other processes	3.82 (1-4)	92	3.62 (2-4)	93
Internal audits focus on checking validity of self-evaluation for a sample of the services	3.53 (1-4)	93	3.29 (1-4)	93
Internal audits focus on indicators of outcomes and quality as well as compliance	3.82 (1-4)	87	3.47 (1-4)	80

Table 10: Mean ratings (and range) for usefulness and feasibility of external evaluation and validation

	Mean Usefulness rating (max = 4)	% useful or very useful	Mean Feasibility rating (max = 4)	% at least somewhat feasible
Quality standards formally set in law or guidance include a greater focus on outcomes, including Quality of Life.	3 (1-4)	92	3.24 (1-4)	80
Providers engage an external agency to independently validate their internal monitoring processes	3.35 (1-4)	80	3.24 (1-4)	87
External evaluation or validation includes people with disabilities	3.88 (3-4)	100	3 (1-4)	80

Internal audits were considered to promote a holistic view of service quality and with the potential to deliver effective assessment and have a real impact on people supported. However, it was suggested that this can only work if it is resourced and becomes part of the culture of the organisation. "Internal audits to be one of the most accessible, least used and at the same time most useful tools for monitoring and quality control." (CZ/Umbrella organisation of service providers representative). Some organisations had developed their own internal auditing instrument based on a peer evaluation concept which was noted as useful and helpful.

In regard to external evaluation, Experts by Experience was seen as a powerful tool for quality evaluation. External evaluation conducted by an authority has challenges such the selection of meaningful criteria for the respective service, as well as valid collection of these data using actually feasible survey procedures and instruments. "It must not be limited to ticking forms. There must be room for the evaluator's discretion, and opinions of evaluators need to be reconciled through joint action, training, reflection." (CZ/Umbrella organisation of service providers representative).

Methods of collecting quality data

Table 11 below illustrates that, overall, almost all the methods identified were rated as useful and at least someone feasible by almost all respondents. The one area where people were less sure about feasibility was

Table 11: Mean ratings (and range) for usefulness and feasibility of different methods of collecting data related to outcomes and quality.

	Mean Usefulness rating (max = 4)	% useful or very useful	Mean Feasibility rating (max = 4)	% at least somewhat feasible
People are supported to complete surveys by someone connected to the services.	3.12 (1-4)	75	3.59 (1-4)	87
If using interviews, the questions are asked by someone not involved in the person's support.	3.29 (1-4)	93	3.47 (2-4)	93
Surveys and interviews with people using services include questions that related to the domains of quality of life and not just about service satisfaction.	3.65 (1-4)	87	3.41 (1-4)	87
During visits, evaluators look at calendars, schedules, weekly plans etc. to get a feel for what opportunities people have.	3.41 (1-4)	87	3.29 (1-4)	87
During visits, evaluators explore whether the plans they have seen actually happen.	3.65 (1-4)	87	3.12 (1-4)	80
Staff surveys include questions about how they are supported by the organisation to do their job well	3.71 (1-4)	93	3.53 (2-4)	87
Family surveys ask about their experiences and how they feel about the services their family member receives – not asked to say how they think the person themselves would feel.	3.71 (3-4)	100	3.12 (1-4)	80
Visits to evaluate quality always include at least a short period of formal observation (except where consent and assent is not given.	3.24 (1-4)	80	3 (1-4)	73

about the suggestion that all visits should include at least a short period of formal or structured observation.

The comments of the survey respondents indicate that their preference was for more qualitative methods and assessment instruments as opposed to surveys. However, surveys are relatively easy to use. Respondents noted that instrument need to be user friendly and tailored to individual needs of a responding client. If a survey is used, it must be easy to understand (FG1).

Conclusion

Although there were mixed views on some items and some elements were viewed as more useful or feasible than others, most elements of the proposed framework were seen as useful. Elements seen as less feasible tended to be those that required a physical presence of managers and senior managers/auditors or evaluators in the services. These were generally seen as valuable but more time-consuming and therefore costly to do. The value of formal structured observations was less well acknowledged, although this has been identified in research and implementation practice as very important, especially when those supported may not be able to be interviewed or a survey completed about their views. However, the difficulties with just using a survey approach were recognised by participants.

More general barriers to service quality were also highlighted in the survey and focus groups – for example, participants note that there were challenges applying the concepts to people who are controlling their own services through a personal budget or other individualised funding mechanism and also that staff providing home care or personal assistance sometimes have to follow a rigid job description and may only have a very short amount of time allocated to visit an individual. It was felt that this prevents flexibility and improvement in services.

Overall summary, conclusions, and recommendations

What approaches and methodologies are disability service providers currently using to measure service quality?

Two overarching approaches to quality monitoring were identified: Internal Audit or Quality Assurance (QA) and External evaluation and validation. Internal audit/QA included several different methodologies: surveys (usually assessing satisfaction with services received); Self-assessment/evaluation by managers, sometimes involving staff; Observations for staff development and feedback, and Visits by senior managers or other organisational staff. External evaluation and validation usually included visits either to check for compliance with standards set by position of external agency or to evaluate quality based on good practice indicators, including involving Experts by Experience.

Analysis of the approaches used indicated that:

- Quality monitoring and review was not usually part of day-to-day practice but was often conducted on an annual basis, although in some countries (e.g., Ireland and the UK) managers were required to visit and check at least compliance with standards on a monthly basis.
- The focus of monitoring was primarily on compliance with standards and on processes related to keeping individuals supported and staff safe, and on whether the policies, processes and systems considered important to provide good outcomes were in place. Outcomes such as the quality of life of people supported were rarely assessed other than in terms of health, safety, complaints, and satisfaction with services.
- Overall, the focus of monitoring and service improvement was related to ensuring that services were not "bad" rather than on what is going well or how "good" services are.
- In general, the approaches and methodologies used by service providers had limitations in their usefulness for a detailed monitoring of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD)[6] , often focusing only on certain human rights such as freedom from harm.
- In most cases, organisations used a combination of approaches/methodologies – e.g., self-assessment and a satisfaction survey and visits from managers.

What approaches and methods were viewed by providers and stakeholders as useful and feasible going forward?

Drawing on the findings above, we proposed a framework for monitoring and improving quality that was consistent with the Framework for Service Quality set out in the EASPD (2022) "Study on Innovative Frameworks for Measuring the Quality of Services for Persons with Disabilities".[7]

We asked a range of stakeholders about the usefulness and feasibility of each element of this framework as set out below:

1. A range of quality indicators at different levels (outcomes, processes, and structures).
2. The use of data that was or could be collected during everyday practice at different levels and that could also be used for quality improvement – daily recording with and about individuals; front line manager observations; team meetings and supervision.
3. Self-evaluation by front line managers and involving staff and service users in this.
4. Visits by senior managers and/or an internal quality assurance or improvement team.
5. Formal organisational audits.
6. External audit/evaluation including involving people with disabilities in these.
7. Different measures used to collect the data – survey/interview.

6 United Nations Convention on the Rights of Persons with Disabilities, December 13, 2006, https://www.ohchr.org/en/hrbodies/crpd/pages/conventionrightspersonswithdisabilities.aspx

7 Šiška, J., Beadle-Brown, J. (2021) *Innovative Frameworks for measuring the Quality of services for Persons with Disabilities*. (n.d.). EASPD. https://www.easpd.eu/publications-detail/report-on-innovative-frameworks-for-measuring-the-quality-of-services-for-persons-with-disabilities/

We presented the results of the survey to two focus groups comprising stakeholders at different levels of the system and from different countries. They were asked to comment on each element from their experience and talk about the barriers to using the different methods set out above and potential solutions for those areas identified as less feasible.

Findings

Indicators and data collection methods:

- Most quality indicators rated as useful and feasible.
- Indicators that involved observations in practice were seen as less feasible.
- Using a Quality-of-Life Framework to review outcomes was seen as useful and a potentially reliable measure of outcomes and quality. However, it was considered slightly less feasible than some of the other approaches due to the apparent complexity and a general lack of awareness of the Qof-Life Framework (Shalock et al. 2002)[8].
- Qualitative methods of collecting information were preferred, although surveys were acknowledged as easier to use to collect the views and experiences of people supported, families and staff. The need for surveys to be as easy as possible to read and complete was highlighted.
- Having someone not involved in service provision to conduct or facilitate the gathering of views of users was seen as important.
- Visits including formal observations were seen as less feasible than other methods.
- Reviewing equipment, resources, and the availability of external sources of expertise was seen as less useful.
- The most useful methods were reviewing individual person-centred, or individuals plans and reviewing staff training and the support they receive, where everyone rated these as useful and almost everyone rated them as at least somewhat feasible.

Data collection opportunities in day-to-day practice:

- Reviewing daily recording (usually required by law or registration/inspection agencies) to monitor quality was generally viewed as useful but not always feasible.
- Including indicators related to Quality-of-Life outcomes in daily recording was also seen as useful but not always feasible.
- Issues raised about daily recording for measuring quality, included:
  - is often based on a medical model;
  - can be counter-productive, time consuming and bureaucratic;
  - can take away staff away from direct work with people supported;
  - involves no or limited engagement with people supported.
- The need for creative and innovative ways to involve people in required recording was highlighted as was getting the right balance between administrative requirements and direct support for individuals supported.
- Collating daily recordings regularly and reviewing them as a team in regular team meetings was noted as less useful than other methods although feasible.
- Team meetings, if organised effectively and focused on positive elements of service provision and quality, were viewed as an important venue for quality improvement although were reported to be demanding in terms of time and staff resources and, therefore, costly.
- Using the person-centred planning meetings to review data on outcomes was rated as very useful and seen as feasible.
- Front-line managers conducting observations of quality and staff practice was seen as both useful and feasible although required sufficient time and frequency to be an effective method for collecting data about quality and outcomes.
- Regular (every 1-2 months) individual supervision with staff was reported to be a useful venue for

8 Schalock, R.L., Brown, I., Brown, R., Cummins, R.A., Felce, D., Matikka, L., Keith, K.D. &Parmenter, T. (2002). Conceptualization, measurement, and application of Quality of Life for Persons with Intellectual Disabilities: Report of an International Panel of Experts. *Mental Retardation*, 40(6), 457-470

quality monitoring and improvement. It was considered particularly useful for identifying potential problems and intervening early, supporting teamwork, and creating a positive work environment.
- Self-evaluation was seen as very useful and relatively feasible, including involving people with disabilities in the process.
- Visits to services by senior managers and/or a quality assurance or improvement team were viewed as less useful and less feasible. If done, findings from the visit should be shared with the team and fed into internal audit processes.
- Senior manager interest in evaluation and presence in services was noted as important to ensuring quality.

Internal audits and external evaluations:
- All proposed elements of internal audits and external evaluations were rated by most respondents as useful and at least somewhat feasible.
- However, it was noted that internal audits needed to be properly resourced and become part of the culture of the organisation.
- The involvement of Experts by Experience in external audits was noted as a powerful tool for quality evaluation.
- External audit conducted by an authority or agency was reported as having challenges. The need to avoid quality being limited to "ticking forms" and for evaluator views to be captured and "reconciled through joint action, training and reflection" was highlighted.

How does monitoring link to service improvement?
- All approaches to monitoring in some way fed into quality improvement processes.
- In most cases, where the approach described was part of a wider quality monitoring system, results were passed up the organisation to senior managers.
- In a few cases, the mechanism was direct feedback to the staff and/or managers and discussion of what could be improved.
- In most approaches, when a service was found to not be meeting all the required standards or quality indicators, an action plan to rectify the issues/ shortcomings was required and senior managers were responsive to ensure implementation.
- Good practice and service quality was rarely formally identified and recognised as part of quality monitoring systems. There were generally only consequences if things were wrong or bad.

Conclusions and recommendations

The European Strategy for the Rights of Persons with Disabilities 2021-2030 contains an initiative to develop a European Framework for Social Services of Excellence for Persons with Disabilities by 2024. The aim of the study was to provide an overview of how service providers are monitoring and ensuring quality in their day-to-day operations and to identify the most useful and valid approaches to measuring quality.
The results illustrate that the most commonly used approach to monitoring quality was self-assessment by managers against a set of standards. Outcomes were rarely measured. Where this happened, the emphasis was on health and safety and on satisfaction with services. Other elements of quality of life of people using services were not assessed for most cases. The methods used did not allow a detailed assessment of whether people's rights under the UN CRPD were being realised. Overall, stakeholders indicated support for approaches that included quality of life and that used observational methods, though they felt these were less feasible to implement. However, many opportunities already exist in organisations to collect data that really allows disability service providers to measure and improve the quality of their support with a focus on the outcomes experienced by people supported, staff and families. The study indicated that these opportunities appear to be rarely taken. Guidance and leadership are needed to encourage service providers to utilise these opportunities for quality improvement with implications at national and European levels.

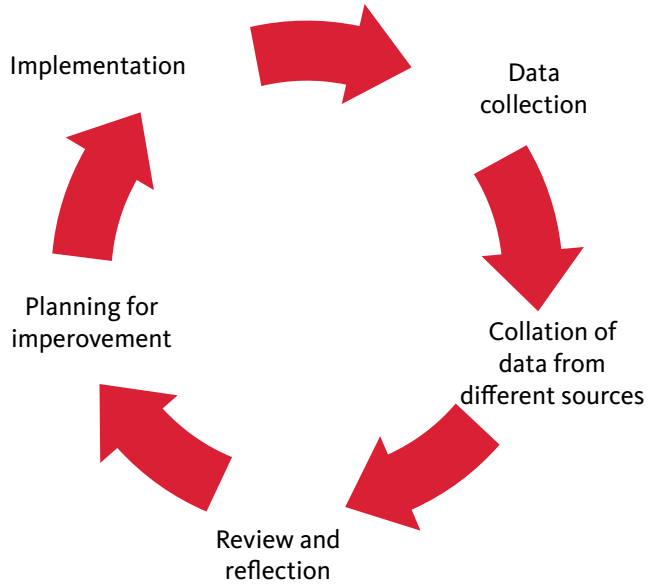
From the findings of this study, a number of key implications are suggested:
- The approach to monitoring quality should be a multi-element and a multi-methods approach to ensure that the experience and views of people supported is captured and a holistic view of service quality is obtained.
- Everyday practices and processes such as daily recording, team meetings, supervision and manager visits can be streamlined with audit processes. This allows services to gather data and review

service quality on an ongoing basis and encourages continual improvement.

- The focus of any quality monitoring approach should be primarily on Quality-of-Life outcomes at both service provider and quality inspectorate levels. This will need to be supported and incentivised by the European Commission but would allow elucidation of how well the UN CRPD is being implemented.
- Observations are recommended for a valid picture of service quality. This requires managers to be present in services and is particularly important in those cases where those receiving services are not able to respond to surveys or interviews.
- Quality monitoring should also include the availability and quality of staff training, supervision, and support.
- Time and structures for reflection and quality improvement are essential. Any information gathered has to be reviewed and used to improve services.

The main phases in the proposed quality monitoring and improvement cycle are illustrated in Figure 2.

Figure 2: Quality monitoring and Improvement cycle



The main phases of the cycle are expanded in Figure 3 and Table 12 below. These summarise the recommended structures and processes that could be used to monitor and improve service quality on an ongoing basis, along with the type of information that would be collected and reviewed and the methods that would ideally be used to do this. We have focused here on internal quality monitoring processes; however, as discussed above, an element of external evaluation and validation can also be useful.

Figure 3: Proposed quality monitoring and improvement system (a description of each box is provided in Table 12)

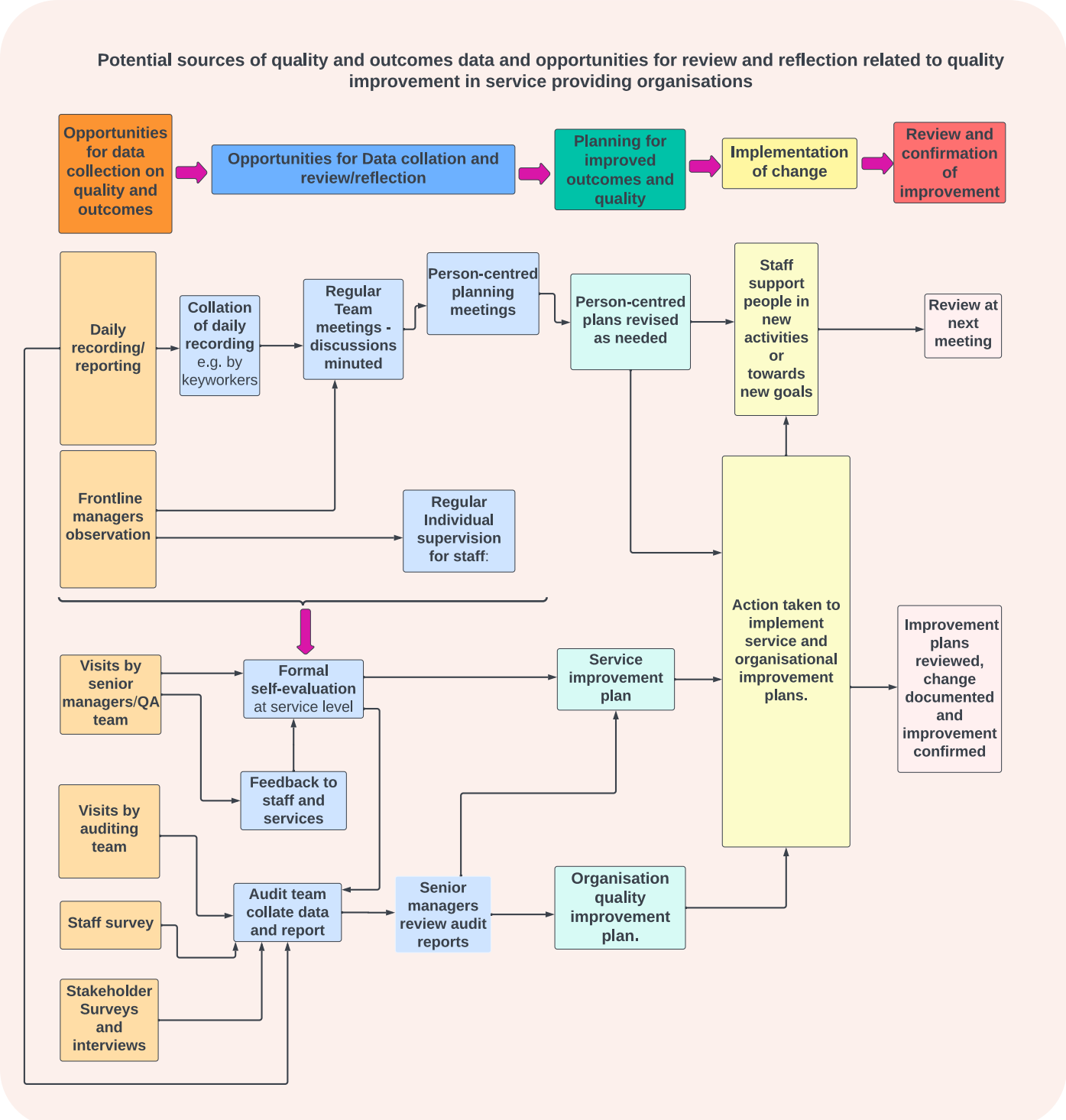


Table 12: Expansion and explanation of each box in Figure 3

Quality monitoring and improvement opportunities	Description
Data collection	
Daily recording/ reporting	Usually legally required and could be expanded to include indicators related to wider QoL – e.g., activities, interactions, choices, and decisions - not just health, medication, errors, complaints etc.
Front-line managers observations	Frontline managers regularly observe staff practice and indicators of Quality-of-Life outcomes. observation of quality. Using a tool focused on outcomes, processes and structures is recommended to ensure consistency and reliability across settings and managers. Observations feed into individual staff supervision and team meetings.
Visits by senior managers/QA team	In some countries someone from the senior management team is required to visit monthly. At least quarterly visits recommended and used to give feedback to front-line managers and staff teams AND into audit processes. Again, a short, structured tool to ensure a focus on practice and outcomes is recommended as helpful to ensure consistency across time and settings.
Visits by auditing team	This is most likely to be done once a year in most settings. Some organisations may do this more frequently. Whilst checking manager or staff team self-evaluations and compliance is important, these should also include a focus on observing user experiences and staff interactions/support. This may feed into both service level action plans and organisational improvement plans.
Staff surveys	It is helpful to assess staff experiences and how they feel about their job, at least for a representative sample of staff, on an annual basis. Feeds into annual audit for review by organisational leadership.
Stakeholder surveys	Using surveys or interviews the perspectives and experiences of those receiving services, their families, and other stakeholders where relevant. Surveys or interviews should ideally be conducted or facilitated by someone independent of the service the person receives or at least by someone not directly involved (i.e., not staff or frontline manager). Ideally families would be asked about their own views of the service and their experiences – not asked to respond on behalf of their family member. Survey findings would feed into the audit.
Data collation	
Collation of daily recording e.g., by keyworkers	Key workers or other allocated staff review daily reporting/recordings and summarise successes and issues to be solved for everyone. Feeds into team meetings.
Audit team collate data and report	It is recommended that organisational audit reports allow organisational leaders to review and discuss how the service is doing in terms of outcomes and experiences (for users, staff, and families) but also provide information to allow discernment of factors impacting on outcomes, including data at the level of organisational systems and processes.
Review and reflection	
Regular team meetings – discussions recorded	Meetings of all staff held ideally every 4-6 weeks. Discusses information collated by key workers for each person supported – successes celebrated, and issues and new opportunities discussed. Discussions are minuted (recorded in writing) and this information can be then summarized and reviewed in person-centred/individualized planning meetings – as well as reviewed as part of self-evaluation processes.

Quality monitoring and improvement opportunities	Description
Person-cantered planning meetings	Progress towards goals, quality of life reviewed, drawing on data collected and discussed in team meetings during the year and combined with direct input from individuals (before or during meetings) and their circle of support.
Regular individual supervision for staff	Ideally every 1-2 months, staff have individual supervision with their direct line manage which draws on an observation of practice. Supervision meetings allow reflection on observations and discussions of issues impacting on staff member's support; Meetings may also identify the need for further training and support. Key issues raised in supervision across a staff team might feed into service self-assessment
Feedback from senior manager visits	Ideally when senior managers have visited the front-line leader and staff team would receive feedback that they would discuss potentially in team meetings, and which would also feed into self-evaluation processes.
Formal self-evaluation/ assessment at service level	Service managers, staff teams and where possible the people receiving services review data from different sources (e.g., collated data from daily recording, outcomes data from team meetings, key issues identified from staff supervision; feedback from managers observations and senior manager visits etc) and reflect on potential factors impacting outcomes and what might be needed to improve quality and outcomes at service level,
Senior managers review audit reports	Audit results reviewed by senior management team/Board of directors/trustees.
	Planning for improved outcomes and quality
Person-centred planning meetings and goal setting	Following review of outcomes and experiences in the person-centred planning meeting, a revised person-centred plan and support profile is developed with the individual and circle of support.
Service improvement plan	Service/quality improvement plan developed by front-line leaders following the formal self-evaluation process, with support from senior management as needed.
Organisation quality improvement plan	Where the organisational audit has identified areas of weakness or gaps in service provision and quality, the senior management team, with the Board of Directors or Board of Trustees or equivalent body as appropriate would develop a plan/ strategy for improving quality and outcomes across the organisation
	Implementation of change
Staff support people in new activities or towards new goals	Ensure all staff are aware of agreed goals, strategies for support, and know how to implement etc. Staff support individuals to participate in new activities and relationships, working towards new goals as identified in their person-centred plan.
Action taken to implement service and organisational improvement plans	Service/ organisational plans are implemented, e.g., staff trained as needed, policies or procedures changed etc.
	Review and confirmation of change
Review at next person-centred/individuals planning meeting	This element takes the process of quality and outcomes monitoring and improvement at the level of the individual back full circle. Drawing on ongoing data collection and review at team meetings and discussion where appropriate with the individual, the changes made would be reviewed at the next person-centred planning meeting.

Quality monitoring and improvement opportunities	Description
Improvement plans reviewed, change documented and improvement confirmed	This element takes the process of quality and outcomes monitoring and improvement at the service and organisational levels back to the start of the cycle. It is very important that the change process is evaluated using the data in the next data collection and review cycle and then feedback provided to managers, staff, and potentially other stakeholders. Confirming improvement is particularly important for staff and manager motivation.

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Annexes

Annex 1: Summary of Approaches and methods used to monitor quality

Method	Service user group	Type of service in which method was used	Country	Who collects the data	Are people with disabilities involved in monitoring quality of services using this method?
Internal audit or evaluation					
Survey or structured interview with people receiving services	• Physical disabilities • Intellectual disabilities • Mental health problems • Dementia • Autism	• In home support/supported living to children and adults • Residential care • Day and employment services • Respite/short breaks • Outreach/ independent living skills • Developmental services for children • Family support services	Norway Ireland Scotland Spain Germany Finland Romania Czech Republic	In Norway and Ireland, the structured interview/survey is conducted by the service manager or by a member of staff who knows the person well. In other countries usually sent as an online or paper survey. People provided with help to complete if needed. Can also ask family or friends to provide support.	As participants in the survey if they are able to do this.
Survey or structured interview with family/friends of people receiving services	• Intellectual disabilities • Mental health problems • Physical disabilities	• In home support/supported living to children and adults • Residential care • Day and employment services • Respite/short breaks • Outreach/ independent living skills	Ireland Scotland Spain Germany Finland Romania Czech Republic	Usually collected by provider as an online or paper survey. Sometimes a phone survey. In Scotland survey sent out by the Care Inspectorate before an inspection.	

Method	Service user group	Type of service in which method was used	Country	Who collects the data	Are people with disabilities involved in monitoring quality of services using this method?
		• Family support services			
Survey or structured interview with other stakeholders (e.g., funders, guardians)	• Intellectual disabilities • Mental health problems • Dementia	• In home support/supported living to children and adults • Residential care • Day and employment services • Respite/short breaks	Norway Spain Czech Republic	Usually an online or paper-based survey is sent by the provider	
Self-assessment by managers and/or staff team against a set of criteria or indicators.	• Physical disabilities • Intellectual disabilities • Mental health problems • Older adults/ dementia	• In home support/supported living to children and adults • Residential care • Day and employment services • Respite/short breaks • Family support services	Norway Scotland Spain Finland Romania	A mix. Mostly front-line managers but in Norway need to include a member of staff in process. In Spain, people with disabilities are part of process.	In Spain people with disabilities are part of the self-assessment process. They are also interviewed by external evaluators.
On-site visits by senior managers or a Quality assurance team to check compliance/ validate self-assessment	• Physical disabilities • Intellectual disabilities • Mental health problem • Older adults/ dementia	• In home support/supported living to children and adults • Residential care • Family support services	Ireland Norway Romania Spain	In most cases visits were conducted by a people from outside the direct operations team – e.g. Those from the quality	
		• Respite/short breaks • Day and employment services	Scotland Czech Republic Finland Romania	assurance team. Sometimes this was just one organisation. In Ireland, senior managers visited services	

Method	Service user group	Type of service in which method was used	Country	Who collects the data	Are people with disabilities involved in monitoring quality of services using this method?
				usually monthly as required by Registration and inspection agencies. This was in addition to visits by a Quality Assurance Team.	
On-site visits by managers or QA team to conduct observations and gather information of service quality or user experiences (goes beyond compliance). Could include informal conversations with people living there and staff.	• Physical disabilities • Intellectual disabilities • Mental health problem • Older adults/ dementia	• Respite/short breaks • Residential care • Day and employment services • Family support services/therapy	Scotland Finland Romania	In Romania, senior and trained clinicians/ practitioners observed new practitioners providing therapy and family support services. Used to check the quality as well as to provide training/ support to new staff. In Scotland, visit by service managers involve observations of staff working practices as well as elements of record keeping etc. In Finland one approach involving visits to services was documented as focusing on ascertaining	

Method	Service user group	Type of service in which method was used	Country	Who collects the data	Are people with disabilities involved in monitoring quality of services using this method?
				whether people are having a good life and participating and that family's trust/have confidence in the service.	
Self-evaluation and reflection by staff focused on outcomes and quality improvement	• Physical disabilities • Intellectual disabilities • Mental health problems	• In home support/supported living for adults • Residential care for adults • Day and employment services	Finland Germany	In Finland the staff team with team leader use Donabedian's framework to reflect on how well they are supporting good outcomes for individuals. In Germany individual planning process is used to review the outcomes and support for an individual on a regular basis.	Yes – in Germany the person is involved in the review of their individual outcomes as part of individual planning process
External evaluation					
External evaluation focused on compliance with standards set in policy or by external agency.	• Physical disabilities • Intellectual disabilities • Mental health problems • Older adults/ dementia	• In home support/supported living to children and adults • Residential care • Respite/short breaks • Day and employment	Norway Scotland Czech Republic Finland	In Norway – the provider commissions approved external organisations to conduct the evaluation in line with national requirements. In Czech Republic and Scotland, the visits conducted	

Method	Service user group	Type of service in which method was used	Country	Who collects the data	Are people with disabilities involved in monitoring quality of services using this method?
				by National Inspection/ regulation bodies.	
External evaluation, focused on good practice indicators, user experiences, or Quality Frameworks.	• Intellectual disabilities • Mental health problems • Older adults/ Dementia	• In home support/supported living to children and adults • Residential care • Family support services • Day and employment services	Czech Republic Germany Romania Scotland	In Scotland the inspection body also do observations on quality of staff interactions etc. as well as check compliance on paperwork, procedures. etc. In the Czech Republic providers can have so called Clients´ Audit (Klientský audit) during which people with disabilities are supported by an NGO to conduct the evaluation. In Germany and Romania, experts or senior practitioners visit servicesto assess the quality of services provided and ensure they are consistent with the framework or trained working methods.	Yes, in the Czech Republic

Annex 2: Areas of quality

Focus of monitoring	Description
Outcomes of those receiving services (and families where appropriate) (i.e., how good people's life was; their quality of life).	Templates included a section for identifying which outcomes for users were explored. The most common quality of life domains that were included under "outcomes" were physical well-being (in particular safety), emotional well-being (including life satisfaction) choice, human rights (e.g., freedom from abuse, dignity, and respect) and control/self-determination. However, other approaches did touch on most other domains. The least explored domain was material well-being. Some approaches didn't assess outcomes for individuals at all but looked at whether policy and procedures were in place to deliver those outcomes. In many templates it was not clear different outcomes were focused on. Examples of where outcomes were more clearly assessed were found in Germany through the use of individual planning meetings which reviewed for each individual different areas of their lives. We did not find any examples of providers using surveys or measures to assess quality of life in any way that could be compared directly or against benchmarks. In the Czech Republic, the Client Audit asked individuals who live in the services who plans the program of activities etc. Whether they can choose what they want to do; whether someone helps them to do what they enjoy, whether they can cook for themselves, and how individuals and staff address each other. As such, these focus primarily on self-determination, the support they receive and their relationships with staff. In Ireland the survey/interview with service users asked questions that fell between looking at outcomes and satisfaction with services. For example, they asked questions such as: are our staff members kind? Do our staff involve you in planning your care and support? Do staff help you to stay safe? Do you know how to make a complaint? Has your life improved with [name of organisation); Do staff help you to keep contact with family and friends? Do staff help you to manage your money? What could we do better? In Finland, one organisation focused on the life outcomes in three domains (Physical well-being, emotional well-being, and personal development) during their self-reflection and service improvement team discussions. They used a tool based on Donabedian's model of service quality to discuss what systems and processes might be impacting on users' outcomes and how it can be improved.
	In Scotland the *Health and Social Care Standards* are the foundation on which the Care Inspectorate have set out their Self-assessment guidelines and inspection focus. These are very person-cantered, improvement focused and well-defined with clear links to service user experience and outcomes. In terms of Quality-of-Life domains, those included can be summarized under choice and control/self-determination, physical well-being, human and civil rights, social inclusion, and personal development. The indicators used in the Standards are primarily about whether the service is supporting people towards such outcomes. However, in self-evaluation and inspection processes the emphasis is more on checking that the policies and systems exist that should deliver such outcomes, rather than establishing whether the outcomes are actually being achieved (or at least there is progress/improvement or maintenance when deterioration is an issue). Surveys are used to ask those who can answer them about how the service supports them in key areas.

Focus of monitoring	Description
Satisfaction with services and support	No common measure was used to assess satisfaction with services. Most measures were very short, and items appeared to have been identified by each organisation separately. Details on the types of questions used were not available for every template. In Norway the survey asked similar types of questions to those mentioned above from Ireland but also asked a question about whether people are happy with the services: If you need something, do staff help you get it? If you communicate something, does someone listen? Other stakeholders were also asked about whether they were happy with their contact with the organisation, with staff etc.
Quality of support and interactions between staff and people supported	In one short breaks service in Scotland, service managers visit services (announced and unannounced) at least once every six months with the purpose of observing the support provided as well as checking compliance with policies, medication records, files, daily logs, and financial records. The service manager would work on shift alongside regular staff and would observe their working practices including person-centredness, behaviour support, choices offered around meals and activities, providing opportunities for independence, being part of the community, administration of medication and building relationships. As such they were able to look at outcomes of the people supported as well as how staff provided support. Feedback was provided to the member of staff and overall team from the observation as part of staff development and service improvement, rather than as part of a more formal quality audit process. In Romania some services for people with disabilities use ABA Therapy as a foundation and guidance is provided by the ministry of Labour and Social Protection in terms of the social service format, physical space required, the therapist characteristics and qualifications, etc. Once a year the service and therapists are evaluated including visits by a development team responsible for and qualified to oversee the quality of the services. They particularly focus on new therapists and provide feedback and supervision. They also observe therapy sessions to evaluate the quality of the service and get feedback from parents. In Germany a similar approach is taken around how organisations providing primarily residential and day services for people with intellectual disabilities and older adults, respond to challenging behaviour and whether practices are in line with good practice. Staff in disability services receive Professional Assault Response Training (PART®) https://www.parttraining.de/. Employees of the company that developed and provide the training and are qualified as in-house trainers carry out assessments and interviews after incidents of violence to ensure that policy was followed and to identify key lessons and how to prevent future incidents. This information is shared in team meetings and used for the improvement of internal processes.
Technical aspects of care such as the provision of personal care or medication administration	In almost all countries at least one approach included a focus on the technical aspects of care such as medication, healthcare provision, personal care, eating and drinking, infection control, etc. This was a key focus for approaches that were focused on checking compliance with standards. For the most part the focus was on the negative side of these – e.g., medication errors, hospital admissions, accidents, mortality, etc.
Physical environment	This was a key focus in the Client Audit used in the Czech Republic– the functionality and appearance of living or social spaces.

Focus of monitoring	Description
	The quality of the environment also featured in the self-evaluation and audit, or inspection visits used in Ireland, Scotland, Spain, Finland and in the user survey in Germany. For the most part, the focus appeared to be on the appearance of the environment, the physical safety, the appropriateness for the users and purpose of the services. It was not clear how much focus was put on accessibility and whether the environment was arranged in a way to promote outcomes such as independence, control etc.
Management/ leadership	Management and leadership were a key focus in most self-evaluation and external inspection-based approaches, and in most of the countries. In Norway the external audit described only focused on management and leadership throughout the organisation – from senior managers through to front-line supervisors. They checked that the processes and systems the organisation said they used were actually happening.
Staffing and staff training	Self-assessment-based approaches did tend to include indicators related to staffing with a primary focus on the required number of staff around. In some systems this was assessed by looking at the number of days the service did NOT have the required staffing ratios - this was then often checked during visits by QA teams or external auditors/inspectors. When staff training was considered in monitoring (e.g., in Ireland, Scotland, Norway), the focus was primarily on checking that staff had completed whatever training was considered mandatory in that country. This varied greatly – in some countries mandatory training was very basic and generic (e.g., food hygiene, fire safety, first aid, basic care procedures etc); in other countries a much higher level and quantity of training was required. For example, in the Czech Republic, the legislation specifies a compulsory number of training hours which staff has to undertake annually.
Person-centred planning/care planning	For the most part, when approaches focused on person-centred planning or care planning it was primarily related to whether a plan had been completed, followed guidance where this was available, and whether people were involved in their own planning process (Scotland, Ireland, Spain etc). However, in Germany, where individual planning was put forward as being part of a quality monitoring process, there was more of a focus on whether people had achieved goals identified in the planning process.
Incidents/ accidents/crises and complaints	This element of quality is to some extent linked to the technical aspects of care. Almost all formal audit processes collected and summarised information about incidents, accidents, injuries, deaths, crises, and complaints (a few included compliments too).

Annex 3: Consistency of the approaches and methodologies used be providers with the UN CRPD

UN CRPD Article	Reflections on quality monitoring processes identified in the approaches identified
Articles 5, 6 and 7: Equality and non-discrimination	There was no obvious focus on whether people were being treated as equal before the law, free from discrimination and being provided with reasonable accommodations in any area of their lives.
Article 8: Awareness Raising	There also appeared to be no focus in any system on whether people were being viewed and received positively in their communities, and whether services were helping people to successfully achieve community inclusion and to promote greater

UN CRPD Article	Reflections on quality monitoring processes identified in the approaches identified
	social awareness of the skills, merits, abilities, and potential contributions people with disabilities could make.
Article 9: Accessibility	Services are clearly not responsible for ensuring accessibility in local communities but do play a part in ensuring people can access all areas of their homes and can advocate for changes in their local facilities to ensure they can access these. In a few approaches, the appropriateness and accessibility of the environment in which people lived, spent their days, or worked was considered as part of the overall picture. However, how well their environments were adapted to support/promote independence, autonomy, choice, communication, and participation did not appear to be a focus.
Article 10: Right to life	Ensuring people's right to life was a primary focus in many approaches, usually in the form of ensuring safety, reducing accidents etc.
Article 12: Equal recognition before the law	From the type of information included in most approaches, it is not possible to know whether people enjoy legal capacity and whether people receive the support they need to exercise their legal capacity, whether their will and preferences are taken account of, whether people are free from conflict of interest and undue influence when making decisions. In some of the countries in which approaches originated, particularly people with intellectual disabilities were under guardianship. Some approaches asked guardians to rate the quality of services. Whether safeguards around decision making were proportional to the degree to which such measures would affect the person's rights and quality of life was not a focus in any system. Many approaches did focus on whether people had choice over certain areas of their lives, but little information was gathered on how decision making was supported even in day to day life, never mind whether services were taking all and appropriate and effective measures to ensure people could own or inherit property, control own financial affairs, access loans and other forms of credit and not be deprived of their property.
Article 14: Liberty and security of person	Although some approaches clearly collected data about information such as restrictive practices, usually in response to challenging behaviour, this was mostly at the level of the fact that it happened – how many times were people restrained.... There was little apparent focus on whether deprivation of liberty was in conformity with the law and from the detailed examples of surveys available we did not find any that asked people whether they felt "free" or were able to come and go as they pleased, although some did ask whether staff helped them to do things that they wanted to do. However, sense of liberty was not something that was generally asked.
Article 15: Freedom of torture or cruel, inhuman, or degrading treatment or punishment	Overall, ensuring people were free from abuse and happy with the support from staff was a key focus in many approaches. Incidents of abuse, exploitation, degrading treatment would have been recorded in every system and in most cases both the situation and the organisations responses would have been reviewed by managers on a regular basis.
Article 16: Freedom from exploitation, violence, and abuse	Many survey-based approaches did ask about whether people were treated with dignity and respect. In a few examples where visits to services were made, there were also observations of interactions between staff and those they supported, to look for lack of respect or undignified treatment (e.g., in Scotland and in the Czech

UN CRPD Article	Reflections on quality monitoring processes identified in the approaches identified
	Republic). In the Czech Republic people were also asked people about whether they felt safe. In Ireland people were asked about whether the service/staff help them to feel safe.
Article 17: Protecting the integrity of the person	In Germany and Romania, there were examples of visits to observe whether treatment, support and interactions were in line with good practice-based frameworks (such as positive behaviour support or equivalent) or technical approaches such as Applied Behaviour Analysis. As noted above, autonomy and decision-making processes, in this case around things like medical treatments, did not appear to feature in any approach to monitoring quality.
Article 19 – Living independently and being included in the community	A small number of approaches did consider whether people were being supported to do things in their community and whether the processes needed to make this possible were in place. However, this was not done in any detail. Most approaches did not include things like where the home was located, whether it was in line with what would be considered the normal range of housing for people without disabilities or whether people really a choice of where they lived and who they lived with. Many of the monitoring systems were used in residential care services where choice over where and with whom people live is often much more limited.
Article 21 – Freedom of expression and opinion, and access to information	We did not find any measures that included a focus on whether people had access to, support to use or experience of staff using their preferred form of communication to help them to express references, and to make choices. However, in some surveys people were asked a question about whether, if they try to communicate, someone listens (e.g., in Norway) or whether information was provided to them in a way they could understand. In other approaches, whether people knew how to make a complaint was the primary focus (Ireland). However, whether complaints were resolved, people's satisfaction did not appear to be assessed, apart from in the self-assessment process in Scotland where managers were expected to provide written evidence of: how the complaints and concerns of each person, their family, advocate or representative, and stakeholders are listened to and acted upon and whether people can appeal; whether People are made aware promptly of the outcome of any complaints and there are processes in place to implement learning from complaints; whether A record is made of all complaints, responses and outcomes and details of any formal investigations undertaken; and whether the complaints process is user-friendly and accessible.
Article 22 – Respect for privacy	Few approaches appeared to consider whether people had privacy in their own home, whether people could lock the door to their rooms, chose when people visited, had somewhere safe to store their personal belongings, opened their own mail. The exception to this was in the Czech Republic where inspection visits check whether people have privacy in their home. However, security and confidentiality of data held about people was considered in some approaches (e.g., Scotland, Norway).

UN CRPD Article	Reflections on quality monitoring processes identified in the approaches identified
Article 23 – Respect for home and the family	Some of the survey approaches asked people about whether staff help them to keep contact with family and friends (e.g., Ireland) and whether family participate in people's lives, where appropriate (e.g., in Scotland). However more detailed information was not available about whether people are supported to have relationships, get married, decide on whether to have a family, have support to bring up a family etc.
Article 24 – Education	Our work was primarily focused on social care and not education services. However, few approaches included any focus on whether people were accessing education or even just developing skills, interests, confidence, mental and physical abilities to their fullest potential. As noted under article 21, it was not known whether people were being provided with reasonable accommodations e.g., communication tailored to their needs and preferences; adapted materials or equipment to support learning and development etc. The Scottish Quality Framework for fostering, adoption and adult placements (which will include children and adults with disabilities) includes in Quality Indicator 1.2 (children, young people and adults get the most out of life) a focus on the extent to which everyone being supported by a service have "positive learning experiences, achieve their goals and aspirations and reach their potential". Services are expected to provide evidence on how they do this in their self-assessment and care inspectorate will check the validity of the self-assessment during an inspection visit.
Article 25 – Health	Although our focus was primarily on social care services and not health services, social care services still have a role in promoting good health outcomes for people with disabilities and support people in crises. Many quality monitoring approaches did focus on health particularly in terms of acute health care and crises– such as accidents, illness, infection control, hospital admissions and mortality. Some did include healthcare decisions when thinking about the autonomy people had. Some approaches also focused on how well services were supporting health and well-being – for example in the Scottish Quality Framework for support services at home – Quality Indicator 1.3 focuses on the extent to which people experience care and support based on relevant evidence, guidance, best practice, and standards; the right healthcare from the right person at the right time; and food and drink that meets their needs and wishes. This includes things like medication systems that support people to take their medication and give people as much control as possible; services helping people to access community health care and treatment at the earliest possible opportunity; information about health care decisions being available in a format that works for them, etc.; and people have access to opportunities that contribute to health education. In the survey for service users, there is the following question: "If I am unwell, staff can recognise this and help me get the right help." Health is also an essential element of the national standards in the Czech Republic, including nutrition, access to therapies and the monitoring of health status.

UN CRPD Article	Reflections on quality monitoring processes identified in the approaches identified
Article 26 – Habilitation and rehabilitation	We did not identify any approach that looked at whether people were accessing services and supports focused on habilitation or rehabilitation that were community-based and local to the person. Nor was there any focus on the use of assistive devices and technologies. However, assessment of needs was a stronger focus in some approaches – for example in Scotland and Germany assessment of people's needs and wishes was seen as an important part of care planning process.
Article 27 – Work and employment	The individual planning process used in sheltered workshops in Germany considered whether people had achieved goals/outcomes that allowed them to move on to either a company integrated workplace or to employment in the open labour market. Whether those using services were being helped to find work of any type or to become employed etc. was not clearly identified in any other approach.
Article 28 – Adequate standard of living and social protection	The least commonly included quality of life domain was that of material well-being – even when people were being supported in their own home. However, some approaches did include Housing as an area of focus (e.g., in Finland). However, whether people had enough money to do the things they needed or wanted to do was not formally assessed in any approach.
Article 29 – Participation in political and public life	We did not find any approach that looked at whether people supported had been supported to vote or whether they were volunteering or participating in other ways in their community.
Article 30 – Participation in cultural life, recreation, leisure, and sport	For the most part, very few approaches gathered detailed information about people's level of participation. In Scotland, the Care Standards do include that people have the choice to "have an active life and participate in a participate in a range of recreational, social, creative, physical and learning activities every day, both indoors and outdoors." Providers have to give evidence of how they do this in their self-assessment and guidance is clear about what would be good practice and what would be weak practice. However, it is not clear how inspectors check whether self-assessment is an accurate reflection of what people actually experience. One of the other approaches identified in Scotland – where managers spend time working in services and observing what people get involved in and how staff provide support, does allow managers to see whether the people supported are accessing cultural, recreational, leisure or sport activities. However, this observation is used to provide feedback for staff and team development rather than forming part of the organisational quality monitoring and assurance process.

EASPD is the European Association of Service providers for Persons with Disabilities. We are a European not-for-profit organisation representing over 20,000 social services and disability organisations across Europe. The main objective of **EASPD** is to promote equal opportunities for people with disabilities through effective and high-quality service systems.

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