

# Measuring Outcomes for Public Service Users



## Glossary

Many of the terms used throughout this report have a range of definitions, the key terms and definitions used in the project and this report are listed below:

**Commissioning** – the Institute of Commissioning Professionals define this as securing the services that most appropriately address the needs and wishes of the individual service users.

**Cost-effectiveness** - a form of economic analysis that compares the costs and outcomes of two or more courses of action. Typically expressed as the ratio of cost:outcome.

**Outcomes** – the result that arises from services use. This project focussed on the outcomes for service users themselves.

**Quality** – the totality of features and characteristics of a service that bear on its ability to meet service users' expectations or needs. These can include inputs and processes such as staff qualifications and complaints procedures.

**Voluntary sector** - this project followed the narrower general charities definition, that is organisations registered with the Charity Commission and meeting criteria of: formality, independence, non-profit distributing, self-governance, voluntarism and public benefit. These clear limits to the definition ensure that information is available to produce robust estimates.

**User experience** – the perceived experience of using a service, for example how well a service user feels they were treated. Usually collected by survey.

**Value for money** – the term used to assess whether or not an organisation has obtained the maximum benefit from the resources available to it.

## Executive Summary

Public services account for around a fifth of total Gross Domestic Product in the UK (ONS, 2009). Taxpayers, service users and providers of public services have an interest in how government spends money on these services and whether the services are good value for money. However, ensuring best value for money is complicated by the lack of a clear definition of the value of public services and a lack of information about what benefits a particular contract will provide. The Measuring Outcomes for Public Service Users (MOPSU) project aimed to inform value for money decisions by developing new, and examining existing, measures of outcomes. The project also explored the role of the voluntary sector in public service delivery.

**Growth in voluntary sector income from government sources has outpaced growth in government spending on public services.** In 2007/08 the voluntary sector received £12.8 billion of funding from government, this accounted for approximately 36 per cent of voluntary sector total income. Nearly three-quarters of government funding to the voluntary sector was in the form of contracts. This gives an indication of the level of involvement of the voluntary sector in delivering public services. Over half of the funding from local government to the voluntary sector went to the social services area and

**The Adult Social Care Toolkit (ASCOT) developed as part of the project enables measurement of key social care quality of life outcomes such as dignity, personal cleanliness, good nutrition and social interaction from the users' perspective.** It will enable commissioners to contract adult social care services from those who provide better value for money, through the more accurate analysis of outcomes. It will also enable commissioners, in partnership with service users, to find the best care services so that they can achieve their desired outcomes, whether this be in residential care homes, day care or care in the home. The toolkit has already been tested in care homes and day care services. Care homes significantly improved residents' quality of life by delivering good outcomes. However, they were better at delivering outcomes in the more basic areas, such as ensuring residents are clean and presentable, than in areas such as giving residents control over their daily lives. Day care centres also improved users' social-care related quality of life, particularly for users with higher levels of need and those who attended 3 or more times a week.

**Those children who started early years education before the age of 3 had higher Foundation Stage Profile assessment scores than children who started at 3 or 4 years old.** However, no consistent relationship was found between the quality of early years education and outcomes for children who attended, based on the measures examined. There was no significant relationship between any of the quality measures used in the study and outcomes as measured by the Foundation Stage Profile assessments. However, sub-scales of

one measure - the Early Childhood Environment Rating Scale – Extended (ECERS-E) -were found to be related to other outcome measures, with higher quality settings showing better outcomes for children. All the quality measures used correlated significantly with each other, but the correlation between Ofsted ratings and the other quality measures used were weak compared to the relationship between all the other quality measures. Since the data were collected (Foundation Stage Profile 2005/06, Ofsted 2005-08 inspection cycle), the Early Years Foundation Stage was introduced and Ofsted inspection frameworks changed, with a clearer focus on the development and early learning of children.

|  |    |
|--|----|
| Glossary .....   | 2  |
| Executive Summary .....  | 3  |
| 1. Introduction .....  | 7  |
| 2. Context .....   | 9  |
| 2.1 Why measure outcomes? .....  | 9  |
| 2.2 Voluntary sector context .....   | 10 |
| 2.3 Adult social care context .....  | 11 |
| 2.4 Early years education context .....  | 12 |
| 2.5 Minimising the burden of data collection .....   | 13 |
| 2.6 The role of UKCeMGA .....  | 14 |
| 3. Public service delivery and the voluntary sector .....                                    | 15 |
| 3.1 Overview of voluntary sector work-strand aims and methodology .....                      | 15 |
| 3.2 Results .....  | 16 |
| 3.2.1 Growth in voluntary sector income from government .....                                | 16 |
| 3.2.2 Funding from different tiers of government.....  | 18 |
| 3.2.3 Central government departments' spending on the voluntary sector                       | 19 |
| 3.2.4 Local government spending by sub-sector .....  | 19 |
| 3.2.5 Grants and contracts.....  | 20 |
| 3.2.6 Dependence on government sources, by sub-sector.....                                   | 21 |
| 3.3 Conclusion .....   | 23 |
| 4. Adult social care.....  | 25 |
| 4.1 Overview of adult social care work-strand.....   | 25 |
| 4.1.1 Aims, studies and stages .....   | 25 |
| 4.1.2 Defining outcomes of adult social care services .....                                  | 26 |
| 4.1.3 Measuring an individual's current social care-related quality of life<br>(SCRQOL)..... | 28 |
| 4.1.4 Attributing outcomes to service use.....   | 30 |
| 4.1.5 Capacity for benefit and comparing ASCOT with low-burden measures<br>31                |    |
| 4.2 The care homes study .....   | 32 |
| 4.2.1 Sample .....   | 32 |
| 4.2.2 Results.....   | 34 |
| 4.2.3 Comparison with regular data collections.....  | 37 |
| 4.3 The low-level services study of day care centres.....                                    | 39 |
| 4.3.1 Sample .....   | 39 |
| 4.3.2 Results.....   | 40 |
| 4.3.3 Comparison with regular data collections.....  | 42 |
| 4.4 The preference study.....  | 43 |
| 4.5 Conclusions.....   | 44 |
| 4.6 The information, advice and advocacy (IAA) services study.....                           | 45 |
| 4.6.1 Introduction and aims .....  | 45 |
| 4.6.2 Information and advice services.....   | 46 |
| 4.6.3 Exploratory stage .....  | 47 |
| 4.6.4 The pilot outcome tool.....  | 48 |
| 4.6.5 Testing the pilot toolkit.....   | 49 |

|       |   |    |
|-------|---|----|
| 4.6.6 | Conclusions .....   | 50 |
| 5.    | Early years education (EYE) .....                                       | 52 |
| 5.1   | Overview of early years education work-strand .....                     | 52 |
| 5.2   | Data used to examine quality and outcomes in early years education .    | 53 |
| 5.2.1 | Data sources.....   | 53 |
| 5.2.2 | Quality measures.....   | 54 |
| 5.2.3 | Outcome measures .....  | 56 |
| 5.3   | Analysis and addressing the attribution problem.....                    | 57 |
| 5.3.1 | Analysis .....  | 57 |
| 5.3.2 | The attribution problem .....   | 58 |
| 5.4   | The sample .....  | 59 |
| 5.5   | Results.....  | 60 |
| 5.5.1 | Comparison of quality measures .....                                    | 60 |
| 5.5.2 | Outcomes of early years education.....                                  | 60 |
| 5.5.3 | Comparing outcomes measures .....                                       | 62 |
| 5.5.4 | Relationship between quality and outcomes in early years education      |    |
|       | 64  |    |
| 5.6   | Costs of early years education .....                                    | 66 |
| 5.7   | Conclusions.....  | 68 |
| 6.    | Outcomes of adult social care and early years education by sector ..... | 69 |
| 6.1   | Adult social care and the voluntary sector.....                         | 69 |
| 6.2   | Early years' education services and the voluntary sector.....           | 71 |
| 7.    | Benefits of the MOPSU project.....                                      | 74 |
| 7.1   | The Adult Social Care Outcomes Toolkit (ASCOT).....                     | 74 |
| 7.1.1 | Cost-effectiveness and value for money .....                            | 74 |
| 7.1.2 | Outcomes-based commissioning, regulation and provision .....            | 75 |
| 7.1.3 | UKCeMGA .....   | 76 |
| 7.1.4 | Future work .....   | 77 |
| 7.2   | Measuring quality and outcomes in early years education .....           | 77 |
| 7.3   | Better data on the funding relationship between the government and the  |    |
|       | voluntary sector .....  | 78 |
| 7.3.1 | Improvements and issues with voluntary sector data .....                | 78 |
| 7.3.2 | Voluntary sector organisation on the Inter-Departmental Business        |    |
|       | Register (IDBR).....  | 78 |
| 7.3.3 | Future work .....   | 79 |
| 8.    | Extending MOPSU principles to other public services.....                | 80 |
| 9.    | References .....  | 82 |

## 1. Introduction

This is the final report of the Measuring Outcomes for Public Service Users (MOPSU) project<sup>1</sup>, a 3 year research project to develop new, and examine existing, measures of public service outcomes. The project focused on two public service areas, adult social care and early years education, as well as examining the role of the voluntary sector in public service delivery<sup>2</sup>.

The overall aims of the project were to:

- promote more effective commissioning of services, placing the issues of quality and value for money at the heart of the decision-making process
- encourage the use of 'outcome' measures to assess the effect services have on their users, across the spectrum of providers
- examine the extent to which the voluntary sector is involved in public service delivery and help to alleviate barriers to entry to voluntary sector organisations

Underpinning the aims of this project was a wish to minimise the burden of data collection and analysis on providers, commissioners and others.

The project was led by the UK Centre for the Measurement of Government Activity (UKCeMGA) at the Office for National Statistics (ONS) in partnership with the National Council for Voluntary Organisations (NCVO), the Personal Social Services Research Unit (PSSRU) at the University of Kent and the National Institute of Economic and Social Research (NIESR). The project was funded by HM Treasury under the Invest to Save Budget. While the project focussed on England the tools that have been developed are applicable across the UK.

This report is organised as follows:

- chapter two discusses the drivers behind the project
- chapter three summarises the voluntary sector work-strand
- chapter four summarises the adult social care work-strand
- chapter five summarises the early years education work-strand
- chapter six examines outcomes and quality of adult social care and early years education by sector
- chapter seven sets out the benefits of the MOPSU project as well as recommendations for future work

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<sup>1</sup> Formerly known as the Quality Measurement Framework project.

<sup>2</sup> More detailed reports from each work-strand are available on the MOPSU website <http://www.ons.gov.uk/about-statistics/methodology-and-quality/measuring-outcomes-for-public-service-users/index.html>

- chapter eight summarises guidance for anyone interested in extending the MOPSU principles to other public services

## 2. Context

### 2.1 Why measure outcomes?

Public services account for around a fifth of total Gross Domestic Product in the UK (ONS, 2009). Taxpayers, service users and providers of public services have an interest in how government spends money on these services and whether the services are good value for money. However, ensuring best value for money is complicated by the lack of a clear definition of the value of public services and a lack of information about what benefits a particular contract will provide.

People do not value services *per se* but rather the effect those services have on them, the outcomes of service use. In order to measure the 'value' of public services we would, therefore, wish to measure the outcomes they confer to service users. This project explored existing, and developed new, measures of service outcomes. It is important to note here that while this project focussed on outcomes for service users, the effects of service use may extend beyond the user themselves. For example parents may benefit from children attending early years education settings by gaining employment and carers may benefit from the person they care for attending a day care centre.

Outcome measures can inform value for money decisions through analysis of effectiveness, one of the 'three Es' through which value for money can be improved (DH, 2009):

- economy – the amount of inputs that can be purchased given a set amount of expenditure
- efficiency – the amount of output produced by a given amount of inputs
- effectiveness – the level of outcome achieved given the output

Without a measure of outcome the focus inevitably falls on economy and efficiency savings. For example, value for money was previously demonstrated via unit cost benchmarking (DH, 2009). However, it is becoming increasingly important to measure outcomes to help improve value for money. The Department of Health (DH, 2009) have stated that effectiveness is key to their transformation agenda. They argue that different ways must be found to deliver the same outcomes in order to realise the greatest value from costs. This lies behind their policy to shift from institutional residential settings towards supported living schemes where people remain in their own homes.

Outcome measures can also inform analysis of cost-effectiveness which is a form of economic analysis that compares the costs and outcomes of two or more courses of action, for example care homes and care in people's own homes. Typically it is expressed as the ratio of cost:outcome. Cost-effectiveness analysis can help commissioners move to a balance of services which has the greatest outcome for the given budget.

A lack of information on the outcomes of services may encourage service commissioners to contract to lowest cost providers rather than to those who provide better value for money. There has been a drive in recent years to move to outcomes-based commissioning rather than commissioning on activity levels. The development of outcome tools can help fill information gaps and enable commissioners to monitor the outcomes different services and providers are delivering.

## 2.2 Voluntary sector context

The drive for value for money in public services has led to an opening of the public service market, over recent decades, to competition from private and voluntary sector providers. The new coalition Government have stated their intent to allow new providers, from different sectors, to enter the public service market in areas such as education, justice and health (HM Government, 2010)

Assessing the performance of voluntary sector provision of public services and comparing across sectors is a challenging task, requiring thorough understanding of the distinctive value the voluntary sector provides. The National Audit Office (2005) *Working with the Voluntary sector* report discusses a number of barriers to entry for voluntary sector providers. These include:

- the concentration by commissioners on numerical measures that do not reflect the outcomes of services
- the excessive demands of bureaucracy including: the large number of funding bodies; a lack of consistency and uniformity between funders; the demand for information disproportionate to the size of the contract

Commissioners could lessen some of these barriers by placing more emphasis on outcomes.

There has also been a lack of information on the role of the voluntary sector in public service delivery. A number of key questions need to be answered, including how much spending on public services is channelled through the voluntary sector.

The aim of the voluntary sector work-strand was to help address the lack of information on voluntary sector delivery of public services. The National Council for Voluntary Organisations (NCVO) – one of the largest umbrella groups for the voluntary sector in England - carried out this research, providing analysis estimating the level of central and local government funding to the voluntary sector, including analysis of sub-sectors such as health and social care. The research used available data sources such as the Inter-Departmental Business Register (IDBR, a register maintained by ONS) and the GuideStar Data Services data base, based on Charity Commission records. The work examined, for example, which government departments have most financial engagement with the voluntary sector, in terms of the proportion of their expenditure that goes to the voluntary sector, and which departments the voluntary sector is most dependent on for funding.

### **2.3 Adult social care context**

The adult social care field is one that has seen a big change in delivery over recent years, from public sector provision to a mixed market where publicly funded adult social care services are delivered by the public, private and voluntary sector. Value for money is particularly important in this field given that the demand for long-term care services is predicted to rise, primarily as a result of longer life expectancy, as people with existing long-term conditions live longer and more people survive into very old age (Wanless, 2006).

Commissioning of adult social care services in England has moved to a more outcomes-based approach and the regulator, the Care Quality Commission (CQC), has committed to a more outcomes-based approach to regulation, with less focus on meeting minimum standards (CQC, 2009). As such it is important that appropriate outcome measures are developed.

Given this need, the Personal Social Services Research Unit (PSSRU) at the University of Kent - the leading UK research body on personal social services - undertook a series of studies on the outcomes of adult social care services, as part of the MOPSU project. There were five main stages to the work:

- Conceptual work to develop an understanding of the concept of 'value' and a practical approach to measurement – the Adult Social Care Outcomes Toolkit (ASCOT)
- Fieldwork to test the toolkit and provide outcome information for a sample of care home residents and day care service users
- Comparison of research measures with routine low-burden indicators, for example information collected by the regulator

- Development of the toolkit
- A population preference study to gauge the relative importance of different outcome domains and enable the inclusion of preference weights in the toolkit.

PSSRU also undertook a separate study to explore the complex issue of defining and measuring the outcomes of information and advice services.

The adult social care work-strand fits with the personalisation agenda, which aims to give every person who receives social care support, whether provided by statutory services or funded by themselves, choice and control over the shape of that support in all care settings (Ministers et al., 2007). The focus is on the outcomes for service users and the preference study provided a unique insight into what people really want from care services. Similarly, the personalisation agenda will place an increasing focus on information and advice services, where such services are critical to enabling people to access services (Baxter, Glenndinning and Clarke, 2006). The voluntary sector provides 37 per cent of all health and social care information (DH, 2007).

## 2.4 Early years education context

In the UK, the past decade has seen a large increase in the investment of government money in early years education, from around £1.1 billion in 1997/98 to roughly £5 billion in 2007/08 (HM Government, 2009). In England, a free early years education place was made available for all four year olds in 1998, following a pledge to do so in Labour's 1997 election manifesto. In 2004 this was extended to all three year olds. In April and September 2006 two pilot schemes started to provide early education and care for 12,000 disadvantaged two year olds in 32 local authorities in England.

The uptake of free entitlement has been high, especially for three year-olds, with attendance rates of 64 per cent and 90 per cent in 2001, for three and four year-olds respectively, increasing to 89 and 97 per cent in 2008 (La Valle and Smith, 2009). There has also been an increased focus on quality of provision, with a number of measures introduced to increase quality including increasing the qualifications and skills of the workforce (Hopkin, Stokes and Wilkinson, 2010).

The rationale for investing in early years education is that it is seen to contribute to important outcomes. However, Sylva et al. (2006) note that research into the outcomes of early years education has tended to focus on high quality provision aimed at disadvantaged children and hence provides stronger support for the impact of early years education than research based on a wider population. Nonetheless, the Effective

Provision of Pre-school Education (EPPE) project, which was the first major UK study to focus on the effectiveness of pre-school education, found a significant impact of pre-school education in terms of both cognitive and social function for all groups, still observable at age eleven (Sylva et al., 2008).

Given the expansion of provision, it is important to assess whether this investment continues to yield positive impacts for children. It is also important to examine whether high quality settings deliver better outcomes for service users.

As with adult social care, the voluntary sector plays a role in the delivery of early years education services. Phillips et al., (2009), in their survey of early years providers in England, found that 22 per cent of full-time day care providers and 64 per cent of part-time care settings were in the voluntary sector.

NIESR carried out the early years education work-strand of the MOPUS project. Their research utilised the Millennium Cohort Study (MCS) (Hansen and Joshi, 2008)<sup>3</sup> data and other linked data, such as Foundation Stage Profile assessments and quality ratings produced by the Office for Standards in Education, Children's Services and Skills (Ofsted), to explore the quality and outcomes of early years education. The analysis included:

- a comparison of Ofsted ratings with other measures of the quality of early years settings
- a comparison of measures of children's cognitive and social development outcomes from the MCS with the Foundation Stage Profile
- investigation of the relationship between quality of early years settings and outcomes for children attending these settings

## **2.5 Minimising the burden of data collection**

As stated in chapter one, an underpinning intention of the project was to minimise the burden of data collection and analysis on providers, commissioners and others. One way in which the project has addressed this issue is by utilising regular data collections, such as the quality ratings of CQC and Ofsted, and Foundation Stage Profile assessments. The adult social care work-strand has also examined ways to collect

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<sup>3</sup> The authors acknowledge the Centre for Longitudinal Studies at the Institute of Education, University of London, as the depositor and copyright holder of the Millennium Cohort Study data and the UK Data Archive as the distributor of the data. None of these organisations bear any responsibility for the analysis and interpretation of the data presented in this report.

important data on the outcomes of services in low burden ways, such as self completion questionnaires.

Another way of minimising burden is to ensure that only the information that is really needed is collected. However, in many fields, not just outcome measurement, there is often a temptation to collect data which are easy to collect.

Once appropriate information has been collected, it is then important to utilise it wisely. Provider burden is often increased by needing to provide several different sets of measures to different parties, such as regulators and commissioners.

## **2.6 The role of UKCeMGA**

UKCeMGA was set up to implement the recommendations of the Atkinson Review (Atkinson, 2005) to improve the measurement of government output and productivity in the national accounts. Public service output in the national accounts is largely measured using cost-weighted activity indices where the growth in the number of people who receive a particular service is weighted by its share of government expenditure. Where possible this has been adjusted for quality, for example survival after hospital treatment and patient experience.

Principle B of the Atkinson Review stated that ‘the output of the government sector should be measured in a way that is adjusted for quality, taking account of attributable incremental contribution of the service to the outcome.’

It is important to recognise the difference between measuring output and measuring outcomes. ‘A reduction in reported crime and fear of crime is an outcome for society. It may be achieved by more police, or different policing, or by other changes like better security devices on cars. To the extent that better policing reduces crime, this can be regarded as the ‘attributable incremental contribution of the service to the outcome’ and regarded as part of output (e.g. used as an explicit quality adjustment). It would be wrong to regard any change in outcomes as the result of public service, without considering causality.’ (ONS, 2008: 3)

The MOPSU project helps to further the Atkinson agenda by exploring the measurement of the attributable outcomes of public services. UKCeMGA provided the project management role for the MOPSU project.

### 3. Public service delivery and the voluntary sector

#### Key Points:

Research on the role of the voluntary sector in public service delivery found that:

- In 2007-08 the voluntary sector received £12.8 billion of funding from government, this accounted for approximately 36 per cent of voluntary sector total income
- Five service areas - employment and training, law and advocacy, education, housing and social services - are heavily dependent on government funding, receiving over half of their total income from government
- Over half of the funding from local government to the voluntary sector went to the social services area
- In 2007/08 nearly three-quarters of government funding to the voluntary sector was in the form of contracts. This gives an indication of the level of involvement of the voluntary sector in delivering public services.

This chapter summarises the final report on government funding to the voluntary sector, produced by NCVO as part of the MOPUS project (NCVO, 2010a)

#### 3.1 Overview of voluntary sector work-strand aims and methodology

The aim of this work-strand was to provide better information about the volume and nature of public service delivery carried out by the voluntary sector. The analysis estimates the level of central and local government funding to the voluntary sector, examining both reported government spending on the voluntary sector and income from government as reported by the charities themselves. The analysis also looks at areas such as health and social care.

The key data sources used were the GuideStar Data Services database, which is based on Charity Commission records, and the Inter-Departmental Business Register (IDBR), a register maintained by the Office for National Statistics. For the first time in such an analysis, voluntary sector organisations were classified according to three different classifications: the Standard Industrial Classification (SIC 2007), the International Classification of Non-Profit Organisations (ICNPO) and the Classification of Functions of Government (CoFoG). ICNPO is an international classification system designed for charities and other non-profit groups and used by the UN. It is therefore the most useful classification system for our purposes and the main focus of this report.

SIC is an international classification system used to look at all sectors of the economy. It is included here owing to its universal acceptance, but is of less use than ICNPO due to its general nature. COFOG is based on the functions of government and therefore is not as applicable to the voluntary sector as the other systems. It is included here as some government departments use this system of classification and therefore is useful when corresponding to them.

The use of these classifications systems enabled analysis and comparison of subsets of charities and of central and local government funding.

It is important to note here that this analysis has been done only as a one-off exercise. However, the information is likely to be needed on a regular and systematic basis, particularly if, as seems likely, the growth in public service delivery by voluntary and private sector organisations continues. There is also much scope for improvement in the available data. These issues are discussed further in chapter 7.

## **3.2 Results**

### **3.2.1 Growth in voluntary sector income from government**

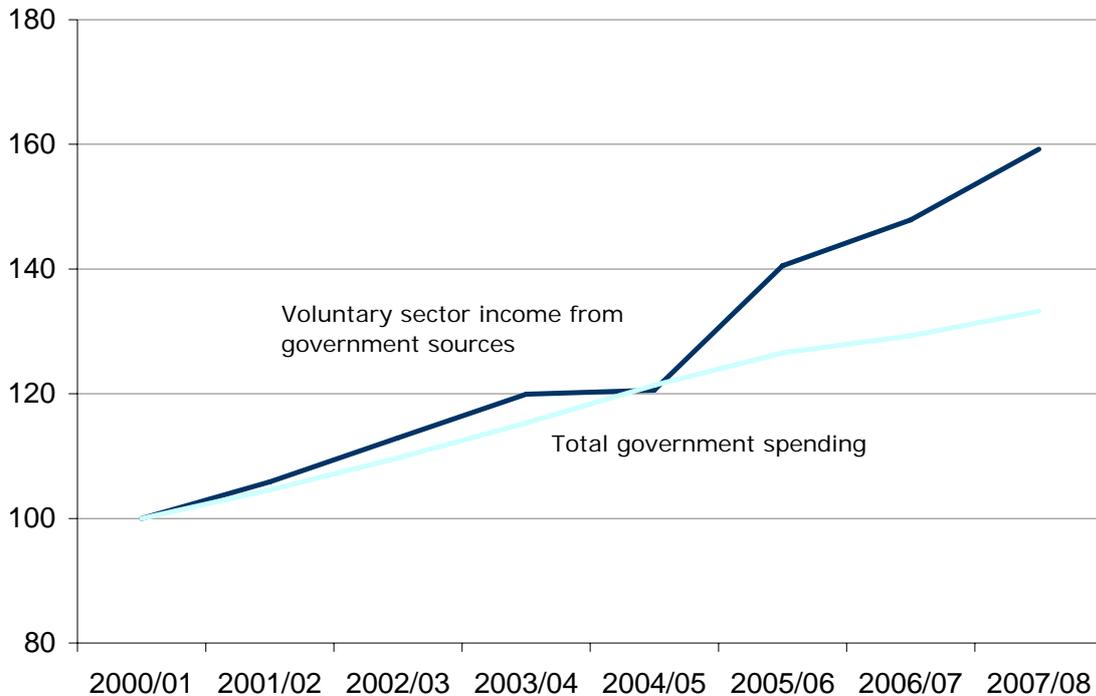
The voluntary sector's income has grown substantially in recent years and a large part of that growth has been income from government sources. In 2007/08 there were over 171,000 voluntary sector organisations in the UK with a total income of £35.5 billion (NCVO, 2010b). These organisations range from small community organisations through to a number of large organisations such as Oxfam, Cancer Research UK and Age UK, with the majority being small organisations.

Total income and income from government sources were shown to have increased year-on-year since 2000/01. Total income increased from £25.1 billion in 2000/01 to £35.5 billion in 2007/08, whilst income from government sources increased from £8.0 billion to £12.8 billion over the same period. In the last year for which figures are available, government income increased by 8 per cent, from £11.9 billion in 2006/07 to £12.8 billion in 2007/08. As a proportion of all income the voluntary sector receives, government income accounts for just over one-third (36 per cent), about the same as the proportion of income received from individuals, which was 37 per cent in 2007/08 (NCVO, 2010b).

Over the last seven years, the increase in the voluntary sector's income from government sources has outpaced the overall increase in government expenditure on public services, particularly during 2005/06 and 2007/08 (see Figure 3.1). In 2007/08, the voluntary sector's income from government sources was 159 per cent of its 2000/01 base, whereas

total government public service expenditure was 133 per cent of its 2000/01 base.

Figure 3.1  
**Growth in voluntary sector income from government sources and total government spending, 2000/01-2007/08**  
 2000/01=100



|   | 2000<br>/01 | 2001<br>/02 | 2002<br>/03 | 2003<br>/04 | 2004<br>/05 | 2005<br>/06 | 2006<br>/07 | 2007<br>/08 |
|---|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Voluntary sector income from government | 100         | 106         | 113         | 120         | 121         | 141         | 148         | 159         |
| Total government spending               | 100         | 105         | 110         | 115         | 121         | 127         | 129         | 133         |

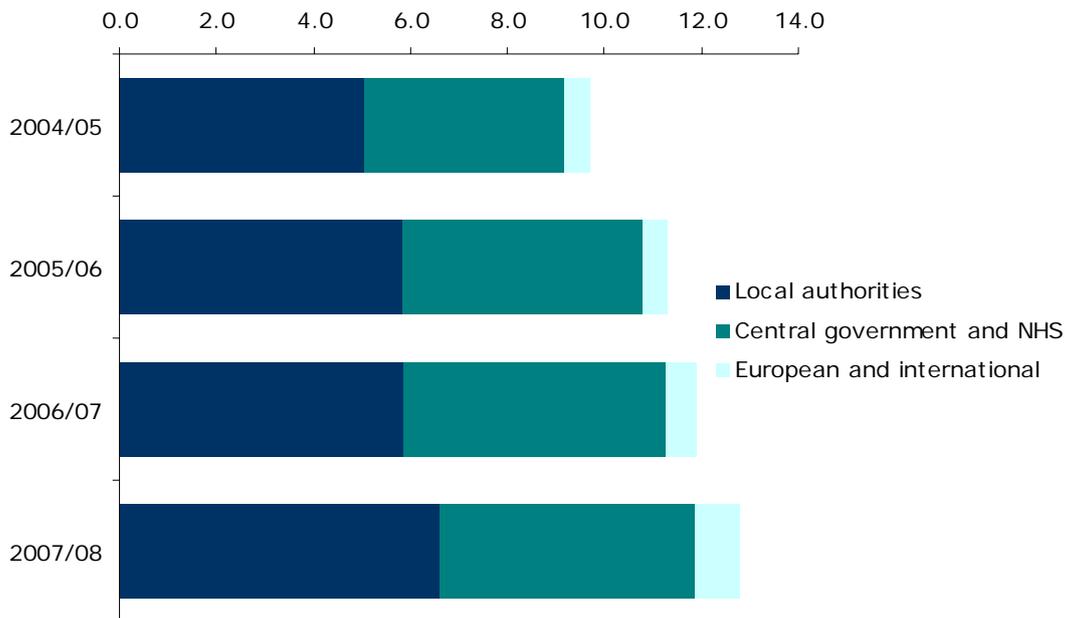
Source: NCVO (2010a)

Although the voluntary sector's income from government sources has grown significantly, it remains only a small proportion of total government expenditure. In 2000/01, the voluntary sector's income of £8.0 billion from government sources accounted for 1.8 per cent of the total government spending of £437.3 billion (HM Treasury, 2009); the equivalent figure after seven years' growth was 2.2 per cent. The Julius Review (2008) estimated that, taken together, the voluntary and private sectors account for around 14 per cent of total government spending.

### 3.2.2 Funding from different tiers of government

Figure 3.2 shows that just over half of the voluntary sector income from government sources, (52 per cent, £6.6 billion), came from local authorities in 2007/08. Central government funding to the voluntary sector accounted for £5.3 billion (41 per cent). The remaining 7 per cent came from European and international sources. This is based on information from voluntary organisations' accounts to the Charity Commission. According to central government reported outturn figures the amount of funding from central government is much smaller (£3.3 billion as compared to £5 billion in 2005/06) (OTS and Charities Aid Foundation, 2009). This substantial difference in the estimates from different sources can be explained in part by the exclusion of most NHS funding from government figures and incomplete returns, but it points to the need to strengthen national government recording of funding to the voluntary sector, discussed further in 3.4.

Figure 3.2  
**Government funding to the voluntary sector by tier of government, 2004/05-2007/08**  
 £ billion, 2007/08 prices



|                            | 2004/05 | 2005/06 | 2006/07 | 2007/08 |
|----------------------------|---------|---------|---------|---------|
| Local authorities          | 5.1     | 5.8     | 5.9     | 6.6     |
| Central government and NHS | 4.1     | 5.0     | 5.4     | 5.3     |
| European and international | 0.5     | 0.5     | 0.6     | 0.9     |

Source: NCVO (2010a)

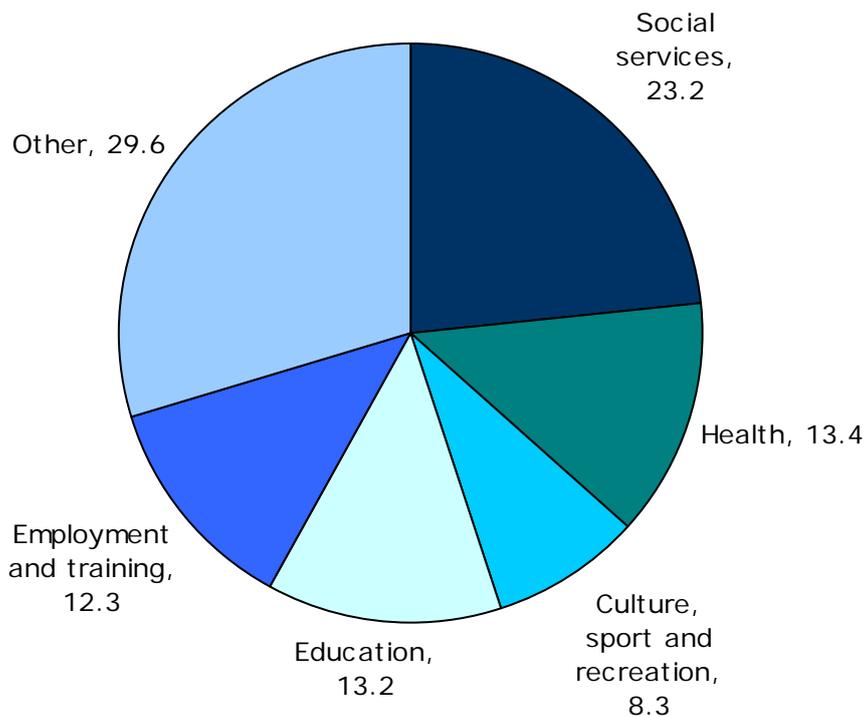
The relative proportions of government funding to the voluntary sector from local authorities and central government vary slightly from year to year but have remained fairly static overall. The proportion of funding

from local authorities decreased slightly between 2004/05 and 2006/07 (from 49 per cent to 47 per cent), and then increased slightly between 2006/07 and 2007/08 (from 47 per cent to 52 per cent). There is thus no clear trend towards greater or less centralisation of government funding to the voluntary sector.

### 3.2.3 Central government departments' spending on the voluntary sector

Figure 3.3 shows the percentage of voluntary sector income from central government that goes to different sub-sectors, as classified by ICNPO. Voluntary sector organisations working in each of the areas of social services, health, education and employment and training receive more 10 per cent of total central government funding.

Figure 3.3  
**Central government funding to the voluntary sector by ICNPO classification, 2006/07**  
 Percentages

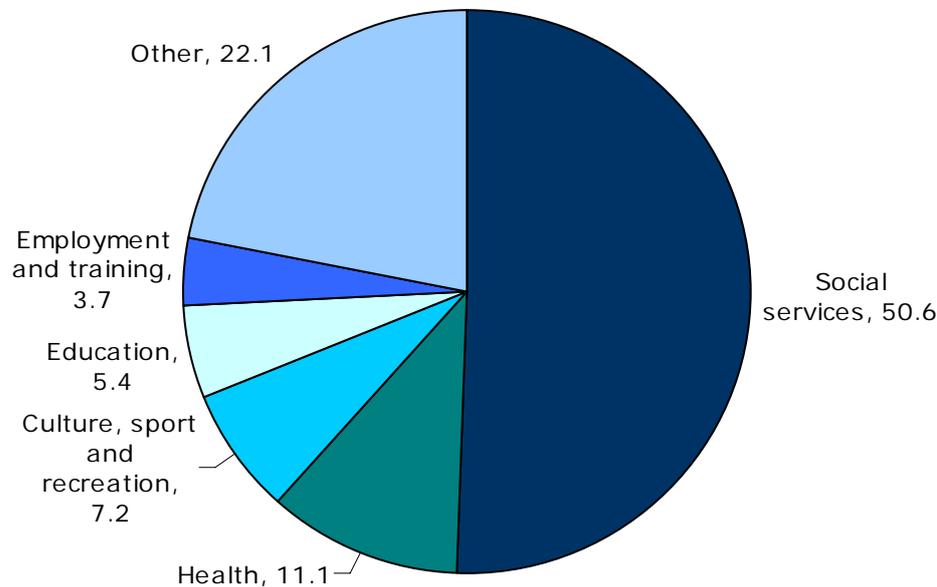


Source: NCVO (2010a)

### 3.2.4 Local government spending by sub-sector

Figure 3.4 shows the percentage of voluntary sector income from local government that goes to different sub-sectors, as classified by ICNPO. Over half of the voluntary sector income from local government goes to voluntary sector organisations working in social services and more than ten per cent goes to voluntary sector organisation working in the health sector.

Figure 3.4  
**Local government funding to the voluntary sector by ICNPO classification, 2006/07**  
 Percentages



Source: NCVO (2010a)

### 3.2.5 Grants and contracts

Government bodies transfer resources to voluntary sector organisations using a number of mechanisms, but such flows can be summarised as either voluntary income (grants) or earned income (contracts). Grants worth £3.7 billion and contracts worth £9.1 billion were awarded to the voluntary sector in 2007/08<sup>4</sup>. The balance between grant and contract funding has changed over time. Table 3.1 shows a continuous upward trend in the total value of contract income; the contract income from government sources has increased by £5.1 billion in the seven years since 2000/01 to £9.1 billion in 2007/8, and the pace of growth has quickened since 2004/05<sup>5</sup>. Over the same time period, government grants to the voluntary sector declined, although the decline may appear deeper due to an increase in grants earlier in the decade.

The increasing importance of contracts, fuelled mainly by an increase in the value of contract income, is evident for both central and local government. Comparison of central and local government funders suggests the latter is more likely to fund through contract mechanisms:

<sup>4</sup> These totals are greater than the sum of the central and local government entries in Table 3.1 because that table excludes grants and contracts from European and international sources.

<sup>5</sup> This shift is likely to have been affected by improved accounting practices.

77 per cent of local government income to the voluntary sector is contracted, compared with 61 per cent of central government income.

Table 3.1  
**Central and local government grants and contracts, 2004/05 and 2007/08<sup>6</sup>**

|   |           | 2004/05  | 2007/08     |      |
|---|-----------|--|-------------|------|
| Central government                        | Grants    | Value (£bn)                                    | 2.2         | 1.8  |
|   |           | Proportion of total income from government (%) | 24.2        | 14.8 |
|   | Contracts | Value (£bn)                                    | 1.8         | 3.5  |
|   |           | Proportion of total income from government (%) | 20.2        | 29.4 |
|   | Sub-total | Value (£bn)                                    | 4.0         | 5.3  |
|   |           | Proportion of total income from government (%) | 44.4        | 44.3 |
| Local government                          | Grants    | Value (£bn)                                    | 1.6         | 1.3  |
|   |           | Proportion of total income from government (%) | 18.0        | 10.5 |
|   | Contracts | Value (£bn)                                    | 3.4         | 5.4  |
|   |           | Proportion of total income from government (%) | 37.6        | 45.2 |
|   | Sub-total | Value (£bn)                                    | 5.1         | 6.6  |
|   |           | Proportion of total income from government (%) | 55.6        | 55.7 |
| <b>Total income from government (£bn)</b> |           | <b>9.1</b>                                     | <b>11.9</b> |      |

Source: NCVO (2010b)

For voluntary sector organisations providing social services, over four-fifths (88 per cent) of their income from local government sources, in 2006/07, was in the form of contracts and fees, giving an indication of the importance to these organisations of delivering local public services.

### 3.2.6 Dependence on government sources, by sub-sector

Although the voluntary sector is independent of government, the funding practices of some organisations can mean that they are dependent on government for their funding. Government funding of the voluntary sector is concentrated in a small number of organisations. Three-quarters of all voluntary sector organisations – approximately 130,000 organisations – do not receive any income from government sources. One quarter of the voluntary sector – around 40,000 organisations – have a direct funding relationship with government. Larger organisations

<sup>6</sup> Note that this table includes only grants and contracts from statutory bodies within the UK; grants and contracts from European and international sources are excluded. In 2007/08 they amounted to around £0.6 billion in grants and £0.2 billion contracts.

are much more likely to receive income from government sources (NCVO, 2010b).

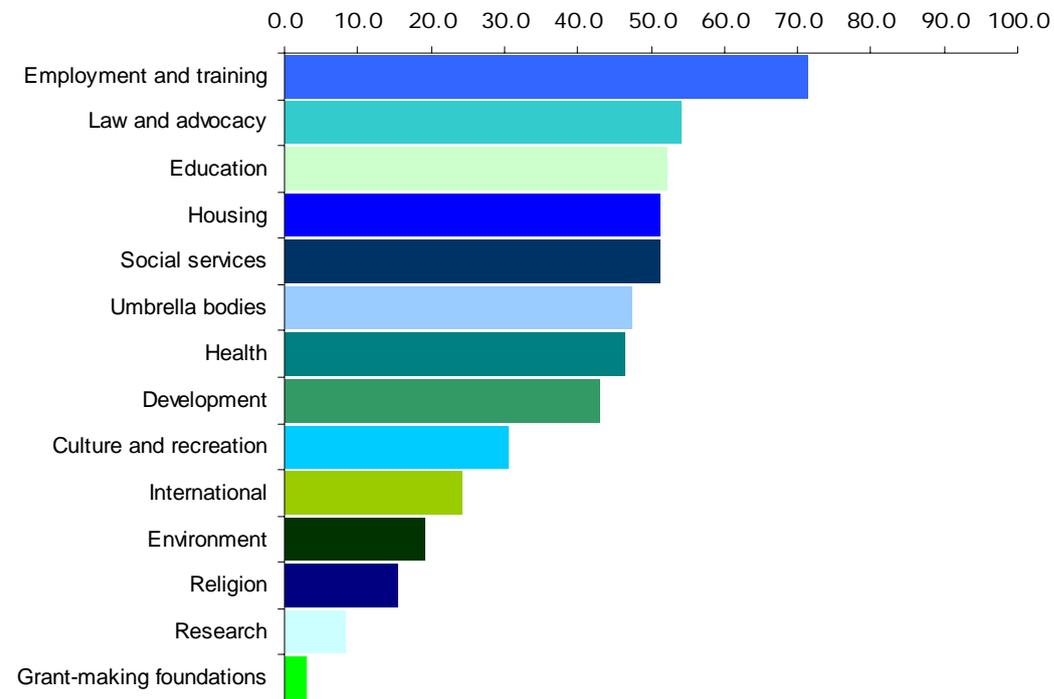
Data from the National Survey of Voluntary Sector Organisations (OTS, 2007) shows that nearly a third (32 per cent) of voluntary sector organisations receive funding from local government. Organisations located in highly deprived areas are more likely to be the recipients of local government funding; this may suggest that this funding is targeted at those working with deprived communities or it may also indicate that organisations based in those areas find it more difficult to attract other sources of funding.

Figure 3.5 shows how dependence varies by sub-sector. Government funding accounts for over 70 per cent of the income received by voluntary organisations within the employment and training sub-sector. This is likely to be due to the high proportion of public services delivered by this sub-sector. Whilst some organisations receive income from government through a variety of funding streams and providers, others receive relatively large amounts of funding from just one or two government bodies or 'pots'. It is these organisations in particular that may become 'dependent' on government funding.

Figure 3.5

**Voluntary sector income from government, by sector, 2006/07**

Percentages



| <b>Proportion of income from government (%)</b> |      |
|---|------|
| Employment and training                         | 71.5 |
| Law and advocacy                                | 54.0 |
| Education                                       | 52.1 |
| Housing   | 51.2 |
| Social services                                 | 51.2 |
| Umbrella bodies                                 | 47.4 |
| Health  | 46.5 |
| Development                                     | 43.0 |
| Culture and recreation                          | 30.4 |
| International                                   | 24.3 |
| Environment                                     | 19.1 |
| Religion  | 15.5 |
| Research  | 8.4  |
| Grant-making foundations                        | 3.1  |

Source: NCVO (2010b)

**3.3 Conclusion**

As a result of the analysis undertaken as part of the MOPSU project we now have a set of robust and accurate information on the funding relationship between government and the voluntary sectors and the extent of voluntary sector involvement in public service delivery and we have that information at a greater level of detail than previously available. Between 2000/01 and 2007/08 voluntary sector income from

government sources increased from 8.0 billion to 12.8 billion. Just over half of this income, in 2007/08, came from local government (£6.6 billion or 52 per cent). In 2006/07 51 per cent of voluntary sector income from local government was for social services. Between 2004/05 and 2007/08 the value of central and local government contracts, as a percentage of total government funding to the voluntary sector, increased from 20.2 per cent to 29.4 per cent for central government and 37.6 to 45.2 per cent for local government. This gives an indication of the importance to the voluntary sector of income obtained through contracts to provide public services.

A number of developments in the quality of information on the funding relationship between government and the voluntary sector have been made through the completion of the project. However, there is still much improvement required if the information is to be available on a regular and systematic basis rather than through a one-off exercise. Data inputs still need improving, despite recommendations from influential reviews and reports such as *Working with the Voluntary sector* (NAO, 2005) which recommended strengthening national and local data on the amount of public sector funding going to the voluntary sector, by funders introducing systems to clearly distinguish payments to voluntary sector organisations from other spending.

Chapter 7 provides further information on the improvements made to voluntary sector data and the future data needs.

## 4. Adult social care

### Key points:

Research using the newly developed Adult Social Care Outcomes Toolkit (ASCOT) found that:

- Care homes delivered substantial outcomes for residents, significantly improving their quality of life
- Care homes were better at delivering outcomes in more basic areas such as ensuring residents were clean and presentable than in areas such as giving residents control over their daily lives
- Excellent quality care homes, as rated by the Care Quality Commission (CQC), delivered better outcomes for residents than those rated poor or adequate homes. However, quality of home only accounted for 5 per cent of the variation in resident outcomes, once other factors were controlled for
- Day care centres also delivered good outcomes for service users, in particular for users with higher levels of impairment and those who attend more than 3 times a week
- Control over daily life was found to be the most important social care outcome in a study of social care outcome preferences of the general public

### 4.1 Overview of adult social care work-strand

#### 4.1.1 Aims, studies and stages

The overall aim of the adult social care work-strand was to develop and test a practical toolkit which could be used by a variety of stakeholders to measure the value of social care services in terms of the effect they have on service users. The remainder of this section and sections 4.2-4.4 explain the development, testing and uses of the ASCOT and the results of the two ASCOT studies. One study was conducted in care homes and one explored outcomes of low-level services, in particular day care centres.

The information, advice and advocacy (IAA) services study was more challenging in that outcomes are harder to define and service measurement is far less developed in the literature. The aim of this study was to develop a valid and reliable measure of short-term outcomes for service users, as described in section 4.6.

#### 4.1.2 Defining outcomes of adult social care services

The first stage in developing an outcome measure is to determine what we mean by 'outcomes' and how these outcomes can be measured. In earlier conceptual work (Forder et al., 2007), PSSRU identified that the main goal of social care is the improvement in *well-being* or *quality of life* that people experience as a result of using the service. However, quality of life is a difficult concept to define and to measure. Through consultation and piloting PSSRU identified a number of components or domains of social care-related quality of life (SCRQOL)<sup>7</sup>. These domains can be categorised as basic or higher order, see Box 4.1. PSSRU have also explored how these domains fit with other frameworks (Forder et al., 2007)

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<sup>7</sup> That is those domains of quality of life we could reasonably expect social care services to affect.

#### **Box 4.1 Basic and higher order SCRQOL domains**

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##### **Basic domains**

###### **Personal cleanliness and comfort**

The service user feels he/she is personally clean and comfortable and looks presentable or, at best, is dressed and groomed in a way that reflects his/her personal preferences

###### **Safety**

The service user feels safe and secure. This means being free from fear of abuse, falling or other physical harm and fear of being attacked or robbed

###### **Accommodation cleanliness and comfort**

The service user feels their home environment, including all the rooms, is clean and comfortable

###### **Food and nutrition**

The service user feels he/she has a nutritious, varied and culturally appropriate diet with enough food and drink that he/she enjoys at regular and timely intervals

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##### **Higher order domains**

###### **Control over daily life**

The service user can choose what to do and when to do it, having control over his/her daily life and activities

###### **Occupation**

The service user is sufficiently occupied in a range of meaningful activities whether it be formal employment, unpaid work, caring for others or leisure activities

###### **Social participation and involvement**

The service user is content with their social situation, where social situation is taken to mean the sustenance of meaningful relationships with friends, family and feeling involved or part of a community should this be important to the service user

###### **Dignity**

The negative and positive psychological impact of support and care on the service user's personal sense of significance

###### **Anxiety<sup>8</sup>**

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Source: Netten et al., 2010

<sup>8</sup> Exploration of the domains as part of validation process for the day care study identified the anxiety domain that was tested and used. Subsequent work has identified potential for double counting so this domain has been dropped.

It is worth noting that the dignity domain is different to the other domains and it was treated differently in the day care study, where it was included in the overall measure, from the care homes study. For the care home study the dignity domain reflects an aspect of people's lives that is only applicable when social care services are being received, that is the negative and positive psychological impact of support and care on the service user's personal sense of significance, and so only the current level was measured. For day care, dignity was thought of more generally in terms of the service user's sense of significance.

#### 4.1.3 Measuring an individual's current social care-related quality of life (SCRQOL)

Having identified the relevant domains, an approach to measuring an individual's current SCRQOL level or score in each domain needs to be developed. The main choice here is whether to ask people to give their own subjective evaluation of their experience in each domain, allowing them to draw on their own frame of reference to distinguish 'good' from 'bad', or whether to infer this from a more objective measure. A basic principle underlying the MOPSU project is that outcomes should reflect, as far as possible, the perspective of the service user. The issue is whether people *feel* they have control over their daily life, rather than whether they *have* control over their daily life (if this could be measured objectively).

The approach to measuring SCRQOL taken by PSSRU is based on the 'capabilities and functioning' approach, developed primarily by Sen (1985). Here 'functionings' refer to how well people function in each domain and 'capabilities' to people's potential to function in the domains. For example, we could define an individual's social participation in terms of how often they see people (functioning) or in terms of how happy they are with their level of social contact (capability), reflecting the fact that people vary in how often they want to see people.

The methods used to measure SCRQOL were different in the day care and care homes studies. For the day care study, the rating of each domain is completed by the service user, either via interview or through a self-completion questionnaire. The responses are on a three-point scale, examples of which are provided in Box 4.2.

#### Box 4.2 Examples of self-completion questionnaire current SCRQOL measures

Which of the following statements best describes how safe you feel? Not feeling safe could be due to fear of abuse, falling or other accidental physical harm, and fear of being attacked or robbed. Please cross one box only ☒

I feel as safe as I want

Sometimes I do not feel as safe as I want

I never feel as safe as I want

Which of the following statements best describes your social situation? By social situation we mean keeping in touch with people and spending time with people that you want to be with. Please cross one box only ☒

My social situation and relationships are as good as I want

Sometimes I feel my social situation and relationships are not as good as I want

I feel socially isolated and often feel lonely

Source: Caiels et al., 2010

While the SCRQOL measures in the day care study aimed to reflect capabilities as far as possible, this was more difficult for the care homes study. For the care homes study there were particular methodological challenges as the majority of care home residents have cognitive impairments, communication difficulties or both. As a result many residents would be unable to carry out the kind of self-rating task used in the day care study. For the care homes study, residents were rated by fieldworkers, over a two day visit to the homes, in each domain using a variety of methods including:

- observations – both structured and more general
- interviews with staff and residents, when they were able to respond
- staff questionnaires and administrative data

Such judgements, particularly when based just on observations and the views of staff, are closer to measures of functioning than capability.

The individual domains can be combined to produce an overall indicator of current SCRQOL. A simple additive indicator would imply that all the domains, and the levels within them, are of equal importance. However, to accurately reflect the value of services, we want to reflect the relative importance of the domains and levels. As the services make use of public money, the preferences of the general population were used to provide a legitimate basis for weighting. Preference weights from previous studies were used in the care homes (Netten et al., 2009) and day care studies (Burge, Gallo and Netten, 2006) and these have been further developed

in the preference study conducted as part of the MOPSU project (for more information see section 4.4).

#### 4.1.4 Attributing outcomes to service use

The set of domains and the variety of methods used to collect the information to assess *current* SCRQOL, as described in the previous section, comprise one component of ASCOT. The other component is a measure of *expected* SCRQOL in the absence of services.

Many factors, such as informal care and support from family and friends, could affect people's current level of SCRQOL. In order to isolate the impact of the service, the outcome, it is also necessary to establish the counter-factual, what would the person's SCRQOL be in the absence of the service, all else being equal? Many outcome measures do not attempt to separate out the impact of the services, they simply measure the overall change in an individual. A simple 'before and after' method could be misleading as the change might not be attributable to the service as other factors, such as disease progression, could have an impact on the measure. Ideally, a randomised controlled trial would be set up to compare matched groups of people who were or were not in receipt of the services. However, this approach is expensive, often impractical and can present ethical difficulties, as access to potentially beneficial services is being denied.

As a result of these issues PSSRU developed an alternative approach to measuring expected SCRQOL in the absence of services. For the day care study this involved asking people directly, in interview, what they expect their SCRQOL would be in the absence of services, if no other service or informal support replaced the service being received<sup>9</sup>. People were asked directly whether they felt that the service helped with each domain of SCRQOL. If they said 'yes' their outcome was the difference between the current and expected ratings. If they said 'no' the SCRQOL gain was either zero, or the difference between current and expected SCRQOL if this was negative. This is a challenging task for people and PSSRU carried out analysis to assess the degree to which users did this successfully, and adjust expected scores when the task was complicated by other service use (Caiels et al., 2010).

While the task of measuring expected SCRQOL was challenging in the day care study it is even more so when we consider that for a substantial proportion of the social care population, their level of communication and cognitive skills severely limit them in responding to the type of structured

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<sup>9</sup> Asking people to think about and isolate the effects of (in this case) day care services in order to establish expected SCRQOL is a challenging task. This issue is discussed further in (Caiels et al., 2010).

questions used to establish people's experienced SCRQOL in the day care study. For the care homes study, expected SCRQOL was rated by fieldworkers, using evidence from observations and interviews, in exactly the same way as current SCRQOL. The fieldworkers were asked to identify the expected levels of SCRQOL in the absence of services by observing the degree to which residents were being helped by the service.

Comparing current and expected SCRQOL enables us to measure the change in SCRQOL that is attributable to service use, the outcome. As mentioned above, only the current, not expected, level of the dignity domain was measured in the care homes study. For this reason when the current and expected measures were combined across domains to create overall ratings of SCRQOL, from which outcome is calculated, they did not include the dignity domain. Dignity is nonetheless an important issue and is discussed further in section 4.2.

#### 4.1.5 Capacity for benefit and comparing ASCOT with low-burden measures

The measures of current and expected SCRQOL enable us to assess an individual's outcome from service use – their SCRQOL gain. However, there are two problems with this approach. Firstly, information collected in the study could be detailed and in-depth. However, if outcomes are to be monitored over time a simplified approach is needed, taking into account issues of burden and resources. This is particularly relevant for the sorts of services where the level of impairment of service users precludes the use of a self-completion questionnaire. Secondly, the focus, up to this point, has been on the individual, but for commissioning, regulatory and national accounting purposes we would be interested in service level information.

Through the MOPSU project PSSRU have further developed the 'capacity for benefit' approach (Burge, Gallo and Netten, 2006) which takes the focus from individual service users to the service itself. The approach involves identifying the potential value that could be delivered by a service, the capacity for benefit, and the degree to which that value is actually delivered, the outcome of the service. Capacity for benefit is the potential benefit that could be delivered if all the objectives of a service were achieved for all those receiving the service and depends on:

- the domains of SCRQOL which the service aims to influence
- the number of people who access the service
- the need level or 'capacity to benefit' of the service users, where individuals' capacity to benefit is the difference between their expected SCRQOL and the maximum level they could achieve in each domain with a 'perfect service'

- what the service hopes to achieve<sup>10</sup>

In order to limit the data collection burden, one of the key objectives of the adult social care work-strand was to make use of information that is already available, about the services and the populations they serve, or to use information that could be collected on a routine basis, for example by the Care Quality Commission (CQC). Comparisons were made between the ASCOT measures and routine data based on two assumptions:

- that expected SCRQOL in the absence of services will be highly correlated with people's needs, such as problems with activities of daily living (ADLs)<sup>11</sup>, cognitive impairment and poor general health
- that how far a service achieves its capacity for benefit, i.e. its outcome, is correlated with the quality of the services as measured by the inspection process

It is worth noting here that quality of life is often confused with quality of care, where the latter refers to the way in which care is delivered and the standards that it meets. Rather, improved quality of life, a good outcome, is a consequence of good quality care. For example, care that is timely and reliable is likely to lead to improved functioning states for recipients.

In order to assess the relationship between outcomes and quality the care homes fieldwork was timed to coincide with the routine inspection of the care homes. For services where no consistent quality measure is available, such as day care services, current SCRQOL had to be measured directly. In both studies, well-established, routine measures of need and other measures of impairment and demographic information were collected to examine the relationship between needs and expected SCRQOL.

## 4.2 The care homes study

### 4.2.1 Sample

The study focussed on two types of care homes – homes for older adults (OA homes) and homes for younger adults with learning disabilities (LD homes). Homes were randomly selected from those inspected or due for

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<sup>10</sup> Social care services have traditionally been, and still predominantly are, concerned with meeting long term care needs or 'maintenance' of service users (Qureshi et al., 1998). However there is increasing policy emphasis on enablement and prevention (Ministers al., 2007), where we might expect to see changes in people's abilities to meet their own needs.

<sup>11</sup> Such as getting dressed, getting in to/out of a chair, washing, preparing meals, walking

inspection between January and December 2008<sup>12</sup>. Of the 444 homes originally selected 173 homes, 39 per cent, took part (83 OA and 90 LD). Although low, this response rate was not unexpected given the intensity of the data collection. The characteristics of the sample LD and OA homes are set out in Table 4.1.

Table 4.1  
**Characteristics of LD and OA homes in the sample**

|   | OA homes | LD homes | All homes |
|---|----------|----------|-----------|
| Number of places (mean)                               | 35       | 7        | 21        |
| Quality rating (% of homes rated as...) <sup>13</sup> |          |          |           |
| Zero stars  | 3        | 0        | 2         |
| One star  | 25       | 26       | 22        |
| Two stars   | 57       | 59       | 51        |
| Three stars   | 16       | 15       | 14        |
| Sector (%)  |          |          |           |
| Private   | 74       | 55       | 64        |
| Voluntary   | 19       | 36       | 28        |
| Local Authority                                       | 6        | 3.4      | 5         |
| NHS and other   | 1        | 6.6      | 3         |
| Home Type (%)   |          |          |           |
| Nursing   | 36.1     | 1.1      | 18        |
| Average weekly fee (£)                                | 525      | 1218     | 861       |

Sources: Netten et al. (2010)

Despite the low response rate, there was a good match on key characteristics such as quality between the responding sample and all homes selected and with care homes nationally<sup>14</sup>.

Given the in-depth nature of the fieldwork a limited number of residents could be included in the 'focal' sample, for which detailed information was collected. The focal residents were sampled from those identified on the Annual Quality Assurance Assessment (AQAA) form provided by the home to the regulator. Of the 860 people selected as focal residents 741 participated, a response rate of 86 per cent. Less detailed information was collected for the remainder of those identified on the AQAA form, the non-focal sample. In total data was collected for 1,050 residents of OA homes, (375 focal and 675 non-focal) and 501 residents of LD homes (366 focal, 135 non-focal).

Table 4.2 sets out the characteristics of the focal and non-focal residents from the OA and LD homes.

<sup>12</sup> Homes rated as excellent were not due for inspection so an alternative approach was needed to ensure adequate coverage. This is described in the full report (Netten et al., 2010).

<sup>13</sup> Star ratings were not available for one LD home

<sup>14</sup> The comparison drew on data from the State of Social Care 2009 report published by the regulator (CSCI, 2009). For more information see chapter 3 of the Netten et al. (2010)

Table 4.2

**Characteristics of residents in OA and LD homes**

|   | Older adults |           | Learning disabilities |           | All homes |           |
|---|--------------|-----------|-----------------------|-----------|-----------|-----------|
|   | Focal        | Non-focal | Focal                 | Non-focal | Focal     | Non-focal |
| Age (mean)  | 84           | 86        | 46                    | 49        | 65        | 80        |
| Sex (% male)  | 30           | 27        | 58                    | 57        | 43        | 32        |
| Level of need<br>(mean on 9 item ADL scale) <sup>15</sup>   | 10.0         | 10.4      | 6.9                   | 6.0       | 8.5       | 9.9       |
| Cognitive impairment<br>(mean MDS CPS score) <sup>16</sup>  | 2.6          | 2.5       | 3.4                   | 2.5       | 3.0       | 2.5       |
| Health-related quality of life<br>(mean EQ5D) <sup>17</sup> | 0.4          | -         | 0.5                   | -         | 0.5       | -         |
| % publicly funded (fully or in part)                        | 55           | -         | 86                    | -         | 76        | -         |

Source: Netten et al., 2010

The resident sample was compared to those from other studies to assess how representative it was. The sample appeared to be typical of residents in the sample homes and care homes nationally.

As mentioned earlier, the methods used to collect the data consisted of a combination of: observations, interviews with staff and residents (when possible), staff questionnaires and administrative data. Given the reliance on fieldworkers' judgements, great attention was paid to training and to assessment of inter-rater reliability (whether different raters make the same judgements under the same circumstances). *Measuring Outcomes of care homes: Final report* (Netten et al., 2010) provides details of the training and validity and reliability analysis.

#### 4.2.2 Results

Figures 4.1 and 4.2 show unweighted current and expected SCRQOL for each domain<sup>18</sup>, for older adults and younger adults with learning disabilities respectively, with 100 representing the best possible SCRQOL rating in each domain. The darker shaded area reflects the expected SCRQOL while the pale area shows the SCRQOL gain in each domain.

<sup>15</sup> Higher score represent higher levels of need. Maximum score of 18 as each item is scored on a scale of 0 to 2 where 0 = no problem with completing activity, 1 = can complete activity with difficulty, 2 = can complete activity only with help.

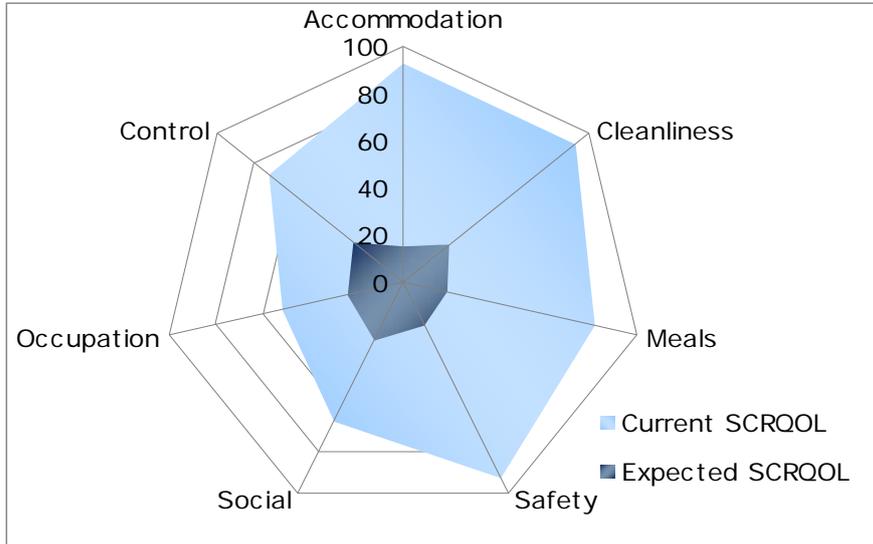
<sup>16</sup> For Minimum Data Set Cognitive Performance Scale (MDS CPS) higher scores represent lower level of cognitive impairment. While it may seem counter-intuitive that adults with learning disabilities have lower levels of cognitive impairment this may be because MDS CPS is designed for people with dementia. The maximum score is 6.

<sup>17</sup> EQ5D is a preference-weighted measure with 0 anchored to 'dead' and 1 to 'good health'.

<sup>18</sup> As only the current level for the dignity domain is measured this domain is excluded from these figures.

This gives an indication of outcome; however, it does not take account of the relative importance of the domains and levels which are discussed in section 4.4.

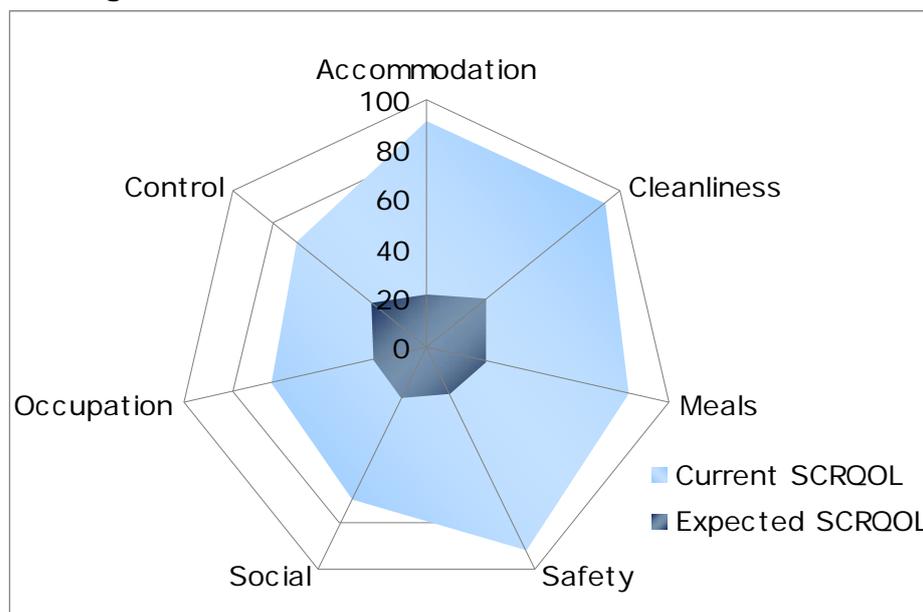
Figure 4.1  
**Unweighted current and expected SCRQOL for older adults**



|                 | Accommodation | Cleanliness | Meals | Safety | Social | Occupation | Control |
|-----------------|---------------|-------------|-------|--------|--------|------------|---------|
| Current SCRQOL  | 93.1          | 93.1        | 82.7  | 92.9   | 65.5   | 52.0       | 71.9    |
| Expected SCRQOL | 15.0          | 24.5        | 19.2  | 20.8   | 27.7   | 24.3       | 27.3    |

Source: Netten et al., 2010

Figure 4.2  
**Unweighted current and expected SCRQOL for younger adults with learning disabilities**



|                 | Accommodation | Cleanliness | Meals | Safety | Social | Occupation | Control |
|-----------------|---------------|-------------|-------|--------|--------|------------|---------|
| Current SCRQOL  | 91.6          | 92.7        | 83.7  | 91.3   | 68.5   | 64.1       | 67.7    |
| Expected SCRQOL | 21.3          | 30.9        | 25.2  | 20.7   | 22.7   | 22.0       | 28.2    |

Source: Netten et al., 2010

While we can see that care homes provide a high level of SCRQOL gain in each domain, the asymmetric pattern reflects the fact that the difference is more limited in higher order domains, which are displayed on the left. Looking at the whole sample together (LD and OA), there is a mean difference of 39.6 per cent between the current and expected needs for the higher order domains and a mean difference of 67.7 per cent for the basic domains. Whilst this confirms that SCRQOL gain is larger in the lower order domains, the difference in current and expected needs scores in the higher order domains were still highly significant for both older adults and people with learning disabilities.

The current level of SCRQOL was higher in the dignity domain than in the other 'higher order' domains; 80 per cent of the older adults and 64 per cent of the learning disabilities sample were observed as having the highest level of quality of life in this domain. This compares to control over daily life, for example, in which 49 per cent of older adults and 40 per cent of people with learning disabilities were observed to have the highest level of SCRQOL.

The overall measures were preference weighted and rescaled so there was a maximum score of 1, with higher values representing higher SCRQOL (lower levels of need). The mean preference-weighted expected

and current SCRQOL for older adults and younger adults with learning disabilities are shown in Table 4.3. Also shown is the outcome, the gain in SCRQOL, represented by the difference between the current and expected scores. Here 0 represents a situation where no needs had been met, so no outcome achieved, and 1 represents a situation where someone would have had high level needs in all domains in the absence of the service but their needs have been met by the service.

Table 4.3  
**Mean current and expected preference weighted SCRQOL**

| <b>Measure</b>  | <b>Older adults</b> | <b>Younger adults with learning disabilities</b> |
|-----------------|---------------------|--|
| Expected SCRQOL | 0.26                | 0.28   |
| Current SCRQOL  | 0.84                | 0.84   |
| Outcome         | 0.58                | 0.56   |

Source: Netten et al., (2010)

There was considerable variation in outcomes for different residents. For older adults outcomes varied between -0.04 and 1 (standard deviation =0.25). For adults with learning disabilities outcomes varied between 0 and 1 (standard deviation =0.24). The maximum possible score was recorded for 4 per cent of older adults and 2 per cent of those with learning disabilities. These residents would have had high levels of need in all domains in the absence of services and scored the maximum possible current SCRQOL<sup>19</sup>.

For both the older adult and learning disabilities samples, significantly<sup>20</sup> better outcomes were observed for those with greater levels of impairment, both physical and cognitive. This suggests that services deliver higher levels of outcome for people with the most potential to improve.

#### 4.2.3 Comparison with regular data collections

##### Predicting capacity to benefit

One of the main objectives of the study was to link the in-depth study measures with routine, low-burden measures to enable us to measure outcomes over time. We would expect that expected SCRQOL, therefore capacity to benefit, would be associated with other measures of dependency, such as ADLs, and demographic factors, such as age and

<sup>19</sup> However, one older adult had a negative score (-0.04), a situation where the care received was undermining their quality of life. Among younger adults with learning disabilities no individual had a negative score and less than 2 per cent had zero level of outcome.

<sup>20</sup> All relationship that are reported as significant in this chapter are significant at least at the 5% significance level

gender. Multi-level modelling was carried out to explore the factors associated with capacity to benefit<sup>21</sup>.

For both older adults and younger adults with learning disabilities there was a significant relationship between the abilities to wash, dress and communicate and capacity to benefit. People with higher levels of impairment had higher levels of capacity to benefit. For younger adults with learning disabilities, mobility was also significantly associated with capacity to benefit and for older adults needing help with personal affairs, anxiety and depression. Again higher levels of impairment were associated with higher levels of capacity to benefit.

In theory, the quality of homes should not have a direct effect on people's capacity to benefit; home-level characteristics would only be related to mean capacity to benefit because different homes cater for different types of resident with these differences not being fully picked up by the individual-level characteristics. For younger adults with learning disabilities, however, capacity to benefit differed between homes of different star ratings with residents of three star homes having significantly higher capacity to benefit than zero/one<sup>22</sup> star homes, all else being equal. The fact that significant relationships were found may reflect the additional impact of residents for whom it is difficult to provide care and support; for example, people with 'difficult' attitudes or personalities not picked up by a measure of challenging behaviour. High quality homes, by their very nature, should be better able to cope with such issues.

Overall the models explained 70 per cent of the variation in capacity to benefit for older adults and 65 per cent for younger adults with learning disabilities. However, fieldworker effects account for 11 per cent of the total variance in both models. Inter-rater reliability and fieldworkers' use of evidence for ratings were both examined to provide a validation check and to aid in the further development of the training and the toolkit.

### Quality and outcomes

It was hypothesised that high quality homes, as rated by the regulator, would deliver better outcomes for residents. If this were to hold true then a model of the relationship between the ASCOT in-depth measures and the lower burden regulatory quality measures would provide a convenient way to predict outcomes over time. Analysis was carried out of the relationship between outcomes and regulator quality ratings, which have

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<sup>21</sup> Initial diagnostic analysis suggested that multi-level modelling was required and so care home level variables, such as home type and sector, were also included as predictors of capacity to benefit. Fieldworker effects were also included.

<sup>22</sup> In the analyses the few zero star homes were grouped with one-star homes.

traditionally tended to focus more on the structure and process of care. Homes were rated on a scale of zero (poor) to three stars (excellent) based on their adherence to minimum standards<sup>23</sup>. Further detail of quality ratings is available in the full report (Netten et al., 2010), however, it is worth noting here that the Care Quality Commission are currently reviewing the quality ratings system. This is discussed further in chapter 7.

When looking at the relationship between quality and outcomes it is important that we allow for expected causes of variation in outcome, other than quality, e.g. demographic factors and dependency levels. Home size, type and sector may also be expected to affect outcomes; again fieldworker effects were also included in the model.

Three star homes did deliver significantly better outcomes than zero/one star homes, however, this did not hold true for all types of home. For OA homes the significant relationship between star ratings and outcomes was only true for personal care homes. Where significant the sizes of the effects were small, accounting for about 5 per cent of explained variance. This is perhaps unsurprising given the high level of intensity of service received by all residents. Residents in high quality homes are likely to receive both more support and better quality support and processes and this could be reflected in the significant relationship between quality and outcomes.

### **4.3 The low-level services study of day care centres**

The low-level services study focussed on day care centres. Day care involves a range of activities and caters for a variety of users, with differing levels of need and dependency. Examples of the types of service available to day care users include: nail cutting, bathing, hairdressing, lunch and activities such as dancing, cards, bingo and cooking lessons.

#### **4.3.1 Sample**

At the time of the day care study there was no national register of providers of day care from which to draw a sample. A sampling frame had to be constructed by a postal survey of all 150 Local Authorities with social service responsibility in England. From the responses 137 service providers were randomly selected and asked whether they would take part and distribute recruitment packs to users that met the inclusion criteria<sup>24</sup>. The recruitment packs were made up of the self-completion

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<sup>23</sup> Zero and one star homes were combined due to the small number of homes rated as zero

<sup>24</sup> These were being aged 65 and over and having sufficient cognitive functioning to understand the consent process and to participate in a face-to-face interview

questionnaire, a letter inviting people to take part and a participant information sheet explaining what was involved<sup>25</sup>.

Of the 5,029 packs handed out, 961 valid responses to the self-completion questionnaire were received, a response rate of 19 per cent. Service users who completed the self-completion questionnaire were asked whether they would be willing to participate in a face-to-face interview. Of those who responded 'yes' (262 people) successful interviews were conducted with 224 service users.

Table 4.4 sets out the key characteristics of the self-completion questionnaire and face-to-face interview samples<sup>26</sup>.

Table 4.4  
**Characteristics of the self-completion questionnaire and face-to-face interview samples**

|  | Self-completion questionnaire | Face-to-face interview |
|--|-------------------------------|------------------------|
| Age (mean)                                 | 81                            | 81                     |
| Sex (% male)                               | 31                            | 32                     |
| Level of need (mean on 10 item ADL scale)  | 3.0                           | 3.3                    |
| Health-related quality of life (mean EQ5D) | -                             | 0.41                   |

Source: Caiels et al., 2010

#### 4.3.2 Results

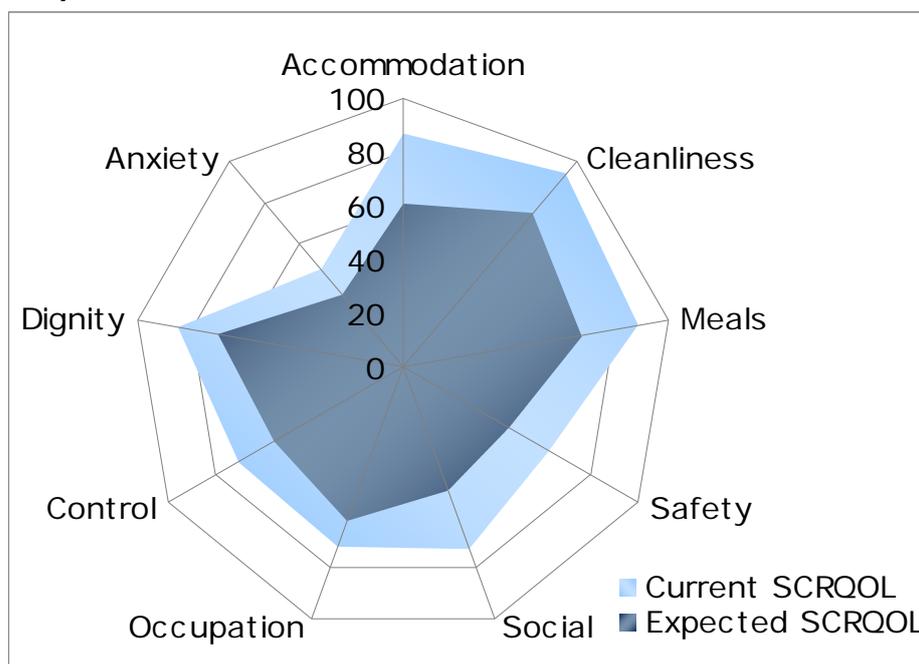
Figure 4.3 shows unweighted current and expected SCRQOL in each domain, for the face-to-face interview sample<sup>27</sup>, with 100 representing the best possible SCRQOL rating in each domain. The darker shaded area reflects the expected SCRQOL while the pale area shows the level of SCRQOL gain in each domain. This gives an indication of outcome; however, it does not take account of the relative importance of the domains and levels.

<sup>25</sup> These can all be seen in the annexes to Caiels et al., (2010)

<sup>26</sup> For the purposes of describing the study population the self-completion questionnaire and face-to-face interview data will be treated separately, but participants who took part in a face-to-face interview also completed a (matched) self-completion questionnaire.

<sup>27</sup> As noted, in view of the potential difficulty of the concept of expected SCRQOL and the aim to minimise burden, expected SCRQOL was only collected from the interview sample. Section 3.3.3 sets out a method to predict expected SCRQOL from other data in the self-completion questionnaire.

Figure 4.3  
**Unweighted current and expected SCRQOL for the face-to-face interview sample**



|               | Current SCRQOL | Expected SCRQOL |
|---------------|----------------|-----------------|
| Accommodation | 86.6           | 60.6            |
| Cleanliness   | 93.5           | 74.4            |
| Meals         | 88.9           | 67.3            |
| Safety        | 62.3           | 44.9            |
| Social        | 71.8           | 48.5            |
| Occupation    | 70.9           | 61.0            |
| Control       | 70.8           | 54.9            |
| Dignity       | 84.3           | 69.4            |
| Anxiety       | 48.2           | 35.5            |

Source: Caiels et al., (2010)

The figure shows that service users felt that day care centres help in many domains, particularly social contact, but also meals and even accommodation. 40 per cent of respondents said that day care directly helped in relation to their home cleanliness and comfort. This may be due to reducing the tasks associated with food preparation and personal cleanliness that would otherwise take place at home. By way of contrast 61 per cent of people felt that day care helped with social contact outcomes.

The overall measures were preference-weighted and rescaled, as for the care homes study, to have a maximum score of 1. Higher values represent higher SCRQOL (lower levels of need). The mean preference-weighted expected<sup>28</sup> and current SCRQOL, for the face-to-face interview

<sup>28</sup> The study specifically addressed the issue of whether people are able to report expected SCRQOL, the result of being without day care rather than being without all forms of support. It was found that respondents were not able to completely isolate the effects of day care and, in particular, expected

sample, are shown in Table 4.5. Also shown is the outcome, the gain in SCRQOL, represented by the difference between the current and expected scores. Here 0 represents a situation where no needs had been met so no outcome achieved and 1 represents a situation where someone would have had high level needs in all domains in the absence of the service and all their needs have been met by the service.

Table 4.5

**Mean (adjusted) expected and current SCRQOL and outcomes for the face-to-face sample**

| Measure                    | Face-to-face interview (mean) |
|----------------------------|-------------------------------|
| Expected SCRQOL (adjusted) | 0.65                          |
| Current SCRQOL             | 0.74                          |
| Outcome                    | 0.09                          |

Source: Caiels et al., (2010)

Outcome was highly skewed with a small percentage of day care users reporting an outcome of 0.4 or more, while close to 20 per cent reported no outcome gain. Outcome ranged between -0.14 and 0.87 (standard deviation 0.13).

As we might expect people with higher needs (as measured by ADL problems) have significantly higher outcomes; these people have a greater capacity to benefit from care and support. Outcomes are also positively associated with frequency of visits to the day care centre. People who visit 3 or more times a week show significantly higher outcomes than those who only visit once a week.

### 4.3.3 Comparison with regular data collections

#### Predicting expected SCRQOL

One of the aims of the study was to be able to infer ASCOT expected SCRQOL from easy to collect, standard measures in order to keep the self-completion questionnaire low-burden, by just collecting current SCRQOL and needs data. We anticipated that there would be a close relationship between expected SCRQOL (as measured in the face-to-face interviews) and needs. If this holds true then a formula can be developed and applied to the self-completion questionnaire data to calculate expected SCRQOL and, therefore, outcome.

The expected SCRQOL formula was developed using regression analysis of the face-to-face interview data and applied to the self-completion

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SCRQOL was lower for people who used other services such as home care. Using statistical analysis, the expected SCRQOL scores are adjusted to remove the confounding effect of other services and support. This is discussed in more detail in Caiels et al. (2010).

questionnaire data. Comparing predicted expected SCRQOL (for the sub-sample of the self-completion questionnaire respondents who also completed the face-to-face interview) with expected SCRQOL measured directly (for the face-to-face interview sample) they compare well; both have (adjusted) means of 0.65. Individual scores did differ, however. For people whose characteristics, such as level of need, are significantly different from the average of the face-to-face interview sample, predictions of expected SCRQOL are less accurate.

For day care services there are no regulatory or routine measures of quality available (as there are for care homes) and so the relationship between outcomes and quality could not be explored. Instead expected SCRQOL can be predicted and current SCRQOL measured directly, relatively simply, using the self-completion questionnaire.

#### **4.4 The preference study**

In order to establish preference weights for the ASCOT domains a preference study was conducted, led by PSSRU and RAND Europe. This innovative general population study involved a sample of 1,000 people and used a method called best-worst scaling. Half of the sample completed an exercise based on the 9 domains (including anxiety<sup>29</sup>) and 3 levels used in the day care study while the other half completed the exercise with 8 domains (excluding anxiety) and 4 levels within each domain in order to see whether a more detailed measure could be developed. Best-worst scaling involves respondents being asked to provide their best, worst, second-best and second-worst choice from a list in which each domain is presented at one of its possible levels, e.g. lowest level of social occupation domain, highest level of control over daily life, middle level of personal cleanliness and comfort. An experimental design was used to construct the combinations of domain levels to present to the respondents, with the order in which the domains were presented randomised. One example from the 27 possible combinations within the experimental design is provided in Box 4.3.

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<sup>29</sup> As mentioned earlier, the anxiety domain was later dropped.

### Box 4.3 Example of preference study options

1. My home is less clean and comfortable than I want
2. I feel as safe as I want
3. I don't always eat the right meals I want, and I think there is a risk to my health
4. I feel much less clean than I want, with poor personal hygiene
5. Sometimes I don't feel I have as much control over my daily life as I want
6. Sometimes I feel my social situation and relationships are not as good as I want
7. I would be treated by other people with the dignity and respect that I want
8. I don't do any of the activities I want to do
9. I sometimes feel worried and concerned

Source: Burge et al. (2010)

For both groups the most frequently selected 'best' option was the highest level of control over daily life domain. Similarly, the most frequently selected 'worst' option was the lowest level of control over daily life domain.

The results from the best-worst scaling indicate the differing importance placed on the ASCOT domains. Table 4.6 shows the domains in order of importance in terms of the value placed on moving from the highest level of need to lowest level of need<sup>30</sup>.

Table 4.6

#### Importance of domains in terms of the value placed on improvement of needs

| Domain                                | Value of improvement |
|---------------------------------------|----------------------|
| Control over daily life               | 4.47                 |
| Social participation                  | 4.19                 |
| Personal cleanliness and comfort      | 3.93                 |
| Safety                                | 3.70                 |
| Dignity                               | 2.78                 |
| Occupation                            | 2.77                 |
| Accommodation cleanliness and comfort | 2.77                 |
| Food and nutrition                    | 2.59                 |

Source: Burge et al. (2010)

### 4.5 Conclusions

The care homes and day care centres study results provide only a snapshot based on a sample of service users and were collected, in part, to test the toolkit. Nevertheless they provide a useful insight into these services. Both care home and day care services were shown to have a strong positive effect on service users' quality of life, but this effect was stronger for 'basic' domains than for 'higher order' domains. For older adults care homes the mean outcome was 0.58, for younger adults with learning disability 0.55 and for users of day care services 0.09. In all cases outcomes were shown to relate to levels of impairment, which

<sup>30</sup> Using the three level scale. While for the most part the three and four level experiments yielded consistent results there were some differences. For more information see Burge et al., (2010).

those with higher levels of impairment showing better outcomes. For day care centres those who attended more frequently also showed higher outcomes. Comparing care home outcomes to quality, as measured by CQC, good and excellent homes did deliver better outcomes than poor or adequate homes. However, the quality of the home explained only a small amount of variation in outcome.

The MOPSU studies of care homes and day care centres have demonstrated the potential of ASCOT as a method for assessing the effect services have on their users' quality of life. Given the development nature of the adult social care work-strand a key element of both studies was testing the validity and reliability of the ASCOT measures. These issues are covered extensively in *Measuring outcomes of low-level services: Final report* (Caiels et al., 2010) and *Measuring the outcomes of care homes: Final report* (Netten et al., 2010). In both cases ASCOT performed well overall in reliability and validity testing. In the case of the care homes study the reliance on observation and hence fieldworker' judgements means that inter-rater reliability and evidence of how fieldworkers made their judgements are important. These were examined carefully and the information used to aid the development of the toolkit and training.

ASCOT will be available, free of charge, from the PSSRU website from June 2010. The potential uses for this toolkit are discussed in chapter 7.

## **4.6 The information, advice and advocacy (IAA) services study**

### **4.6.1 Introduction and aims**

This study differs from the other two social care studies as outcome measurement in the information and advice field was at a much earlier stage of development. Information and advice services are increasingly being seen as an important area of activity and have been prioritised in a number of recent policy papers (DH, 2006; CLG, 2008). Information, advice and advocacy (IAA) services are particularly important in the social care field where such services are critical to enabling people to access mainstream services (Baxter, Glenndinning and Clarke, 2006) and where current policies which aim to increase choice and control have also increased the need for information and advice. Despite this, information and advice services find it difficult to obtain secure, long-term, funding. In part this is due to the difficulty in demonstrating the value of such services when competing for scarce resources.

Initial discussion with IAA providers, conducted as part of this study, identified that few organisations measure outcomes whether as a one-off

exercise or as part of their overall quality assurance framework. It seems there are three barriers to such measurement.

- Demand from commissioners – where performance data was demanded this was output, rather than outcome, data. The former perceived as allowing ‘tangible evidence’ and enabling simple comparisons across organisations
- Capacity and resources – IAA services are often small, voluntary sector organisations, reliant on numerous small short-term grants and staffed by volunteers; their primary focus is the provision of appropriate, timely information and support so there is limited capacity to collect and analyse outcomes information
- Diversity of services and service users – users present with a variety of needs and problems and receive a wide variety of service, from a leaflet or short telephone call to repeat in-depth discussions and advocacy. Any one IAA service may also provide information on a range of topics from financial advice to housing and health. Such diverse activities and user characteristics lead to recognisable challenges in designing a robust tool.

Nevertheless, there was a desire to move from measuring outputs to measuring outcomes. The aim of this study was to begin to develop an approach and tool for measuring outcomes of IAA services<sup>31</sup>. Such measurement had to be low-burden and encompass a wide range of activities and service users.

The study consisted of two stages: the exploratory stage and piloting stage. The exploratory stage looked at existing research on the aims and outcomes of IAA services, investigated the acceptability, plausibility and feasibility of outcome measures in the field of IAA services, and developed a first draft of the outcomes tool to be cognitively tested. The testing stage involved piloting the tool across eight IAA providers, exploring different types of administration (face-to-face interviews, telephone interviews and self-completion questionnaires).

#### 4.6.2 Information and advice services

Before discussing the two stages it is important to clarify the range of IAA services that we focussed on. For the purposes of this study we were interested in services whose principal objective is the provision of information and advice to individuals for their own purposes, rather than to organisations or society, and the outcomes for these individuals, rather than for society more broadly. Due to the necessity for a low-

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<sup>31</sup> The IA work was at a much earlier stage of development than the other PSSRU MOPSU work, there was never an intention to provide a tested IAA tool.

burden tool, long-term outcomes, such as improved quality of life and financial stability, were excluded.

Services can carry out a range of activities including the provision of:

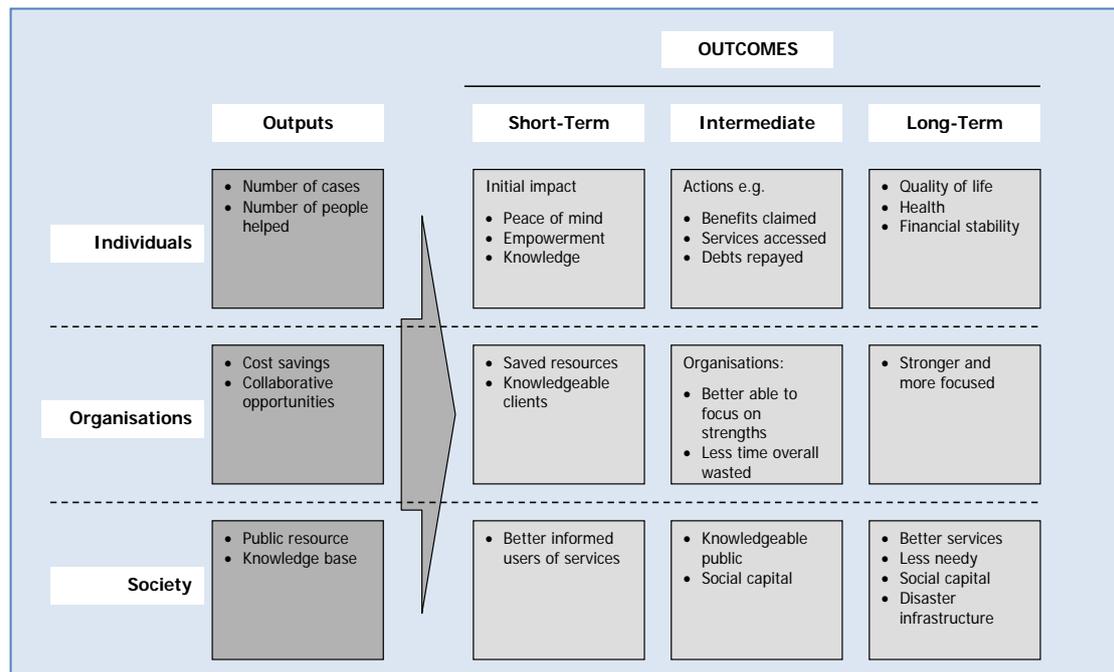
- Self-help information (e.g. website or leaflets)
- Assisted information – providers assist users in finding information
- General help – providing person to person (by telephone or face-to-face) advice and assistance (e.g. explaining options and filling in forms)
- General help with casework – negotiating on user's behalf with a third party
- Specialist help (e.g. legal representation)

Services at the two extremes of the spectrum – those that provide self-help information and those that provide specialist help - were excluded from this study as one-off access to self-help information was unlikely to lend itself to robust measurement and specialist help was likely to require a different set of outcome questions.

#### 4.6.3 Exploratory stage

Three activities were carried out at the exploratory stage; a literature review, consultation with service providers and users and development of a draft outcomes tool. Following the review of the literature (reported in Netten and Forder, 2008) it was decided to adapt Saxton et al.'s (2007) model of information and advice service outcomes, as shown in Figure 4.5. This provides the basis for the exploratory stage of this study.

Figure 4.5  
**Model of IAA service outcomes**



Source: Windle et al. (2010)

The consultation phase involved a series of semi-structured interviews (via telephone or face-to-face) with 34 key informants (providers and service users). The aims of the interviews were to identify how outcomes were defined and identify existing approaches to measurement. Analysis of the interviews highlighted the difficulty of providing a clear definition of outcomes, however, some key outcomes began to emerge, as detailed below.

- Increase in knowledge – through attending an IAA service, users, in the short-term, should know more about their problem and the actions they could take
- Empowerment – users should be enabled to extend their decision-making ability and to take control of their circumstances
- Problem resolution – in the intermediate to long-term the user should undertake a particular action, or series of actions, to begin to resolve their problem or access the service they need

#### 4.6.4 The pilot outcome tool

The outcomes tool was developed from analysis of the exploratory stage and consisted of a series of predominantly 'tick-box' style questions to assess three areas:

- User characteristics
- The IAA service 'encounter'
- Outcomes (short- and intermediate-term)

User characteristics are likely to affect the outcome of IAA service use as some people will be less able to understand and act on the information and advice received. Seven questions about user characteristics were included; age, sex, ethnicity, whether the service user lived alone, ability to deal with paperwork or forms, overall quality of life and postcode<sup>32</sup>

Eight questions were included to assess the users' experience of IAA service use and their pathway to seeking information. These included questions about the nature of their problem, whether the individual knew where to get help, how users rated the knowledge of the person who provided the information and advice, how easy the information or advice was to understand and how helpful it was.

Two specific questions were used to measure short-term outcomes:

'Following your contact with the service, how much more do you know now?'

'How would you feel if you face a similar situation in the future?'

To assess intermediate-term outcomes two general questions were asked:

'Did you get the help that you wanted?'

'What happened as a result of your contact with the service?'

In order to address the attribution problem, discussed in section 4.1.4, a final question was asked to try to establish what would have happened if the IAA service had not been accessed.

'If you didn't get the help you did from the information and advice services, how confident would you be to take forward the issues?'

A total of 26 cognitive interviews were carried out, 23 with service providers and three with expert users. The interviews served an iterative process with the tool being refined throughout.

#### 4.6.5 Testing the pilot toolkit

Piloting of the toolkit was conducted in seven IAA services with 79 users. Information was gathered using different administration types in order to begin to explore suitability: 48 users completed self-completion questionnaires (61%), face-to-face interviews were conducted with 28 users (35%) and telephone interviews with a further 3 (4%).

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<sup>32</sup> Postcode was used to assess the level of deprivation experienced by the user, based on the Index of Multiple Deprivation.

The results of the outcome and attribution questions are shown in tables 4.7 and 4.8.

Table 4.7

**Results from outcome questions**

| <b>Outcome question</b>                                      | <b>Percentage</b> |
|--|-------------------|
| Following contact with IAA, how much more do you know?       | 36                |
| A great deal more  | 53                |
| Quite a lot more   | 10                |
| Don't know any more  |                   |
| How would you feel facing a similar situation in the future? |                   |
| Confident I would know what to do on my own                  | 13                |
| Confident I would know where to go for help                  | 79                |
| Not confident, I would only have some idea of what to do     | 4                 |
| Not confident at all, I wouldn't know what to do             | 4                 |
| Did you get the help wanted?                                 |                   |
| More help than wanted  | 31                |
| Got the help wanted  | 61                |
| Got less help than I wanted                                  | 5                 |
| Didn't get any help at all                                   | 1                 |
| What happened as a result of your contact with the service?  |                   |
| I followed the advice I was given                            | 80                |
| I followed some of the advice I was given                    | 19                |
| I followed none of the advice I was given                    | 1                 |
| I wasn't able to follow the advice I was given               | 0                 |

Table 4.8

**Responses to the attribution question**

| <b>Question</b>  | <b>Percentage</b> |
|--|-------------------|
| In the absence of the services how confident would you feel? |                   |
| Confident I would know what to do                            | 6                 |
| Confident I could find out what to do                        | 43                |
| Not confident I could find out what to do                    | 27                |
| Not confident at all, I wouldn't know what to do             | 21                |

4.6.6 Conclusions

Measuring the outcomes of information and advice services presents a number of challenges.

- It is difficult to define outcomes given the diverse nature of the services and the service users
- Developing a robust but low-burden tool is essential as users often have quite brief contact with services so would not want to complete a lengthy questionnaire or interview to provide outcomes information
- While self completion tools may be lowest burden they may not be suitable for all groups. For example, people may access IAA services as they have difficulties filling in forms
- It can be difficult to get users to respond for the reasons given above

- Data collection may also be resource intensive to the IAA provider

Given these challenges this work has taken an important step forward, developing a practical set of questions to assess short- and intermediate-term outcomes. Outcomes were identified through interviews with IAA providers and users and a small core of valid and reliable questions developed. Within this study, the administration of the pilot outcomes tool was tested through self-completion questionnaires, structured face-to-face interviews and telephone interviews. There are advantages and disadvantages to each of these approaches. However, given the diversity of IAA services and service users any further development of the tool will require a choice of administration.

The difficulties in recruiting users were fully discussed within the interim report (Windle et al., 2009) and further explored in *Measuring the outcomes of information and advice services: Final report* (Windle et al., 2010). For example, for the self-completion questionnaire a response rate of 32 per cent was achieved. While allowing for different modes of administration may encourage users to take part, there was anecdotal evidence that the IAA advisors felt that discussion of the research project sat uneasily with their roles.

In assessing how the development of the tool should be taken forward, there are four key areas which need to be addressed.

- Encouraging policy makers, commissioners and providers to recognise the importance of collecting outcomes data
- Incorporating data regularly collected by IAA services, such as activities and debt resolution, into the tool
- Developing the outcomes tool to include questions that infer long-term outcomes, such as changes in quality of life and financial stability
- The developed tool needs to be further tested with vulnerable and 'hard-to-reach' users

## 5. Early years education (EYE)

### Key points:

Analysis based on the Millennium Cohort Study, 2005/06 Foundation Stage Profile assessments and ratings from 2005-08 Ofsted inspections, shows that:

- Children who started early years education before the age of 3 had higher Foundation Stage Profile assessment scores than children who started at 3 or 4 years old
- Ofsted quality ratings were significantly correlated with other quality measures but the relationship was weak compared to the relationship between all the other quality measures
- Controlling for other factors, there was no significant relationship between any of these quality measures and outcomes as measured by the Foundation Stage Profile assessments
- Controlling for other factors, reported total costs did not vary significantly by sector

There have been changes since the study was carried out. With the introduction of the Early Years Foundation Stage in 2008, the quality of Foundation Stage Profile assessment scores has improved, as moderation became embedded, and Ofsted have introduced a new inspection framework with a clearer focus on the development and early learning of children.

This chapter summarises the final report on quality, outcomes and costs of early years education, produced by NIESR as part of the MOPSU project (Hopkin, Stokes and Wilkinson, 2010).

### 5.1 Overview of early years education work-strand

The aim of the early years education work-strand was to measure what benefits are produced by early years education services for those attending. There are a range of possible outcomes that result from a child's attendance at early years education services. The study focussed on outcomes for children and outcomes that accrue within a short time period. A range of child outcomes were considered covering cognitive, social and physical development. However, services also deliver wider outcomes including outcomes for parents, such as being able to gain employment.

Underpinning the aims of the MOPSU project is a goal to minimise the administrative burden on service providers. In the spirit of this goal we seek to exploit existing regularly collected measures of both the quality and outcomes of early years services and so have focussed particularly on quality of setting as measured by the Office for Standards in Education, Children's Services and Skills (Ofsted) and child outcomes as measured by the Foundation Stage Profile (FSP) assessments. As well as focusing on these regularly collected measures, we also investigated the relationships with less routinely collected quality and outcome measures that are widely accepted and used in research studies.

## **5.2 Data used to examine quality and outcomes in early years education**

### **5.2.1 Data sources**

#### **The Millennium Cohort Study**

The analysis is based on data collected as part of the Millennium Cohort Study (MCS). The MCS is the first new birth cohort study in the UK since 1970, and one of the largest studies of its kind. The Economic and Social Research Council (ESRC) funded study has been operating since 2000 and is following the lives of nearly 19,000 babies born between 2000 and 2002 in the UK. The first sweep collected data about the children and their families when the children were nine months old, the second sweep at three years old and the third sweep at five years old.

The MCS collects information on cognitive, social and physical development as well as background information about the families and children.

#### **The Quality of Childcare Settings sub-study**

This study also used data from the Quality of Childcare Settings sub-study from the MCS project (Mathers, Sylva and Joshi, 2007) which explored the quality of 301 childcare settings in England attended by 631 children participating in the MCS. These settings were visited between March and November 2005, and focused on provision for children aged between three and five. The 301 settings participating in the sub-study were visited by specialist researchers who collected data on the quality of the settings, using well-established and validated observational rating scales. Information on centre characteristics, such as sector, and number and qualifications of staff employed, were also collected, through interviews with centre managers.

## 5.2.2 Quality measures

Overall we had four key measures of quality of early years settings:

- Ofsted inspection results
- three out of seven sub-scales from the revised Early Childhood Environment Rating Scale (ECERS-R)
- all four sub-scales from the extended Early Childhood Environment Rating Scale (ECERS-E)
- scales from the Caregiver Interaction Scale (CIS)

### Ofsted inspections

Data from the 2005-2008 Ofsted inspection cycle were merged with data from the Quality of Childcare sub-study where possible<sup>33</sup>. In the 2005-2008 cycle, childcare settings were inspected on quality of care with judgements based solely on the 14 National Standards and where the childcare provider was eligible to deliver the free early education entitlement they were also inspected on quality of nursery education. Quality ratings of nursery education focused on the difference provision made to progress towards early learning goals in the six areas of learning and were based on the Curriculum guidance for the Foundation Stage.

The Quality of Childcare sub-study sample included a number of nursery education providers and primary schools. In 2005-08 inspections of nursery education providers included a rating for overall effectiveness of provision; inspections of primary schools included an assessment of the quality and standards in the Foundation Stage

Since 2005 judgements have been made on the same four-point scale from 'outstanding' to 'inadequate', see Table 5.1.

Table 5.1

#### Description of Ofsted ratings

| Rating       | Description  |
|--------------|--|
| Outstanding  | Exceptional settings that have excellent outcomes for children                           |
| Good         | Strong settings that are effective for children  |
| Satisfactory | Settings that have acceptable outcomes for children but which have scope for improvement |
| Inadequate   | Weak settings that have unacceptable outcomes for children                               |

Source: Ofsted (2006)

It is important to note here that Ofsted inspections have changed since the data used in this study were collected following legislative changes to

<sup>33</sup> We are very grateful to Ofsted and the Centre for Longitudinal Studies for their help in matching this data.

the Foundation Stage. There is now a stronger focus on outcomes for children and safeguarding<sup>34</sup>. This has implications for the interpretation of results as discussed in section 5.7 and chapter 7.

### The Early Childhood Environment Rating Scale (ECERS)

The ECERS has been used extensively as a quality measure in research and is also used in practice for the purpose of quality improvement. The original ECERS (Harms and Clifford, 1980) and the revised version, ECERS-R (Harms, Clifford and Cryer, 1998) were developed in the US but have been used in many countries, including the UK. ECERS is designed to evaluate the quality of settings providing for children between the ages of two and a half to five years. In the Quality of Childcare sub-study, three of the seven ECERS-R sub-scales<sup>35</sup> were used, namely:

- personal care routines
- language and reasoning
- interaction

The extension to ECERS (ECERS-E) was developed in the UK as part of the Effective Provision of Pre-school Education (EPPE) project (Sylva, Siraj-Blatchford and Taggart, 2003). Its development was intended to create a measure more appropriate for English settings with a greater focus on curricular aspects of provision. The Quality of Childcare sub-study collected all four ECERS-E sub-scales:

- literacy
- mathematics
- science
- diversity

As with ECERS-R we consider each sub-scale separately and also the overall ECERS-E score (the mean of the four sub-scales).

### The Caregiver Interaction Scale (CIS)

The CIS (Arnett, 1989), which evaluates the quality of interactions at a setting between children and those who care for them, was also collected in the Quality of Childcare sub-study. The analysis mainly considers the positive relationships sub-scale of CIS in line with previous literature relating CIS to outcomes.

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<sup>34</sup> For more information see the Ofsted website <http://www.ofsted.gov.uk>

<sup>35</sup> We consider separately the three sub-scales that are available to us and also combine these by calculating the mean value of the three sub-scales to form what might be thought of as a 'partial' ECERS-R score.

### 5.2.3 Outcome measures

The analysis focuses on 6 outcome measures:

- the FSP assessment
- three sub-scales of the British Ability Scales (BAS)
- a difficulties score from the Strengths and Difficulties Questionnaire (SDQ)
- a pro-social behaviour score from the (SDQ)

#### The Foundation Stage Profile (FSP)

2005/2006 FSP assessment data were collected for DCSF and have been merged with the detailed survey data from the Millennium Cohort Study (MCS). The Foundation Stage Curriculum, in place at the time of data collection, covered children's learning and development, and was a statutory requirement for all government-funded early years education for children aged 3 to 5.. The FSP assessments are completed by the end of their final foundation stage year, when the child is aged five. They are cumulative, teacher-assessed and consist of six areas of learning:

- personal, social and emotional development
- mathematical development
- communication, language and literacy
- creative development
- knowledge and understanding of the world
- physical development

The foundation stage encompassed education for pupils aged three to five: most commonly the first year being in a nursery setting and the second being in a reception class of school. The FSP assessment is completed at the end of a child's first year in school, hence we also control for the length of time a child had attended school at the time the FSP was completed (Hopkin, Stokes and Wilkinson, 2010).

The main advantages of the FSP assessment data are that they are collected annually, in England, and cover a range of aspects of development. Given the project intention of minimising the burden on service providers in terms of data collection, it is a crucial measure and the main focus of the analysis where the relationship between quality and outcomes is explored. However, the quality of FSP data is uncertain prior to 2008 because the moderation process had not been properly

established resulting in inconsistencies across settings. Analysis of FSP has suggested that since 2005 improvements in the way assessment and moderation have been conducted have contributed to a downturn in the percentage of children achieving the highest scores (DCSF, 2008).

In September 2008 the Early Years Foundation Stage replaced the Foundation Stage Curriculum, the National Standards for Day Care and the non statutory Birth to Three Matters. The EYFS covers both learning and development and children's welfare. It applies to all schools with nursery and reception aged children and to all Ofsted registered settings with children from birth to 5, regardless of their funded status. The EYFS was introduced to ensure that all children are provided with a high quality learning experience regardless of the type of setting they attend.

### [The British Ability Scales \(BAS\)](#)

Measures of cognitive development were also collected in the MCS using three sub-scales from the BAS. One of them, the BAS naming vocabulary sub-scale, where children are asked what a picture is of, was administered by interviewers to the members of the cohort during both the second and third sweep of data collection, when the children were aged three and aged five. It is the only measure of cognitive development for which we have a repeat measure. The other two sub-scales, where children are shown pictures and asked which go together (picture similarities), and are shown a pattern of coloured blocks and asked to copy (pattern construction), were administered only during the third sweep.

### [The Strengths and Difficulties Questionnaire \(SDQ\)](#)

Children's behavioural development was evaluated using the SDQ, developed by Goodman (1997). Main respondents (most often the child's mother) were asked to complete the SDQ as part of the self-completion module during the main MCS interview. It was included in both the second and third sweep of data collection when the children were aged three and aged five and is the only social/behavioural development measure for which we have repeat observations for children. Two SDQ scales are examined: a measure of pro-social behaviour and a total difficulties score based on four sub-scales (emotional symptoms, conduct problems, hyperactivity and peer problems).

## **5.3 Analysis and addressing the attribution problem**

### **5.3.1 Analysis**

The analysis of quality and outcomes in early years education is split into three parts. First, we consider how the measures of quality compare with each other. We recognise that different quality measures are measuring differing aspects of quality, for example Ofsted (2005-08) inspections go beyond assessing quality as they aimed to identify non-compliance with prescribed requirements for registration and were constrained by National Standards. However, we would still expect there to be a positive relationship between Ofsted quality ratings and other quality measures. The size of such correlations will help us to draw conclusions when we estimate the relationship between quality and outcomes.

Second, we develop models of the factors, other than setting quality, that impact on child outcomes, using a large dataset. A child's social, cognitive and physical development will be influenced by many factors other than provider quality, such as the home learning environment and family characteristics. It is important to include all of these factors in order to isolate that part of the outcome that is attributable to early years education services and to assess the influence of provider quality on outcomes (the attribution issue is discussed further in section 5.3.2). However, the sample of children for whom we have data on the quality of their provider is small, so we consider the influence of these other factors for a much bigger sample of children. This provides a benchmark against which we can assess the effect of these factors, and provider quality, on the smaller sample data, for which quality of provider is available.

Third, we then explore the relationship between quality of early years education settings and children's outcomes, with the aim of identifying whether higher quality settings are associated with better child outcomes, and, in particular, whether this can be seen from regularly collected measures of quality and outcomes. While quality and outcomes are not the same thing we might assume that high quality settings will confer the most benefit to users.

### 5.3.2 The attribution problem

Section 4.1.4 introduced the attribution problem, that is how to isolate the effect of public service use on outcomes, in this case in terms of social, cognitive and physical development, when other factors will have an effect, for example the home learning environment and parent characteristics.

To address this issue many factors were controlled for when examining the impact of early years education, and the quality of that education, on child outcomes. Included in these controls are measures of ability collected when children were aged three. For most of the outcomes measures, including the FSP, we only have a measure at a single point in

time, at age five. However, for the naming vocabulary assessment and the measures from the Strengths and Difficulties Questionnaire we do have repeat measures at age three and five. This gives us good estimates of change over time for children in these measures.

The MCS also includes assessment of children using the Bracken School Readiness Assessment at age three. Including this data with the other measures of child development at age three in the models for the outcomes where repeat measures are not available will at least allow some assessment of developmental changes over time.

A further attribution issue which needs to be addressed is the fact that the FSP assessment is completed at the end of a child's first year in school. To control for this we include in the models the length of time a child had attended school at the time the FSP was completed.

#### 5.4 The sample

For the analysis of outcomes of early years education we were able to include all those MCS children for whom complete FSP assessment data and all the outcome measures at sweep 3 were available. This provides a sample of 7,939 children. We compared the sample with the sample of all 9,717 MCS children living in England at the time of sweep 3 using a number of key characteristics and found no substantial differences between the two samples.

The benefit of the full MCS sample is its size but it lacks detailed data on service providers and in particular measures of quality. As such we turn to the Quality of Childcare sub-study sample for the analysis of relationships between different measures. Availability of quality and outcomes data meant that not all the Quality of Childcare sub-study settings could be included in the analysis. Ofsted nursery education ratings and quality of care ratings were available for 202 childcare settings, with overall effectiveness of provision ratings available for 18 nursery education providers and a rating of quality and standards in the Foundation Stage available for 35 primary schools, giving a sample of 255 providers<sup>36</sup>.

One option would have been to limit the analyses to only the children and settings for which all the measures were available. It was decided, however, to use the full data available for each particular analysis, and thus vary the sample size, in order to maximise the number of children in

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<sup>36</sup> It is worth noting here that the number of settings available for analysis from the Quality of Childcare sub-study project is considerably greater than the number of settings used in analysis in the EPPE project (141 settings).

the analysis<sup>37</sup>. More detailed information on sample sizes is available in Quality, Outcomes and Costs in Early Years Education (Hopkin, Stokes and Wilkinson, 2010).

## 5.5 Results

### 5.5.1 Comparison of quality measures

Before analysing the relationship between quality and outcomes it is helpful to understand the relationship between different quality measures. Whilst they will differ because they may be measuring different aspects of quality, some relationship between them would be expected. We first consider correlations between the mean scores of all the Quality of Childcare sub-study quality measures and the Ofsted inspection judgements. The results of these analyses are shown in Table 5.2.

Table 5.2  
**Correlations between quality measures**

|                                      | ECERS-E | ECERS-R | CIS positive relationships sub-scale | Ofsted Childcare | Ofsted Nursery Education |
|--------------------------------------|---------|---------|--------------------------------------|------------------|--------------------------|
| ECERS-E                              | 1.00    |         |                                      |                  |                          |
| ECERS-R                              | 0.64    | 1.00    |                                      |                  |                          |
| CIS positive relationships sub-scale | 0.55    | 0.69    | 1.00                                 |                  |                          |
| Ofsted Childcare                     | 0.26    | 0.19    | 0.17                                 | 1.00             |                          |
| Ofsted Nursery Education             | 0.24    | 0.14    | 0.15                                 | 0.82             | 1.00                     |

Source: Hopkin, Stokes and Wilkinson (2010)

All the quality measures were significantly<sup>38</sup> and positively correlated with each other. The correlation between the two ECERS measures is strong (0.64), as are the correlations of the CIS positive relationships subscale with both ECERS measures (0.55 and 0.69). However, while the correlations with Ofsted ratings are significant they are only weak. The largest correlation for the Ofsted ratings is with the ECERS-E measure, (0.26 for childcare and 0.24 for nursery education), which we might expect given that ECERS-E was designed with English settings in mind.

### 5.5.2 Outcomes of early years education

<sup>37</sup> In practice, restricting the analysis to the same consistent group of children makes little difference to our results.

<sup>38</sup> Throughout this report all findings reported as significant are significant at least at the 5% significance level

Many factors other than quality of early years setting will influence child outcomes. The MCS provides a rich source of data on many of these determinants of child outcomes, including those identified by previous research, which needed to be included in the analysis of the smaller Quality of Childcare sub-study sample. Given this, we first estimated models for the outcome measures using the full MCS sample in order to gauge the relative importance of these factors on the child outcome measures. The factors include child characteristics, such as gender and ethnicity, family characteristics, such as mother's qualifications and family socio-economic status and home learning environment, which was captured by whether the child had help with reading, writing and numbers at home.

The full MCS data does include some information about the settings that the children attended and we use this information to investigate the relationship between four key pieces of information (attendance at early years education, the type of setting, the age of the child when first attended and whether they attended full-time or part-time) and each of the child outcome measures. Only 7 per cent of the sample did not attend any early years education setting. 30 per cent started early years education prior to age two, 31 per cent at age two, 27 per cent at age three and only 3 per cent started at age four or above<sup>39</sup>.

Controlling for all the child and family characteristics discussed above, we found that there was no statistically significant difference between total FSP score for children who attended early years settings and children who did not. Statistically significant differences were found in terms of the age children started early years education. Compared to children who were aged three when they started early years education, children who started before their third birthday had a higher FSP score, by around 1.5 points on average. Children who started after their fourth birthday had a lower FSP score by three points on average. Type of setting had no significant impact on FSP score.

Similar analyses for other outcome measures found no impact of attending early years education. For BAS outcomes there were no significant differences in outcomes by age or type of setting but for the total difficulties and pro-social behaviour measures outcomes were better for those who started EYE between 36-48 months.

The evidence on the overall impact of attendance at early years education is in contrast to much of the previous evidence on child outcomes. In particular the Effective Provision of Pre-school Education (EPPE) project which found that attending pre-school had significant

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<sup>39</sup> For 2 per cent of the sample age started was not known.

benefits for children's development in English, mathematics and pro-social behaviour, using measures such as the BAS and a teacher completed questionnaire on children's social/behaviour development, and that these benefits largely persist at age eleven (Sylva et al., 2008).

Where attendance at early years education is nearly universal then it may not be surprising to find estimates that are not statistically significant because one of the groups concerned is relatively small. However, this is a large data set and even with just seven per cent of children not attending we have nearly 600 children not attending provision in the sample. When nearly all children attend provision then the positive effects previously observed may become diluted by children who do not greatly benefit from the provision but still attend because nearly all other children attended. Given that the results were in contrast to previous research we investigated whether there was a significant impact of attending early years education for any disadvantaged groups and found that for children from the lowest socio-economic groups there was a positive impact on total FSP score of roughly two points, but the impact was only statistically significant at the ten per cent level (Hopkin, Stokes and Wilkinson, 2010)

### 5.5.3 Comparing outcomes measures

The FSP is a key measure of child development. The correlations between the FSP areas of learning and the MCS outcome measures were calculated and these are shown in tables 5.3 and 5.4.

Table 5.3

**Correlations between FSP cognitive development area of learning and MCS measures**

|   | FSP- communication language and literacy | FSP- mathematical development | FSP- creative development | FSP- knowledge and understanding of the world | BAS- naming vocabulary | BAS- picture similarities | BAS- pattern construction |
|---|--|-------------------------------|---------------------------|---|------------------------|---------------------------|---------------------------|
| FSP- communication, language and literacy     | 1.00                                     |                               |                           |   |                        |                           |                           |
| FSP- mathematical development                 | 0.89                                     | 1.00                          |                           |   |                        |                           |                           |
| FSP- creative development                     | 0.71                                     | 0.67                          | 1.00                      |   |                        |                           |                           |
| FSP- knowledge and understanding of the world | 0.74                                     | 0.74                          | 0.69                      | 1.00  |                        |                           |                           |
| BAS- naming vocabulary                        | 0.42                                     | 0.41                          | 0.30                      | 0.35  | 1.00                   |                           |                           |
| BAS- picture similarities                     | 0.25                                     | 0.25                          | 0.19                      | 0.21  | 0.28                   | 1.00                      |                           |
| BAS- pattern construction                     | 0.34                                     | 0.35                          | 0.25                      | 0.26  | 0.34                   | 0.34                      | 1.00                      |

Source: Hopkin, Stokes and Wilkinson (2010)

Table 5.3

**Correlations between FSP social development area of learning and MCS measures**

|  | FSP – personal, social and emotional development | SDQ total difficulties | SDQ pro-social behaviour |
|--|--|------------------------|--------------------------|
| FSP – personal, social and emotional development | 1.00   |                        |                          |
| SDQ total difficulties                           | -0.33  | 1.00                   |                          |
| SDQ pro-social behaviour                         | 0.19   | -0.39                  | 1.00                     |

Source: Hopkin, Stokes and Wilkinson (2010)

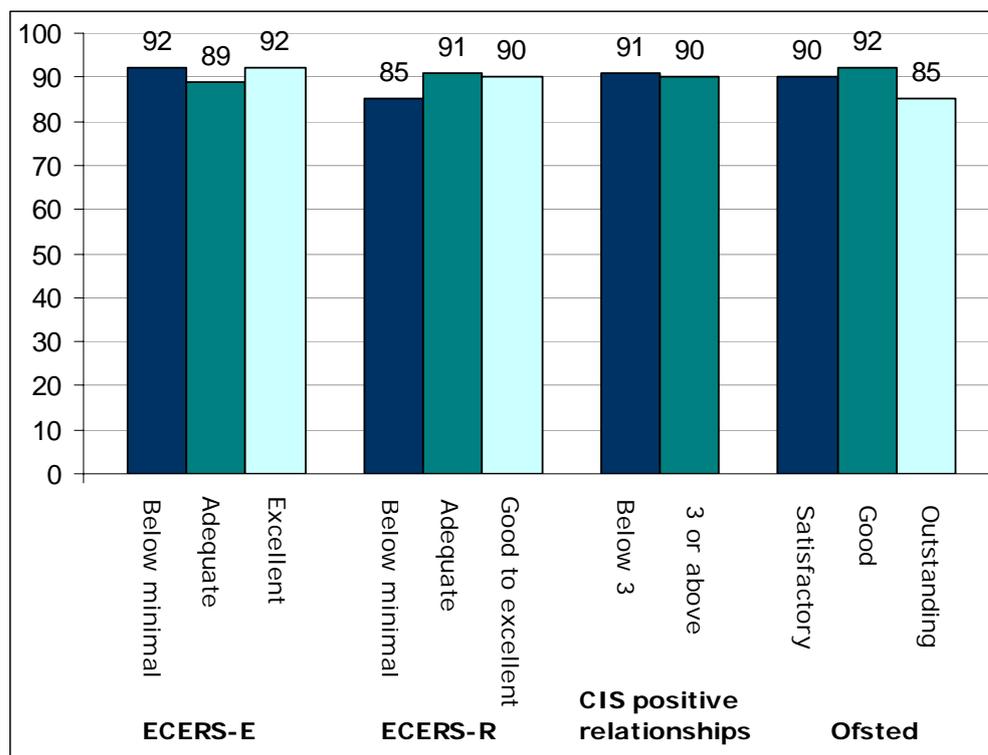
Overall correlations between FSP sub-scales were strong and correlations between different outcome measures were weaker. However, all correlations were significant and in the direction you would expect.

#### 5.5.4 Relationship between quality and outcomes in early years education

The main aim of this research was to examine the relationship between setting quality and outcomes for children, focussing on the routinely collected measures, that is, outcomes as measured by the FSP assessment and quality as measured by Ofsted inspections<sup>40</sup>. Figure 5.1 shows the average total FSP score by Ofsted and other quality ratings.

<sup>40</sup> Throughout this analysis we use the Ofsted nursery education rating for childcare settings and the overall ratings for nursery education providers and primary schools. For 166 of the 202 childcare settings, the ratings for the quality of care and for the quality of the nursery education were the same. Further, for 91 of the 202 childcare settings, the ratings for all inspection areas were the same and for a further 64 settings eight out of the ten ratings were the same. Given this, using the childcare rating makes no difference to the overall results.

Figure 5.1  
**Average total FSP score by quality rating<sup>41</sup>**  
 Mean



Source: Hopkin, Stokes and Wilkinson (2010)

As discussed previously, it is important to control for other factors which may impact on child outcomes, other than setting quality. To do so we used multivariate models<sup>42</sup> and included, in separate models, the above four quality measures, along with the child, family and other setting variables which initial analysis (reported in 5.5.2) suggested were important. This analysis showed that, when other factors were controlled for, none of the quality measures were statistically significant predictors of FSP score.

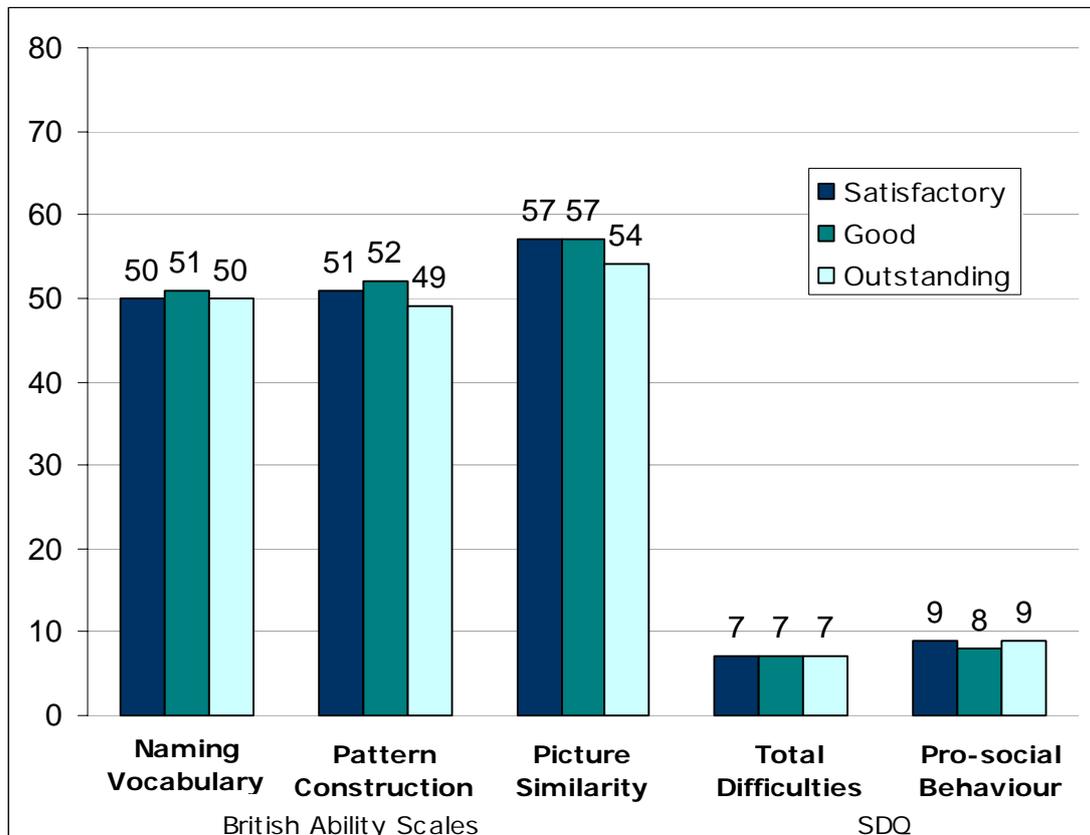
Again this analysis was repeated for the other outcome measures, figure 5.2 shows the MCS outcome measures by Ofsted rating. The relationship between ECERS-E and naming vocabulary was significant. Here children in settings rated as higher quality on the ECERS-E scale had higher average total BAS naming vocabulary scores. Looking at the ECERS-E sub-scales the Literacy sub-scale was, unsurprisingly, the only sub-scale with a significant association with naming vocabulary. ECERS-E sub-

<sup>41</sup> In the sample 6 children attended 3 settings rated as inadequate by Ofsted – results are not shown due to the small number of observations, although they are included in the models.

<sup>42</sup> We estimate clustered regression models for our outcome measures, with clusters for each setting because typically there is more than one child in each setting. The number of MCS children attending these settings varied from 1 to 16; 435 children (78 per cent) were attending settings also attended by other MCS children.

scales were also looked at in relation to the total difficulties and pro-social behaviour outcomes. The findings here were that, while the ECERS-E overall was not significant, the Mathematics sub-scale was significantly related to both measures. Children who attended higher quality settings as measured by the ECERS-E sub-scale scored lower on average on the total difficulties scale, with lower scores indicating better outcomes, and higher on average on the pro-social scale than those in lower quality settings.

Figure 5.2  
**Average outcome by Ofsted rating**  
 Mean



Source: Hopkin, Stokes and Wilkinson (2010)

More detailed analysis can be found in Hopkin, Stokes and Wilkinson (2010).

The EPPE study also found that quality, as measured by ECERS-E, was related to some, but not all, measures of outcome (Sylva et al., 2008).

### 5.6 Costs of early years education

The Quality of Childcare sub-study did not collect information on the costs of providing these services, so a value for money assessment for

the providers in the study cannot be carried out. Detailed analysis of the costs of providing early years services are rare and cost-benefit studies of early years services are relatively few in number and have tended to focus on interventions for children from disadvantaged backgrounds (Melhuish, 2004).

The term cost, along with related terms such as fees, income and expenditure, are often used in different ways depending upon the context and are sometimes even used interchangeably. For the purposes of this study we are concerned with the costs incurred by providers. Measuring the costs of early years services also poses numerous problems, particularly for voluntary sector organisations, which are most likely to be receiving some services in kind, such as free use of premises and volunteer staff (Campbell-Barr, 2009).

One study that collects information about the costs incurred by providers in delivering early years services is the Childcare and Early Years Providers Survey. The Childcare and Early Years Providers Survey is a large-scale study series that started in 1998, and has been carried out in 2001 and 2003, and annually from 2005. The most recent data available for this study were from the 2007 survey (Nicholson et al., 2008). The sample for analysis consisted of 1,634 providers. In terms of ownership, more than half were in the private sector (53%) and a third were in the voluntary sector (33%). The remainder were largely located in the maintained sector: either local authority owned (6%) or in a school or college (4%).

There is a considerable degree of non-response on costs questions in the survey. Providers who do not know their costs or choose not to provide the information are a problem for analysis of the data but this is not uncommon in large surveys asking for sensitive information. Overall, five per cent of providers chose not to give information on total outgoings and 39 per cent of providers reported that they did not know their total outgoings. The proportion of 'don't knows' is surprisingly high. It may be that this was a form of non-response to the costs questions, from providers who were not willing to spend time seeking out the information requested. Local authority, school or college owned providers were the most likely to report that they did not know their total outgoings (53 per cent) while voluntary sector providers were the least likely to report this, although even for these providers, 30 per cent reported not knowing total outgoings.

Looking at those who did respond<sup>43</sup> the mean and median total outgoings, per year per child, are £1,511 and £955 respectively. When other factors are taken into consideration, such as the size of provider, managers' qualifications and the proportion of children with special educational needs, we found no significant differences in total outgoings by sector. Wage costs were higher in the maintained sector than in the private and voluntary sectors whilst rental costs in the private sector were higher than in the voluntary and maintained sectors. We found no strong evidence that providers in different sectors have any large cost advantage in delivering early years services.

## 5.7 Conclusions

The main aim of the analysis was to see whether high quality settings deliver better outcomes for service users, particularly using regularly collected measures of quality and outcomes. We found no statistically significant relationship between quality, as measured by Ofsted, and outcomes, as measured by the FSP assessment. None of the Quality of Childcare sub-study measures of quality were significantly related to total FSP score and similarly Ofsted ratings did not predict any of the other outcome measures considered. However, there were significant relationships between the ECERS-E subscales and the naming vocabulary, pro-social behaviour and total difficulties outcomes. Here children who attended settings rated as higher quality had better outcomes.

We also found that all the quality measures were significantly correlated with each other but whereas the correlations between the ECERS and CIS measures were strong Ofsted ratings were only weakly correlated with other quality ratings.

Since the introduction of EYFS in 2008 the Ofsted inspection framework has changed and all providers are now subject to one inspection of the Early Years Foundation Stage – care and education are not separated out. All childcare providers who deliver the EYFS must now deliver the legal requirements relating to learning and development of children in their care. EYFS is now used as the basis of regulation of all providers of EYE or childcare (birth to five) and there is a stronger focus on outcomes for children and in particular their achievements and the progress they make in their learning and development in relation to their starting point<sup>44</sup>.

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<sup>43</sup> 20 settings reported a figure for total outgoings costs per child above £10,000 and we exclude these settings from our analysis.

<sup>44</sup> For more information see the Ofsted website <http://www.ofsted.gov.uk>

## 6. Outcomes of adult social care and early years education by sector

### Key points:

There was no significant difference in outcomes between care homes in different sectors. However, residents in voluntary sector care homes tended to have fewer needs.

There was no systematic difference in outcomes between early years providers in different sectors. But there were sector differences for some outcome measures.

Given the specific project focus on the third sector analysis was undertaken, where possible, to explore differences in quality and outcomes across sectors in both the adult social care and early years studies. This chapter presents key comparisons between the voluntary, private and public sectors.

### 6.1 Adult social care and the voluntary sector

In the work-strand studying adult social care services in care homes (see Chapter 4) service quality and outcomes were compared across sectors on the basis of the measures used in the study. Of the 83 care homes in the older adult sub-sample, 19 per cent were in the voluntary sector, 74 per cent in the private sector and 6 per cent were public sector providers. For care homes for younger adults with learning disabilities, the corresponding proportions were 36 per cent, 55 per cent and 6 per cent. The care homes study sample was not stratified by sector, but there is no reason to suppose it is not representative of the three sectors

Table 6.1 shows capacity to benefit, the maximum possible SCRQOL score minus the expected level in the absence of services, by the sector of the home. There was one significant difference between sectors: among homes for older adults, residents of voluntary homes had lower capacity to benefit than private and public homes for older adults, an average score of 0.67 compared with 0.75 for private sector homes and 0.81 for public sector homes. So the residents of voluntary sectors homes had higher levels of expected SCRQOL, that is lower levels of need. Among LD homes there were no significant differences between capacity to benefit by sector.

Table 6.1  
**Mean capacity to benefit scores by sector of home**

|   | <b>Voluntary</b> | <b>Private</b> | <b>Public (LA/NHS/other)</b> |
|---|------------------|----------------|------------------------------|
| Older adults                              | 0.67             | 0.75           | 0.81                         |
| Younger adults with learning disabilities | 0.72             | 0.71           | 0.76                         |
| All                                       | 0.70             | 0.74           | 0.78                         |

Source: Netten et al., (2010)

We might expect that voluntary sector homes, having a common uniting purpose, might be able to draw on additional input and support from relatives, surrounding communities, volunteers or others. This might explain the lower levels of residents' capacity to benefit from the services that were found for the voluntary sector in OA homes. It may also be that, if these homes fit with people's beliefs or are seen as particularly trustworthy or expert, people are prepared to move into the homes at an earlier stage than they would be otherwise – again resulting in voluntary sector homes catering for a less dependent population, and thus with lower capacity for benefit. In neither instance should this be seen as the homes providing less valuable services.

In Chapter 4 we calculated for care homes a measure of outcome or gain in SCRQOL by looking at the difference between the current and expected SCRQOL . Table 6.2 presents these figures by sector. Controlling for other factors which may be associated with outcomes, there were no significant differences in outcomes between sectors.

Table 6.2  
**Mean current and expected SCRQOL and outcome, by sector**

|  | <b>Voluntary</b> | <b>Private</b> | <b>Public (LA/NHS/other)</b> |
|--|------------------|----------------|------------------------------|
| <b>Older adults</b>                              |                  |                |                              |
| Expected SCRQOL                                  | 0.33             | 0.25           | 0.19                         |
| Current SCRQOL                                   | 0.87             | 0.82           | 0.82                         |
| Outcome  | 0.54             | 0.57           | 0.63                         |
| <b>Younger adults with learning disabilities</b> |                  |                |                              |
| Expected SCRQOL                                  | 0.28             | 0.29           | 0.24                         |
| Current SCRQOL                                   | 0.85             | 0.82           | 0.86                         |
| Outcome  | 0.57             | 0.53           | 0.62                         |
| <b>Total sample</b>                              |                  |                |                              |
| Expected SCRQOL                                  | 0.30             | 0.26           | 0.22                         |
| Current SCRQOL                                   | 0.86             | 0.82           | 0.83                         |
| Outcome  | 0.56             | 0.56           | 0.61                         |

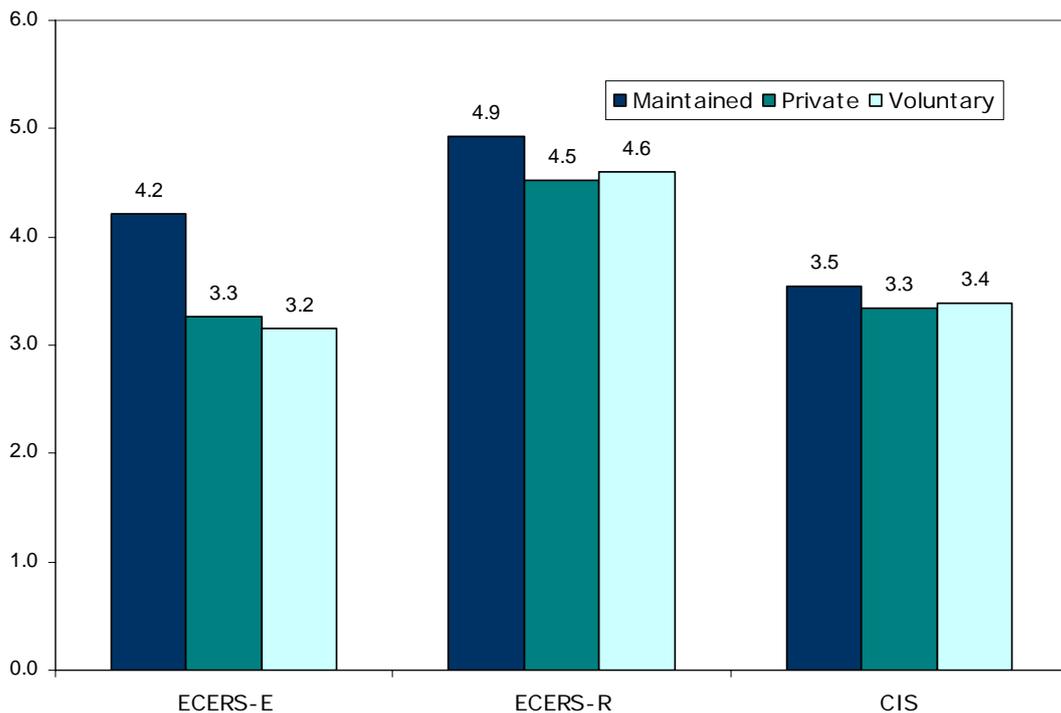
Source: Netten et al., (2010)

## 6.2 Early years' education services and the voluntary sector

In the work-strand studying early years education services (see Chapter 5) information was available about the sector of the early years service providers (maintained, private, voluntary) so it was possible to compare service quality and outcomes across sectors, on the basis of the measures used in the study. Of the 255 early years settings included in the MCS Quality of Childcare sub-study analysis, 52 were in the maintained sector, 57 were voluntary sector providers and 146 were private sector providers. It was not stratified by sector, but there is no reason to suppose it is not representative of the three sectors.

Figure 6.1 compares the quality of the early years education service by sector based on three of the QCS measures of service quality used in the study.

Figure 6.1  
**Average quality rating by sector**  
Mean



Source: NCVO (2010a)

This shows that the quality of the service as measured by ECERS-E was higher for providers in the maintained sector than for providers in the voluntary and private sector, an average score of 4.2 compared with 3.2 and 3.3 respectively. For the other two quality measures, ECERS-R and CIS, the variation was less clear: the differences between scores in the maintained and voluntary sectors were not statistically significant, but

the scores for the private sector were significantly lower than for the maintained sector.

On all three measures of service quality, there was no significant difference between voluntary and private sector providers. There was similarly little difference between voluntary and private sector providers in quality as measured by Ofsted ratings; compared with both of them the maintained sector had higher percentage of 'Outstanding' settings and a lower percentage of 'Satisfactory' settings, see Table 6.3.

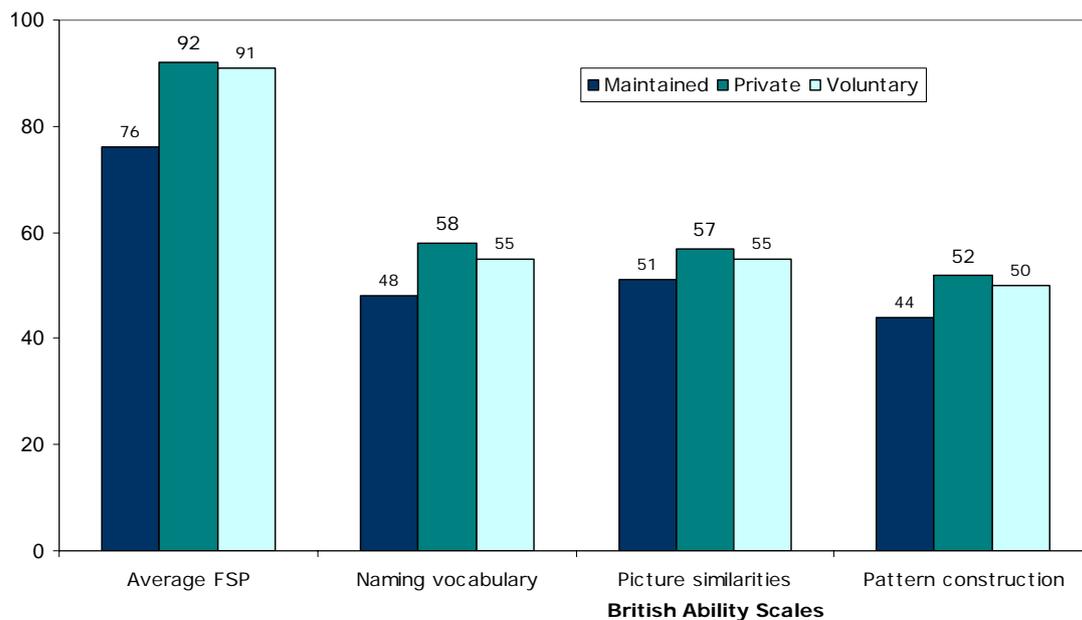
Table 6.3  
**Percentage of settings with different Ofsted ratings, by sector**  
 Percentages

|            | <b>Outstanding</b> | <b>Good</b> | <b>Satisfactory</b> | <b>Inadequate</b> |
|------------|--------------------|-------------|---------------------|-------------------|
| Maintained | 32                 | 51          | 17                  | 0                 |
| Private    | 5                  | 67          | 26                  | 1                 |
| Voluntary  | 7                  | 64          | 25                  | 3                 |

Sources: NCVO (2010a)

Figure 6.2 compares outcomes of early years education by sector, using the Foundation Stage Profile (FSP), and three sub-scales of the British Ability Scales. Controlling for other factors, there was no significant relationship between sector and FSP assessment scores. The maintained sector did significantly better than the private sector when looking at naming vocabulary outcomes.

Figure 6.2  
**Average FSP and BAS outcomes by sector**  
 Mean



Source: NCVO (2010a)

Looking at the two measures from SDQ there was no significant differences between sector when looking at total difficulties but children in maintained sector settings had significant worse scores on the pro-social behaviour score than those in private sector settings (Hopkin, Stokes and Wilkinson, 2010).

## 7. Benefits of the MOPSU project

This chapter reports on a number of benefits which can be realised as a result of the MOPSU project, addressing the drivers behind the project as set out in chapter 2.

### 7.1 The Adult Social Care Outcomes Toolkit (ASCOT)

A major benefit resulting from this project is the development of the new toolkit (ASCOT) which will be available on-line and will allow those in the adult social care field to measure and monitor the outcomes of social care services from a user's perspective. The toolkit was tested in day care centres and care homes; however, it was developed to be applicable across services and client groups. It could be used in a variety of settings, including in the service users own home to measure the outcomes of home care. The mixed modes of administration, self-completion questionnaire, face-to-face interviews and observation, will allow outcomes data to be collected across the spectrum of adult social care users, from those with relatively low level needs, for example those who have difficulty doing their shopping and cooking meals, to those with high level needs, such as people with dementia.

The population preference study offers a unique insight into the priorities and preferences of the general public, in terms of the aspects of social care which they consider most important.

There are a number of applications of the ASCOT and the outcomes data it generates.

- It can be used to inform cost-effectiveness and value for money
- It can aid outcomes-based commissioning by allowing commissioners to measure outcomes
- It can be used by the regulators and commissioners to monitor service performance in addition to current process led quality ratings
- It can be used by providers to demonstrate their outcomes and to help them improve services over time
- The data could be used, in the future, to adjust adult social care for quality in the ONS work on measuring government output and productivity

#### 7.1.1 Cost-effectiveness and value for money

Being able to measure the value of services in terms of the impact they have on service users enables us to explore issues of value for money and cost-effectiveness. If the toolkit is utilised, and outcomes data

collected on a regular basis, this information could help inform government policy. This fits with the new quality framework, set out by DH in Building the National Care Service: White Paper" (DH, 2010), which states that the framework "is about how we make sure that people are safe, and are treated with compassion, respect and dignity; it is about driving up the effectiveness of care" (DH, 2010:pg). If sufficient ASCOT data were collected we could begin to answer questions such as whether care homes provide value for money, given the level of need in the population served, compared to alternative social care services such as home care.

To calculate cost-effectiveness we can take, for each service or provider, the ratio of costs to benefits measured as outcomes. Reporting this in the standard format of the annual cost of day care required to produce an outcome improvement from 0 to 1 on the ASCOT scale. These cost-effectiveness ratios could be compared with each other. Generally speaking if the increase in quality of life from service use (per pound of expenditure) is greater for one service than for the best alternative, then more funding should be devoted to the service and less to the alternative. If social services authorities adopt a cost-effectiveness rule of this nature, then this is likely to change the balance of services that are funded. An outcomes-based cost-effectiveness rule, for example, will have different implications than a purely needs-based rule.

Alternatively the cost-effectiveness of a particular service could be compared to some pre-determined cut off point, based on how much policy makers and society are prepared to pay per extra ASCOT outcome. For health services the National Institute of Clinical Excellence (NICE) operates with a guideline figure of £30,000 i.e. the global willingness to pay for an increase in one person's health-related outcomes for a year from being in full health compared to dead (QALY) is £30,000 per year. Cost-effectiveness was calculated as part of the day care study with a figure of £24,770 per year being obtained. The point estimate is below the NICE threshold, although this is subject to some uncertainty. PSSRU calculated that there is a 92 per cent probability that day care is cost-effective at a £30,000 per ASCOT threshold (Caiels et al., 2010).

### 7.1.2 Outcomes-based commissioning, regulation and provision

Given the move towards outcomes-based commissioning of services it is important that commissioners can assess outcomes in a consistent manner. The new toolkit will enable commissioners to commission on the basis of outcomes, enabling them to define and measure the outcomes they wish to obtain from a specific contract. This may also help broaden the market by reducing barriers to entry that exist addressing the concern for the Voluntary sector Commissioning Task Force that the lack

of focus on outcomes presents a barrier to voluntary sector organisations wishing to tender for public service delivery contracts.

The gains from outcome measurement come from being able to commission services for the range of potential users in a configuration that best achieves desired objectives, such as improved quality of life, at an appropriate level of spend.

Providers are increasingly wishing to assess and demonstrate their outcomes for their own purposes, to inform service improvement, and when bidding for contracts to deliver social care services.

While there is a relationship between the regulator's quality ratings and outcomes, lack of much explanatory power for individual level outcomes is a drawback when it comes to basing commissioning decisions on the current ratings. The ASCOT approach could be used by the regulator to evaluate services, in terms of the impact they have on their users, their outcome, as part of the regulatory process. CQC are currently reviewing their quality ratings and the release of ASCOT is timely. Their strategy for 2010-2015 (CQC, 2010) highlights improved outcomes for people using services as one of six dimension of high quality care. CQC are working with PSSRU to see how the tools developed and experience gained through the MOPSU project can help inform the development of their inspection process and quality ratings.

### 7.1.3 UKCeMGA

Adult social care is currently measured in the National Accounts using a cost-weighted activity index which weights together growth in activity (e.g. hours of home care) by share of local government expenditure. The limitations of this approach are that:

- a measure based on activity fails to take into consideration 'intensity of need' for different clients
- no consideration is taken of the quality of care provided
- welfare of clients is also affected by unpaid carers e.g. friends and family and similarly there is a need to consider the impact of adult social care on carers

Outcomes data generated by ASCOT could be used in UKCeMGA's measurement of government output and productivity to improve the current measure by adjusting output in a way that takes into account not only the quality of the service provided but the level of needs in the population served. This is discussed further in *Quality adjusting adult social care output and productivity* (ONS, 2010).

#### 7.1.4 Future work

For the Outcomes of Social Care for Adults (OSCA) project PSSRU are building on the ASCOT to generate a gold standard preference-weighted measure of social care outcomes that can be used in a variety of circumstances. OSCA is funded by DH and its objectives are to:

- develop a measure of social care outcomes that captures all relevant domains and has credibility in the social care community
- test a variety of approaches to establishing preferences for methodological soundness and practical application with the general population
- conduct a large-scale population preference study
- develop a set of weights for calculating social care and weighting measures of social care output
- explore how service user views differ from the general population and establish alternative preference weights if appropriate
- identify what affects preferences among the general population and service users

As part of the OSCA project PSSRU are using ASCOT to assess outcomes of home care. This project is scheduled to finish in January 2011.

In April 2010, the Information Centre for Health and Social Care piloted a new national adult social care User Experience Survey. The questions in the survey have been based on the ASCOT. The pilot is testing the methodology and the questionnaire with the aim of carrying out the survey in early 2011. The experience of assessing outcomes in care homes that PSSRU developed during the MOPSU project are being used to assess the feasibility of extending the User Experience Survey to care home residents, who have previously been excluded.

#### 7.2 Measuring quality and outcomes in early years education

The early years education work-strand raises questions about the weak relationships between various quality and outcomes measures. The work highlights the importance of establishing what information is required, by parents, providers, local authorities and others, to help make decisions, about which early years setting to choose for their children or which providers are providing the best value for money, and how this information can be obtained.

It is promising that Ofsted have begun to focus more on outcomes for children and in terms of their achievements and progress in relation to the Early Years Foundation Stage and it would be interesting to re-

examine the relationship between quality and outcomes once the new framework is fully embedded.

### 7.3 Better data on the funding relationship between the government and the voluntary sector

#### 7.3.1 Improvements and issues with voluntary sector data

A number of developments in the quality of information on the funding relationship between government and the voluntary sector have been made through the completion of the project. However, there is still much improvement required. This is partly because, as mentioned earlier, the improved information is available only as a one-off exercise when the information is actually needed on a regular and systematic basis. The other problem is that the data inputs still need improving, despite recommendations from influential reviews and reports such as *Working with the Third Sector* (NAO, 2005). The NAO report recommended strengthening national and local data on the amounts of public sector funding going to the sector, by funders introducing systems to clearly distinguish payments to third sector organisations from other spending. There are three particular challenges:

- Despite the NAO report recommendations, it is still very difficult at program level to get detailed spending information from government departments
- It is difficult to reconcile the estimates from different sources, for example estimates of government income from third sector data and estimates of funding to the sector from government data, as mentioned earlier. Estimates of central government expenditure, collected by the Cabinet Office, are still hampered by differences in record keeping between departments and remain difficult to reconcile with data supplied by recipients
- The accounting and reporting framework for Charities does not mandate organisations to report on income received from public bodies for the delivery of services

#### 7.3.2 Voluntary sector organisation on the Inter-Departmental Business Register (IDBR)

As part of the MOPUSU project NCVO have undertaken a feasibility study to systematically explore the classification and coverage of voluntary sector organisation within the IDBR. The aim of the study was to explore whether a general method for adding a voluntary sector marker to the IDBR could be developed and to help classify bodies correctly to the charitable sector on the ONS IDBR database.

Another benefit of improving the classification of voluntary sector organisations in the IDBR is that it could help improve the measures of NPISH in the national accounts. Improving NPISH would also have a knock-on effect on the work of UKCeMGA who are required to deliver data on expenditure on healthcare in the UK to OECD for the OECD compendium publication “Health Data”. These data include all health expenditure including expenditure by the private sector, households and the voluntary sector. Estimates of healthcare expenditure by NPISH are based on a DH commissioned research paper published in 2006 that included data sampled from Guidstar and the IDBR (IFF, 2007). Improvements to the IDBR will help improve these health expenditure estimates in the future.

### 7.3.3 Future work

In this section we consider what needs to happen now to address the issues raised above, using the experience gained on the project to recommend how best to improve information about public services and the third sector. Box 7.1 sets out the key recommendations for NCVO and ONS to improve third sector data.

#### **Box 7.1 Recommendations for improving third sector data**

Improve representation of voluntary organisations in key sampling frames such as the IDBR, through:

- better recognition (‘flagging’) of the voluntary organisations already included
- the addition of organisations currently ‘missed’
- the addition of information about the sub-sector and type of organisation

Review and improve the way in which third sector activity is measured in National Accounts, particularly NPISH expand

Audit available data on the third Sector, with aim of identifying key gaps, limitations and inconsistencies and how to address these

Regularly publish in future years of the NCVO Almanac some of the additional information provide by the project – those that do not currently require special one-off work.

Further improve the classification of non-profit organisations and the consistency of classifications used, through more work comparing the different methods of classification, such as the International Classification of Non-Profit Organisations (ICNPO) and the Standard Industrial Classification (SIC).

## 8. Extending MOPSU principles to other public services

This chapter summarises the report *Extending the MOPSU principles to other public services* (Dobbs, Clark, Spence and Sheild-Johansson, 2010) which discusses how the MOPSU approach can be extended to other public services.

There is an increasing desire and need to measure service outcomes across many types of public services and ideally to develop measures that are not particular to one service but can be used or adapted across a range of different services, allowing for comparison. For the MOPSU project we limited focus to two particular public services, adult social care and early years education. However, for many other public services exactly the same issues apply – the need to measure quality and outcomes to help assess true value for money and improve services.

It is therefore hoped that the MOPSU approach can be extended to other types of public services, with further development. Such further development is beyond the scope of the project. The knowledge and experience accumulated during the project, however, is a useful starting point for further measures to be developed. We have used the term 'extendibility' for this work and this chapter sets out the principles and how they could be extended.

In summarising the MOPSU approach we have identified five principles on which it is based:

- the service outcomes and their limits are clearly defined
- the outcomes are based on the experience of service users
- the aim is to isolate and measure the outcomes that can be attributed to the service, and to exclude the impact of other factors outside the service
- the service outcome is divided into a number of different domains, and an overall outcome measure is obtained by adding together the domain scores, weighted by the relative importance of the domains in the view of service users or the general population.
- the outcome measures are as low burden as possible, ideally by carrying out a special study relating the detailed outcome measures to simpler and more routinely-collected indicators

For anyone wishing to extend the principles to other service areas the extendibility report provides further guidance including a set of criteria that provide a means of making an initial assessment of whether the MOPSU approach might be extended to a particular service and examples of two services which illustrate more fully the nature of the criteria and

provide a guide for others making such assessments in the future as to how they are applied. The two services, hospices and offender management, were selected to illustrate different aspects and challenges.

The criteria are grouped under three key headings.

- Whether accepted data/measures already exist
- Policy, statistical and stakeholder needs
- Involvement of voluntary sector/market

The guidance is aimed at those who are grappling with outcome measurement for a particular service – they may be policymakers or they may be commissioners, providers or regulators of public services. When drawing up methods for measuring outcomes, or revising existing methods which have been found inadequate, the first step is often to look at what other measures are available, to see whether they can be applied to that particular service. It is usually easier and cheaper to adapt an existing measure rather than design a new one from scratch, and it also generally provides some guarantee of success, providing the measure being adapted is based on robust development and testing and/or has been shown to work well on another service.

We hope that the MOPSU extendibility guidance will help those looking at outcome measurement for a particular service to judge whether the MOPSU approach might be applicable to their service area.

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