An Chomhairle Náisiúnta Eacnamaíoch agus Shóisialta
National Economic & Social Council
NESC

# Achieving Quality in Ireland's Human Services - A Synthesis Report

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An Oifig Náisiúnta um Fhorbairt Eacnamaíoch agus Shóisialta
National Economic & Social Development Office NESDO

# National Economic and Social Council

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2. The Council may consider such matters either on its own initiative or at the request of the Government.

3. Any reports which the Council may produce shall be submitted to the Government, and shall be laid before each House of the Oireachtas and published.

4. The membership of the Council shall comprise a Chairperson appointed by the Government in consultation with the interests represented on the Council, and

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   - Four persons nominated by the Irish Congress of Trade Unions;
   - Four persons nominated by community and voluntary organisations;
   - Four persons nominated by environment organisations;
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An Chomhairle Náisiúnta Eacnamaíoch agus Shóisialta
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# Achieving Quality in Ireland's Human Services - A Synthesis Report

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## Abbreviations

**BOMs**
Boards of Management

**CCTV**
Close Circuit Television

**CQL**
Centre on Quality and Leadership

**DEIS**
Delivering Equality of Opportunity in Schools

**DES**
Department of Education and Skills

**ERC**
Educational Research Centre

**EU**
European Union

**FSC**
Forest Stewardship Council

**GP**
General Practitioner

**GPSU**
Garda Professional Standards Unit

**GSOC**
Garda Síochána Ombudsman Commission

**HFH**
Hospice Friendly Hospitals

**HIQA**
Health Information and Quality Authority

**HSE**
Health Service Executive

**ISO**
International Organisation for Standards

**LAOS**
Looking at Our Schools

**NCCA**
National Council for Curriculum and Assessment

**NESC**
National Economic and Social Council

**NHI**
Nursing Homes Ireland

**OECD**
Organisation for Economic Co-Operation and Development

**P&DC**
Performance & Development Culture

**PISA**
Programme for International Student Assessment

**QSR**
Quality Service Review

**SL**
Service Level Agreement

**WSE**
Whole School Evaluation

**WSE-MLL**
Whole School Evaluation-Management, Leadership and Learning

# Executive Summary

This study summarises the findings in the NESC series of reports *Quality and Standards in Human Services in Ireland*. A principal hypothesis underlying these reports has been that a 'silent revolution' has occurred in Ireland regarding the regulatory infrastructure over certain human services. Over the last decade and more, there has been dramatic change in the oversight of some services, underpinned by standards, that has gone largely unremarked. In relation to residential care for older people, for example, the establishment of the Health Information and Quality Authority (HIQA) as an independent regulator of residential centres has had a significant effect on the quality of care within these places. How regulation is conducted can have a crucial bearing on the quality of a human service like education or disability services. NESC believes that examining these and other areas could offer vital insights into how far Ireland has travelled in terms of securing high-quality services and gauging what still has to be accomplished. It is for this reason that NESC undertook a review of the international research and policy on achieving quality through standards as well as completing sectoral reports on how standards were being achieved and quality attained in the following areas: (1) policing; (2) schools; (3) disability services; (4) residential care for older people; (5) home care for older people; (6) end-of-life care. Different approaches to fostering improvements have been adopted in each of these areas and the rationale for this synthesis report is to compare and contrast the different areas and see if any common themes emerge that could help to cultivate quality in other human services.

A legitimate question to ask is why should we be concerned with the quality of human service provision at a time of economic austerity and financial cutbacks. It can be argued, however, that quality should be inherent in how we provide human services and it is thus of concern more than ever, as we need to ensure optimal use of scarce resources. As well as the idea that quality should be intrinsic in the provision of human services, people are now more aware of their rights and the obligations due to them by service providers, and are more prepared to challenge inadequate services. Irish society is also more diverse and there is an expectation that services should be more tailored to meet people's needs. This has the potential added benefit of making services more efficient, with less waste.

As argued in all of NESC's recent work, there is an important complementarity between economic and social development. Therefore, at a time when we need to promote economic growth, we also need the support of quality social systems. An added dimension is the importance of public trust in Ireland's institutions and their capacity to deliver quality services. In many areas that trust has been lost as a result of gross systems failures in some services and settings. There is a need to repair that deficit and, thus, a wide-ranging assessment of the systems of quality, standards and accountability in human services can be seen as addressing the critical issue of trust in Ireland's public authorities.

In examining these matters, the report is structured as follows. Chapter 1 sets out why NESC has a concern for the provision of quality human services, as described in the preceding paragraphs. Chapter 2 summarises some of the insights of the first NESC report in this area, *Quality and Standards in Human Services in Ireland: Overview of Concepts and Practices*. It argues for a broad notion of regulation, encompassing non-State as well as State actors and using a variety of different instruments — from legal sanction to moral pressure and peer review — to help produce quality, tailored outcomes. These instruments are most likely to promote quality when they are accompanied by review and revision of practice by those who deliver human services. In effect, practitioners are encouraged to 'work out a better way to work'. Ideally, this kind of review should be guided by the question of whether standards or guiding norms are being fulfilled: for example, are service users being adequately consulted in the delivery of services? This can help make the assumptions behind service delivery more transparent as well as making it easier to compare different ways that people deliver services.

Chapter 3 summarises the contents of the NESC sectoral reports. It applies their insights to assess the nature and efficacy of the various regulatory regimes as to what extent they deliver quality in the following sectors: policing, schooling, disability, residential and home care for older people, and end-of-life care. Each of these sectoral reports exemplifies a different approach to delivering a quality service, what this report terms 'multiple routes to quality'.

Chapter 4 builds on this analysis to suggest some positive courses of action that would be conducive to further improvement and reform in each of the sectors. Many of these individual recommendations have a common basis in a possible development that is termed a 'centre supportive of continuous improvement'. This refers to the idea that the 'policy centre' which might comprise of a regulator and government department or agency, should be concerned not just with whether individual organisations are abiding by standards but how they can be supported in this endeavour, and how the entire sector can be continuously improved. Being supportive does not mean that the policy centre has succumbed to 'regulatory capture': it is primarily supportive of standards because of the beneficial effects that they can have on services. Because it is supportive in this way, it means that the policy centre might need to need to be deeply provocative in relation to current practice if it does not abide by the best current understanding of how to exemplify standards.

Chapter 5 concludes the report by enquiring about the implications of this notion of a 'supportive centre' for Ireland's current strategies of public sector reform. The chapter suggests that the two concerns of a policy centre, improving the performance of individual organisations and assessing the efficacy of the overall field of practice, puts a premium on what the OECD (2008) has called a performance dialogue. Often it will be government departments that will have to institute this dialogue. They will need to maintain the balance of being supportive whilst also being willing to be provocative if services are not delivering standards and quality. This may involve prompting general improvements by providing services through alternative institutional mechanisms, such as social enterprises, which might have a greater capacity to deliver higher-quality services. Ireland already has a hybrid welfare system combining public, private and voluntary elements. What this study has found is that it is the organisational capability and disciplines of quality that lead

to a continually improving regime of quality service provision, regardless of the institutional origins of the service providers. The challenge is to provide an environment conducive for quality service providers to flourish, to share the benefits of that experience, and so bring about wider systemic improvements in the provision of quality services.

# Chapter 1
# Why a Concern for Quality Services?

The focus of this report is on how quality in services like eldercare, supports for people with disabilities, and schools can best be attained. What is meant by a quality service? The first NESC report in a series on this subject[1] defined a quality service as one in which service delivery and outcomes are free from deficiencies or unjustifiable variations, adhere to agreed standards, and meet the needs and informed expectations of the service user. To take an example: we would not think education of sufficient quality if it was not able to adapt itself to meet the particular needs of individual citizens whilst prompting broadly similar outcomes for all.

Talk of quality in a time of economic austerity and financial cutbacks may seem like a luxury. People may wonder whether more emphasis should be put on securing basic services and ensuring access to them. This is an understandable stance but we should be careful about creating a division between 'basic' and 'quality' human services as if the latter is somehow superfluous. Quality should be seen as a basic expectation for all users of human services and not something that might supplement the delivery of services if resources happen to be available. Rather, quality should be seen as intrinsic to the delivery of human services provided by the State, private sector, voluntary sector and communities. This is not to say that issues around costs are not important. However, the report will argue that, in some sectors, the institutional arrangements that could produce quality may also help diminish costs.

Apart from the idea that quality human services are a basic expectation, are there other reasons to support this idea? A number of others suggest themselves. People are now more aware of their rights and the obligations due to them by service providers and so are more prepared to challenge inadequate services. Many of the changes in the structures of regulation of important human services, such as policing or eldercare, hinge on the realisation that people wish to have their voices heard regarding the quality of service delivered to them. Whilst these expectations may have been overlooked or neglected in previous times on the basis that the service provider knows best, this stance is increasingly untenable.

Whilst Irish society is perhaps less deferential now, it is also more diverse. Even if people did not demand services suited to their needs, providers would have to be prepared to reshape their services to suit the differing circumstances of people. Take education as an example: even if the goals are universally held — for instance, a guarantee that all children will be literate and numerate by a certain stage — the

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1 *Quality and Standards in Human Services in Ireland: Overview of Concepts and Practices* (hereafter referred to as the Overview report).

fact that not all children learn at the same pace or in the same way means that education has to be adapted to the circumstances of individual students and shaped accordingly. Variety may arise as much from cultural diversity as social disadvantage or individual characteristics. Whatever its origins, it is now more difficult for service providers to deny the relevance of disparate social conditions and the implications of these for how practitioners do their work. The upshot is that if Ireland is to claim that it provides quality human services for all, those services must be adaptable to the circumstances of the individuals that use them.

Apart from the idea that civil society is now more articulate and vociferous in pressing its claims, there are other reasons for supporting the idea that quality human services are indispensable, namely that they are vital for social *and* economic progress. We judge the quality of our society by the manner in which we care for our most vulnerable, be they young, old, disabled or disadvantaged. Not only are quality public services goods in themselves that people rightfully expect, they are also an indispensable feature of enhanced economic performance. Recent falls in employment have been fuelled by the disappearance of many relatively low-skilled jobs that are unlikely to reappear in great numbers. A return to sustained economic growth will be partly dependent on there being a sufficiently skilled cohort of people that are able to fill the positions available. We cannot expect to make headway against Ireland's unemployment without embracing a service model that is able to accommodate itself to the variety of requests, both in terms of the supply of and demand for labour, placed upon it and adapt accordingly. This is only one example of how a core human service such as labour-market policy can play a vital economic role. Other obvious examples include childcare, education and eldercare and the implications of this project for reform of the public services will be analysed in the last chapter.

Establishing that investment in human services has both an economic and social benefit does not help to answer how these resources should be deployed in particular situations to best effect. We know, for example, that investment in the very early years of a child's life can have the greatest economic benefit. And we also know about the advantages accrued from interventions like the American Perry Preschool Project, which demonstrates a ratio of benefits to costs in the order of 7:1 by steering its participants away from adverse outcomes like prison in later life. But what is difficult to gauge is how an intervention like the Perry Project would translate and be implemented into a different context than the one in which it was first developed; it is not a simple matter of replication since the background and subjects in America and Ireland differ so dramatically. Rather, it is a matter of finding an appropriate organisational arrangement for the effective deployment of resources that will produce quality outcomes.

An alternative to addressing questions of effective organisational arrangements is often sought in the language of rights: if the need for quality services could be expressed in the form of rights, this may help mobilise political support and aid their delivery. However, NESC (2002) has previously suggested that rights cannot always deliver the simplicity that is supposed to be their main advantage. The language of rights often expresses its claims in a sort of 'line item way, presenting each individual's case peremptorily, as though it brooked no denial, no balancing, no

compromise' (Waldron, 1993: 26). But rights cannot escape issues of scarcity and compromise and are often best realised through experimentation; for example, it is not always immediately evident what kind of care best suits a person with disabilities. Discovering answers to issues like these means connecting rights with standards and benchmarks that have two functions: they serve as a yardstick to gauge how adequate current practice is and also help to specify how matters might be improved.

A related reason to undertake detailed work on quality and accountability is that Irish public authorities have, to a very significant degree, lost the trust of the people. In setting out the rationale for this project, the Council noted that a number of developments are raising awareness of quality, standards and accountability. Among these is the fact of gross systems failure in some services and settings and, more widely, acceptance that current standards and accountability regimes have been inadequate (NESC, 2011: 3). All are agreed that a degree of trust is necessary if systems of services and regulation are to work effectively in the service of society and the economy. But trust, once lost, is not easily regained. One view is that it depends on the honesty and other values of those in positions of authority; thus the key to trust is to find ways of putting into authority only those that can be trusted. While the right values are a necessary condition for trustworthy public authority and human services, they may not be sufficient—either to generate trust or ensure quality services tailored to the needs of individuals. Experience shows that, in certain contexts, good people can participate in the provision of bad services and regulation. For a variety of reasons, professional accreditation on its own no longer guarantees trust, quality or accountability. Conversely, where trust does exist—for, example, in our willingness to eat food prepared by others or fly in airplanes—it would seem to be based more in our assurance that appropriate institutions and procedures are in place than in a belief in, or knowledge of, the values of those running these systems. NESC's work over a decade—on policy making, implementation, partnership, social and economic rights and Ireland's experience in the EU—suggests that it is institutions rather than values that should be the focus of analysis and that are amenable to improvement. Thus, a wide-ranging assessment of the systems of quality, standards and accountability in human services, such as has been undertaken in this project, can be seen as addressing the critical issue of trust in Ireland's public authorities.

One of the main themes of this report and the projects it synthesises is to examine this issue of the most appropriate institutional arrangements for the realisation of quality services. A guiding intuition has been that a 'silent revolution' has occurred in Ireland regarding the regulatory infrastructure over certain human services. Over the last decade and more, there has been dramatic change in the oversight of some services, underpinned by standards, which has gone largely unremarked. In eldercare, for example, the establishment of HIQA as an independent regulator of residential institutions has had a significant effect on the quality of care within these places. And in education, there has been a discernible shift in how the Inspectorate conducts itself to improve inspection coverage as well as the emergence of other important bodies.

NESC believes that examining these and other areas could offer vital insights into how far Ireland has travelled in terms of securing high-quality services and gauging what still has to be accomplished. It is for this reason that NESC undertook a review of the international research and policy on achieving quality through standards as well as completing sectoral reports on how standards were being achieved and quality attained in the following areas: (1) policing; (2) schools; (3) disability services; (4) residential care for older people; (5) home care for older people; (6) end-of-life care. These studies were developed through a variety of different methods, including desk research, interviews and focus groups. Different approaches to fostering improvements have been adopted in each of these areas and the rationale for this synthesis report is to compare and contrast the different areas and see if any common themes emerge that could help cultivate quality in other human services.

The report is structured in the following way. Chapter 2 summarises some of the insights of NESC's Overview report. It argues for a broad notion of regulation, encompassing non-State as well as State actors and using a variety of different instruments—from legal sanction to moral pressure and peer review—to help produce quality, tailored outcomes. Chapter 3 summarises the contents of the NESC sectoral reports, and applies their insights to assess the nature and efficacy of the various regulatory regimes operating in the following sectors: policing, schooling, disability, eldercare, home care and end-of-life care. Each of these sectoral reports exemplifies a different approach to delivering a quality service, what this report terms 'multiple routes to quality'. Chapter 4 builds on this analysis to suggest some positive courses of action that would be conducive to further reform in each of the sectors. Many of these individual recommendations have a common basis in a possible development that is termed a 'centre supportive of continuous improvement'. This refers to the idea that a regulator and/or department should be concerned not just with whether individual organisations are abiding by standards but how they can be supported in this endeavour and how the entire sector can be continuously improved. Strategies such as capacity building and diffusing knowledge about successes are important in this regard. Chapter 5 concludes the report by enquiring about the implications of this notion of a 'supportive centre' for Ireland's current strategies of public sector reform, and the importance of institutional connectedness.

# Chapter 2
# How Can Quality Human Services be Realised?

If it is accepted that quality services are a legitimate aspiration, how can they be realised? NESC's work on reviewing standards and quality in human services is based on the hypothesis that many of the new organisations concerned with standards and oversight in many different policy areas, such as eldercare or education, could be crucial in securing quality services by stimulating awareness of standards and enabling organisations to achieve them. NESC in its Overview report reviewed the international literature in terms of how the regulation of standards could contribute to continuous improvement.

It should be noted that NESC understands standards not as a set of prescriptive rules but mainly as a set of norms to guide improvement. For example, in the standards governing care in residential institutions for the elderly, there is a standard enjoining consultation and participation. But the way in which this standard is made real is as follows: the resident contributes ideas to and participates in the day-to-day activities of the residential setting. This is not a rule in the sense that it does not specify in a detailed fashion how the resident should contribute to the life of the institution: in that sense it is more like a norm 'drive safely', rather than a rule of the type 'drive at 50km/h in this zone'. This is not to say all standards are as open-ended as this but many of them are.

The NESC Overview starts from a consideration of the argument that an improvement in standards requires a strong, autonomous regulator ready to sanction those organisations that are not performing adequately. Many people in Ireland might support this assumption given the role that a lightly regulated banking sector has played in our economic decline and how little oversight there had been of institutions providing care. Strong regulators with sanctioning powers are deemed to be an appropriate corrective to the granting of excessive discretion to service providers and their personnel. This latter approach has been characterised as a bottom-up approach to guaranteeing standards, based on the presupposition that those 'at the coalface know best'. But many now think that this can lead to too much professional discretion and possibly arbitrariness so that a more 'top-down', sanction-oriented approach is needed to ensure high-quality services and systems.

Disputing the adequacy of both 'top-down' and 'bottom-up' approaches in isolation, the NESC report drew attention to the idea of 'responsive regulation', a term popularised by the Australian scholar John Braithwaite. His contribution has been part of an attempt to transcend the debate between top-down or bottom-up approaches or what is elsewhere known as calls for more regulation or deregulation. Instead, he emphasises collaboration between regulatee and regulator with the latter only turning to sanctions as a last resort when co-operation is exhausted. This approach has been colloquially expressed by Braithwaite as 'speaking softly while carrying a big stick' and has been graphically illustrated as a

pyramidal relationship with the regulator employing a graduated arsenal of sanctions, beginning with persuasion and ending with some form of incapacitation. Resort to more serious sanctions is triggered when less onerous ones fail to bring about any change in behaviour. The advantage of using a system of graduated sanctions is that it (a) allows for decision-making to be carried out at the frontline without tying up organisations in excessive regulations; and (b) allows for intervention short of a 'nuclear option' of closure or whatever other form of incapacitation is favoured.

But Braithwaite's contention about the centrality of establishing a productive relationship between regulator and regulated has been turned against him. If frequent and intensive contact between regulator and regulatee is difficult to achieve, then this renders his overall goal of a sustained conversation about standards and quality vulnerable. Or, as another Australian-based scholar puts it, 'in many industries there are insufficient repeat interactions between regulator and regulatee as to make a pyramidal approach viable in practice' (Gunningham, 2010: 129).

Given the intrinsic limits of State coverage in regulation, Gunningham has detailed a model of 'smart regulation', which is designed to overcome these deficiencies. His central proposition is that it is important not to over-emphasise the role of the State as a

> substantial body of empirical research reveals that there is a plurality of regulatory forms, that numerous actors influence the behaviour of regulated groups in a variety of complex and subtle ways and that mechanisms of informal social control often prove more important than formal ones (*ibid.*: 131).

Ideas about Smart regulation also emerged from the realisation that neither State law nor free-market incentives provided an answer to many serious environmental problems. A context such as this led to a search for a broader coalition of actors that might act as quasi-regulators such as trade associations, advocacy organisations and community groups; it also impelled a broader range of policy tools beyond State law such as economic instruments and information-based strategies. On this view of regulation, a non-State body might be responsible for both establishing standards and overseeing their implementation by ensuring that consumers of the service are both aware of these standards and insist that the provider lives up to them. There are many instances of this kind of development.

As the NESC Overview report highlights, much of the progress in the EU with respect to standards relies on self-certification according to a commonly agreed process. Civil society organisations have managed to achieve similar progress. For example, given the failure of States (at a global level) to agree targets in 1992 in relation to sustainable forestry, civil society groups began to develop their own standards and means of checking these through the creation of a Forest Stewardship Council (FSC). This is a process by which forests are certified by private actors to abide by higher standards, often on the basis that this may facilitate access to commercial markets. Marks & Spencer, for example, has committed to embedding environmental principles in all of their 2.7 billion products and this will be done by using a

recognised environmental certificate such as the FSC. Ireland enjoys quite a high ranking—fourth in the world—with approximately 65 per cent of Ireland's forests covered under the scheme (Marx & Cuypers, 2010). Given that this kind of self-certification is deemed to have 'significant potential' (*ibid.*: 430), it is worth examining whether similar tactics could alleviate some of the difficulties faced in implementing standards in an area like disability services. This is examined in Chapter 4.

Another implication of smart regulation is the emphasis it puts on the involvement of service users, which is increasingly seen as an important factor in the development and application of standards for the provision of quality human services. The main reason put forward for engaging people who use services is the importance of getting a range of perspectives, especially with regard to whether the desired outcomes have been attained. Engagement with users is paramount if we consider that, in many circumstances, there are no ready-made blueprints that can help resolve their issues. Any solutions have to be developed through an exploratory process with the users themselves as providers trying to estimate what would work best for a distinctive set of circumstances. Usually this will not mean one isolated action but a series of different steps, delivered over a period of time, which means that collaboration with users will often have to be ongoing. Encouraging user participation is part of a process of illuminating what outcomes the individual or group would like to have and the steps involved in reaching this goal.

If smart regulation advises us to look beyond the formal State regulation and ask how non-State bodies might contribute to raising standards, another variant of responsive regulation asks us to take a closer look at what is going on inside these regulated organisations. Going under the label 'meta-regulation', it suggests that regulators do not directly intervene but primarily encourage organisations to install systems of monitoring and self-regulation. Regulators and overseers seek to assure themselves that these systems are adequate and being followed, i.e. it is the regulation of self-regulation. In the aftermath of many regulatory failures, governments have encouraged organisations to adopt advanced systems of managing risk and require regulators to assess how well these systems are operating, rather than directly inspecting for risk themselves. The regulator specifies the goals that are to be achieved and leaves it to those operating at the frontline to work out how best this can be done. It is less about the regulator checking compliance with rules and more about encouraging organisations under its charge to put in place their own mechanisms of internal control and monitoring. This is not to say that the regulator has a passive role since it involves challenging organisations to prove that they have appropriate systems in place, thus provoking a continuous cycle of self-reflection about performance. Approaches like this have now been adopted in environmental management systems and food safety, and are being introduced in some human services areas.

A limitation of Braithwaite's approach is that he has relatively little to say about how this kind of internal regulation is done. Writers such as John Seddon (2008) underline the importance of practitioners asking the following question—'What measures are you using to help you understand and improve the work?' And others

such as Malcolm Sparrow (2008) talk of 'picking important problems and fixing them'. But importantly, Sparrow also talks of 'parsing the problem', that is, breaking it down into its important causal components to stymie the problem – he gives the example of road deaths being caused by four distinct phenomena such as infants not properly restrained, each of which calls for a distinctive form of intervention. And an author such as Sabel writes of the importance of diagnostic monitoring whereby practitioners probe the reasons behind success or failure so they can recraft their interventions (Sabel & Simon, 2011).[2]

Ideally, this probing of professional practice should be connected to questions about how standards are being fulfilled. Because a standard like a resident's right to be consulted and participate in the life of a care home does not produce a formulaic answer, it has to be accompanied by a question like the following: 'how do we know a resident is really participating in the life of this institution?' If standards are accompanied by this kind of professional reflection, there are two advantages. They can open up local practice and make it more transparent by judging it against certain benchmarks. And they can help to compare and co-ordinate across local practices through appraisal against these common benchmarks, thus facilitating a judgement about which local practice appears to be working best (Simon, 2011).

Historically, professions have resisted standards on the basis that they cannot capture the complexity involved in decision-making and therefore rigidify judgements. They have argued that if users of services are to be fully accommodated, it is best to let professions make the decisions about how this can be done, since the particular nature of the presenting circumstances can never be fully captured in any standard. Yet it is now conceded that the kind of informal, tacit judgement enacted by professionals can harbour rigidities as well. These kinds of decisions are 'vulnerable to unconscious and inarticulate stereotypes developed from prior experience. These stereotypes can be more dangerous than standards because they are less readily subject to critical examination and testing' (*ibid*.: 28). Standards are one way of exposing these unconscious presuppositions by forcing people to ask whether all relevant factors have been followed or observed. For example, the NESC Overview report details how checklists are being increasingly used in medical interventions to avoid the problem where each individual assumes that another person has taken care of a critical task. Matters cannot proceed unless each item on the checklist has been observed. Standards are themselves not infallible and should be open to correction but are one way of helping to instil ongoing learning by requiring practitioners to question and justify their decisions. Instead of being a barricade against progress, standardisation provides the

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[2] Richard Rumelt (2011) makes a similar point that the distinguishing feature of 'good strategy' is that it is based on a diagnosis of an issue that names the fundamental obstacles to progress and a guiding policy that sets out how the obstacles might be ameliorated. Conversely, 'bad strategy' is distinguished by its failure to guide 'by embracing the language of broad goals, ambition, vision and values'. To take an example from this project, a 'bad strategy' in the disability sector would be to set a goal to provide personalised, rather than institutionalised, care without providing a diagnosis of the current barriers to achieving this goal. This is mistaking goals for strategy and is based on a statement of desire rather than a plan to overcome an obstacle.

foundation on which improvements are based (Ford & Crowther, quoted in NESC, 2011: 33).

The second useful function of standards is that they help co-ordinate practice across different organisations and localities. They do this by insisting that every organisation or locality adhere to common standards and this allows some central unit to gauge the progress of each and make relative judgements.

Perhaps one of the most developed examples is that of the Quality Service Review (QSR). This is a broad term for a set of processes and tools designed to review human service systems such as child welfare. It is based on the premise that each case, examined through an in-depth review, can be used as a test of how well the overall system is functioning. A two-person team, including an agency official and an outside reviewer, examines a case over two days, beginning with a file review before interviews with the child, family members, non-family caregivers, professional team members and others with pertinent information. The reviewers then score the case numerically in terms of two sets of indicators, the first concerning 'child and family status' and the second concerning how well the system is dispensing a quality service appropriate to the child's needs. Initial scoring is refined in meetings between different review teams and then with caseworkers and supervisors. Following these clarifications, general conclusions are drawn to highlight the systemic significance of the findings (see Noonan *et al.*, 2009).

The QSR helps establish paradigmatic instances of what the goals such as 'child safety' and 'family stability' mean and how they might be made real. It also facilitates continuous improvement while simultaneously promoting increased accountability by requiring staff to make explicit the tacit professional knowledge that informs their actions. This transparency enables improved oversight by governing bodies, at the same time as frontline discretion is increased. Thus, the agency learns to improve while monitoring what it does, and the same process that makes customisation of services effective makes it accountable as well.

Standards themselves are subject to revision through a process like QSR as it is recognised that they can easily become outmoded and end up restricting, rather than enhancing, practice. User involvement means that this kind of process is not some kind of technocratic audit ritual of flowcharts and reviews. It should be grounded in assessing how adequately the well-being of a citizen is being advanced through engagement and consultation (Department for Education, 2011).

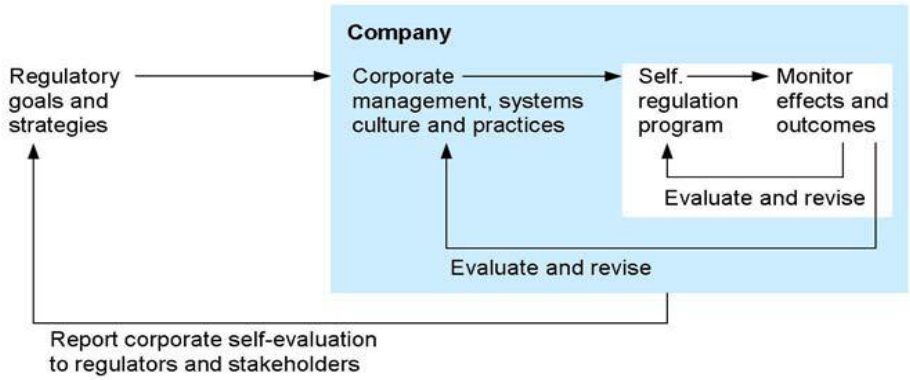
One of the most advanced methods of revising not just practice but also the standards involved in benchmarking practice is a model known as triple-loop learning (see Figure 2.1). The first loop of learning occurs when practitioners monitor their achievement and make adjustments to gain improved outcomes. Evaluating in this manner needs to go beyond the recording of outputs and encompass some attempt to specify what effect the organisation's activities have had on the reduction of harms and/or improvement in the provision of a quality service.

The second loop occurs when this kind of practical learning is noted by managers who subsequently adjust their systems and routines to take account of it. It usually

falls to a central authority such as a corporate headquarters to undertake the task of double-loop learning. Undertaking double-loop learning would mean establishing reasons for apparent success or failure, suggesting what these results might mean for operational procedures and then disseminating these findings to all relevant parts of the organisation or other entities that would consider them and revise their interventions in light of the new data.

Triple-loop learning occurs when a regulator or oversight authority obliges organisations to report on their own self-regulation strategies so that regulatory agencies can determine whether the ultimate objectives of quality service provision are being met (Parker, 2002: 259), as per the ideas of 'meta-regulation' described earlier. It is up to the oversight body to perform a 'double-check' on the solutions devised by the regulated organisation and regulators should be 'proactive in checking how self-regulation was implemented' (Parker, 2004: 113). Part of this evaluation would involve engagement with relevant stakeholders, including service users, and subsequent publication of the results, promoting transparency.

**Figure 2.1 Triple-Loop Learning**




Source: Parker (2002: 278)

Policy learning through meta-regulation—one of the principal themes of a great deal of research on regulation—demonstrates that it is not usually achieved through a bilateral relationship of the kind described in some of Braithwaite's work. High standards are often achieved through the involvement of multiple parties, what might be termed a regulatory regime, which involves entities like formal regulators, oversight bodies, central policy bodies, service delivery bodies, campaigning groups, service users and concerned citizens (see the earlier discussion of 'smart regulation').

If this is the case, then it behoves some organisation to ensure that this regime is working in an optimal way, in terms of its coherence and ultimate effectiveness; and where it does not exist some entity has to help create this kind of regime. This could be conceived of as an element of meta-regulation, ensuring that all relevant regulatory bodies and strategies are in tune with and supporting each other, what we might term a fourth loop. This might mean creating a regulatory forum at which progress around agreed standards could be discussed and assessed, and the contribution of each relevant body staked out. Looking at regulation in this way means that it is not really a bilateral kind of relationship that is depicted as operating in a pyramidal fashion, as suggested by Braithwaite. Instead, it is more like a network or web of different bodies and the assembly and efficacy of this arrangement should be as much a concern as the behaviour of the regulated organisations. This point is taken up again in Chapter 5.

## 2.1 Conclusion

This chapter has reviewed some of the most important concepts and research that have been discussed more extensively in NESC's Overview report. It put forward a broad model of regulation derived from a variety of sources. It has drawn inspiration from John Braithwaite's urgings to transcend either top-down or bottom-up approaches to regulation as a means of ensuring quality performance. It has taken sustenance from his notion that regulation is best understood as comprising a mix of punishment and persuasion. However, this chapter has noted that this might still suggest quality is secured through a bilateral relationship between regulator and regulatee and through some combination of top-down and bottom-up approaches. Instead, we have taken on the arguments of smart regulation that numerous actors, other than State entities, influence the behaviour of regulated groups in a variety of complex and subtle ways other than the invocation of formal legal powers. And describing matters in terms of some kind of balance between top-down and bottom-up might neglect how the work of practitioners can be conditioned by the intervention of the regulator.

This last point is in keeping with the arguments of meta-regulation, namely that regulators should encourage organisations to set up their own systems of monitoring and managing quality that the regulator then scrutinises. In this respect, standards have a vital role to play and can be introduced and maintained through a number of different ways. Whilst standards are extremely important, they must be themselves open to revision lest they petrify the practice that they are meant to improve. Avoiding this possibility of rigidity means that standards should be embedded in some system that encourages continuous revision. Triple-loop learning is one means of doing this but what should be monitored are not just systems of oversight but also the efficacy of the entire regulatory regime. These insights will be employed in describing the nature of the regulatory regime and assessing how well they are working in the next two chapters.

# Chapter 3
# Multiple Routes to Quality – A Summary of the Sectoral Reports

## 3.1 Introduction

This chapter presents summaries of how the standards infrastructure operates in a number of different policy areas: disability services, schooling, eldercare, end-of-life care and policing. These summaries of the sectoral reports illuminate the nature of the regulatory regime in question — what organisations with what powers are in place to achieve standards — and what these regimes have achieved, i.e. how well they are contributing to the provision of quality services. Information on each of the areas was uncovered through a process of documentary review, interviews with significant participants working in the area and workshops with key participants. In documenting the obvious, and at times remarkable, gains made in the different areas, this chapter shows that there are many different ways of achieving high standards or that there are multiple routes to a quality service. By this, we mean that there is no single, definitive way to realise quality across all sectors so that a plurality of approaches is not necessarily a hindrance to more responsive and effective human services. Diversity does not mean each of the sectors cannot learn from each other and this issue will be examined in Chapter 4. Therefore this chapter is mainly concerned with summarising the contents and findings of each of the sectoral reports. And Chapter 4 explicitly compares how each sector has striven for quality and divulges some themes common to all of the areas.

## 3.2 Policing

The examination of policing in Ireland is contained in the NESC report *Policing and the Search for Continuous Improvement (No. 127)*. Policing as a human service has been included in this project for a number of reasons. It is worth examining since its functioning is largely dictated by the discretion of individual officers, which raises the question of how standards are maintained and improved. Prior to reforms in 2005, it had largely been left to the police force to regulate itself through imposition of its own disciplinary regulations after investigation by its own officers. Various scandals dented the credibility of this notion and led to the establishment of the Garda Síochána Ombudsman Commission (GSOC) to investigate complaints against the gardaí (although complaints of a minor nature may still be examined by serving gardaí). Other entities have also been set up, which could potentially constitute a 'new system of accountability' (Vaughan, 2005). The Garda Professional Standards Unit (GPSU) exists to ensure that garda behaviour is in conformity with stated

policies; the Garda Síochána Inspectorate examines whether garda policy and activity is in line with international best practice; and the Joint Policing Committees and Local Policing Fora are institutions that enable gardaí to liaise in a formal manner with local representatives over matters related to crime and disorder.

The question posed in the NESC Policing report is whether this range of oversight entities is contributing to improvements and overall quality within the Irish police force. It may be that the orientation is to ensure that police officers do not contravene the basic standards of internal disciplinary regulations and of the criminal law. This would mean that the oversight bodies are based around standards for compliance rather than quality performance. Achieving the former goal would provide some reassurance, but would hardly equate to a high-quality police service.

### 3.2.1 Institutions Contributing to Oversight of the Gardaí

The regulation of policing in Ireland has been profoundly affected by the introduction of the Garda Síochána Act 2005, which is most notable for the range of new bodies that has been established to enhance standards and accountability within An Garda Síochána. These are discussed below.

The **Garda Síochána Ombudsman Commission** (GSOC) is responsible for receiving and dealing with complaints made by the public concerning the conduct of members of the Garda Síochána. The most notable difference of GSOC from the previous complaints body, the Garda Complaints Board, is that it employs a number of independent investigating officers to examine the more serious cases rather than relying on serving officers within the gardaí (some complaints relating to issues like discourtesy are deemed suitable for informal resolution and are handled by the gardaí)..

In the period from mid-2007 to the end of September 2011, GSOC received just over 10,900 complaints of which 6,000, or 55 per cent, were admitted for investigation. A total of 2,555 complaints were referred to the Commissioner of the Garda Síochána for investigation and related to relatively minor matters that were handled by the garda authorities, although supervised by the Commission. GSOC referred a total of 111 files to the DPP with a recommendation that a prosecution be considered, and a further 89 files were referred to the Commissioner of the Garda Síochána with a recommendation that they be processed under the internal garda disciplinary procedures. In addition, six investigations were undertaken to examine matters in the public interest even if a complaint had not been received (Minister for Justice and Equality, 2011: Dáil Debates – Wednesday, 7 December 2011).

GSOC has noted that there are certain aspects of garda activity that it is precluded from investigating or where there is ambiguity about the appropriateness of its jurisdiction. Among these are that a complaint is not admissible insofar as it relates to the general direction and control of the Garda Síochána by the Garda Commissioner. Another problem for GSOC is that it is often difficult to determine the point at which inefficiency or under-performance can become a 'neglect of duty' – and therefore constitute a breach of the Disciplinary Code. This latter point

is important since GSOC has recently indicated that a significant number of complaints 'fall into what could be described as service complaints and GSOC has engaged with the Garda Síochána to seek mechanisms to better identify and resolve such issues without, necessarily, the need to apportion blame' (Garda Síochána Ombudsman Commission, 2011: 27).

A great deal of the debate on the achievement of high standards in policing has focused on both the extent of the powers granted to GSOC and the extent of its autonomy from An Garda Síochána. Emphasis on greater formal enforcement powers draws sustenance from the issue of police malpractice that gave birth to GSOC but its prominence may obscure some of the necessary conditions for both upholding and improving standards in general. Greater legal powers vis-à-vis both individual officers and the garda organisation itself may be of less importance than a greater understanding of the reasons why events occurred as they did and a willingness to learn from any review and establish appropriate remedial action. GSOC's various reports show that there are serious harms often associated with policing of the roads yet until credible explanations are offered — is this to do with vehicles, training, policy, road conditions and so on — issues like this will not be resolved.

The role of the **Garda Inspectorate** is to promote excellence and accountability in the Garda Síochána. Accomplishing this means ensuring that the resources available to the Garda Síochána are used to achieve the highest level of efficiency and effectiveness in its operation and administration as measured by reference to best international policing practices. The Garda Inspectorate carries out its inquiries either at the request of, or with the consent of, the Minister for Justice and is required to submit reports of these inquiries to the Minister with recommendations for any action that the Inspectorate considers necessary. To date, it has published seven reports on various topics including a forward-looking review of policing in Ireland; an examination of how child sexual abuse cases are being dealt with by gardaí; and a report on resource allocation. In this last report, the Inspectorate commented that An Garda Síochána does not have 'systems in place to measure workload' (Garda Síochána Inspectorate, 2009: 5). These kinds of systems are necessary to have the 'right numbers of police officers in the right places at the right times to meet community needs' (*ibid*.).

The **Garda Professional Standards Unit** (GPSU) is an internal body within An Garda Síochána. Its role is to examine and review the operational, administrative and management performance of An Garda Síochána with reference to the best standards of comparable police services. Its role is considered to be preventative in the sense that it concentrates on those processes that are considered to bear significant risk. GPSU examines three or four full divisions every year to ensure that they are following appropriate procedures, with the investigation often lasting up to a period of three weeks. Following this examination, the findings are then sent on to the relevant officer in charge of the division, highlighting strengths and pointing to areas that could be improved.

The work of GPSU represents an interesting and innovative attempt by an organisation to continuously review and improve its operations, thus raising

standards. Its detailed work reflects the multi-faceted nature of the garda organisation as it deals with incidents relating to public disorder, traffic, immigration and human trafficking to name but a few. Notwithstanding this broad portfolio of tasks, a crucial component in achieving high standards of policing will be the quality of the relationship with communities and how the gardaí are perceived to be contributing to that. This is the concern of the following two institutions.

The ways in which the gardaí liaise with a community have been reshaped by the establishment of two new kinds of body, **Joint Policing Committees and Local Policing Fora.** The former have been established in every local authority area and provide a formal space for gardaí, local authorities and political and community representatives to review patterns of crime and disorder in an area and the factors behind these patterns. A more localised form of engagement is provided for through the establishment of local policing fora that have been set up in the Local Drug Task Force Areas, places in which an integrated response has been established to counter serious drugs issues.

### 3.2.2 Assessment of the Efficacy of the New Oversight Organisations

Acknowledging that the establishment of these bodies constitutes an improvement in the regulation and oversight of the gardaí should not blind us to some of the outstanding problems. There are, perhaps, three issues with the operation of these institutions that may impede them from contributing to a cycle of continuous improvement. First, it is not clear whether they are sufficiently diagnostic to uncover the causes of the matters that come before them. Does GSOC, for example, have an idea about what might be some of the causal factors behind complaints and could some remedial work be undertaken on the basis of this knowledge? Our sectoral report on policing demonstrated that this is the basis for good practice in other jurisdictions. Do the joint policing committees conduct the kind of analysis that would enable them to uncover the factors that lie behind a particular pattern of crime or do they simply note the aggregate rise or fall of specific crimes over a certain period?

The second issue is whether the institutions are able to analyse and unpick specific problems or 'concentrations of harms' as Sparrow (2008) calls them. His reasoning is that many organisations rely on generic processes to resolve troublesome issues rather than relying on specific analysis of particular issues. The case study within the NESC Policing report examined a consultation process between police, local authority and community in a particular area. It demonstrated that whilst the gardaí responded quickly to citizen concerns, some personnel wondered whether the most appropriate solution was being adopted. This was because often a tried-and-trusted method such as CCTV was being used to deal with a problem without asking whether this was addressing the underlying causes. The Policing report concluded that problem-solving could be assisted through a process of review and comparison of various solutions that have been tried throughout the country (something that has also been suggested to the Department of Justice and Equality when it undertook public consultations on a forthcoming White Paper (2011: 11). Recommendations of this sort touch on the third problem encountered in the area

of policing, namely the question of whether the linkages between institutions suffice to sustain and drive improvements.

This last issue relates to whether the bonds between the oversight and consultative institutions are of the necessary quality to propel lasting progress; this would entail that their work should complement each other. But there is reason to believe that this might not be the case. For example, the Garda Professional Standards Unit examines whether the actions of gardaí are in line with stated policies. But does it examine how well gardaí are meeting the requirements of communities, which is difficult to capture in any policy document, other than in the most general terms? Looking at the activity of investigating complaints, research is converging on the idea that oversight should concentrate on the causes of police misconduct, rather than just looking into the symptoms, that is, complaints. What this more diagnostic model of oversight frequently finds is that the causes of complaints often stem from 'the failure of management to put in place good policies and procedures to govern officer conduct' (Walker & Lorenz, 2011: 23). A finding like this makes it clear why there should be evident linkages between an oversight body like GSOC and an internal review body like GPSU. Of course, it has been claimed that such linkages do exist, in that one body like GPSU takes cognisance of the findings of others like GSOC or the Inspectorate. But this seems to occur at a relatively informal level without discernible signs of progress. This is not a failing peculiar to policing; there are many instances within the Irish policy system whereby networks are said to form but it is difficult to gauge the progress they have made.

## 3.3 Schools

### 3.3.1 The School System in Ireland

The role and scope of standards in Ireland's primary and secondary education system is examined in the NESC report, *The School System*. The responsibility for many aspects of education in Ireland lies with the Minister and the Department of Education and Skills (DES), for example, budget allocation, pupil/teacher ratio, curriculum and examinations. However, schools at local level have a large degree of autonomy in relation to how they manage their allocated resources in the context of the needs of their pupils and the school context. Nevertheless, since the commencement of the Education Act in 1998 there have been a number of key pieces of legislation and the establishment of specialist bodies, which may influence how this autonomy is exercised. The powers of these bodies are detailed below and then we assess how they are contributing to the achievement of standards and achievement of quality in schools.

### 3.3.2 The Education Act 1998

Under the Education Act 1998 the Minister for Education and Skills is responsible for quality and assurance within the education system in general. The Act defines

the functions of an inspector in his/her dealings with teachers and school management and specifies the role and obligations of the DES Inspectorate division in relation to standards and quality in primary and post-primary schools.

The DES Inspectorate division is responsible for the external monitoring and evaluation of schools. In the decades up to the late 1990s, oversight through inspection of schools by the Department of Education had been described as 'virtually non-existent' (post-primary school) or 'rare, benign and rather haphazard' (primary schools) (McNamara & O'Hara, 2005: 268).

The Education Act 1998 also places the role and responsibilities of School Boards of Management (BOMs) as managers and employers on a statutory footing. It clearly articulates the responsibility of BOMs in relation to the quality of the teaching and learning outcomes in their schools, and the publishing and sharing of information relating to the operation and performance of the school. Significantly, the Act also articulates the role of the BOM in the appointment, suspension and dismissal of teachers.

### 3.3.3 Teaching Council

The Teaching Council, established in 2006, is responsible for the regulation of standards and accreditation of initial teacher education and continuing professional development programmes and induction arrangements for newly qualified teachers. In 2007, the Council published a *Code of Conduct for Teachers* and a revised draft in 2011. The revised draft Code is divided into two sections. The first section, entitled *Ethics of the Teaching Profession*, articulates the values that underpin the work of teachers in the practice of their profession. The second section is entitled *Standards of Professional Conduct* and sets out the high standards of professional conduct and practices that are required of registered teachers. On commencement of all elements of the Act it will be possible, following due process, for the Council to deregister teachers who are in breach of the Code of Conduct.

### 3.3.4 National Council for Curriculum and Assessment

Responsibility for the design of the curriculum at both primary and post-primary level lies with one of a number of specialist agencies that have been established during the last decade, The National Council for Curriculum and Assessment (NCCA). The brief of the NCCA is to advise the Minister for Education and Skills on matters relating to the curriculum for early childhood education, primary and post-primary schools, and the assessment procedures employed in schools and examinations on subjects that are part of the curriculum. In addition to developing the curriculum for primary schools and the junior and senior cycles for second-level schools, the NCCA has also produced guidelines for the teaching of these curricula, for teaching children with general learning disabilities, assessment guidelines and tools, and curriculum-planning tools.

### 3.3.5 Oversight Processes in Schools

Ireland's approach to quality assurance emphasises school-development planning through internal school review and self-evaluation with the support of external monitoring and evaluation. In 2003, the DES published *Looking at Our Schools* (LAOS), which sets out the framework against which both primary and post-primary schools are measured and reviewed. It was published as a set of evaluation guidelines for schools and teachers, and provides a common language that is understood by the Inspectors and schools. It is also used by the inspectorate as the basis for the evaluation framework in conducting Whole School Evaluations and other external evaluations of the work of primary and post-primary schools. Whole School Evaluation (WSE) is a process of external evaluation of the work of a school carried out by the inspectorate and was initiated on a phased basis in 2003/4 in the primary sector. It was intended that the LAOS self-evaluation guidelines would support the development of a culture of self-review and evaluation that would be driven from within the schools themselves and that the WSE process would complement this approach as well as providing external validation and accountability.

However, research has shown that many schools have seen the LAOS process as a 'one-off' exercise and it has been largely restricted to the collation and improvement of planning and policy documents. Illustrating this level of impact, researchers found the idea that 'the discipline code might be evaluated as a success or failure through some process of data collection and analysis was a completely alien concept in most cases' (McNamara *et al*., 2011: 70). Some principals and inspectors confirmed the view that the process was largely impressionistic and lacked grounding in hard data. Important information such as levels of absenteeism was often not available in a usable format and there appeared to be a paucity of information on such items as pupil aptitudes or attitudes. Hence, it has been concluded that 'no process that could be remotely regarded as systematic evidence-based self-evaluation was occurring in schools' and is a 'key weakness' in the entire process (*ibid*.: 71).

Since the launch of the LAOS and WSE the DES inspectorate has designed a range of inspection models in order to respond to the needs of schools, develop their capacity for development and internal review and evaluation, and improve standards and overall levels of accountability for learning outcomes in the school system. These inspection models include: the Whole School Evaluation-Management, Leadership and Learning (WSE-MLL), which has only recently been introduced in second-level schools and complements the standard WSE; subject inspections; curriculum inspections; thematic inspections; and incidental inspections where inspectors visit schools unannounced. These incidental, unannounced inspections, which were introduced in primary schools in 2010 and post-primary schools in October 2011, are designed to evaluate the quality and effectiveness of aspects of the education provided in schools under the normal conditions of a regular school day.

The DES Inspectorate gathers and generates a lot of information and data about what is happening in schools in terms of how they are managed and the quality of teaching and learning in schools in general. This information is made available to

individual schools that have been the subject of an inspection. In addition, all WSE reports and compilation reports of incidental inspections are available on the DES website.

### 3.3.6 School-Based and External Assessment

Assessments can be influential in guiding the work of schools and teachers since they provide information and benchmarks against which schools can measure how well or otherwise their students are progressing in relation to desired standards and learning outcomes, and with regard to national and international norms. The State examinations, i.e. the Junior and Leaving Certificates, are an example of one type of assessment. The DES and Educational Research Centre (ERC) also participate in international assessments. The most familiar of these is the OECD's Programme for International Student Assessment, commonly known as PISA.

A lot of data is generated within the education system that is available to DES policy makers and schools to enable them to improve standards and quality in the school system. The recently launched National Strategy to Improve Literacy and Numeracy among Children and Young People has been influenced by some of this data. However, as a general rule, even though Irish schools and their teachers assess their students at least twice during the primary-school cycle, they do not necessarily engage with and utilise student achievement data for decision-making, benchmarking and information purposes. There is a need to bridge this gap through supporting the development of the technical expertise to use this data at school level.

### 3.3.7 Conclusion

The Irish school system provides an example of a sector that has many arrangements in place designed to support the achievement of standards and accountability. It is a good example of how standards and quality can be influenced by a diverse range of organisations in a number of different ways. However, if the processes of self-improvement lack focus thanks to an absence of information that would point to where problems might be, then there is little that supporting institutions such as BOMs or the NCCA can do. Obviously, they can craft well-formulated policies and suggest changes to procedures but unless these are adopted at the frontline of teaching, there is little likelihood that benefits will accrue (see National Council for Curriculum and Assessment, 2011). Conversely, if self-evaluation was underpinned by the collection of evidence and a willingness to interrogate practice, then these other bodies might be able to play a more influential role. Chapter 4 examines whether these possibilities might be bubbling up through the educational landscape thanks to the development of some new initiatives.

## 3.4 Disability Services

### 3.4.1 Introduction

The area of disability services and the strides it has made in terms of achieving quality is examined in the NESC report, *Quality and Standards in Human Services in Ireland: Disability Services*. While the majority of people with disabilities in Ireland access general health and social services (mainstream provision), specialist services are delivered to six per cent (approximately 50,000) of people with physical, sensory and intellectual disabilities, which costs the State €1.2 billion a year.[3] Services are offered by both large and small service providers and can vary by region. Most of the disability services, although funded by the State, are run by voluntary providers and community organisations. One-sixth of provision is in the form of congregated settings (residential care, mainly for people with intellectual disabilities), a high proportion as compared with other European countries.

### 3.4.2 Institutional Make-up of the Disability Sector

Unlike other service sectors in Ireland, specialist disability services are not yet inspected by a regulatory authority and, in broad terms, there is no State regulation of the disability sector. Many service providers have no quality systems in place. Organisations are contracted by the Health Service Executive (HSE) to provide services and complete a Service Level Agreement (SLA) setting out their policies and procedures, which, until recently, varied in the extent to which they focused on quality measures. This is one side of the story of the disability sector. However, another side exists, which shows the excellent quality provision by some voluntary providers who have searched for the most internationally acclaimed quality-assurance procedures in the absence of any State involvement. The active engagement of voluntary disability organisations is a distinguishing feature of the disability sector in terms of its regulatory and quality-assurance system. While there is a move towards greater levels of formal regulation, the disability sector remains largely self-regulatory, varying from services that are demonstrating excellence to ones where little is known about the quality of their service.

There is widespread recognition in the disability sector that the current model of provision for people with disabilities has to move toward a more equal and progressive system. Both the Department of Health and the HSE have been developing policy in this area, which, when implemented, will bring dramatic shifts away from congregated settings towards individualised budgets, person-centred supports and a more inclusive approach to providing disability services in the community. It is estimated that this transformation will take approximately seven years to move from congregated settings to person-centred, tailored provision (Expert Reference Group on Disability Policy, 2011).

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3 HSE figures for 2009.

It is likely that some parts of the regulatory system will emerge more quickly. For example, standards for residential services, developed by HIQA as the main regulatory body for the sector, are due to be made mandatory by 2013, along with inspections and the registration of service providers. In addition, the HSE is developing its SLAs to have a stronger quality focus. In general terms, there is a need to pull all services upwards through continuous quality improvements and mandatory standards. However, tensions exist in the disability sector that reflects the challenge that this will bring. For example, some stakeholders are fearful about the danger of services being brought down to a minimum level of quality and the potential loss of innovative practice, whereas others consider the commencement of mandatory standards to be the most critical and urgent first step to regulatory reform, to provide a reassurance of consistency in the quality of services provided.

### 3.4.3 Consequences of the Configuration of the Disability Sector

In considering the disability sector in this light, several observations can be made:

First, as yet, the quality and delivery of disability services are variable. Since most of the services originated from local need and were provided through voluntary and community organisations, they are not distributed evenly around the country and vary widely in terms of what they provide. This is expected to change with a new national policy being finalised by the Department of Health. However, while high-level policy goals and strategies have been in place since 2004, and standards for disability services were developed in 2004 and 2009, there has been considerable delay in progressing these fully.

Second, there has been little formal regulation in the sector, with a lack of mandatory standards and no external oversight or inspections, so that the services have been free to develop as 'independent republics', providing care as they see fit. Standards would provide a necessary common foundation and could complement disability services' work on quality assurance and continuous improvement.

Third, there has been a lack of focus on outcomes, with the exception of some service providers, and little accountability in terms of the quality of service delivered. International and national good practice point to the value of identifying and measuring outcomes in disability services. There would be great value in developing a coherent and integrated set of outcome measures for disability services and policy.

Fourth, the capacity to monitor, reflect, problem-solve and share the learning has not been developed and therefore the ability of the disability sector to self-regulate and exemplify learning within individual organisations is, at best, patchy, i.e. good in some areas but absent in others. There are existing data systems that could be further enhanced to focus on outcomes and other quality aspects, as well as considerable research expertise that can be drawn upon for evidence-based practice. As the services change and develop there will be valuable opportunities to reflect and learn about what does and does not work in both mainstream and tailored services that could be exchanged between service providers and wider stakeholders.

Fifth, service user involvement has increasingly been evidenced as being key to successful regulatory systems at all levels of service design, delivery, regulation and monitoring of outcomes and processes. Understanding what service users want and how they evaluate services is critical to the delivery of a quality service. Currently, the disability sector is open to criticism for providing services that are not always what people want, and that do not meet all needs. However, the most progressive and thoughtful service providers have taken a lead in criticising the limits of traditional congregated settings. A closer relationship with service users, their families and advocates, would keep services 'real' as needs and wants change over time.

### 3.4.4 Conclusions

Given the variable state of care in the disability sector and the expectation that the HSE (or its successor body) will take a more active role, it is timely to consider what role regulation will play in the delivery of quality disability services in future. Quality within the sector is being driven by many different factors, including the work of visionary voluntary providers, ambitious policy draft proposals, the pressing need for greater cost efficiencies and a recognition that more needs to be done to protect vulnerable groups in the State's care. There are enormous challenges in changing the model of provision, particularly when resources are limited, but there are a growing number of examples whereby service providers are moving towards more individualised supports for the same or fewer resources, while striving to achieve a high-quality service. Chapter 4 will examine what kind of institutional arrangements might support these kinds of efforts, in ensuring the provision of quality services.

## 3.5 Standards in Home Care and Residential Care for Older People

### 3.5.1 Introduction

Improvements in the quality of home care and residential care for older people are investigated in the NESC reports, *Home Care for Older People and Residential Care for Older People.*

Standards for the care of older people provide an example of two different approaches. First, there are mandatory regulations and standards for all residential centres for older people, through the Health Act 2007, which also established HIQA as an independent inspectorate with strong powers to assess the extent to which these standards and regulations are met. This is the clearest example of the enforcement of explicit, legally-based standards through regular inspections undertaken by an autonomous regulator in human services in Ireland.

Second, care of older people at home remains unregulated, whether that care is provided by the State, the private sector or a voluntary organisation. A variety of draft standards do exist for home care, parts of which are being implemented on a voluntary basis. However, the HSE has recently awarded a tender for organisations to provide new home care packages on its behalf, and this requires those awarded the tender to demonstrate quality standards in a range of areas. This new process should increase the overall quality of management and care in home care packages, being dubbed by some as 'regulation by the back door'.

The following are the most important groups within this policy area of standards in the care of older people:

- The **Department of Health** formulates policies for the health services, and so is the key government department influencing strategic development of standards for the care of older people;

- **HIQA, the Health Information and Quality Authority** is a State agency set up by statute in 2007. It has devised standards for the care of older people in residential settings, and inspects these settings;

- **The Health Services Executive** (HSE funds all public health services in Ireland, and also runs many of them. This means it is implementing standards for the care of older people in the services it provides (such as residential settings). It also provides support to the nursing homes that manage to meet standards, through entities like its Nursing and Midwifery Professional Development Units;

- **Nursing Homes Ireland (NHI)** is the representative organisation for private sector and voluntary nursing homes in Ireland with 325 members. It was on the consultative group that drafted standards for quality care in residential settings for older people, and now provides supports to members to implement these standards;

- **Home Care Association** is the trade association representing private home care providers in Ireland;

- **Service Users** within residential settings are now consulted more frequently thanks to the new legislation.

The rest of this section concentrates on the relationship between HIQA and the residential centres for which it is responsible.

### 3.5.2 HIQA: Functions and Powers

HIQA began by drafting the *National Quality Standards for Residential Care Settings for Older People in Ireland*, in consultation with a wide variety of stakeholders, including the general public. From this process, there emerged 32 different standards, grouped into seven sections. Among them are sections dedicated to rights, health and social-care needs, and quality of life to name a few. The degree to

which residential settings meet the regulations (which spell out in detail what primary legislation intends) and standards (which are linked to the regulations and in some places encourage continuous improvement) is assessed through inspections and monitoring by HIQA. The inspection process began in July 2009, and a number of different types of inspection are carried out by HIQA. In general, the most thorough is the 'registration inspection', and once a residential setting has passed this, it is registered to provide a specified type of care to a specified number of people, for the next three years.

When carrying out the inspection, inspectors meet with residents, relatives, the 'person in charge' and other members of staff. They examine records, including care plans, medical records, accidents and incidents log. They observe care and eat meals with residents. An inspection report is compiled from the evidence gathered, and an overall assessment on the safety and quality of care provided to residents is given. An assessment is given for each of the 32 standards, noting good practice and any improvements required. The provider of the residential setting then has six weeks to draw up an action plan detailing how to address these requirements. All inspection reports are published on the HIQA website. Another element of the registration process assesses the 'fitness' of the 'person in charge' (usually the manager) and the 'provider' (usually the owner) to provide the service. In addition to inspections, those in charge of a designated centre must ensure that HIQA is formally notified when certain serious incidents take place.

A centre that does not meet the requirements on regulations, standards and/or 'fit person' assessment can be subject to a number of forms of enforcement under the Health Act 2007. The strongest form allows HIQA to end the operation of the centre. It can also refuse to register a centre or limit the scope of its operation. Or else, HIQA can prosecute for breaches of the regulations. HIQA has the capacity to enter premises at any time and to seize any data-storage mechanism, such as documents, records, computers, without a warrant. By September 2011 approximately twenty centres had closed, either due to HIQA taking procedures to close them or the centres themselves deciding to close on foot of the HIQA inspection regime.

### 3.5.3 Support Processes

In terms of learning, there is an emphasis on continuous improvement within each individual centre in the standards and regulations for residential centres (and in the requirements of the new procurement process for home care packages). A number of residential centres also meet informally to share learning but HIQA does not play a strong role in this. This means that the range of practice that HIQA is familiar with and could share is not being made available to residential centres.

Instead, private companies and industry associations provide opportunities to share learning. For example, the industry association NHI runs education days for members to help them meet the various standards. The training provided is based on demand from members, and is related to what HIQA is asking residential settings to do to comply with the standards. Many residential settings have had to develop new policies and procedures in order to meet the HIQA standards, and NHI has

assisted them to devise and implement such policies. A number of Irish residential centres have also received private sector accreditation, such as the Q Mark and ISO.

Within the HSE, one of the most significant supports has been that of 'Practice Development'. Using facilitation, participating staff are encouraged to observe and question current work practices, and change them. A national project involving seventeen residential settings from the four HSE regions was carried out between 2007 and 2009. Meanwhile, the HSE does provide learning supports for residential centres, but not for home care operators.

### 3.5.4 Residents as Service Users

Overall, the standards aim to be person-centred and many of them specifically focus on involving the service user and gaining their perspective on accessing and receiving care in the centre. There is also a strong emphasis in these standards on the procedure for residents (and others) to make complaints. A resident is also entitled to an advocate/advocacy service, often drawn from community volunteers, when making decisions relating to consent to treatment or care.

### 3.5.5 Consequences of the New Regulatory Regime in Eldercare

This section will first focus on some of the positive outcomes emerging from the new regime before outlining some of the challenges. All those interviewed for the report saw the introduction of the standards regime as beneficial as it has been instrumental in restoring public confidence that had been shaken by certain scandals. Other perceived benefits included the positive perception of HIQA's independence and the fact that the new regulations covered HSE centres for the first time. HIQA's strong powers also drew a positive response as these enabled it to put in place procedures to close down centres that did not meet the regulations. Greater transparency via publication of inspection reports on HIQA's website was seen as a spur for improvement.

Respondents noted some challenges around the following areas. Some believed that there was excessive paperwork required under the new regime although others believed that the requisite documentation of practice was important in reviewing care and promoting learning on care within the centres.

The costs involved in implementing standards, such as purchasing new equipment, adjusting premises and employing extra staff, is sometimes raised as a challenge. However, the benefits of such investment are seen to be increased confidence in the standard of care being provided, as well as wider social and economic benefits for older people and their families, along with business benefits for privately run homes. Detailed data from the United States shows that the costs of implementing regulation and quality-improvement initiatives in residential centres can be reduced, and in some cases cost less than providing lower-quality care, through the use of practices such as results-orientated leadership, collaborative management, reduced staff turnover, and implementation of key care processes.

Reverting to our Irish study, in trying to establish a baseline of good practice it was observed that inspection had become like airport security—'you have to check everyone, even though it isn't necessary for everyone.' One respondent classified the residential centres into three types: the very good (who don't really need the standards); the very bad (who need to be closed); and the mediocre (who need to be nudged to improve). The question then is how this last group can be stimulated to make more progress. HIQA's stance has been that it is the provider's responsibility to come up with a solution and put it in place in order to meet the regulations (which avoids a 'tick-box' solution). In this context, other means of support are being sought out by persons in charge, and are being provided through 'self-service', often at great expense, or through a range of other private and statutory sector organisations.

### 3.5.6 Conclusion

HIQA's operation as an independent regulator has been welcomed by those concerned with standards and quality in the area of care for older people. The fact that it is autonomous and possessed of strong sanctioning powers has meant that centres providing unacceptable care are not registered, and this is helping to bring about a less variable system of care. Having established a credible baseline of practice, it now faces the challenge of improving the performance of many institutions without wanting to compromise the independence of the inspection process. How this dilemma might be resolved is discussed in Chapter 4.

## 3.6 Standards for End-of-Life Care

### 3.6.1 Introduction

This policy area has been examined in the NESC report, *Quality and Standards in Human Services in Ireland: End-of-Life Care in Hospitals*. As three-quarters of deaths in Ireland take place in hospitals and long-stay care, the Hospice Friendly Hospitals (HFH) programme aims to introduce a more person-centred hospice-type approach to death in these facilities. This five-year programme was initiated by the Irish Hospice Foundation (a not-for-profit organisation) in 2007, in partnership with the HSE, and supported by the Atlantic Philanthropies, the Dormant Accounts Fund and the Health Services National Partnership Forum.

### 3.6.2 Implementation of the Standards — Supports and Sanctions

As part of the HFH programme, an audit of the deaths of 1000 people in hospitals in Ireland in 2008–9 was carried out. This audit used questionnaires to capture the deceased person's final journey from various perspectives: the nurse and doctor who provided most care in the last week; a relative; and hospital management. Eighteen key issues that affect the quality of end-of-life care were identified from this audit, and using these together with the views of healthcare staff, bereaved

relatives and other stakeholders, *Quality Standards on End-of-Life Care in Hospitals* were developed. These identify what hospitals should strive for as they try to improve end-of-life care in Irish hospitals. They are now being implemented on a voluntary basis in 23 acute hospitals throughout Ireland.

The senior management of each hospital signs a Memorandum of Understanding with the HFH programme, with the hospital agreeing (among other things) to introduce an end-of-life care development plan, to establish a Standing Committee for this plan, which is representative of all staff groups, and to assign responsibility for the work to a senior manager. In return, the HFH provides a range of supports to these hospitals, including an end-of-life care co-ordinator to work with the hospital, and access to all HFH resources.

The audit of 1,000 deaths is one resource, and data collected for each hospital as part of the audit allows the hospital to identify areas where improvement is needed. The hospital's end-of-life care development plan is based on this information. The Standing Committee meets monthly to prioritise which parts of the plan to implement, and to monitor progress on this. Specialist working groups under the Standing Committee are set up to progress particular aspects of the work. The end-of-life care co-ordinator plays an important role in raising awareness of the standards throughout the hospital, problem-solving, and carrying out specific tasks to make sure the development plan is implemented.

Other supports that the HFH programme provides include practical resources to be used in the hospital, such as the Resource Folder for each ward, which contains guidelines (e.g. on how to break bad news), leaflets (e.g. information for bereaved relatives), and checklists (e.g. have all the necessary procedures been followed after a death, such as completing the death notification form). Other resources include sympathy cards to send to relatives, a family handover bag for the deceased person's property, and a ward altar. A training programme called Final Journeys has also been developed, to raise awareness of the importance of good end-of-life care and of the range of hospital staff that are involved in this. Staff have reported that these practical tools allow them to provide more of the type of care that they already aim to provide, allowing them to show greater respect for the dying/deceased person, and to assist bereaved relatives. These supports are particularly important in a context where the standards are adopted voluntarily and are not supported by the force of legislation.

### 3.6.3 Learning

The HFH programme has set up a range of activities to encourage learning on better end-of-life care in hospitals. It has developed a programme of practice development, which is being implemented in eight acute hospitals. Over two years, the staff taking part in the practice development programme are trained and encouraged to observe and question current work practices, and change these in order to provide more patient-centred care. This approach to change is considered a powerful tool as it encourages reflection on patterns of work, how people work together, and how power is shared.

Recently, hospitals have begun After Death Review multi-disciplinary meetings of ward staff, to allow them to reflect on and learn about the care delivered to a recently deceased person in a ward. Feedback from bereaved relatives is also considered. This process promotes a culture of continuous improvement in the services delivered.

Another learning mechanism is the Hospice Friendly Hospitals Network. This meets at least three times a year, and brings together the chairs, deputy chairs, end-of-life care co-ordinators and public interest representatives of all the hospital Standing Committees throughout Ireland. The network shares information and good practice on end-of-life care, and feeds back to the HFH programme on the types of support needed by those championing change in end-of-life care in hospitals.

Meanwhile, the HFH programme managers receive feedback from each hospital on a quarterly basis. The programme itself is overseen by a Steering Committee with representatives from the HSE, Department of Health, HIQA, GPs, nurses, doctors and patients. The composition of this Committee has changed over time, depending on the phase of development of the programme. A number of the programme's resources have also been changed over time, where a different approach might be more effective, or a new need is identified—for example, the recent introduction of After Death Review meetings. Evaluations of the Final Journeys training and of the audit process have been carried out.

### 3.6.4 The Service User

The overall aim of the standards is to make the experience of dying in a hospital better for the patient. The importance of good communication with both patient, and family (who become service users also) is stressed, as well as the management of pain. Nonetheless, many patients would prefer to die at home. To help develop this aspect, the HFH programme has recently employed a 'pathfinder', to develop mechanisms for more people to die in or closer to their homes; and to facilitate the development of a network of care providers in home, hospice and hospital environments.

### 3.6.5 Conclusions on End-of-Life Care

The Hospice Friendly Hospitals programme and its *Quality Standards on End-of-Life Care in Hospitals* provide an excellent example of how standards can be driven from the 'bottom up'. The impetus for these standards came from a voluntary organisation, which sourced funding, encouraged a range of State stakeholders to become involved, and then recruited 75 per cent of acute hospitals in Ireland to take ownership of these standards and implement them. The HFH programme undertook a review of practice based on a systems approach and made improvements based on this data.

The HFH programme has also put in place a comprehensive range of supports, which are constantly evaluated. Some of the supports are designed to be immediately useful, while others promote long-term cultural change. A key focus is

awareness raising and continuous improvement. There are also a range of mechanisms to identify good practice, and to share it among those working in different organisations. This focuses particularly on sharing learning between implementing hospitals.

The HFH programme managers consider that implementation of the standards is mixed. While some aspects are progressing well, they would like to see more progress on certain aspects of the standards, including: how to recognise when patients are dying and how to tell them that; how to ensure there are adequate numbers of staff; prioritisation of single rooms for the dying; greater priority given to staff training; and the condition of mortuaries.

## 3.7 Conclusion

This chapter has reviewed what has been accomplished in several sectoral areas in relation to attempts to build up an infrastructure dedicated to the pursuit of standards and quality in Irish human services. In each of the areas, notable efforts have been made to set up institutions that would oversee service providers and contribute to the enhancement of quality. It is a remarkably disparate story with many routes to quality. Some sectors, such as eldercare, seeking quality through mandatory standards overseen by a strong State regulator, whereas others have relied on entirely voluntary efforts, such as end-of-life care. Other sectors have not really broached the question of standards, preferring to leave it to the professions themselves to tackle the issue. This has been the approach in schools until recently. Given this diversity, it is difficult to say that one approach should be preferred over others. That said, it still might be worth attempting to compare progress in a more explicit fashion to see if any overall lessons regarding the attainment of quality can be learnt from the experiences of each sector. This is done in the next chapter.

# Chapter 4
# Piecing Together the Jigsaw of Quality Services

## 4.1 Introduction

Chapter 3 has described the institutions and regimes that have been put in place to improve performance and quality of services. This chapter takes a more analytical stance by assessing what still has to be done to help ensure a quality service in each of the different policy areas. In effect, it spells out what pieces of the 'quality jigsaw' are still missing. In spite of the numerous achievements and progress made toward greater quality, no policy area can claim that it has achieved a systemic transformation that would ensure all organisations within particular sectors are experiencing continuous improvements.

After setting out two tasks that are fundamental for future quality improvements in each sector, this chapter also brings together these insights by drawing out some common themes. This composite picture may be of assistance in prompting greater quality in other human services not surveyed in the various reports.

## 4.2 A Regulatory Web of Compliance and Consultation for Policing

A range of institutions now exists to oversee the activity of gardaí and ensure that it upholds certain standards. The Garda Síochána Ombudsman Commission functions to ensure that garda behaviour does not contravene criminal law or internal disciplinary regulations; the Garda Professional Standard Unit exists to ensure that garda behaviour is in conformity with stated policies; the Garda Síochána Inspectorate examines whether garda policy and activity is in line with international best practice; and the Joint Policing Committees and Local Policing Fora are institutions that enable gardaí to liaise in a formal manner with local representatives over matters related to crime and disorder.

Considering that in the 80 years prior to 2005, there had been scant external oversight of the garda save for that exercised by the Department of Justice, this profusion of bodies constitutes a significant change in the regulation of policing. Many members of the public now believe that it is appropriate that there is an independent body to investigate complaints and that this fosters accountability of the gardaí and improves interaction with the public (Garda Síochána Ombudsman Commission, 2011: 50). Accountability has also been boosted through the

establishment of the joint policing committees across the country. These entities enable the gardaí and local authorities to meet with elected and community representatives several times a year to analyse what is contributing to crime and disorder and suggest how this might be alleviated. Apart from the interaction of the gardaí with the public, the internal workings of the organisation is now more regularly and critically scrutinised through the work of the Inspectorate and the Professional Standards Unit.

Yet the last chapter documented three significant problems in this area: (1) there appeared to be insufficient diagnosis of problems that allowed them to be resolved rather than just reacted to; (2) whilst there is evidence that the garda organisation is now more responsive, it is not evident that the best solution is always being adopted and there appears to be few means for deciding on this question; and (3) the different institutions brought in under the 2005 Act do not appear to be sufficiently interlinked to bring about lasting improvements in terms of the quality of the policing service.

It may be that these problems are magnified by deficiencies in what Chapter 2 termed a system of triple-loop learning. In the absence of the first loop, problems arise when gardaí struggle to analyse what difference in outcome their intervention might have produced; without the second loop, a corporate centre such as Garda Headquarters finds it difficult to review the effects of similar community safety initiatives around the country and revise practice in light of the lessons drawn; and if the third loop is not completed, regulators like GSOC or the Inspectorate are unable to review the self-monitoring of the corporate body they oversee and encourage them to revise practices to extend successes and minimise weaknesses. The NESC report *Policing and the Search for Continuous Improvement* concludes that what is needed for a higher-quality police service is neither stronger, top-down powers for a regulator like GSOC nor just more processes of bottom-up consultation, but ensuring that both parts of the 'regulatory system' interact or braid with each other to produce higher standards than could be achieved through a single process.

The idea that the various parts of the system need to cohere with each other might be beginning to be realised. For example, GSOC has expressed a wish that a notion of a service complaint be introduced; this would mean that where a person is dissatisfied with the standard or level of service provided by the gardaí, it might be resolved by a frontline supervisor such as a sergeant rather than by a superintendent invoking the disciplinary code (Garda Síochána Ombudsman Commission, 2012). In effect, it is trying to move toward a process of greater meta-regulation whereby matters are dealt with in an administrative fashion expeditiously. Additionally, the chairman of GSOC has expressed his wish that the Commission work more closely with the Garda Inspectorate on issues that arise regularly in complaints so that they might form the basis of a wider review (The Irish Times, 14 February 2012). However, the former commissioners of GSOC did express a regret that the process of making changes to the governing Act to enable these kinds of developments has been 'very slow' (Garda Síochána Ombudsman Commission, 2012: 23). This underlines the importance of some central node within

the network of oversight and consultative bodies assuming responsibility for overall coherence and efficacy of the regulatory regime.

To sum up, within the realm of policing, there is ample evidence that standards have been maintained thanks to the introduction of many oversight and liaison bodies. Establishing these organisations could be akin to creating the parts from which an engine for continuous improvement might be constructed. But the engine still has to be built and so the parts still have to be connected. More work needs to be done between the organisations to discover why certain kinds of complaint reoccur every year and what are the most progressive examples of policing in the country. The NESC report on policing indicated that this could not just be a high-level task conducted by formal oversight institutions such as GSOC or the Inspectorate; it had to be accompanied by more ground-level work such as the example above of a sergeant resolving service-level complaints. And in terms of promoting good practice, more could be done to examine and disseminate why certain initiatives have been successful.

The problem seems to be that we lack an adequate design for how this might be done. What would an institutional architecture that drives quality in policing look like? This question is examined in the latter part of this chapter and is not unique to policing. In the next section, we examine the experience of school reforms as this sector has confronted similar issues to those in policing. The school system has experienced the establishment of a number of oversight and liaison bodies as well, but there may be the possibility for greater progress here as attention is now focusing more explicitly on standards, as part of an effort to drive improvements in literacy and numeracy outcomes. This drive may well have profound implications for the work of all the new bodies that contribute to quality in the school system.

## 4.3 Encouraging Quality through Self-Regulation in Schools

As described in the last chapter, the occasional form of regulation of Irish schools, prevalent up to the late 1990s, has been overturned through the augmentation of bodies like the Inspectorate and the Boards of Management (BOMs) and the introduction of new entities such as the Teaching Council and the National Council for Curriculum and Assessment (NCCA). The work that these bodies do has been detailed in the last chapter and will not be restated here. Research has shown both that schools 'matter' (Smyth & McCoy, 2011: 7) and that teacher effects are significant (Nye *et al.*, 2004)—that is, what happens within the school and classroom can overcome other disadvantages that children face. It is worth exploring how schools can contribute to quality and continuous improvement and how the educational bodies concerned with standards can build on this. There are several relatively new initiatives that have been designed to address what appear to be significant failings within Ireland's school system, which might also play a catalytic role as regards self-evaluation within schools.

One of these initiatives is known as DEIS (Delivering Equality of Opportunity in Schools) and is designed to tackle educational disadvantage. A comparison of groups participating in the DEIS programme in 2007 and 2010 shows higher scores in reading and mathematics for the latter group. Three reasons have been suggested for this improvement. First, schools were encouraged to set clear targets, particularly in the areas of literacy, and most engaged in this process. Second, DEIS is the first programme of its kind to provide literacy and numeracy programmes to participants rather than assuming that students will naturally possess these capabilities or automatically acquire them in the course of their education. And third, a system of supports was introduced to assist schools in the planning and implementation of programmes (Weir *et al*., 2011). The Department of Education and Skills (DES) (2011b) has recommended that the planning process deployed in DEIS schools is pertinent to securing improvements in all schools. Particularly relevant are the strategies in relation to target-setting, monitoring of progress and subsequent review of the standards.

Despite the importance of standardised testing for monitoring students' learning and informing schools' self-evaluation processes, the use of such tests has been 'relatively rare in Irish primary schools'. And the situation is even 'less satisfactory at post-primary level' (Department of Education and Skills, 2011b: 76). Primary teachers are not using the information as best they could and outcomes are not always effectively reported to parents.

However, another national initiative, the National Strategy to Improve Literacy and Numeracy among Children and Young People, may address this. It seeks to assess students' progress with respect to literacy and numeracy by reference to clear outcomes. Such a development is thought to necessitate a 'curriculum that combines clear statements of learning outcomes and accessible examples of what learners should know or be able to do in literacy and numeracy' (Department of Education and Skills, 2011a: 73). The DES suggests that a curriculum with examples and outcomes would provide a 'reliable framework of reference against which teachers, parents and students can benchmark achievement and progress' (*ibid*.: 74). It has been proposed that the information arising from standardised testing will be used at the:

- Individual level – whereby teachers can adjust instruction to suit the needs of individual learners and to inform them and their parents about their progress;

- School level – so that principals and BOMs can see how they can adjust learning strategies within schools (see also Department of Education and Skills, 2011b: 78–9);

- System level – to inform national educational policy for literacy and numeracy and identify ways of improving the performance of the school system.

Advocating the use of such tests and ensuring that this happens would not only have important implications for pupils and teachers but also for schools, BOMs and the education system. Schools would be affected by being required to incorporate the data arising from testing into their evaluation of their own practice, which may

go some way to filling the information deficit that has been identified in the Whole-School Evaluation process. Principals would be required to report to BOMs on the results of standardised tests and the Boards would have to be trained in the interpretation of such data. And the DES has committed itself to analysing the outcomes of the Strategy so as to provide trend data on achievement in different categories of school, and explore how this kind of information could be used to 'assist schools in benchmarking their standards against a norm for similar schools and to set targets for improvement' (*ibid*.: 83). This last point is supported by Smyth who argues that information collected at the school level is likely to be of limited utility without comparable information on the national context (Smyth, 1999: 226). In other words, some sort of national architecture needs to be built so that the appropriate benchmarks for performance can be established.

If the introduction of the National Strategy to Improve Literacy and Numeracy among Children and Young People is to be of benefit, further work is needed to progress standards within schools. The NESC report, *Quality and Standards in Human Services in Ireland: The School System*, identified two outstanding challenges:

i. To cultivate a culture and discipline of reflective practice within schools based upon relatively objective evidence rather than subjective impressions; and

ii. To establish a national data and standards framework that provides a secure basis for judgement about quality and improvement.

There is some evidence that progress is being made on the first issue. In 2011, the Inspectorate of DES took steps to address this challenge by issuing newly published drafts of *School Self-Evaluation Guidelines* for primary and post-primary schools. The guidelines contain some exemplars of what practice in schools with significant strengths would look like. Providing benchmarks like these goes some way to addressing the problems with the Looking at Our School model, discussed in Chapter 3.

Since October 2011, the Guidelines have been in trial use in twelve pilot schools at primary and post-primary level in urban and rural settings. Schools in the pilot phase completed a cycle of self-evaluation and devised and implemented a school improvement plan by May/June 2012. They have collaborated with the Inspectorate, who wanted to learn about the effectiveness of the draft Guidelines and who have amended them accordingly, and made a final version available in September 2012. To support self-evaluation by schools, the NCCA has been asked to recast the curricula in terms of learning outcomes and provide exemplars illustrating what these outcomes might mean in terms of students' work (Hislop, 2012: 19).

These are commendable developments, but the importance of advancing a discipline of professional review should not neglect how this could be supported by a national data and standards framework. For example, the NCCA has also pointed out the need for some sort of mechanism or forum to facilitate the formative use of standardised assessment and link it to changes in teachers' practices and

improvements in the learning of students: to bring this about, teachers need '*a process by which they can analyse the data, link the information to their own teaching, and test the links using parallel, but different, evidence from others in professional learning teams*' (National Council for Curriculum and Assessment, 2011: 37, italics in original). This statement indicates that formative assessment should be used not only to stimulate positive changes in student performance but also in teachers' practice, which is not the norm in most OECD countries (Looney, 2011). Effective teacher appraisal systems could indicate good teaching and assessment practices and identify areas for improvement (this is one of the most notable features of the case study provided in Box 4.1, discussed later in the chapter). The Inspectorate of the DES has indicated that the use of multiple forms of assessment information 'should be a major area of development over the next few years' and will be an element of continuing professional development for school principals (Hislop, 2012: 20-1).

If we compare the two policy areas of policing and education, similarities and differences emerge. Similarities appear because both policy areas have witnessed a profusion of bodies whose purpose is to either oversee the work of the respective professions and/or liaise with them for the purposes of improvement. Differences emerge because the question of what constitutes good teaching may be illuminated thanks to the emphasis on standards in the recent National Strategy to Improve Literacy and Numeracy among Children and Young People. No such clarity exists in policing, where the question of what stands for good policing is left to individual localities to decide within certain limits. An institutional mechanism like the forum called for by the NCCA might be of benefit to policing. It might be thought such a mechanism would be superfluous if only agreement could be reached on the standards that are appropriate for a quality service, and that a willingness exists to ensure that they are observed. In some respects, the area of disability services represents an opportunity to test this claim.

## 4.4 Implementation of Standards as the Answer? The Experience of Disability Services

As our summary in Chapter 3 on disability services has demonstrated, the recent history of standards in the disability area is complex. High-quality services are funded alongside services that are unproven in quality terms, resulting in a plethora of what have been termed 'independent republics', organisations providing services on their own terms, which may or may not be appropriate. Despite widespread and prolonged consultation, the level of progress on the implementation of standards in the disability sector has been partial as only one set of standards, the Standards for the Assessment of Need for Children under 5, has been put on a statutory footing.

Given the experience in eldercare, it is likely that the eventual introduction of mandatory standards with external inspection and monitoring will have two positive effects on such a fragmented environment. Laying down clear benchmarks for good performance might make some service providers more self-conscious and their

practices more transparent by showing how far they are from a quality service. Introducing standards would also make it possible for a regulator or some other oversight body to compare and contrast across different service providers and identify good practice.

These are positive reasons for introducing standards and these are shared by many working in the disability sector. But there is an anxiety that there may be a mismatch between the residential standards and emerging models of provision that will not be residentially focused. More specifically, they worry about a lack of value placed on the measurement of outcomes for individuals as opposed to the assessment of care from the institutional perspective of centres. This introduces a level of complexity that has not been apparent in either the policing or schools sectors. In those sectors, we have just seen how the question of standards for improvement is being broached. But what the disability area shows us is that agreement on a set of principles or standards only gets one so far; they still have to be configured to suit the particular circumstances of individuals. Whereas traditionally the problem may have been accomplishing the first task — getting agreement on a shared vision — now the main issue may relate to the second task — ensuring that care suits the individuals concerned. This would require adopting the kind of diagnostic problem-solving perspective of Rumelt, Sparrow and others (see Chapter 2). It would not assume that a consensus on goals is all that is required.

In the provision of care for people with disabilities, this means inquiring how issues of uncertainty and diversity can be managed. Matters are uncertain because people are often unsure about the best way to proceed. The NESC report, *Quality and Standards in Human Services in Ireland: Disability Services* recounted an episode involving a man in his fifties who had Down's syndrome and a significant hearing impairment. This man signalled that he no longer wanted to live in a group home but staff were at a loss about how to accommodate him. The first location didn't work out and staff had to figure out what the problem was (NESC, 2012: 93). It may be thought that uncertainty arises from a diverse set of different issues that people with disabilities present. But we can see from the example above that even being confronted with a restricted set of issues can create uncertainty. Obviously, the more diversity there is among people with disabilities, the greater the uncertainty.

Because of these two issues, it is important that regulation of the disability sector encourages both flexibility and adaptability. In relation to flexibility, rules and standards should be adjusted to different conditions, which means that different bodies can subscribe to common targets and timetable, and then design their own actions to meet these. Adopting a flexible approach would meet one of the challenges for the disability sector, which consists of how to 'regulate individualised, customised supports'. This would require some degree of self-certification — for instance the Centre on Quality and Leadership (CQL) model — a position from which the State has often shied away. Evidence suggests, however, that because private certification schemes do not enjoy the same taken-for-granted legitimacy as State authorities, they have to work harder to obtain it from a variety of sources, including civic groups and international organisations. High standards often result as

they become recognised and institutionalised as constituting good business practice (Overdevest & Zeitlin, 2011).

Admitting some variation facilitates the second advantage, that of adaptability. In contrast to a regime that insists on compliance with a set of uniform standards, allowing for some variation in the care of people with disabilities would allow providers to explore what constitutes the best kind of service. Encouraging adaptability and customised responses seems appropriate to a strategy where the best solution is not known in advance and different responses could be encouraged and the most suitable selected. Judging what works is crucial if a virtuous sequence of improvement is to be initiated and standards are to be revised upwards, but cannot necessarily be known in advance.

Allowing for variation might also help address another obstacle to raising standards in disability services, namely that of cost. There may be a fear that instituting a genuinely radical reorientation of care for people with disabilities may impose a great financial cost, both in terms of equipping institutions and providing formal oversight of this new system. But this assumption would seem to ignore the many examples of best practice already operative within the system; and it overlooks the potential that this innovative work could help to transform the rest of the system (Department of Health, 2012: 169).

Drawing upon industry leaders to drive up standards overall is not unusual. For example, the Japanese have sought to develop the world's most energy-efficient products in twenty-one different areas. They have achieved this goal through what is known as the 'top-runner method'. This refers to a process whereby the product with the highest energy efficiency sets the standard, triggering a 'run' to the top among manufacturers. Since peer organisations have already accomplished this advance, it is difficult for rival firms to dispute its feasibility. Government consults with firms operating within particular sectors to discuss how they can achieve the standards and then resets the standards accordingly, (Kimura, 2010). Based on this method, the 2010 target for the fuel economy of vehicles was achieved by 2005. In contrast, the US approach of State-mandated standards with financial penalties for those firms that fail to meet targets has not been as successful (Mikler, 2009).

While this kind of collaborative approach is important, it will still be necessary to have a regulator with some kind of sanctioning powers. Disparities will continue to exist because some entities provide a poor quality of care. In these cases, any regulator would need to have the capacity for some kind of remedial measures that might ultimately escalate to forbidding an organisation to provide care.

With this in mind, there may be two primary tasks for the disability sector:

i. Establish a regulator capable of overseeing the quality of care within the disability sector;

ii. Explore best practice to see how it could be a basis for exemplifying mandatory standards within the sector as per the top-runner method.

Reviewing the experience of the policing and school sectors, one might think that the major obstacle to inaugurating quality services is gaining sufficient support for an agreed vision or set of standards. For instance, with regard to schools, the most important task might be thought to be gaining agreement on appropriate literacy and numeracy outcomes for pupils. But what the disability sector demonstrates is that there would still be questions about the adequacy of such standards: are they appropriate for this person and how can they be modulated to suit him or her? Quality service providers would need to be able to continually review the foundations on which their services are based so that they can improve their services in line with people's needs. Taking the learning from diverse experiences and using it to reshape how standards are conceived and services are delivered is then a crucial component in continuous improvement of human services. The provision of a space for reflection or forum for dialogue could provide an opportunity for the relevant parties to meet, to share their learning from the range of approaches and experiences adopted and to identify areas for improvement.

Also important is the existence of a strong regulator. Whilst the presence of such a regulator may be able to obtain compliance with certain standards by some parties through the threat of sanctions, this may not suffice for other organisations. These more 'middling performers' may believe that they lack either the knowledge and/or capacity to improve their arrangements and may need assistance from some external body. This hypothesis will be elaborated in the next section on eldercare.

## 4.5 Establishing Quality through an Independent Regulator: The Experience of Residential Care for Older People and its Extension to Home Care

In many respects, the field of care for older people might seem to exemplify how quality can be instilled in human services through the actions of an external regulator concerned with standards. In the case of residential care (home care is only covered by draft standards, which are being adhered to by some private operators), regulations and standards are mandatory and HIQA acts as an independent inspectorate, possessing strong powers, up to the ultimate sanction of closure. Every residential centre has to undergo a registration inspection in order to obtain a licence to operate. Owners and managers have to demonstrate their capacity to meet the standards. Monitoring of significant events and regular reporting of these to HIQA helps the regulator decide on which centres they should prioritise for their visits and there are also spot checks.

It may seem that the existence of a strong and independent regulator is one of the most distinctive features of the residential care of older people but there are other important features that should be noted. HIQA is dependent on residential centres for older people continuously monitoring themselves on matters such as how many patients are bed-bound, how many have pressure sores or wounds, and how many are dispensed drugs as well as many other important events. Even a strong regulator with sanctioning powers depends, to a significant degree, on institutions

regulating themselves just as the ideas of meta-regulation (reviewed in Chapter 2) imply. And this degree of 'self-regulation' is augmented by the decision to place all inspection reports on HIQA's website so a centre's deficiencies are obvious to all, thus providing a spur to improvement.

A willingness on the part of the regulator to exercise its powers has been welcomed by many working in the sector as they believe it has boosted confidence in those centres still providing care. There is also a greater focus on service users as many of the standards specifically focus on involving residents through instruments like a representative group that can give feedback on all matters affecting them. Residents can also access an advocacy programme when making decisions relating to whether they consent to treatment or care.

In Chapter 3, we outlined many of the benefits ushered in through this new regulatory regime. Among them were an affirmation of HIQA's independence; a belief that its strong sanctions would drive out those not committed to the provision of quality care; a perception that there is now a more level playing field as HSE-run centres are also inspected; greater involvement of residents in decisions affecting them; and the promotion of a more standardised approach to care with less variation in quality.

Perhaps the most significant challenge for HIQA in the area of residential care for older people is how it should deal with those operators that one interviewee classified as the mediocre, in contrast to the very good centres that did not really need standards and the very poor that needed to be closed down. HIQA wants to encourage service providers to take into account local conditions, to reflect on what is required and to take ownership of the standards agreed to be implemented. HIQA is resolute that it will not tell the operator how the standards can be met as it wants to avoid formulaic responses, although this stance may be conditioned by two factors. HIQA may well believe that it is important to first ensure that every centre provides care according to a set of minimum standards and only then concentrate on improvements. And providing guidance and promoting improvement may also have proven difficult due to resource constraints. Some private companies and State organisations, such as the HSE, try to fill this void but some providers still found that it took great expense and effort to establish what constituted best practice. One interviewee remarked that three managers worked on how best to meet the standards. Many regulators have faced the dilemma of trying to be as effective as possible with scarce resources. Hong and Braithwaite (2012) write that nursing home inspectorates in the US were so concerned with getting the basics done that they rarely had the time to 'pick important problems and fix them' as Sparrow advocates. A reform introduced in the US in 1987 tried to resolve this issue by requiring nursing home staff to meet with residents' representatives to reach agreement on one important problem and fix it. In effect, this is picking up the injunction of smart regulation to deploy non-State actors as quasi-regulators.

Leaving organisations to figure out for themselves how they should meet the required standards did not necessarily lead to a successful resolution. Providers still struggle with conflict between different standards: for example, the appropriate level of risk or medicines for residents. If, as might be expected, these inevitable

conflicts are resolved through individual encounters, this invariably raises the question of the consistency of the inspection process. Do all providers have a chance to address their concerns or are some inspections more rigid than others? Issues of conflict and consistency are raised again when one factors in what the residents of a centre for older people might want. Residents' perceptions of the quality of a centre might differ from a regulator like HIQA and they may disagree with some of its judgements. For example, it has been mooted that several community nursing homes will be closed, the reasons being a lack of money, a moratorium on recruitment and the lack of capacity to meet HIQA standards. Residents of one home staved off this course of action by seeking legal redress (*The Irish Times*, 29 November 2011). This indicates an issue in which service users may need to become more involved, along with representatives from HIQA and the HSE, together with service providers.

While the residential aspect of the provision of care for older people might seem to possess many of the features (which other sectoral areas do not) that comprise a high-quality human-service regime — mandatory standards, independent regulator with strong sanctions and publicity of results — it still faces challenges. These centre on the issue of how average or mediocre performance can be enhanced and whether centres should be left to their own devices in addressing this issue. Whilst some centres get together with like-minded others to establish how standards can best be met, other organisations do not fare so well. This would suggest that HIQA should give greater support, exploring and disseminating what best practice might mean and how it could be accomplished. It is worth noting that HIQA, in its Standards for Safer Better Healthcare (2012), has promised to support service providers in developing self-assessment of their capacity to meet these standards and develop a 'monitoring for improvement approach'.

If one important future task for the eldercare sector is to explore how HIQA could act as a 'supportive centre', then another may involve taking a critical view of the reasons why people enter and remain within residential centres. The NESC report, *Residential Care for Older People*, documented that a greater proportion of Ireland's population of older people, relative to the EU average, lived in nursing homes and hospitals. Ireland's population of older people is expected to increase, with an estimated 1.4 million people over 65 in 2041, growing from 0.5 million in 2011. There are a number of implications of this growing population of older people for the provision of quality care in the future. These implications relate to the costs of providing long-term care, but also the options and choices older people will have. Some of these issues have been raised in the report of the Working Group on Long Term Care (2008) but they have persisted. Obviously, lessening dependency on long-term institutional care will be difficult since solutions will have to be found by aligning different services more closely with each other, and this 'joining-up' between institutions has always been difficult.

Undoubtedly, there will be a heavy demand on residential places if present trends continue. In relation to costs, there are estimates of the cost of long-term care tripling by 2060. Cognisant of these long-term escalating costs, government has underlined the need for 'additional policy measures in order to safeguard the long-term sustainability of the public finances' (Department of Finance, 2012: sec. 6.3).

Given the scale of these possible long-term costs, it is sensible to look at alternatives to residential care. Potential alternatives are very much in line with current government policy and older people's desire to remain in their own homes for as long as possible. For this to come about, adequate supports need to be provided and the quality of those supports needs to be assured (see the earlier discussion on home care standards, which are not mandatory at the moment).

The HSE has estimated that up to three-quarters of the people assessed for long-term residential care had not been considered for or provided with home care options (HSE, 2011). This seems to contravene the HSE's own commitment to 'support older people to remain independent, in their own home or within their community environment, for as long as possible' (HSE, 2012: 44). This trend could be alleviated by: (i) HIQA being given (through amendment of the Health Act 2007) responsibility for the standards within home care; and (ii) the Department of Health exploring, in conjunction with the HSE and HIQA, how reliance on residential centres might be lessened and how older people might be encouraged and supported to reside within their own communities. In its National Service Plan 2012, the HSE has committed to allocate funding away from residential care and to increase intermediate care capacity, which would 'prevent inappropriate admissions to long-term residential care' (*ibid*., 2012: 44). This is only one possible outcome of the recommendation in NESC's report, *Quality and Standards in Human Services in Ireland: Residential Care for Older People*, namely that relevant regulators and the Department of Health examine and address the challenges of providing and co-ordinating sufficient quality long-term care in an equitable and sustainable way.

If there are efforts to encourage a greater number of older people to remain in their homes and communities, needs to be accompanied by assurances that the quality of care will be equivalent to that pertaining to residential care. This is not unproblematic as the NESC report on home care demonstrated. That report states that only the standards applying to home care packages contracted out by the HSE must be met, and so the majority of home care (i.e. that provided directly by the HSE, and that provided on a private basis by voluntary or private organisations) is not yet subject to standards' requirements.

If coverage is one problem, the means of quality assurance may be another. Once providers have demonstrated that they have procedures in place to ensure a high standard of care, they may receive funding from the HSE. This might be described as a form of *ex-ante* meta-regulation as it relies on providers providing assurances about their capabilities before the actual provision of home care. The obvious question is how the work of the service providers is overseen in practice and how standards might be assured.

The HSE tender for home care packages contains provisions that will allow the HSE to receive data from service providers to help it monitor the quality of service provided. All of the draft standards frameworks referred to in the NESC *Home Care for Older People* report require home care organisations to put procedures in place to regularly improve their service, and to assess their quality, in conjunction with the service user. This mechanism facilitates learning on the quality of the service to

take place within the organisation. However, the fact that service providers will be competing for business under the HSE tender for home care packages means that the inclination for networks to share learning may be slower to develop than if such competition was not in force. Perhaps one way of getting around this is to require that the work of the best providers be treated as an exemplar for how standards can be attained by more poorly performing organisations (see the discussion of the top-runner method in the previous section). Undoubtedly, this would place more importance on a regulator building up a positive engagement with the regulatee rather than maintaining its relational distance. While some might believe that this might detract from its efficacy as a regulator of standards, it could be argued that a more collaborative approach would lead to enhanced care. Certainly, this is the experience of the last policy area reviewed in this chapter, which is end-of-life care.

## 4.6 Improving Quality through Voluntary Agreement – End-of-Life Care

Improvements in the area of end-of-life care seem to contradict many of the truths obtained from the theory and practice of regulation. Such improvements have been achieved without the existence of an autonomous regulator with a range of sanctions that can be imposed on those who are unwilling to abide by stipulated standards. Instead, its success is predicated on a voluntary association of hospitals that have undertaken a process of continuous review and improvement of their practices through a number of different steps.

The first is through the initial audit that helped draw up the Standards and Development plans for end-of-life care. The audit has been described by one leading US specialist in end-of-life care, Joanne Lynn, as a 'remarkable undertaking, unequalled anywhere else' (Irish Hospice Foundation, 19 May 2010). It has revealed what care inputs and outcomes are important for a quality system of care and how individual hospitals are faring with regard to these. The second review process is known as 'practice development', whereby staff are encouraged to reflect critically on their end-of-life care practices, identify practices that are in keeping with best-practice norms and challenge unacceptable practices. And the third is the after-death review meetings that had been previously determined by the work practices of different wards.

Learning is also conducted between hospitals through the benchmarking reports that are available every three months to demonstrate how they are meeting the 36 key inputs and outcomes. Hospitals are able to use this information to establish how they are progressing in comparison to the top 25 per cent, although it is not quite clear whether this information is being used to drive progress or whether it simply reassures hospitals that are not in the lower cohorts. The Hospice Friendly Hospital Network is designed to share best practice, and in so doing to assist those hospitals that might be experiencing some difficulty in implementing the standards. Thus, it functions by sharing information and good practice in relation to end-of-life care in acute hospitals, and by suggesting the type of supports that should be made

available to those championing change in the hospitals. In spite of this assistance, some interviewees considered that the process of implementation has been mixed. Areas where progress still needs to be advanced includes how to recognise when patients are dying; how one should converse with them; and how to ensure that adequate staff are available.

It might be that the HFH programme could benefit from a more structured exploration of what seem to be the more intractable issues and how they are being resolved in the better performing hospitals, i.e. a more diagnostic analysis of overall progress. One of the common problems with the kind of network established in this area is that it exists on a voluntary basis. Whilst voluntarism is good and can be the basis for innovative practices, its downside is that it 'feeds variability' in the sense that not every institution is working according to a common set of precepts around quality and approved practices. For this reason, 'voluntarism cannot be the basis for systemic improvement' (Elmore, 2008: 61) in the sense that all organisations within any given system are propelled towards quality. If voluntarism inspires improvements to a degree, then the question of how to engineer further systemic improvement arises. One possibility mooted in the NESC report, *End-of-Life Care*, is to tie future funding allocation to the implementation of the *Quality Standards for End-of-Life Care in Hospitals*.

If extending and deepening engagement with these standards is one future task, another might be to enquire how well the HFH programme has met the needs of patients. An estimated 25 per cent of people die at home, a figure that has been largely unaltered throughout the existence of the HFH programme. Yet nearly a quarter more are described as being suitable to die at home by nurses, doctors and relatives (National Audit, 2008/9) and nearly two thirds of people have expressed a preference to die in their own homes. When one considers the cost of a hospital bed ranges from €588 for a day case bed to €2600 for a critical care bed in a major teaching hospital (PA Consulting Group, 2007: 155), then there are strong financial as well as normative reasons to explore whether more people can be facilitated to spend their last days in their homes. This is the purpose of the Pathfinder project which has been established by the HFH to examine how people's wishes to die in their own homes can be fulfilled. Facilitating this option will not be cost-free; it will depend on palliative care being extended beyond cancer and an extension of home care services as well as other adjustments (McKeown, 2011).

There are, perhaps, two primary tasks for end-of-life care. The first is to ensure that good practice is observed and implemented in all hospitals; and the second is to enquire how the system can begin to surmount itself by asking how people can die, not in hospitals, but in the surroundings of their own homes. Accomplishing these tasks will require greater input from organisations at the centre of policy development and funding allocation, which is explored in the next section.

## 4.7 A Centre Supportive of Continuous Improvement

Earlier in the chapter, the idea that there are multiple routes to quality was introduced. By this it was meant that there was no definitive institutional arrangement for delivering continuous improvement in human services; rather quality services could be obtained in a number of different ways. The overview given thus far of the policy areas reinforces this point. Each of these areas encapsulates a different approach, reflecting its particular institutional composition and the origins of its route towards quality. There has been significant progress in each area investigated in the sectoral reports, and yet there has still not been systemic, continuous improvement in any of them, although the Hospice Friendly Hospital movement comes close. But the political imperative for reform and the persistent economic crisis accelerates the need for transformation so that services can do 'better with less'. This is true not just in relation to the sectors examined in the NESC series of reports but also across the entire suite of human services within Ireland. So can anything be gleaned from the reports that could advance this issue?

One possible way of answering this is to examine if there any common themes or elements across the different sectors and which could then be extended to other policy areas that have not been considered by NESC. If one considers both what has been achieved in terms of reform and what has yet to be brought about, several common themes emerge:

i. Establish regulators/oversight agencies to ensure high standards (eldercare, policing);

ii. Ensure that there are coherent linkages between regulators/oversight agencies and the policy centre (policing, eldercare, home care);

iii. Encourage organisations to undertake audits and review their own practice (end-of-life care, schools) to establish reasons for success or lack of progress;

iv. Regulators should make greater use of successful organisations to stimulate wider innovation (schools, disability, home care) and work with struggling organisations to boost performance (eldercare);

v. Regulators should work with the policy centre and service users to analyse how services should be configured to deliver cost-efficiencies and user satisfaction (eldercare, end-of-life care).

One way to encapsulate all of these elements might involve the notion of a 'supportive centre for standards'. Drawing upon the responsive regulation literature and the data gathered in the research reports, it would seem that relying on the threat of sanctions, or even a prescriptive approach, will only raise standards to a certain level. It will not secure continuous improvement. For this, there needs to be a process of dialogue and guidance with organisations that are struggling to abide by standards. In addition, it is important that this process of guidance and support not be left to regulators alone; it should also involve relevant line departments,

peer organisations and user groups. Guidance may well involve some of the following: boosting capacity for change; identifying what works well in certain situations; disseminating knowledge of good practice; and building links between different organisations to ensure that the less able are supported.

To flesh out this notion of a supportive centre, it is useful to consider a successful example of this kind of approach to gain a fuller understanding of what it might involve. Box 4.1 details the reform process within the schools of the State of Victoria, Australia. It is important to note that this example is being used to illustrate how a 'policy centre' can drive systemic change through an exacting yet supportive process. Hence, it should be considered to have general relevance for many different human services rather than its significance being confined to the educational sector.

From the perspective of Victoria's education department in the early 2000s, schools fell into a number of different categories. A few were struggling, many were traditional and some were beginning to transform their levels of performance and development. The outstanding question for the education department was how it could institute a process whereby most schools were engaged in a cycle of continuously progressive development. The department decided that for this to happen, all schools had to:

- Be aware of good practices and their outcomes;
- Be willing to adopt good practices from elsewhere; and
- Have access to effective mechanisms for transferring those good practices

The context in which Victoria's schools operated was one where decision-making in key areas had been devolved to principals and/or school councils, a situation akin to Ireland. This was not seen as an obstacle to reform as it partly resembled how many progressive organisations functioned, where the role of the centre was to actively facilitate the 'transfer of good practices from innovative individual "business units" across the whole organisation' (Boston Consulting Group, 2003: 9). To enable this kind of transformation, it was recommended that the Department of Education 'can and should play a far more active role in supporting the transfer of excellent practices and, further, that it should utilise "levers" exist to execute a well-designed workforce development strategy in a self-managing schools environment', (*ibid*.). Some of the levers are detailed in Box 4.1 below.

It is generally agreed that the establishment of a Performance and Development Culture (P&DC) in 2005 was crucial to improvement. This is a process whereby schools and teachers were required to engage in self-assessment based on multiple sources of feedback (see diagram in Box 4.1), which would pinpoint areas for future development. The specifics of how to operationalise P&DC was left to the schools, and an accreditation process, validated externally, was put in place to affirm those that succeeded. By 2009, about 98 per cent of schools had been accredited. An external evaluation reported that P&DC had been a significant catalyst for professional review and learning as well as contributing to overall systemic

improvement (Kamener, 2012). One major limitation of the P&DC process is that it was a 'one-off'—after a school had developed a P&DC system that achieved accreditation, it had no further incentive either to maintain or to improve that system. Thus the prospect for systemic transformation of Victoria's schools was lessened.

Considering the case of schools reform in Victoria, Australia, is helpful in dispelling some possible misunderstandings about the notion of a supportive centre. First, it does not mean that the centre is 'captured' by those organisations it is meant to be regulating; the centre is primarily supportive of standards that lead to continuous improvement and secondarily of the institutions that are meant to be upholding these standards.

Second, the centre is not hands-off in how it operates; rather it is quite demanding in insisting that certain processes are followed. Where standards are in an early phase, this might be considered as an argument for the 'centre' to adopt a top-down, prescriptive approach in an effort to raise standards. But two arguments cut against this consideration: the first is that after the initial 'squeeze' by the centre — what Hopkins (2011) designates as an 'outside-in' approach — institutions begin to reach a plateau in terms of performance; the second is a more positive one that many high-performing schools function not by adhering to some central prescriptions but by asking themselves what changes in student learning do they wish to see in any given year, and then seeking supports for this quest in the wider policy environment. This kind of 'inside-out' approach has been described (in relation to schooling) as follows:

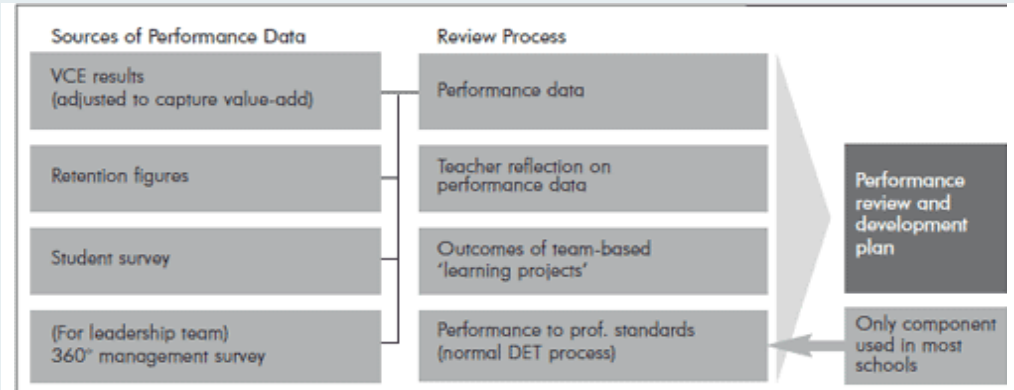
> In those schools that have made the jump from 'good to great' however, the linear logic of policy implementation has been inverted. Instead of doing 'outside-in' better or more efficiently, they begin ... at the other end of the sequence with student learning. It is as if they ask, 'What changes in student learning and performance do we wish to see this year?' Having decided these, they then discuss what teaching strategies will be most effective at bringing this about, and reflect on what modifications are required to the organisation of the school to support these developments. Finally, they survey the range of policy initiatives from the State and federal governments to see which they can most usefully mould to their own improvement plans (Hopkins, 2011: 11).

## Box 4.1 Raising Standards in Victoria's Schools

In 2003, the Labour government of Victoria, Australia, identified a need to take action to improve educational outcomes for all students. Problems included high variations in outcomes between classes in particular schools; variations in outcomes between schools with similar student intakes, and a heavy concentration of poor outcomes in some schools. A number of interlocking strategies were identified as pivotal for reform. These included:

1. **Focusing on student learning:** Achieved through (a) improved reporting on student achievement; and (b) development of broad assessment processes against which defined standards of learning at key points were measured.
2. **Building Leadership Capacity:** Victoria's schools fared badly on effective performance management so that constructive feedback was not deployed and support to minimize unsatisfactory performance was lacking.
3. **Establishing a Performance & Development (P&D) Culture:** An accreditation scheme based on self-assessment that stresses the use of multiple sources of feedback on teacher performance (see diagram) and its use in customised teacher-development plans.
4. **Providing Mentoring and Peer Support:** Through the P&D scheme, teachers began to observe and give feedback on their peers' performance.
5. **Encouraging Improvement through External Reviews:** Schools with differing levels of performance were subject to graduated interventions.

One example of the changes introduced is demonstrated by the diagram below, which shows the internal review process introduced into schools and how it differs from the normal review process.



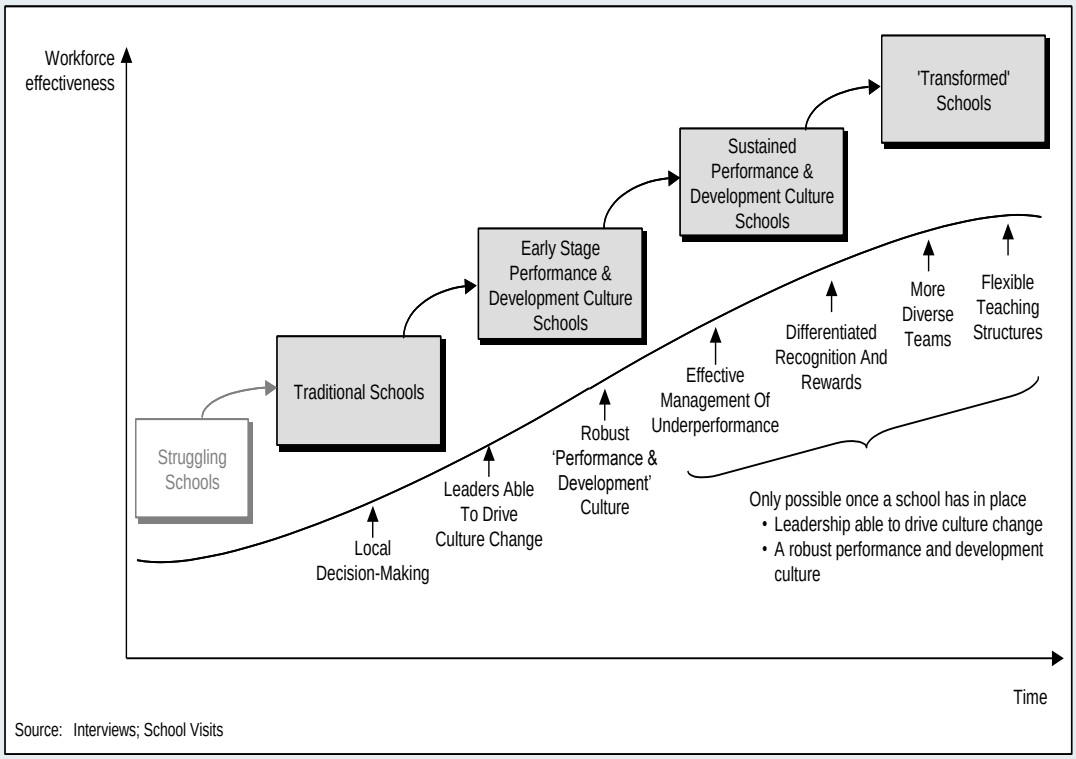

Based on the internal review, regional offices can allocate schools to one of four increasingly intensive external reviews: negotiated; continuous improvement; diagnostic; and extended diagnostic. Reviews vary according to the time external teams spend in the school and the nature of problems within them. In conjunction with this team and the regional network leader, schools identify the requisite key improvement strategies. A further component of reform is the requirement that Victoria's highest-performing schools take on further responsibility by sharing their knowledge and capacity with other schools.

The Victoria schools reform programme has been identified as an example of 'effective large scale reform ... from which others can learn' (OECD, 2008: 204–8) and as an example of a 'world-class service' (UK Government's Cabinet Office's Strategy Unit, 2009). This is not to say that obstacles to reform do not persist. In particular, there is a need to use disaggregated data to focus attention on disadvantaged pupils and isolated schools. And more could be done to involve families and communities.

Hopkins labels this approach as moving from an era of prescription — in which the centre mandates change — to an era of professionalism in which service providers use data to evaluate their clients' needs and personalise services for them. However, he is wary of adopting a bifurcated approach where the prescriptive approach is suitable for those areas in which standards appear to be lacking and the professional tack is appropriate once all institutions have attained a certain level. He notes that it is 'not possible to simply move from one phase to the other without self-consciously building professional capacity throughout the system' (Hopkins, 2011: 4). What this entails is that even a prescriptive approach should seek to instil some of the characteristics of the professional approach so that it can germinate and flourish. Perhaps the most important of these is that it seeks to encourage an 'inside-out' approach by all service providers as they ask themselves whether what they are doing is appropriate to both the overall standards or objectives laid down and the circumstances of the service user(s).

Building leadership capacity within the schools so that senior personnel have the ability to progress an enhanced performance culture is crucial for maintaining a trajectory of continuous improvement, as Figure 4.1 underlines. Schools could not become transformed organisations without this kind of approach. It is worth asking whether any of the regulators/policy centres reviewed in this NESC project have envisaged a similar process of systemic, institutional change for their sector. Or is it the case that the focus is on how well individual organisations are functioning? If the latter situation holds, is there any scope for asking how more systemic change could be introduced into particular sectors? For example, the Value for Money Review notes that within the disability sector, delivery of services and supports has been evolving towards a more person-centred approach, but that the pace of change has been slow and uneven (Department of Health, 2012: xxvii). In other words, change has not been systemic enough. The report nominates the HSE to take responsibility for driving change towards a person-centred policy approach. Systemic change would be triggered through the establishment of pilot projects in conformity with revised Service Level Agreements and their mainstream application. But achieving transformation within a sector may require more than piloting and mainstreaming. Proposals pertaining to schools reform in Victoria, Australia, are instructive in this regard.

**Figure 4.1 Evolutionary Development of Victoria's Schools**




Source Boston Consulting Group (2003)

One suggestion for achieving systemic change in Victoria's schools was that the Education Department should establish a centre dedicated to raising performance levels through identifying excellent practices and disseminating how they operate throughout the system (see Figure 4.2). The centre would begin by identifying excellent practice by using the school review process on which it already insists; the centre can then use this exemplary practice as a template for schools to follow by setting out what has happened in an explicit fashion; in effect, they codify best practice in the manner of the checklist utilised to cut down on errors in medical interventions, discussed in Chapter 2. Of course, there is always a danger in laying bare what has worked elsewhere that people may strive to slavishly replicate work that has been codified. Rather it should be seen as a prompt that helps people consider how they might emulate, rather than just 'implement', what has been successfully tried elsewhere.

In Section 4.3, we highlighted the NCCA's suggestion that there needs to be some kind of mechanism or forum in which teachers can engage in collaborative, yet critical, discussion that explores how their professional practice can best exemplify the desired standards. Japanese education is noted for its tradition of lesson studies in which groups of teachers review their lessons and how to improve them, in part through analysis of student errors. Teachers whose practice lags behind that of the leaders can see what good practice is and this helps to spur continuous improvement (Schleicher, 2012). It is worth repeating that the value of this kind of professional and institutional connectedness is not restricted to education; we have suggested that it would be valuable in human services like disability services, eldercare and policing, as well.[4]

This form of intensive collaboration is not particularly well represented in Figure 4.2 but fits with the idea of dissemination, namely that the centre should use the knowledge that it has obtained from high-performing schools to assist those organisations that might be lagging behind, always bearing in mind that circumstances often differ and so too must practice. And finally, it should seek to recognise and reward those schools that have excelled, affirming not just what they have achieved but also the processes through which they have secured better outcomes. This should be treated as an illustrative example of how a unit at the centre can help co-ordinate quality improvements across an entire sector, along the lines of triple-loop learning as outlined in Chapter 2. There might be items that can be discounted without doing damage to this central point, perhaps the rewards system, for example. Equally, there might be features worth including, such as using schools that have been deemed exemplary in the recognition phase to articulate how schools might best consult with pupils and parents and how they can use this feedback to change their teaching practices. This would be akin to the top-runner method discussed in Section 4.4. on disability services. Using the work of the most innovative to provoke the regime into further advances rather than letting it rest on its laurels is one of the most important tasks of a 'policy centre'.

Many of these points are in keeping with the notion that an oversight body concerned with general systemic change should actively publicise the knowledge that would support such change. The usefulness of knowledge transfer is predicated on the idea that it can provide some of the answers to the problems that poorly performing organisations need to address as opposed to just informing them that they are falling short in several respects. Elmore (2008: 41) illustrates this contrast in regulatory style by arguing that giving organisations information about 'the effects of their practice, other things being equal, does not improve their practice' whereas showing them how things can be done differently might improve matters.

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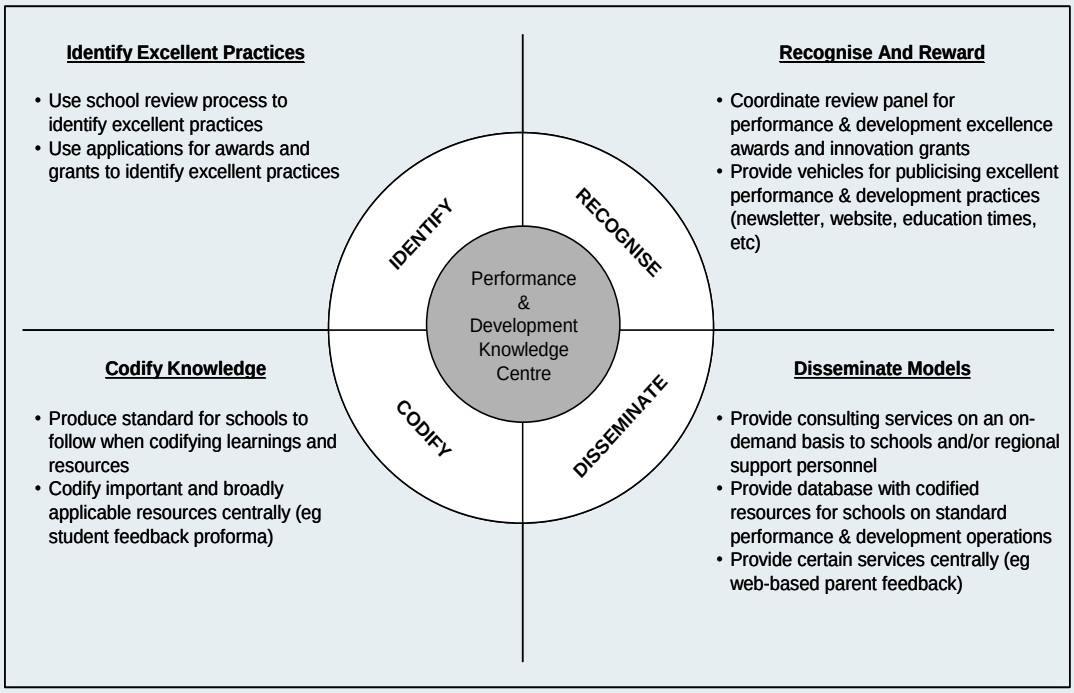
[4] It is worth highlighting that the Department of Education in Victoria never established this kind of centre. This may explain the comments of many teachers who called for continuing advice and support on how to maintain and extend a Performance and Development Culture within their school (Starr 2009). The Department have tried to rectify this issue by setting up an online learning network, known as Ultranet, to facilitate the exchange of knowledge between teachers and schools (personal communication with Victoria's Department of Education and Early Childhood Development).

**Figure 4.2 Essential Elements of Performance and Development Knowledge Centre**




Source Boston Consulting Group (2003)

Again, it is worth asking whether any regulators in Ireland have developed similar processes to identify and disseminate best practice. Surveying all the sectoral reports, the Hospice Friendly Hospitals network approximates most closely to the example above in its concern to highlight effective ways of working. However, the sectoral report on end-of-life care argued that many staff changes in the HSE have meant that engagement with the programme has been inconsistent, which weakens the prospect of the HSE sustaining implementation of the standards into the future. In some respects, how the Schools Inspectorate has operated in recent years is akin to a knowledge and development centre by recommending, for example, that the planning process used by DEIS schools provide a template for all schools. It is worth underlining that this guidance was to be provided not just by the Inspectorate but also by the support services and education centres (Department of Education and Skills, 2011b: 21), i.e. it is a network of bodies that provides support.

## 4.8 Conclusion – Achieving a Systemic Transformation of Human Services in Ireland

This chapter has assessed the progress made in the sectoral areas examined in the NESC series of research reports on quality and standards. There has been significant progress in establishing a new regulatory architecture that is conducive to raising standards in a variety of different human services. Examples include the establishment of several oversight/consultative bodies in policing; the increasing emphasis on self-evaluation in schools supported by the Inspectorate; the beneficial effects of HIQA's regulation on residential eldercare; the capacity of many providers to provide personalised care in disability services; new forms of ex-ante monitoring for quality in home care; and the evident elevation of standards in end-of-life care within many hospitals.

However, the chapter has also noted that there is an imperative for systemic transformation for political, economic and social reasons (and the various rationales for quality sketched in Chapter 1 still hold). Political because there is now a much greater tailwind behind public sector reform than was previously the case; economic because organisations have to establish that they are producing quality services in a cost-effective way; and social in tailoring services to better meet service users' needs.

Achieving these goals will require something additional to what has occurred to date. Rather than regulators just focusing on the extent to which individual organisations have implemented standards, they need to take a view on how to achieve systemic transformation, as depicted in the process in Figure 4.2, and set out the tools that will support such a change. This means establishing where all relevant organisations stand in terms of a 'ladder of achievement' — are they high, low or average — and gauging what is needed to move them up this ladder. This is what Victoria's Department of Education did to improve 'traditional' schools, although arguably it did not see this as a recurrent process so not all schools were 'transformed'.

From the foregoing discussion it seems reasonable to suggest that such instruments would involve the following:

1. An explicit mandate from the policy centre (the policy centre being a government department, agency or regulator) about the standards/goals to be achieved;

2. An injunction for organisations to assess their capacity to observe said standards and set out what changes will be required to do so;

3. A readiness on the part of the centre to lend support/guidance in the form of capacity-building and/or technical instruments to assist organisations in self-review;

4. A willingness on the part of the regulator/policy centre to assess sectoral areas both individually, in terms of how single organisations are abiding by the standards (for example, through inspection and monitoring), and collectively, by asking are there problems common to many institutions that can be resolved by highlighting the work of the most successful organisations;

5. A determination on the part of the regulator/policy centre to publicise and disseminate more effective ways of working, which have been uncovered in its review; and

6. A resolve, by both regulators and relevant departments/agencies, to assess how the entire sectoral field is functioning and suggest alternative ways of working if necessary.

It is obvious that the foregoing involves more focus on the work of the regulator/policy centre than on those entities that are to be regulated than has traditionally been the case in analyses of standards and human services in Ireland. Often, the focus of attention has been on the development of as many standards as is necessary to encompass all major facets of an organisation's performance; there has been much less attention on what the regulator should do to ensure that these standards are observed, aside from invoking formal legal powers.

But rather than just laying down a set of standards and calling for them to be 'implemented', the issues identified above require a regulator to figure out what needs to be done to support continuous improvement in the quality of services. This point can be missed in a concern to resolve an alleged 'implementation deficit' within many services, by stipulating that numerous standards must be met; but if successful improvements or reform is to occur, it may be that more attention needs to be given to issues of support and guidance, often with reference to the most innovative providers.[5] This point is taken up in the final chapter, where the implications of this report on plans for public service reform are considered.

[5] Rumelt (2011) notes that a good strategy includes a set of coherent actions designed to resolve problems picked out in the diagnosis. In his words, they are not 'implementation' details but the 'punch' in the strategy. If there are concerns about 'implementation', it often means that strategy has been confused with goal-setting, and plausible actions to advance objectives have not been articulated.

# Chapter 5
# Instituting a Dialogue Around a Quality Performance

This chapter briefly explores what are the overall implications of the NESC series of standards reports for reform of public services and ensuring that quality is inherent in their delivery. In the previous chapter, it was argued that a great deal of progress had been made across the six sectoral areas surveyed. Yet what has generally been missing is a 'centre supportive of continuous improvement', which is a regime that unites regulators, departments, service providers and user groups together in a way that helps deliver significant reform conducive to quality and high standards.

Of course, government has already set out a number of general reform proposals. In November 2011, the Department of Public Expenditure and Reform launched a public service reform plan that encapsulated a number of different commitments. These included placing customer service at the core; maximising new and innovative service-delivery channels; and leading, organising and working in new ways. Many of the commitments involve achieving greater efficiencies and more value for money, through measures such as streamlining administrative operations and putting more services online. Measures like this are essential to reduce the government's deficit and will help free up more staff for frontline services. But even apportioning a greater number of staff to engage with citizens may not be enough to enhance quality. The nature of the support provided by practitioners and how it is organised may be more important for quality than the sheer number of staff, which is a point made in the *Value for Money and Policy Review of Disability Services* (Department of Health, 2012: 130).

The Programme for Government (2011) also contains a number of commitments pertinent to the issue of quality public services. Broadly speaking, these involve the following:

- Use a range of external standards and benchmarks to improve performance and with greater accountability for results;
- Give public service bodies freedoms, balanced with new accountability, to adapt work practices to local staff and customer needs;
- Open up delivery of public services to a range of providers;
- Citizens have a basic right to key information on the performance of key services; and
- Put resources into citizens' hands to acquire services that are tailored to better suit their needs.

Reform built on the premises above would seem to be based on the idea that government should: (a) set clear expectations about desired level of performance; (b) give more choice and voice to service users; (c) allow services to be adapted to local needs; and (d) put in place mechanisms to ensure accountability and measurement of progress towards desired outcomes. Much of this is compatible with the NESC work on standards but the latter goes into some more detail about the mechanics of the delivery of services consistent with quality. In particular, it stresses the need for the policy centre to build capacity to enable organisations to review themselves against requisite standards; compare results of similarly placed organisations; leverage the performance of the most successful organisations to catalyse the work of others; and engage, with other oversight/consultative bodies, in general analysis of a policy area (like eldercare or policing), and ask whether the sector could function more efficiently and effectively by operating differently. Suggested mechanisms to enable this to happen include a centre supportive of continuous improvement and some type of forum where the issue of achieving high standards can be explored and exemplified. What also needs to be made explicit is that while this appears to be a supportive process, it also needs to be provocative to avoid complacency and to stimulate improvements.

All of this is in keeping with what the OECD, in its 2008 review of the Irish public service, termed a 'performance dialogue' between departments and the organisations that fall under their remit (OECD, 2008). Often public service organisations find it difficult to decide on and focus on key priorities, sometimes succumbing to short-term pressures to the detriment of a more strategic stance on desired outcomes. Related to this, there is a deficit in terms of performance measurement as some fundamental steps need to be taken in relation to data collection and usage, particularly around outcomes (Boyle, 2011). Murray (2010: 88) considered that the quality of performance of public sector organisations 'in relation to external indicators of excellence' or what this report would call 'standards' was wanting.

While not incorrect, this line of analysis might be said to be too partial, based on a few case-studies (Murray, 2010). A study encompassing a range of alternative organisations and sectors, as the series of NESC reports, *Standards and Quality in Human Services* that we synthesise here, comes to a somewhat different set of conclusions. Obviously, it would be difficult to deviate from the general proposition that the Irish structures of public administration have been dominated by concerns about compliance and may often lack the metrics to establish that there have been improvements. But the picture is not quite as stark as this, as the various NESC reports show that there have been evident gains.

The clearest example of a successful 'performance dialogue' is in relation to the area of end-of-life care where the audit uncovered the four areas in which improvement needed to be made; and networks within and between hospitals helped to analyse and raise performance levels. Other policy areas are beginning to demonstrate a similar commitment to embracing a sustained conversation about high-quality performance. In relation to schools, the Department of Education and Skills has now published its school self-evaluation guidelines and requires schools to benchmark themselves against the outcomes of the results of the National Strategy

to Improve Literacy and Numeracy among Children and Young People. In Chapter 4, it was argued that the Department has to ensure that this information is used to probe what kind of changes in teaching practice are required to elicit a better performance from students. HIQA, in the publication of *Standards for Safer Better Healthcare* (2012), has committed to providing examples of how to implement national standards and develop a continuous process to identify areas that may require more specific guidance (*ibid*., 2012: 10). Not only does this policy development point to the kind of relationship recommended in the NESC report on residential care for older people but it also indicates that broader issues germane to the entire sectoral area should be included in any performance dialogue.

Hence, it is important to emphasise that the idea of a 'performance dialogue' should not be restricted to the relationship between service provider and regulator or oversight body. Discussions about optimal performance levels should also encompass the totality of organisations working in a particular area. Questions such as the following would be relevant: are there issues that keep cropping up for individual organisations; how well-linked are the various oversight bodies within a given field; and could a sectoral area deliver services in a more economical way?

The analysis in Chapter 4 offered several examples of this kind of performance dialogue. The Garda Ombudsman Commission has expressed its wish that its work be aligned with the Garda Inspectorate to try to resolve systematic issues. And the report on End-of-Life care pointed to the merits of more stable connections between the HSE and the network of hospitals in relation to looking at what needs to be in place to facilitate people to die in their own homes in accordance with their wishes.

This level of institutional connectedness is necessary not only for addressing overall levels of performance but also for asking can the service be delivered in a more economical way. The *Value for Money and Policy Review of Disability Services* (Department of Health, 2012) indicates that many people believe that the current institutional model of care is economically unsustainable. Yet the document notes that the move toward a more tailored and potentially more affordable service of greater quality has been slow and that there needs to be a more fundamental transformation of the sector. This can only achieved by developing the kind of performance dialogue suggested above, namely, asking how adequately is the sector functioning and what changes should be made to improve it?

This connects with the discussion of triple-loop learning in Chapter 2. There it was suggested that regulators should assess organisations' efforts to self-regulate and, after appropriate consultation, suggest improvements where necessary, having been informed through examples of good practice elsewhere. This is part of an appropriate performance dialogue between regulator and regulatee. It assumes that the capacity to monitor, assess and revise operations is present; otherwise it will have to be instilled by the regulator operating in concert with practitioners. There is some evidence that this is becoming increasingly accepted. As mentioned above, HIQA would seem to assent to this view in its publication of the standards for hospitals.

But the discussion in Chapter 2 also implies another facet to a performance dialogue, which concerns the overall functioning of the policy field or sector in question. Chapter 2 suggests that there needs to be a fourth loop whereby overall progress of the sector in general could be discussed and the possible contribution of each 'regulatory' body set out. This is important not just for the effectiveness of the overall sector but also for answering whether services in the sector can be delivered more economically. As set out in Chapter 4, making significant economies in areas such as eldercare and end-of-life care requires this system-wide view. The establishment of a quality forum, either at sectoral level or cross-sectoral, which includes policy makers and implementers, regulators, service providers and service users, has the potential to fulfil the requirements of this fourth loop.

Dialogue on these matters should not be restricted to State bodies; as shown by the reports in eldercare, many private companies may be involved in providing care, or in the case of disability services, many community and voluntary groups are doing likewise. Any review of the overall efficacy of care within these fields has to involve these kinds of bodies.

From an overarching perspective there is obviously a tension between asking an organisation or set of bodies to regulate against a discrete set of standards and to stimulate fundamental change. This may be particularly the case when one is seeking to transform a sector, as has been suggested in the case of disability services, care of older people and end-of-life care. Regulators may have an inclination to stick to what they know best, and departments may believe that if there are obvious improvements in a sector, like there has been in residential care for older people, this course of action should be continued. What one sees will be a series of incremental improvements that are ultimately supportive of the *status quo*. But this avoids the question of whether resources are being put to the best possible use. Could the money being spent on keeping many older people in residential centres be better used to offer these people a superior quality of life within their own communities? In short, could there be greater innovation in this form of care? To stimulate improvements of this nature we might need to consider alternative institutional mechanisms that would be able to demonstrate how resources could be used in a more productive and satisfying way that is conducive with current government policy.

If one takes as an example the field of care for older people, is there a better way of delivering services? As things stand, money is distributed to institutions that may or may not be in a position to offer optimal services. These institutions may be regulated in a manner that offers some improvements. But what if the total amount of money available for different kinds of care for older people, within a distinct geographical area, was available for tender to social enterprises? These enterprises could demonstrate how they would use the funds to meet audited needs, having also raised matching funds from the private and/or philanthropic sector. By specifying up-front how they would deal with issues like dementia and immobility, social enterprises would provide both an outcomes-based focus as well as a natural comparator to existing care arrangements. Facilitating alternative models of care could prove to be a stimulus for innovation in the way envisaged in the 'top-runner' model, discussed earlier. It might prove to be a crucial feature of the expansive

notion of a 'performance dialogue' that is concerned with the overall functioning of a policy area and the best use of resources therein.

Stimulating this kind of institutional variety to help generate quality services would not be alien to Ireland's model of human services. NESC's report, *The Developmental Welfare State*, underlined the fact that Ireland has long had, and will continue to have, a hybrid welfare system, combining public, private and 'voluntary' elements (NESC, 2005). It suggested that the important question is how these different kinds of provider combine in delivering income transfers, services and innovation to meet new needs. Our review of systems of quality, standards and accountability in the provision of six human services has underlined both the hybrid nature of the Irish system and the critical role of services in social protection. With the obvious exception of policing, the other human services involve a combination of State, private and voluntary providers and resources. Furthermore, even where the State is a dominant regulatory authority, as in residential homes for older people, and the dominant funder, as in disability services, other organisations play an important role in driving systems of quality and standards, such as they are. Indeed, in describing the evolution of these systems over the past decade, we have used the idea of 'many routes to quality' to capture this institutional variety.

This leads us to suggest that in thinking about the further development of the systems of quality, standards and accountability in human services, we should resist making all these systems State-centric and should think about how to make the most of the fact that Ireland has a vibrant tradition of civil-society organisations in these areas. This is evident, for example, in the fact that in services for people with a disability, a sector yet to be covered by much State regulation, the lead providers are 'voluntary' and non-for-profit entities—indeed, the best of these have used cutting-edge international quality systems. In this vein, we suggest that, in the case of disability services, a key challenge is to find a way to ensure that these lead providers are an engine of continuous improvement for the sector as a whole. But we must clarify the nature of the evidence on Ireland's vibrant 'voluntary' sector and the inferences that can be drawn from it. This is important in a context in which some are advocating increased reliance on provision of human services 'in the community' and the centrality of the 'values' of those providing care. What we have found are examples of strong organisational capability in provision, quality assurance and innovation in complex human services; this is not the same as strong widely dispersed willingness and capability to provide such services. Nor is it obvious that it is the values of these leading providers, rather than their disciplined approach to quality and learning, that explains the developmental nature of their services. In other words, what we have found behind the provision of quality services is evidence of organisational capability and disciplines of quality, and not social capital *per se*.

## 5.1 Conclusion

Summarising the NESC series on quality in human services, this report has contended that there has been a great deal of progress made to ensure that some

of Ireland's human services live up to high standards. At a time when many Irish citizens exhibit a lack of trust in the State and display pessimism about its capacity to achieve public good, this is a proposition worth restating. Only a short time ago, many of Ireland's human services were effectively self-regulated with professionals in each sphere acting as the main arbiters of quality. In this respect, there has been considerable change as a new or enhanced regulatory infrastructure has promoted greater scrutiny of the question of standards in many different areas. The NESC reports have documented the following: there is now a more effective oversight infrastructure for investigating complaints against gardaí; schools will be required to issue a five-year improvement plan and regularly evaluate their progress; there is now considerable momentum towards a more personalised model of care in the disability sector, which could build on much of the innovative work that has been accomplished by non-governmental organisations; HIQA has operated as an effective regulator of care for residential institutions for the elderly; and the Hospice Friendly Hospital movement has established where end-of-life care needs to be improved and have regularly monitored progress on this issue. All of this has been achieved in the last ten years or so and it is valid to acknowledge the extent to which many organisations have travelled in terms of improvements in quality.

But we also find that further steps are necessary to turn these important developments into a really effective system of quality assurance, tailored services and continuous improvement. This report has argued that a dialogue on performance at two levels is necessary for greater improvements in terms of quality services. At the first level, individual organisations need to be helped to improve. This would involve scrutiny of the following kind. Is the regulated organisation capable of assessing its own capacity? Is it able to undertake improvements? Does it need assistance or guidance from another body? And are there existing examples of success that it needs to emulate? All of these are part of the conversation about quality that needs to take place, and this report has instanced some examples where this is beginning to occur. At the second level, there needs to be scrutiny about the overall quality and cost of services within a given field. Questions such as the following are all relevant: how well linked are the various oversight agencies? Does their work dovetail with each other? Is the work of the best service-delivery units being used to catalyse the performance of others? And could the sector deliver a service more economically? This report has found that inquiry and dialogue at this second level, concerning systemic improvement, is less well advanced. The report has articulated some ways in which this agenda of large-scale transformation could be progressed. This includes our argument that the 'policy centre' must not only insist that frontline providers engage in serious monitoring of outcomes and processes, but combine this with a more supportive stance. The enhanced and modified role of the policy centre would include establishing and convening a forum through which the examples of the most successful could be explored and emulated as per the top-runner method; it would see the centre leading the consideration of alternative institutional models of provision such as social enterprises that could act as a stimulus for wider change in a given policy area. Undoubtedly, there are other means by which systemic improvement could be obtained. Building on the considerable advances to date, we should be prepared to experiment and innovate, in the interests of quality and cost, to discover what

are the best ways to achieve wide-spread high standards in Ireland's human services.

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