Disability-relevance of quality assurance systems in social services

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Serge Ebersold
Laurène Le Cozanet

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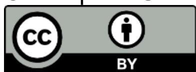

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1 Executive summary

1.1 Definition and framework of the quality of personal social services

Several national documents, which are binding to varying degrees, address the issue of quality of social services including services specifically aimed at people with disabilities and services aimed at different groups of users. However, there is no comprehensive definition of what constitutes quality in social services.

Two sets of documents provide a framework for the assessment of the two main categories of organisation that may provide services to people with disabilities. A distinction must indeed be made between, on the one hand, personal support services, on which a 2014 report noted a lack of evaluation, and for which a whole world of certification has recently been developed, and, on the other hand, social and healthcare settings and services (*Établissement ou Service Social ou Médico-Social*, ESSMSs). Both these sectors are subject to regulations that have evolved over time, setting out the national evaluation procedure and the certification obligation.

The documents that provide guidelines for these procedures – from the National Authority for Health *(Haute Autorité de santé)* for ESSMSs and from the Ministry of Economy and Finance for personal support services – seem to be broadly in line with the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) and the voluntary European Quality Framework for Social Services, although these documents are not central references. There are also certification systems, some of which are validated and made mandatory by public authorities or proposed by associations, and some of which officially claim to be based on the CRPD and the European Quality Framework.

The literature on the evaluation of the quality of personal support services is dominated by practical guides and management research, but also includes a significant component oriented towards a critique of evaluation, mainly from practitioners, but also academics. These authors focus on the problems of evaluation as a measure of performance, particularly in the care sector, which is difficult to objectify.

1.2 Evaluation of the quality of social services

Regarding the main weaknesses of quality assurance in France, it should be noted, firstly, that there is still a strong separation (in the framework texts, in the literature and in practice), between mainstream services and the disability services sector. Disability seems to be little considered in the evaluation of services not officially oriented towards people with disabilities. There is also a general lack of user participation in the definition of quality and its evaluation – including in the design of reference frameworks. Finally, if there is one objective that is not sufficiently pursued to meet people’s needs, it is the accessibility of the ordinary environment.

As already noted, the UN CRPD is not a central reference for the national evaluation procedure: rather, references are made to an array of texts and recommendations which are in line with the French legislation from 2005.[1] However, the principles that underpin this procedure and that are mentioned in the relevant texts and recommendations correspond fairly well to the principles of the CRPD. Self-determination and the centrality of the person being supported are displayed and assumed objectives. But the discrepancy between discourse and practice can be questioned. Although the Reference Framework for the ESSMSs (its implementation being too recent to evaluate) does indeed set out objectives in line with the CRPD, several critics point out the obstacles to the effective implementation of the objectives, in particular the lack of financial and human resources, in a sector that has been in crisis for several years.

As for the European Quality Framework, although the CRPD does not appear to be a central reference, its principles are indeed claimed in texts such as the National Authority for Health Reference Framework, and in the certification frameworks of associations such as Handéo, an associative body managed by managers of social services organisations. However, there are several indications that there is a significant gap between the standards and the conditions under which they can be respected in practice. One of the most problematic points appears to be the lack of focus on accessibility issues, including universal design of social services: there are many indications that people with disabilities have still considerable difficulties accessing dedicated and mainstream services.

1.3 Impact of quality assurance mechanisms

As the evaluation procedure for ESSMSs has recently been reformed, no impact assessment has been conducted at this time. A report by the General Inspectorate of Social Affairs stated that the previous procedure made it possible to improve the quality of services, while regretting that there was ‘no satisfactory instrument for measuring quality’.[2] In the case of personal assistance services, the observation is rather that there is a general lack of quality assessment, which makes it difficult to comment on its impact.

1.4 Recommendations for France

Developing piloting tools aligned with the UN principles in the elaboration and implementation of quality frameworks for social services.

Reducing the separation between mainstream and disability-specific sectors.

Taking into account workplace realities in the performance of quality assessments.

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1 Law No. 2005-102 of 11 February 2005 for equal rights and opportunities, participation and citizenship of people with disabilities, https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000000809647/.

2 Hesse, C., and Leconte, T. (2017), ‘The internal and external evaluation system of ESSMS’, Inspection générale des affaires sociales (IGAS) (General Inspectorate of Social Affairs), https://www.igas.gouv.fr/IMG/pdf/Rapport_2016-113R_.pdf.

1.5 Recommendations to the European Commission

Supporting upskilling and reskilling processes in the social and healthcare services sector.

Encouraging the financing of projects that support systemic transformation of services towards quality coherently with UN CRPD principles instead of focusing solely on evaluation procedures.

Discouraging segregation between disability-specific services and mainstream services when monitoring policy developments in the sector of personal support services across the Member States.

2 Conceptualising quality of essential services provided directly to the person: framework, definition, and research in the Member States

A distinction must be made between two types of service providers: providers of social and healthcare services (ESSMSs) and providers of personal support services (SAP).

ESSMSs are defined by the Code of Social Action and Families – to which they are subject – as establishments and services responsible for providing support and care to 'fragile' populations in situations of precariousness, exclusion, disability or dependence (children, elderly people, people in difficulty, people with chronic pathologies, families in distress or fragile situations, etc.). Their activities may concern prevention, reception (emergency or not, with or without accommodation, medical or not), adapted education, social support, help through work, readaptation and professional rehabilitation, assistance at home (for daily living, care services or help with social integration), social and healthcare support in an open environment, help with social integration, screening, other help, support, training or information, advice, expertise or coordination, protection, etc.

Thus, among the ESSMSs aimed at meeting the needs of adults and children with disabilities, we can distinguish:

- organisations for prevention, screening and early support;
- organisations providing support in an ordinary living environment; and
- support services within institutions.

As for personal support services (SAP in French), their scope includes a heterogeneous set of 26 activities, which can be grouped into three main categories: services for daily living (housekeeping, gardening, etc.); assistance and support services for the elderly or dependent persons; services for families (home childcare, school support, etc.).[3] Home care services (provided by nurses or care assistants) fall under the social and healthcare sector. Service providers can provide the service directly to the beneficiary or go between other services (i.e. looking for workers on behalf of the beneficiary).

ESSMSs and SAPs are sometimes difficult to distinguish, as they pursue similar objectives. However, they are not subject to the same regulations. ESSMSs come under the Code of Social Action and Families, and are supervised by departmental councils, while personal support services are subject to the Labour Code and are supervised by the Ministry of Economy and Finance.

Since 2016, policies and strategies have aimed to orient the social and healthcare sector towards personalisation and inclusiveness.[4] The latest strategy for 2017-2021 aims to support the quantitative development of the offer, but also to encourage its transformation in favour of adequacy of responses, continuity of trajectories,

[3] Law No. 2005-841 of 26 July 2005 on the development of personal support services and various measures in favour of social cohesion, https://www.legifrance.gouv.fr/loda/id/JORFTEXT000000632799/.

[4] Five-year strategy for the development of the social and healthcare services offer (2017-2021), which still frames policies in the social and healthcare sector. See https://handicap.gouv.fr/bilan-de-la-strategie-quinquennale-devolution-de-loffre-medico-sociale-2017-2021.

inclusiveness, greater territorial integration of support and an improvement in its quality. One of the key concepts of this strategy is the shift from an institution or place-based approach to a life course-based approach. However, the sector is still characterised by a very high level of administrative and organisational complexity, which impedes appropriate evaluation of quality.

2.1 Definitions and frameworks

The quality of services is very frequently invoked in political discourse and reference documents. However, it is never precisely defined, either in general or specifically for people with disabilities. The observation of a former Inspector General of Social Affairs in 2016 still seems to be relevant: '"Quality" itself is never defined, despite the frequency of this term and the formula "continuous improvement of the quality of activities and services provided'.[5]

The two main national sources of guidance for the quality of services in France are the Reference Framework for the Evaluation of the Quality of ESSMSs[6] and the National Quality Charter for Personal Support Services.[7]

1. Reference Framework for Social and Healthcare Settings and Services (ESSMSs)

Firstly, it should be noted that any creation of an ESSMS is in response to (local) calls for projects. These include requirements relating to the quality of support, which generally refer to the Recommendations of Good Professional Practice issued by the National Authority for Health and, previously, the National Agency for the Evaluation and Quality of Social and Healthcare Settings and Services (which became part of the National Authority for Health in 2018), as well as requirements regarding specific governmental instructions, depending on the plan (e.g. for autism).

The current evaluation procedure is based on a Reference Framework for the evaluation of the quality of social and healthcare settings and services, which has been converted into a handbook intended for the evaluating bodies. These two documents were approved in 2022, following a reform of the evaluation procedure initiated in 2019 (see below). Although they do not define the quality of services, the introduction to the Reference Framework sets out the objectives assigned to the evaluation system: 'to enable the person to be an actor in his or her own life', 'to strengthen the quality dynamic within settings and services' and 'to promote an approach that is meaningful for the ESSMSs and their employees'. Four 'fundamental values' underpin the Framework: 'the person's power to act', 'respect for fundamental rights', 'an inclusive approach to support' and 'ethical reflection by social and healthcare workers'.

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[5] Marquis, M. (2016), 'Evaluation, between control and attention', *Le portique. Revue de philosophie et de sciences humaines*, http://journals.openedition.org/leportique/2870.

[6] See: https://www.has-sante.fr/upload/docs/application/pdf/2022-03/referentiel_devaluation_de_la_qualite_essms.pdf.

[7] See: https://www.entreprises.gouv.fr/files/files/directions_services/services-a-la-personne/qualite/guide_utilisation_cnq.pdf.

The UN CRPD is one of the many references in the document, but the main references remain French texts (laws, specific action plans and good practice recommendation). This corroborates observations made by researchers that the Law of 11 February 2005[8] has 'tended to overshadow the scope of the UN Convention on the Rights of Persons with Disabilities in France. … Its influence on French disability policy has remained very limited until recent years, when it has been increasingly mobilised by associations and experts in the sector'.[9]

However, principles similar to those of the CRPD, in particular the objective of promoting a person-centred approach putting the person at the centre and fostering self-determination, are emphasised in the national policy guidelines and have been largely taken up in the recent reform of the evaluation of the ESSMSs. The situation of people with disabilities was clearly taken into account in the development of the Reference Framework, alongside many other conditions, in accordance with the broad scope of intervention of the ESSMSs.

2. National Quality Charter for Personal Support Services (SAP)

Regarding personal support services, it should first be noted that service providers are subject to a wide variety of regimes, which can only be outlined here. They must be registered in order to benefit, and to allow their clients to benefit, from the tax and social benefits specific to the sector. Next, in order to carry out certain service activities (with so-called vulnerable groups, in particular people with disabilities, for activities such as the care of children with disabilities, as well as assistance with daily activities, driving a personal vehicle and accompaniment outside the home as an agent), the service providers must obtain a licence issued by the state and, in order to do so, they must comply with the licence specifications. These specifications require that the provider 'carries out internal checks at least once a year on the application of the specifications, which can be achieved by adhering to the National Quality Charter' and 'carries out a survey at least once a year among clients on their perception of the quality of the service provided.'[10] Finally, since 2015, activities carried out for older persons, persons with disabilities or those suffering from chronic pathologies fall under the regime of the authorisation issued by the departmental councils (assistance with daily living activities, help with social integration, driving a personal vehicle and assistance with travel outside the home as a service provider).

The National Quality Charter for Personal Support Services, which was initiated by work with actors in the personal support services sector and is now the responsibility of the General Directorate for Enterprises of the Ministry of Economy and Finance, is presented as 'a tool to support organisations to progress in the quality approach'.[11] It is based on the principle of voluntary and free membership for registered and approved organisations, and has become mandatory since July 2016 for authorised

[8] Law No. 2005-102 of 11 February 2005 for equal rights and opportunities, participation and citizenship of people with disabilities, https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000000809647/.

[9] Revillard, A. (2022), 'A study to assess disability policy in France: uncertain effects', *Servir*, 2022/6, pp. 48-50, https://www.cairn.info/revue-servir-2022-6-page-48.htm.

[10] Order of 1 October 2018 laying down the specifications provided for in Article R. 7232-6 of the Labour Code, https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000037466369.

[11] See: https://www.entreprises.gouv.fr/files/files/directions_services/services-a-la-personne/qualite/guide_utilisation_cnq.pdf.

organisations. Much shorter and broader than the ESSMS Reference Framework (particularly as it concerns extremely varied services, which it would probably have been even more difficult to place under common criteria), it sets out six sets of principles:

- Welcome. Availability. Responsiveness.
  Responding quickly and appropriately to each request.

- Clarity. Thoroughness. Transparency.
  Providing complete and reliable information throughout the service.

- Personalisation. Listening. Follow-up.
  Adapting our intervention to the changing needs of our clients.

- Competence. Experience. Know-how.
  To provide clients with competent and professional staff.

- Confidentiality. Respect. Discretion.
  Respecting the privacy and intimacy of clients.

- Quality. Evaluation. Improvement.
  Improve practices to enhance customer satisfaction.

The Charter's user guide, which details these principles, never specifically mentions people with disabilities.[12]

In addition, all these organisations can apply for certification, which allows them to obtain automatic renewal of their licence. In December 2020, the Ministry of Economy and Finance validated the reference systems of four certifiers: Afnor, SGS-ICS, Bureau Veritas and Handéo Services, which we will discuss later.[13]

In conclusion:

- Although many services are covered by this dual framework for ESSMSs and personal support services, services related to education and social and vocational integration, from which people with disabilities can benefit when they do not take place in specialised organisations for people with disabilities, are not evaluated.

- Two national bodies set the framework that describes the quality of social services: the National Authority for Health (for ESSMSs, operating under the Code of Social Action and Families), and the Ministry of Economy and Finance (for personal support services, in accordance with the Labour Code).

[12] The authors were unable to access the self-assessment questionnaire used to prepare for membership, which is only available on a platform reserved for member organisations.

[13] See: https://www.servicesalapersonne.gouv.fr/actualites/bercy-valide-pour-4-ans-la-conformite-des-referentiels-de-certification-des-sap.

- The European Quality Framework is not officially taken into account in any of the frameworks: it is not mentioned anywhere. However, some of the principles set out in the National Authority for Health Reference Framework and in the Charter of the Ministry of Economy and Finance echo it, as we shall see below.

2.2 Research, studies and national debates

The notion of evaluation is polysemous and covers a plurality of practices and objectives that may contrast with one another. The literature on the quality of social services – quality assurance in France – reflects this fact. Four categories can be distinguished.

1. Practitioner literature – by educators, evaluators and administrators

These are guides or commentaries on the state of the sector, written by consultants, trainers and directors of facilities.[14] Federations and specialised publishers also produce guides, memos and summary sheets to provide ESSMSs with tools for their quality approach.[15] These publications are part of the vast sector of professional literature devoted to management guides for social and healthcare activities.[16]

2. Literature from or produced in association with academic research

Academic literature is scattered, but is dominated by a management approach. Indeed, this is the discipline that has been most interested in the quality of human services (in particular through the issue of governance of services and, more broadly, of organisations in the social economy),[17] but the publications that are available seem to be quite dated. Authors from the social and educational sciences have also contributed to this literature, including recently, notably in the context of publications in association with Belgian authors and publications.[18]

3. Studies conducted or commissioned by associations working in the field of disability

These include the studies carried out under the aegis of Handéo Services' National Observatory of Human Aid, APF France Handicap and ConfCapDroits. To the knowledge of the authors, none of them deals with the evaluation of the quality of services as such, but insofar as these three organisations claim to be guided by the

[14] Loubat, J-R. (2022), 'Following up and co-assessing the pathway and the support plan' in: *Coordinating pathways and personalised plans in social and healthcare action*, Paris, Dunod, pp. 215-246; Batifouler, F., and Noble, F. (eds.) (2022), *Leading innovation in social and healthcare action at a time of transforming the offer*, Paris, Dunod; Loubat, J.R. (2020), *Thinking management in social and healthcare action* (3rd edition), Paris, Dunod.

[15] For example the WEKA group (www.weka.fr) and the Federation of Regional and Territorial Organisations for the Improvement of Health Practices (https://www.forap.fr/).

[16] Fort, F. (2021), *The great guide to the management of social and healthcare activities and overall performance. Towards a management 3.0*, Afnor éditions.

[17] See, for example, the work of Francesca Petrella and Nadine Richez-Battesti or the article by Dominique Phanuel and Isabelle Lemaire in issue 2015/4 of *Gestion et Management Public* and that of Nathalie Dubost in issue 2014/4 of the *Gestion* review.

[18] See, for example, Gaspar, J-F., 'Waiting rooms: (making) people wait in the world of social work', *Espaces et sociétés*, 2019/1-2, pp. 103-115, or *Pensée Plurielle. Parole, Politiques et Réflexions du social.*

CRPD, by the respect of rights and by support for independent living, their studies may be similar to forms of national evaluation of public policies.[19]

4. Public reports

The studies mentioned above are often presented as aiming to make up for the shortcomings noted in the literature produced by the public authorities. However, public reports are accumulating, at the risk of becoming redundant. They all note the lack of data on people with disabilities and their support. The national survey of establishments and services for disabled children and adults (known as ES-Handicap), conducted every four years, is an exception on this point.[20] The use of the Global Activity Limitation Indicator in a growing number of surveys could fill this gap, as could the implementation of the 'Handidonnées – Panorama of data on disability in the territories' platform.[21]

Both practitioner literature and academic research literature are marked by a vigorous debate. Two blocks oppose each other in the vast literature on evaluation: the '"guides" setting out the principles and methodology of evaluation', and the '"black books" analysing the errors and/or harmful effects of certain evaluation practices'. There is a tension between two orientations of evaluation, one 'managerial' and the other 'critical, ethical and democratic'.[22] Beyond the social and healthcare sector, a significant tradition of criticism of evaluation as a 'quality approach', associated with the managerial imperatives of performance and rationalisation, is likely to make the use of the notion of 'quality' sensitive for many authors.[23] Applied to social work, this notion can sometimes take on an even more sensitive aspect. Several authors warn, for example, of the risk of obscuring invisible work, as well as the subjective and collective dimensions of work, in favour of an organisational approach.[24] Others emphasise the 'unprovable' nature of the quality of practices, the non-operational, non-instrumental part of social work, which often motivates the commitment of workers, against the injunction to objectivity and the use of indicators.[25]

[19] As with a recent (2022) report on the contribution of home help and support services to the implementation of so-called 'inclusive habitats': 'Human assistance & inclusive habitats. The effects on the habitat when the home help and support service is (co)carrier of the project', https://www.handeo.fr/publications/etudes-rapports-et-recherche/aides-humaines-et-habitats-inclusifs.

[20] See: https://drees.solidarites-sante.gouv.fr/sources-outils-et-enquetes/lenquete-aupres-des-etablissements-et-services-pour-enfants-et-adultes.

[21] See: https://handidonnees.fr/. The project is supported by the CNSA, the regional health authorities and local authorities, and is piloted by the Ancreai Federation (the federation of regional centres for studies, actions and information in favour of people in vulnerable situations).

[22] Marquis (2016) http://journals.openedition.org/leportique/2870.

[23] Da Silva, N. (2020) 'Quantifying the quality of care. A critique of the rationalisation of French liberal medicine', *Revue française de socioéconomie*, pp. 261-280; Vidaillet, B., *Evaluate me*, Seuil, 2013; Bruno, I., and Didier, E. (2013), *Benchmarking. The State under Statistical Pressure*, Paris, La Découverte.

[24] For example, Danièle Linhardt and Christophe Desjours. See also Barbe, L. (2015), 'Evaluation at the risk of misunderstandings', *Actualités sociales hebdomadaires*.

[25] Pierre Becheler refers in particular to the potentially dehumanised nature of 'risk prevention'. See also Karpik, L. (2007), *The Economy of Singularities*, Paris, Gallimard; Gadrey, J. (2003), *Socio-economics of Services*, Paris, La Découverte.

Practitioner literature as well as academic literature on service quality appear to reproduce the distinction between mainstream and disability sectors. Thus, we find some publications specialising in disability, or taking as a case study organisations that concern people with disabilities,[26] while other publications discuss social services in a general fashion. For example, a special issue entitled ‘Quality of public services: plural approaches’, of the journal *Informations sociales* of the French National Family Allowances Fund (2018) mentions disability only four times in 128 pages, once in the summary of a report commissioned by Handéo, and the two other times to give the number of places in the disabled children’s sector, and only ‘for comparison’ with the child welfare sector. One article explicitly includes people with disabilities in the scope of the analysis, but without specifically looking at the way they are treated – and is based on research conducted in 2010-2011.[27]

More broadly, studies on the quality of services very rarely include the issue of the rights of people with disabilities. When they do, they primarily question the participation of people with disabilities as users in their own support and in its evaluation (see below). An exception is found in the studies produced by the ‘observatory’ associations on disability and related public aids and policies. As for the CRPD principles, they only constitute a working reference for the work of associations. In the other publications, they are sometimes mentioned in the description of the regulatory landscape, without constituting an incentive for the analysis.

Some significant publications:

- Marion Scheider-Yilmaz and Raúl Morales La Mura, ‘User participation: from the field of possibilities to the real modalities of representation’, *Pensée Plurielle*, 2021/1, pp. 36-52, https://www.cairn.info/revue-pensee-plurielle-2021-1-page-36.htm.

This article is illustrative of social science literature on the relationship between evaluation and participation. The figure of the user has been ‘legitimised by the public authorities’ in debates on the evaluation of services, in particular through the gradual structuring of user representation in numerous consultative bodies, including local ones. However, the authors note a shift from a ‘representation of needs arising from a usage report’ to a ‘representation of needs shared by a category of public’, which is likely to make invisible some of the needs that emerge from the actual use of the service. The authors point to the absence of a ‘general architecture for collecting the voice of users’.

- Pierre Bechler, ‘The (wicked) tongues of evaluation: regulatory requirements and an evaluator’s state of mind’, *Le Sociographe*, 2021/2, pp. 54-66, https://www-cairn-info/revue-le-sociographe-2021-2-page-54.htm.

[26] Phanuel, D., and Lemaire, I. (2015), ‘Reconciling ethics and performance in the social economy: what contribution can strategic vision and quality make? The case of A.I.D.E.R.’, *Gestion et Management Public*, 2015/2, pp. 5-30, https://www.cairn.info/revue-gestion-et-management-public-2015-4-page-5.htm?contenu=article.

[27] Sardas, J-C., Gad, S., and Hénaut, L. (2018), ‘Quality services for family carers. Co-constructing personal assistance plans and structuring a territorial offer’, *Informations sociales*, 2018/3, pp. 58-67.

This article illustrates the critique of evaluation by practitioners. The author, a social worker who has become an external evaluator and is close to retirement, looks back on his experience. According to him, external evaluation (the procedure in force for ESSMSs before the recent reform) has become an ‘economic niche’, that gave ‘rise to the work of *agencies* … to multiple training proposals, guides and books, and even coaching actions intended for associations’. He points out the excessive bureaucracy to which this procedure has given rise and emphasises the ‘unquestionable’ nature of the quality of practices and the non-instrumental part of social work, which motivates his commitment, against the injunction to objectivity and dehumanising indicators.

- Nathalie Dubost, ‘Professional culture and quality approaches in the French social and healthcare sector’, *Gestion*, 2014/4, pp. 185-192, https://www.cairn.info/revue-gestion-2014-4-page-185.htm.

This article is based on the management literature on quality assurance. The author, a lecturer in management, has investigated several case studies on social and healthcare settings and services in order to examine the contributions of quality assurance. According to the author, three conditions are necessary for the quality approach to lead to an improvement in practices: managers must carry out sensemaking work to go beyond simple compliance; a consultant from the sector must be called in to provide both distance and professional proximity; employees must be called upon to participate. The author emphasised the need to anticipate the risks of demotivation linked to the limits that quality assurance may reveal.

There is no evidence that research on the quality of social services has an impact on quality assurance frameworks and processes. There is only one academic member of the National Authority for Health’s Commission in charge of social and healthcare services, a sociologist of disability and peer support, whose work is not focused on the issue of quality.[28] Several authors advocate a rapprochement between research and practice on the one hand, and between research and policy on the other.[29]

2.3 Analytic reflection

In order to enhance the quality social services designed to support independent living for persons with disabilities, the quality framework could be improved by:

- Clarifying the definition of quality of services: simplifying the recommendations, bringing in the contributions of research, particularly in the social sciences, on quality in social work, in particular taking into account all forms of working time. Indeed, the issue of time is highlighted in several texts examining the application of evaluation to social work. As a state councillor wrote, in the ‘current tensions in social and healthcare settings ... the question ... of the number of people available to provide qualitative support comes up with as much – or sometimes more – insistence than that of salaries’. Staffing ratios, which correspond to an approach based on an establishment, are insufficient information in the context of a service approach centred on the pathway: ‘face-to-face time’ is what matters.

[28] See: https://perso.univ-rennes2.fr/en/eve.gardien.

[29] See, for example, Ponnou, S., and Lemoine, M. (2021), ‘Subverting the evaluation mechanisms of social and healthcare settings: a clinical and anthropological approach’, *Pensée Plurielle*, 2021/1, pp. 53-75, https://www.cairn.info/revue-pensee-plurielle-2021-1-page-53.htm.

As in all care professions, 'the mere description of acts is inadequate to fully quantify the time required for support': it is necessary to think about the time for acts, the time 'required by other needs': coordination, collective review of practice, but also the time for 'this discrete component of support' which is 'the time of "being with", time for listening, speaking or silence'. All these times must be recognised.[30]

- Specifying the indicators that will make it possible to attest to arrangements that promote the effective participation of users in the evaluation process: more broadly, the quality framework should be adjusted to the stated objectives of the transformation of the offer (in favour of greater flexibility, involving the people supported): evaluation is still largely organised around the organisations (and does not make it possible to evaluate integrated service packages in a given territory, for example, or anything relating to the accessibility of the environment) and remains a matter for professionals. The development of participatory forms of assessment can be supported through training for people who are 'usage experts' and, as a state councillor suggests, by increasing the use of adapted communication tools which 'allow for exchanges with "non-verbal" people or those who have a poor command of written or oral expression'.[31]

- Designing a quality framework in line with the current issues that employees of social and healthcare services are facing: indeed, the main participants in the development of the frameworks are often quality managers or directors of organisations, and occasionally representatives of social and healthcare workers. Although the speeches accompanying the revision of the evaluation procedure have emphasised that the jobs situation in the area of social services is being taken into account, the texts and procedures are nonetheless criticised for their complexity and lack of pedagogy (especially in this transitional period), but also for the mismatch between the increased requirements and the still insufficient resources available to the social and healthcare sector. The attractiveness of social and healthcare work has been announced as a government priority, but actual implementation has been slow to materialise.

[30] Piveteau, D. (2022), 'Experts, actors, together... for a changing society', report to the Prime Minister, https://www.gouvernement.fr/rapport/12713-rapport-de-denis-piveteau-experts-acteurs-ensemble-pour-une-societe-qui-change.

[31] Piveteau (2022), https://www.gouvernement.fr/rapport/12713-rapport-de-denis-piveteau-experts-acteurs-ensemble-pour-une-societe-qui-change.

3 Quality assurance and evaluation of the quality of social services

3.1 Types of quality assurance

As it has already been indicated, the quality assurance process varies considerably between ESSMSs and personal support services. This section describes the assessment procedure for ESSMSs, the procedure for adherence to the National Quality Charter for Personal Support Services and Cap'Handéo certification.

These three systems have in common the promotion of a person-centred approach, but in a much more developed way in the case of ESSMS evaluation and Cap'Handéo certification. The CRPD is a reference for these two procedures – a secondary one for ESSMSs evaluation and a central one for Cap'Handéo. The evaluation of the ESSMSs and certification through the Cap'Handéo label focus on the 'structure' as well as the 'process',[32] even if the evaluation of the ESSMSs does so in a particular way, insofar as it focuses on the person more than on the process itself. The National Charter, on the other hand, is only interested in the process.

These three systems do not have the same status in law, but all three are recognised in the national context for quality. Quality monitoring is required for all services, but not in the same way. The ESSMSs, which constitute a complex landscape, are subject to a procedure introduced in 2002 and revised in 2019 (the first evaluations under the new regime are underway). Personal support services are an even more heterogeneous group and are above all concerned with a certification process and strongly recommended adherence to the National Quality Charter, which is much lighter on quality monitoring. Because of the very broad definition of personal support services, a wide range of services are subject to quality monitoring, with the notable exception of those relating to the education and social spheres and integration into the world of work, where they are provided outside the scope of specialised bodies. One thing that is outside the scope of these procedures, however, is everything related to environmental accessibility.

The ESSMS evaluation procedure was introduced and made compulsory by a law enacted in 2002.[33] This law established the promotion of quality improvement of services and the rights of users as a framework for the functioning of establishments. It was supplemented by a 2007 decree specifying the qualifications and competences of organisations authorised to carry out evaluations,[34] and then a 2010 decree on the timetable for evaluations and the procedures for reporting the results of evaluations.[35] It was then based on a double evaluation, with an internal part, carried out by the ESSMS itself, which had to provide evidence of the implementation of a continuous quality improvement process, and an external part, carried out by an organisation

[32] See: Quality_of_services-Report_Finall.pdf (easpd.eu).

[33] Law No. 2002-2 of 2 January 2002 aimed at renovating social and healthcare action, https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000000215460/.

[34] Decree No. 2007-975 of 15 May 2007 setting the content of the specifications for the evaluation of the activities and quality of services of social and healthcare settings and services, https://www.legifrance.gouv.fr/loda/id/JORFTEXT000000822015.

[35] Decree No. 2010-1319 of 3 November 2010 on the evaluation schedule and the methods for reporting the results of evaluations setting the content of the specifications for the evaluation of the activities and quality of services of social and healthcare settings, https://www.legifrance.gouv.fr/loda/id/JORFTEXT000023001910.

mandated by the service provider to evaluate the relevance, impact and coherence of the actions deployed with regard to the missions entrusted to it and the needs and expectations of the assisted populations.

The system was criticised. According to the General Inspectorate of Social Affairs, the evaluation reports were considered useful by the authorities responsible for renewing authorisations ('the evaluation process has a real impact on the quality of services, although there is no satisfactory instrument for measuring quality'), but the General Inspectorate regretted a lack of 'room for manoeuvre in terms of reorganising social and healthcare services'.[36]

Similarly, in 2018, a report for the National Assembly stated that much progress had been made as a result of the evaluations, but referred to criticisms from workers who had been evaluated, as well as from family associations and evaluation authorities, who suggested that the accreditation of evaluators was 'only an administrative procedure'. The author emphasised that the contractual relationship between the ESSMSs and the evaluation bodies (the former choosing the latter) led to doubts about the impartiality of the evaluators. More broadly, she pointed to a lack of supervision of evaluators (some of whom are only interested in the financial gain from the activity), the complexity and heterogeneity of the evaluator landscape, a lack of support for the ESSMSs in drawing up their evaluation specifications and in choosing the evaluator, and the wide variability of evaluation costs.[37]

A common criticism of these reports, in addition to the cumbersome and time-consuming nature of the procedure, was the lack of national support for the quality approach in the form of a common reference framework. Thus, the evaluations were considered to be too disparate and of little use to the supervisory authorities and the organisations themselves.

The law of 24 July 2019 therefore entrusted the National Authority for Health with the task of improving the evaluation system by producing a common reference framework for all ESSMSs. The distinction between internal and external evaluation has been eliminated. The evaluation procedure is now based on a cycle including self-evaluations and specific actions related to the activity of the organisation and all actions undertaken by ESSMSs to improve quality for the benefit of the persons accommodated, with an evaluation every five years (instead of seven) by a third party organisation independent of the organisation. The common national Reference Framework and the Assessment Manual, approved in 2022, must be used by the service providers to carry out the self-assessments, and by the evaluating bodies, which must be accredited by the National Authority for Health on the basis of specifications that it has defined. The evaluation reports have the same structure for all facilities; the results of the evaluation must always be sent to the pricing and control authority, but also to the National Authority for Health. The assessed facility must additionally ensure the widest possible internal dissemination, in particular to the decision-making body, the staff representation body and the social life council. The

[36] Hesse and Leconte (IGAS) (2017), https://www.igas.gouv.fr/IMG/pdf/Rapport_2016-113R_.pdf.

[37] Vidal, A. (2018), report by the mission for the evaluation and control of social security financing laws on the development of the quality approach within EHPADs [assisted living facility for elderly people] and its evaluation system, https://www.assemblee-nationale.fr/dyn/15/rapports/cion-soc/l15b1214_rapport-information.

results are made public. A secure information system, Synaé, has been created to carry out the evaluations. It includes the criteria of the reference system and provides the participants with the corresponding evaluation grids regarding the identified targets, and enables the report to be generated from the recorded data.

Membership of the National Quality Charter for Personal Support Services is based on a self-assessment every two years, using a self-assessment questionnaire. This results in a self-assessment report associated with a list of proposed actions to be implemented in order to make progress. A model action plan to be completed based on the list of proposals is provided to organisations, as well as a library of practical papers on implementing the principles. Membership gives access to a communication kit (logo, poster and brand guide), enabling organisations to highlight their adherence to the Charter.

As the user guide points out, these tools

> 'complement the quality procedures already in place in the sector by taking up, for example, most of the requirements of the accreditation specifications, the national specifications for home help and support services, the … good practice recommendations and the certification guidelines. Nevertheless ... the self-assessment questionnaire and the associated proposals for action do not include all the regulations applicable to personal support services'.[38]

If approved and certified organisations are up to date, they benefit from simplified measures to renew their licence when it expires and to adhere to the National Quality Charter.

The Cap'Handéo label is one of the four certification schemes mentioned earlier. Handéo is a social economy group of employers and managers in the service sector, and describes itself as 'run by and serving people with disabilities, people in vulnerable situations and people who have lost their independence due to their age or social situation (elderly people, socially excluded people and people in reintegration situations)'. Created in 2007 on the initiative of disability organisations,[39] it aims to 'liberate the power to act of disabled and elderly people by enabling them to live fully at home and in the city'. Handéo's activities are explicitly part of the framework of the implementation of the CRPD, and the organisation claims to act for the effectiveness of the right of people with disabilities to live in society, with the same freedom of choice as other people and the right to personal mobility and accessibility. Handéo runs an observatory and, via Handéo Services, offers certification/labelling activities, through which it is working to build up a professional network that it can support via Handéo Solutions, a training organisation that also offers consulting services. The group's website indicates that 'today, there are more than 400 Cap'Handéo services that support more than 150 000 disabled and elderly people in some sixty departments'.

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[38] See: https://www.entreprises.gouv.fr/files/files/directions_services/services-a-la-personne/qualite/guide_utilisation_cnq.pdf.

[39] Handéo is now composed of 23 members: APF France handicap, Fédération APAJH, Nexem, UNAFTC, Mutuelle Intégrance, Fisaf, Paralysie Cérébrale France, Trisomie 21 France, Autisme France, UNAPEDA, Fondation OVE, UNAFAM, Groupe APICIL, Fondation ANAIS, UNA, UNADMR, FEDESAP, Adedom, and the federation of PEP, FEHAP, SNADOM, UNAPEI and GCMS POLYCAP.

Without denying the organisation's commendable efforts, it is worth noting that these certification activities are run by service sector managers.

The label is based on 'collaborative, participative and evolving' Cap'Handéo approaches, whose standards are presented as having been built with the people concerned and their representatives, with service providers and institutional partners. The Cap'Handéo Personal Support Services reference framework, created ten years ago, became a certification accredited by the French Accreditation Committee in 2017.[40] In August 2022, a third version of the standard came into force.[41] This reference framework is intended for personal support services organisations working as service providers, supporting people with disabilities and authorised to do so. Where applicable, the organisations should have been approved for at least two years. The framework is also intended for nursing care and assistance services and for multi-purpose home care and assistance services that have been authorised and have been operating for at least two years. All these bodies must be committed to respecting the legislation and regulations relating to home help, support and care services or personal support services, and to respecting the Recommendations of Good Professional Practice in the social and healthcare sector and the guidance drawn up by Handéo.

The certificate is awarded for a period of three years, at the end of a documented certification procedure which comprises several stages: examination of the applicant's application; an on-site certification audit (of the central organisations and any secondary organisation), the purpose of which is to check that the service complies with the requirements of these standards and which gives rise to one or more audit reports; the opinion of the national certification monitoring committee, in the light of the anonymised audit report; and the decision to award the certificate produced by Handéo Services. The duration of the on-site audit varies according to the number of beneficiaries/clients and employees involved, the number of people supported (and their types of disability), the type of organisation, the number of sites providing inclusive living and the distance between the different sites, but in any case such audits last several days. An audit is carried out at the external service provider(s) as soon as the overall annual subcontracting rate exceeds 30 %.

The audit is carried out by auditors who are employees or authorised subcontractors trained in the reference framework and who are committed to respecting the ethical rules of Handéo Services. It consists of several stages: an opening meeting (presentation of all the participants and the audit), the audit itself (collection of 'factual evidence of the functioning or malfunctioning of the system', visual checks, interviews with employees, observation of situations), the establishment of audit findings based on the comparison of evidence (non-conformities, points of vigilance and strengths), a summary meeting (the auditor works in isolation to produce the results, with daily progress reports if the audit lasts several days, which allows the department to 'analyse its deviations and [to] start thinking about corrective actions'), a closing meeting with the presentation of the audit results, and conclusions. The auditor does not decide whether or not to grant certification.

[40] COFRAC Accreditation No. 5-0624: https://www.handeo.fr/cap-hand%C3%A9o/services-la-personne.

[41] See: https://www.handeo.fr/sites/default/files/2022-05/CSAP_R%C3%A9f%C3%A9rentiel%20CapHandeo%20Certification%20SAP_VF.pdf.

After transmission of the forms indicating any non-conformity, the candidate is given a period in which to respond and, if necessary, to conform to the standard. The non-conformity and points of vigilance can be lifted after verification of the effective implementation of the corrective actions. Finally, the report is sent to Handéo Services, which anonymises the applicant and presents the report to the Cap'Handéo national certification monitoring committee for a technical opinion. The final decision is taken by Handéo Services, based on the auditor's findings and the opinion of the national certification monitoring committee: immediate awarding of certification, request for an additional audit or refusal to award.

Before the end of the three-year certification cycle, the service can request an on-site renewal audit. During the certification cycle, Handéo Services sets up a monitoring system to ensure that the certificate is maintained during its period of validity by checking that the certified service still complies with the requirements of the standard, based on: a documentary audit between the 15th and 18th month of the certification cycle, mystery calls to the service, verification of discrepancies that were not corrected during the last audit, additional verification of certain characteristics, and a telephone or videoconference interview with the service manager or the contact person responsible for the certification process. This audit gives rise to a report submitted to Handéo Services which confirms (or revokes) the certification.

Insofar as these are quality processes, with a dynamic towards quality improvement through dialogue between the evaluating bodies and the bodies being evaluated, it may be assumed that there is necessarily a degree of informality.

As far as the ESSMSs are concerned, it should be noted that there are a great many evaluation bodies with very varied methodologies. While the reform may have standardised and formalised the methodologies, the procedure requires the evaluators to adapt the evaluation manual to the specific characteristics of the ESSMSs, explicitly entrusting them with responsibility for this adjustment.

During the discussions on the Reference Framework, members of the National Authority for Health's Commission in charge of social and healthcare services also expressed their concern that the text was 'too general' and might not be adapted to the specificities of the organisations and their populations, placing 'a great deal of responsibility' on the evaluators, 'who will have to embody the Reference Framework while at the same time being in tune with the specificities of the organisations', in order to identify deviations from the standard. In response to these concerns, other members of the Commission, including the Commission Chairman and the Head of the Directorate for the quality of social and healthcare support, highlighted the value of a reference framework that was sufficiently cross-cutting to support not so much compliance monitoring but rather 'a dynamic construction of quality' based 'on the trust placed in the evaluators'. In their view, the generalist dimension would make it possible to consider people not solely in terms of their disability, and to encompass the entire social and healthcare sector under the same Reference Framework. The complementarity between the Reference Framework and other reference documents, such as the Recommendations of Good Professional Practice, was emphasised.

This debate led in particular to the question of support for evaluators, which was partially resolved by the publication of the specifications imposed by the National Authority for Health on evaluators and the introduction of Afnor accreditation.

All this does not mean that the procedure necessarily falls into informality, as there are, in particular, fairly precise Recommendations of Good Professional Practice and Codes governing specific sectors of intervention such as autism, children or domestic violence. The degree of compliance with these standards seems to vary considerably depending on the evaluators, although there have been no studies to provide more precise information on this subject.

As far as personal support services are concerned, as we have seen, they are responsible for carrying out their own quality procedures, which most probably includes a large degree of informality, for example in quality control visits.[42]

3.2 Types of services

All ESSMSs must carry out the assessment process described above. As far as personal support services are concerned, since 2016, bodies under the authorisation regime have been obliged to adhere to the National Quality Charter for Personal Support Services, and therefore to comply with the membership procedure. As for the organisations under the 'permit' regime, the licence specifications provide for annual internal controls 'which can be achieved by adhering to the National Quality Charter', along with an annual survey 'among customers on their perception of the quality of service provided'. Finally, it should be remembered that these organisations may request certification (such as the Cap'Handéo label), which allows them to obtain automatic renewal of their accreditation.

However, it is important to remember that the very definition of a person with a disability is likely to be problematic, insofar as, in France, this definition is closely linked to a medical diagnosis, and insofar as this definition determines the allocation of aid. The definition proposed by Handéo is as follows:

> 'A person is considered disabled whether the disability is innate or acquired before or after the age of 60 (this definition therefore also includes elderly people who have lost their autonomy). Disability is defined by law as any limitation of activity or restriction of participation in society suffered by a person in his or her environment due to a substantial, lasting or permanent impairment of one or more physical, sensory, mental, cognitive or psychological functions, a multiple disability or a disabling health disorder. However, people may present differences according to the degree of autonomy, the type of deficiency ... the pathology ... and be in progressive and irreversible situations.'[43]

[42] See: https://www.domiblue.fr/details-est-il+possible+de+controler+la+qualite+du+service+a+domicile+de+domiblue-349.html.

[43] See: https://www.handeo.fr/sites/default/files/2022-05/CSAP_R%C3%A9f%C3%A9rentiel%20CapHandeo%20Certification%20SAP_VF.pdf.

3.3 The formal bodies

As far as the ESSMSs are concerned, quality assessment is entrusted to accredited assessors, but the procedure is supervised by the National Authority for Health. The National Quality Charter for Personal Support Services is based on a self-assessment. Finally, the certification procedure for the Cap'Handéo label is entrusted to auditors who are employees or authorised subcontractors trained in the standards and who are committed to respecting the ethical rules of Handéo Services.

More broadly, over the last two decades, the development of evaluation practices has been accompanied by the emergence of a new professional environment which includes auditors, evaluators and quality specialists, as well as directors, managers or quality referents in the organisations. The extremely heterogeneous nature of this professional environment has been highlighted in several reports.

The quality assessment process is initiated at the request of the organisations, which are obliged to do so by law. As noted above, in the case of personal support services, the authorisation to practise is linked to the use of a quality assessment process. As far as the ESSMSs are concerned, their authorisation is also linked to the evaluation; moreover, the new procedure is now synchronised with the contractual dialogue. Every five years, the ESSMSs must sign a multi-year contract of objectives and means, including performance objectives, with the state.[44] Until the 2019 evaluation reform, reports emphasised that the gap between evaluation and contractualisation made them mutually irrelevant (in particular the incentive nature of the financial aspects of the multi-year contract).[45] The new procedure has been designed so that evaluation feeds into the contractual dialogue.

The ESSMSs are also subject to inspections or monitoring by the General Inspectorate of Social Affairs.[46] A dissertation in law submitted in 2020 questioned the relevance of inspections, in view of the rise of quality approaches.[47] Indeed, for the author, the inspection/control is challenged by the continuous quality improvement approaches. He considers inspection as 'essentially linked to administrative policing', whose consequences are 'complex to implement'.

As for personal support service providers, their very large number makes systematic inspections unlikely.[48] However, waves of inspections are carried out from time to time,

[44] See: https://www.cnsa.fr/outils-methodes-et-territoires/organisation-de-loffre/performance-des-etablissements-et-services-medico-sociaux.

[45] Vidal (2018), https://www.assemblee-nationale.fr/dyn/15/rapports/cion-soc/l15b1214_rapport-information; Hesse and Leconte (IGAS) (2017), https://www.igas.gouv.fr/IMG/pdf/Rapport_2016-113R_.pdf.

[46] See: https://www.igas.gouv.fr/Guide-pour-la-preparation-d-un-controle-d-etablissements-ou-de-services-sociaux.html.

[47] Barlet, C. (2020), 'Place and role of the inspection-control in the field of healthcare, social and social and healthcare settings and services', law thesis, University of Rennes 1, https://ged.univ-rennes1.fr/nuxeo/site/esupversions/e1de09bf-342e-44b8-a893-31e6711d241d?inline.

[48] In 2009, a report by the General Inspectorate of Social Affairs on an 'Investigation into the quality of home help services for the elderly' noted 'the difficulty of control and evaluation (controls and audits carried out on the basis of documents and never on the premises of the beneficiary, little power of the General Council over the operators, despite its management of the personalised autonomy allowance, contractual salaries for reasons of cost, involvement of numerous State

notably by the General Directorate for Competition, Consumer Affairs and Fraud Control of the Ministry of Economy and Finance.[49]

3.4 Stakeholders, experts by experience and organisations of persons with disabilities

The National Authority for Health guidelines and manual were designed by members and staff of the Authority, as well as representatives of social and medical-social establishments and services, and representatives of users of these establishments and services, who met in several working groups. These documents were subject to extensive consultation, and part of the reference system was tested before being finalised. The National Authority for Health's Commission in charge of social and healthcare services, mainly made up of directors of organisations, includes two directors of associations in the social and healthcare sector focused on disability, a director of establishments for APF France Handicap, and a peer-helper representing people in exclusion situations. The members of the consultation committee included representatives of the main disability associations. However, the working groups were mainly made up of managers and quality managers from public and private ESSMSs. The user representatives numbered 13 out of 151 members of the working groups, representing users of all social and healthcare services, not only people with disabilities.

In spite of the openness of the process, notably through a call for participation and then the setting up of a consultation platform, this Reference Framework has been criticised by a group of disability associations, notably for the lack of involvement of users' representatives, their relatives and employees.[50]

The National Quality Charter for Personal Support Services seems to have been designed primarily by service managers, but there is a lack of information on this subject.

Finally, the Handéo group explicitly claims to have designed the certification frame of reference by involving representatives of service users as a priority; the list of group members (see above) makes this quite plausible, even if, here again, there is a lack information on the details of the process.

It should be remembered that the main academic publications on service evaluation processes point to the difficulties of involving the people being supported (see above).

services, without any real coordination, etc.)'. See: https://www.vie-publique.fr/rapport/30716-enquete-sur-les-conditions-de-la-qualite-des-services-daide-domicile.

[49] Ministry of Economy and Finance, General Directorate for Competition, Consumer Affairs and Fraud Control, 'Control of fairness in personal support services', 12 October 2016, https://www.economie.gouv.fr/dgccrf/controle-loyaute-des-services-a-personne; 'Control of compliance with the regulation of home help and support services', 5 May 2020, https://www.economie.gouv.fr/dgccrf/controle-des-services-daide-et-daccompagnement-domicile.

[50] See the joint statement: https://static.mediapart.fr/files/2021/12/16/evaluation-has-211216.pdf. The signing associations were the Association les 4A, Autisme France, CRAIF, Fédération Française, Sésame Autisme, Fédésap, FFDys, FFP, Groupe Polyhandicap France, Hyper Supers TDAH France, HyperSupers TDAH France, PAARI, PEPA, Unafam, UNAFORIS and Unapei.

3.5 Methods and methodologies

The framework for adherence to the National Quality Charter for Personal Support Services and the Cap'Handéo certification process have already been detailed. On the whole, a wide variety of methods can be used to implement quality procedures, and the self-assessment questionnaire seems to be very widespread.

The recent reform of the evaluation procedure for ESSMSs has given the National Authority for Health the opportunity to propose new methods, with the aim of harmonising practices. Thus, each of the three chapters of the Reference Framework (person, employees, organisation) is associated with a different evaluation method, inspired by practices in the health sector:

- The 'accompanied tracer' *(L'accompagné traceur).* This method is centred on an analysis of the accompaniment of a person supported by the evaluated organisation. It is based on gathering the person's experience (with the person's consent) and the views of the employees supporting him or her.

- The 'targeted tracer' *(Le traceur ciblé).* This method is centred on an interview with the employees of social and healthcare establishments or services, and is carried out by a multidisciplinary team: the practitioner meets with the staff, before talking with the management to clarify the elements collected and observed.

- The 'system audit' *(L'audit système).* To evaluate the organisation of the ESSMS, the facilitator meets with the management before talking to the staff to evaluate the control of the processes in the field; if necessary, an interview is also organised with representatives of the social life council.

These methods have been criticised. The associations criticising the process of developing the reform, as mentioned above, pointed out the risk that the 'accompanied tracer' method, centred on one person, would fail to take into account the complex variety of beneficiaries in the social and healthcare sector. During the discussions on the validation of the Reference Framework, a director of an association specialising in integration through economic activity and housing, a member of the National Authority for Health's Commission in charge of social and healthcare services, pointed out that the vocabulary of 'tracer' is more akin to the vocabulary of health establishments and could be unsuitable for the social and healthcare sector. The head of the National Authority for Health's Directorate for the quality of social and healthcare support told the association director that the evaluators would 'be instructed to read up on the vocabulary before visiting the facilities'.[51]

3.6 The indicators

Among the quality monitoring systems described, the Cap'Handéo label is the one that most corresponds to the CRPD and the European Quality Framework. The standards are organised in six sections (adaptation and organisation of the service; know-how and interpersonal skills of social and healthcare workers; links between the

[51] Minutes of the meeting of the National Authority for Health's Commission in charge of social and healthcare services, 17 December 2021, https://www.has-sante.fr/upload/docs/application/pdf/2022-05/csms_pv_2021_12_17_vd.pdf.

organisation and the disability stakeholders; evaluation and improvement of services and satisfaction of the person with a disability; relations between the service provider and Handéo services; and follow-up of the certification process). It clearly pursues the objective of independence of the supported person, in particular through the 'co-construction of the individualised project', the 'flexibility of the services' and their adaptability, the guarantee of a continuity of service, 'an organisation and a functioning at the service of the person', a knowledge by the service provider of the 'sectorial context (social, social and healthcare, health and common law) and local [context] ... which allows the partnership relations', 'a coordination between the various actors of the accompaniment'.[52]

The voluntary European Quality Framework principles of 'outcome-oriented' and 'respect for users' rights' are covered by the whole section on 'evaluation and improvement of services and satisfaction of the person with disabilities' (with regular monitoring of the service, effective handling of complaints, annual and individual measurement of the satisfaction of the person with disabilities, people's advisory committees and strengthening of the quality of life and working conditions; as well as the establishment of monitoring procedures for certification. Cooperation and coordination between the different support actors is mentioned in at least two indicators (15 and 16), and the competence of the workers and their working conditions are the main subject of the section headed 'The skills and know-how of social and healthcare workers'.

The National Authority for Health Reference Framework is organised in three chapters (the person, the employees and the organisation). The objective of independence and self-determination of the person is clearly highlighted, in particular in the first chapter, which recommends ensuring that the supported person is correctly informed and expresses himself/herself – and that his/her views are invited and taken into account; that he or she is involved in the review of the service's operating procedures and that his/her effective participation is encouraged both in the organisation and outside; that he/she can get involved in social, cultural and civic life, while benefiting from adapted support including peer assistance. The person must be an 'actor in the personalisation of his or her support project' and should be assisted to this end, and those around them must be involved in their support. A series of criteria are explicitly aimed at supporting the person's autonomy, in particular in accessing and maintaining housing. Continuity of care is also targeted by a set of indicators.
Regarding the staff, the indicators concern good treatment and respect of the fundamental rights and individual liberties of the supported person, their views and participation, the co-construction and the personalisation of their support plan and supporting them towards autonomy, in particular in monitoring their schooling, their professional career and in the development of capacities and skills. Finally, the organisation must define a strategy for preserving the person's autonomy and preventing the risk of isolation of the people it supports, and it must ensure the implementation of this strategy.

In contrast, although the indicators in the Reference Framework seem to be in line with most of the principles of the voluntary European Quality Framework, those of availability and accessibility do not seem to have infused the indicators in the National

[52] See: https://www.handeo.fr/sites/default/files/2022-05/CSAP_R%C3%A9f%C3%A9rentiel%20CapHandeo%20Certification%20SAP_VF.pdf.

Authority for Health Reference Framework. This can be explained by the fact that these two principles are targeted by specific public policies as part of the strategy for transforming social and healthcare services, although these two fundamental principles are less directly evaluated as a consequence. This is also true for the principle of affordability, insofar as the price of services is defined by the pricing authorities (the regional health agency (ARS) or the general council). It is therefore understandable that the quality assessment framework does not mention it. However, this seems to allow each actor to avoid responsibility in this matter.

4 The impact of quality assurance mechanisms and systems and promising practices: strengths and weaknesses

As regards the ESSMSs, some of the public reports already mentioned concern the quality assurance system prior to the reform. As the implementation of the reform has only just begun, however, no study on its impact is yet available.

4.1 The impact of quality assurance mechanisms

The evaluation follow-up procedures for each of the three quality monitoring systems described has been discussed above. Regarding the system for evaluating ESSMSs, and as already mentioned, according to the General Inspectorate of Social Affairs, 'the evaluation process has a real impact on the quality of services, although there is no satisfactory instrument for measuring quality'.[53] In the case of personal support services, on the other hand, the observation is rather that there is a general lack of quality assessment, which makes it difficult to comment on its impact.

However, we can mention, with regard to the Cap'Handéo label, an impact study dating from 2018 which focused on the perception of users. Eighty people with disabilities or their relatives who use service providers for their human assistance needs (whether or not they have the Cap'Handéo label) responded to a questionnaire, mainly by telephone, targeted at 150 to 200 persons. As the authors of the study indicated, the service providers contacted 'rarely had the time required to [facilitate contact with respondents], a request that could be perceived as the threat of an intrusive view of their activity'. These people were then invited, in a more qualitative way, 'to clarify different points, to relate and describe certain situations'.[54]

The report is organised in three parts, each corresponding to a share of the population surveyed: the 46 % who describe an optimal quality of service; the 19 % for whom the quality of service is poor; and the 34 % for whom it is average. The analysis of these last two groups highlighted the need for Cap'Handéo to better assess the gap between the standard and the quality of the actual support, and the need to make the label more visible to help people choose their service providers. The authors found that none of the respondents had mentioned the 'Local Group of Users and People with Disabilities' which, according to the label's standards, the service provider must set up at least once a year to gather opinions and suggestions, although several respondents indicated that their opinion had been sought elsewhere. Furthermore, 60 % of people whose service provider has the label are in the intimate relationships category (compared to 31 % without the label), which reflects the positive impact of the label: 'there is a greater likelihood of finding reliable, consistent, everyday allies in providers with the label, whose professional skills enable them to meet the person's needs, than by using a provider who does not have the label. This response to needs, when it is of optimal quality, gives a central place to the person, his or her wishes, expectations and constraints'.

[53] Hesse and Leconte (IGAS) (2017), https://www.igas.gouv.fr/IMG/pdf/Rapport_2016-113R_.pdf.

[54] Handéo (2018), *The Cap'Handéo Personal Support Services Label: what impact does it have on supported persons?*, https://www.handeo.fr/sites/default/files/2021-07/OBS_Rapport_ImpactLabel_SAP_PSH_10_07_2018.pdf.

Concerning the follow-up of the quality assurance results and the requirements, the issue of the score and the follow-up to the evaluation – and more particularly the question of the duration of the score – has been the subject of a debate, in the context of the reform of the evaluation of ESSMSs, within the National Authority for Health's Commission in charge of social and healthcare services.

Finally, we lack the data to discuss the time required for quality improvement. This would call for an assessment of quality assurance systems.

4.2 The role of human rights NGOs, Ombudsman, and other related offices

We have mentioned the contribution of associations such as Handéo (also a certifying body), APF France Handicap and ConfCapDroits. The authors are not aware, however, of any involvement of international human rights organisations in the quality assessment. The Ombudsman was involved in the definition of the National Authority for Health Reference Framework, if only through the use of its guides as references to the text. As has been noted, however, the main actors involved remain the facility directors and quality professionals.[55]

4.3 Reflective analysis

Although the UN CRPD is not always a central reference for quality assessment systems for services for people with disabilities in France, recent texts (e.g. the ESSMS Assessment Reference Framework and the Cap'Handéo label) clearly and widely echo it. More broadly, the institutionalisation of common frames of reference for organisations is to be welcomed, which makes it possible to standardise and professionalise evaluation, and thus to ensure quality monitoring at local and national levels. However, several weaknesses must be pointed out.

As already indicated, the recent reform of the evaluation of ESSMSs, as well as the thinness of the National Quality Charter for Personal Support Services, places a great deal of responsibility on the evaluators, who must adapt the reference frameworks to the specificity of each organisation and who should be familiar with the regulations to which it is subject. At the same time, there is a strong incentive to produce highly formatted assessment reports (which are rather synthetic and follow identical outlines despite the diversity of real situations), which seems to be less due to the general character of the frame of reference than to the procedure itself, with a large number of evaluations carried out in a reduced time, to be managed by overworked authorities who therefore prefer to read calibrated syntheses.[56]

The procedures do not seem to allow for a user's lived experience to be incorporated (see below). The emphasis placed on participation seems to have little effect in terms of quality evaluation, to the detriment of the autonomy of the people supported. In addition to what has already been noted, we can mention the debates within the National Authority for Health's Commission in charge of social and healthcare services on the Reference Framework. Members of the Commission pointed out the difficulties

[55] The annual survey of the Defender of Rights on discrimination in employment may be mentioned. In 2022 the survey focused on the personal support services sector, but it did not include a quality assessment.

[56] Marquis (2016), http://journals.openedition.org/leportique/2870.

that evaluators might have in gathering the views of supported persons, as certain elements of proof are not easily verifiable (such as 'the person can speak to the employees'), or as questioning supported persons about their 'good treatment' (rather than about their support in general) would 'incite them to feel obliged to adopt a positive or negative position'.[57]

There is a discrepancy between the recommendations and the reality of the support and the working conditions of the employees. Working conditions are formally part of the evaluation criteria, but they do not seem to be taken enough into account in the evaluation process itself. And as a state councillor explains, although most social and healthcare workers adhere, in principle, to the objective of empowering people as set out by the public authorities, they find it difficult to put it into practice and may feel it as a 'paradoxical injunction'.[58]

Indeed, the incentive to focus on the person reinforces the need for interaction between actors, and for support in defining and carrying out a plan; it also affects the relationship between staff and the person being supported, as employees are no longer in a position of superiority. Support is thought of as a service, and includes 'themes that go beyond the traditional socio-educational framework' such as a person's intimate life, and 'user expertise' becomes a legitimate contribution to the support process. However, these trends are sometimes considered unrealistic, especially in 'professional and family circles close to people living with the most severe disabilities', who are likely to be at risk in mainstream settings. The call for deinstitutionalisation can be experienced as 'a challenge to a meaningful working environment', both psychologically[59] and in terms of the working environment, with many employees becoming self-employed and risking the 'uberisation' of the sector. These fears are shared by some families of people with disabilities, 'who find in stable and organised forms of accommodation [a relay] of their own mobilisation'.

According to a state councillor in a 2022 report intitled 'Experts, actors, together... for a changing society', major difficulties faced by this sector include the blurring of the boundaries of the profession with the appearance of new functions that struggle to be recognised while leading those who do not take them on to feel threatened with devaluation; increased multidisciplinarity of the work, sometimes interpreted as an 'instruction to be versatile, disregarding ... the technical nature of each profession'; and

[57] Minutes of the meeting of the National Authority for Health's Commission in charge of social and healthcare services, 17 December 2021, https://www.has-sante.fr/upload/docs/application/pdf/2022-05/csms_pv_2021_12_17_vd.pdf.

[58] See Piveteau (2022), 'Experts, actors, together... for a changing society', report to the Prime Minister. A state councillor and former director of the National Solidarity Fund for Autonomy, Denis Piveteau was commissioned by the Prime Minister in November 2021, in a context of crisis in the social and healthcare support sector, to deliver a report in February 2022 on the work in this sector. He promoted an approach 'centred on the person and his/her life course'; all the actors he met supported 'the self-determination of the person supported' but reported 'disarray' in the face of the 'inertia of the structures', 'fixed mentalities', 'insufficient resources' and 'unsuitable organisations. See: https://www.gouvernement.fr/rapport/12713-rapport-de-denis-piveteau-experts-acteurs-ensemble-pour-une-societe-qui-change.

[59] 'Some of the wording of the report of the United Nations Committee on the Rights of Persons with Disabilities [Concluding observations on the initial report of France, 4 October 2021, CRPD/C/FRA/CO/1] has been harshly experienced by people who are very involved in their work'. Piveteau (2022), https://www.gouvernement.fr/rapport/12713-rapport-de-denis-piveteau-experts-acteurs-ensemble-pour-une-societe-qui-change.

an increased focus on 'knowledge of experience', which is likely to be perceived as a negation of the competence of professionals. At the same time, the increase in expenditure brought about by the pathway approach (adaptation to individual choices and increased technicality) is not reflected by the pricing system, which is mainly based on the occupancy rate or quantitative objectives in terms of places, which 'leave little room for the flexibility required by alternative care methods'.[60]

Similarly, exceptional funding, whose mechanisms increase the burden of management tasks, is increasingly being used, which 'contributes to demobilising the teams that do not benefit from it', while the 'mainstream environment' makes little contribution to financing the additional cost of bringing it closer to the social and healthcare support sector (regarding split periods, transfer of expertise and accessibility). Finally, the regulatory channels of the professional sector of social and healthcare support are outdated, and autonomy policies remain highly fragmented and poorly coordinated. It is therefore important to improve the recognition of the work of social workers.

Reflection on the principles to be placed at the heart of evaluation is useless if it is not combined with reflection on the conditions of implementation. This is one of the main lessons of the 2022 report prepared by a state councillor for the Prime Minister. It is therefore important, according to him, to support the integration of the social and healthcare sector, which is very fragmented, by mapping the professions and the links between them as well as other sectors of activity, but also by setting up a partnership body to 'coordinate the issues common to all the professions', such as a 'sector committee' including actors from the public services, representatives of training organisations and universities. Finally, in terms of funding, it is important to 'neutralise, if not eliminate, the effects of the multiplicity of funders' by implementing 'automatic fungibility'. Project support should be deployed so that project-based funding does not overburden professionals. Moreover, it would be appropriate to change the organisation of funding to support the transformation of the system, as 'stable funding goes to ordinary activities and short-term, precarious funding goes to the most interesting projects'.

Furthermore there is the assessment procedures that do not support the general transformation of the services system. The assessment procedures are characterised by tension between the necessary generality of the reference system and the indispensable specificity of evaluations, while respecting the singularity of the activities of each service. This tension seems to be resolvable by taking the redesign of the services system itself a step further, adapting the evaluation procedures to this new system.

This is the other essential contribution of the 2022 report to the Prime Minister: the quality assessment methods must follow the national transformation of the supply of social and healthcare services more closely.[61] The author of the report supports the National Authority for Health approach, i.e. 'less the uniformity of a standard than the ability to adapt to situations', stresses the incentive value of the contract between

[60] Piveteau (2022), https://www.gouvernement.fr/rapport/12713-rapport-de-denis-piveteau-experts-acteurs-ensemble-pour-une-societe-qui-change.

[61] Piveteau (2022), https://www.gouvernement.fr/rapport/12713-rapport-de-denis-piveteau-experts-acteurs-ensemble-pour-une-societe-qui-change.

establishments and the state (CPOM), and insists on the need to provide suitable statistical measurement and monitoring tools (‘for many years, French public statistics have been vigorously criticised, both by national and international authorities, for their blindness with regard to disability and autonomy’). However, while the author recommends strengthening the theme of ‘empowerment’ in the ESSMS Assessment Reference Framework (‘it is a question of clarifying what, in the operation of the organisation, makes it possible to guarantee that autonomy, initiative, interaction with the environment and participation in organisational choices are a central objective, both for the people “supported” and for the professionals who support them’), to this end he insists that the evaluation must support the transformation of the collective living environment. The aim is to encourage, through assessment, the transformation of work organisations (in particular the effective participation of supported persons and employees in the running of the service), cooperation and association with mainstream activities, the taking into account of all the time required for quality support (see above), and recognition of user expertise.

In the meantime, the author of the 2022 report shifts the focus to a more systemic level. In order to move away from the ‘institution approach’ towards a service approach, where the person ‘will remain the decision-maker in the use of his or her living space, in his or her freedom to come and go and to be absent, and in his or her consent to community life’ and will see his or her ‘social role’ acknowledged, the author stresses the need to rethink the entire system. He thus proposes to abandon the notion of social and healthcare settings in France, in favour of the notion of ‘social and healthcare service’, which corresponds to the current development of service platforms. Meanwhile, in addition to providing financial support for innovative practices (see above), it is necessary to allow professionals, organised around the life course of individuals, to maintain a framework offering them resources and possibilities for cooperation in order to adapt to situations. Evaluation must thus be linked to this transformation towards a more flexible and personalised support system. If the development of participatory forms of evaluation is to come to anything, the authorities must be equipped to receive this type of evaluation. It is therefore necessary to train those who work with organisations implementing participatory management, and to include an HR strategy component in the contracts between the service providers and the state, which the people supported must help to draw up. It is necessary to accompany the reform of the evaluation with a training plan: training for management functions, which integrates the elements of the Reference Framework and the National Authority for Health Recommendations of Good Professional Practice, but also training to help people who are ‘usage experts’ to ‘structure and transfer their expertise’. Finally, the author of the report strongly recommends the use of communication tools which ‘allow for exchanges with “non-verbal” people or those who have a poor command of written or oral expression’, but also those which allow for dialogue with the ordinary environment, such as ‘pedagogical kits’.

It is with these elements in mind that we have selected the promising practices detailed below. It should be noted, however, that these practices predate the implementation of the new evaluation procedure for ESSMSs.

4.4 Promising practices

We have been able to identify several academic articles and reports from public bodies and associations that focus on the implementation of public policy measures or on the modalities of inclusion of supported people. However, these studies are national in scope and do not allow for the identification of innovative evaluation practices, nor do they explicitly address the issue of quality. Thus, as things stand, we have not been able to identify three cases to detail here, so it has not been possible to fill in the table intended for this report as requested.

Currently, it seems that the most reflective practices in quality assessment are based on social science work. Indeed, the authors have identified publications by social science researchers who have offered their services as evaluators of ESSMSs in the context of action research projects. These studies have the advantage of shifting the definition of quality and its evaluation in a direction that is more likely to allow the person being supported to have their views taken into account and to participate in the evaluation. We can mention two major publications.

The first concerns the evaluation of a medicalised residential institute set up in 1996 offering people with severe motor disabilities educational training to enable them to live independently in their own homes.[62] This involves living and training in the institute for an average of four years, after which people are able to live in their own homes. According to the report, 'this training has enabled over 150 people to live "at home" in society'.

The evaluation survey, which was carried out between February and June 2020, involved various social science methods around a strategy aiming to 'maintain a socially situated view of the individual who has benefited from the service'. 'The aim is to understand the existing resources and constraints (human, technical and financial) and the strategies (withdrawal, resistance, bypassing, negotiation) that the person adopts to mobilise his or her resources or deal with his or her constraints', in order to 'characterise the effects of the scheme in terms of personal autonomy', based on the expertise of the person being supported.

A second crucial aspect of this evaluation is that it took into account the interaction between the individual and his or her environment in order to 'understand the conditions for a better quality of life and the production of opportunities'. The survey was therefore based on an approach of the 'entourage monograph' type, which consisted of meeting supported persons through interviews and conducting several interviews with them (between 3 and 12 in this case), with people from their entourage, but also with staff from the organisation and professionals supporting them. These interviews were completed by means of a socio-demographic and opinion questionnaire.

Finally, it is important to emphasise the care taken by the investigator to obtain the informed consent of all participants, and the selection of the participants solicited was defined 'collegially on the proposal of a working group of the Institute's team', in order

[62] Kerbouc'h, S. (2020), 'Training in 'disability governance'. Evaluation sociological study of the PéVA training, independent living pedagogy', research report, Paris, https://shs.hal.science/halshs-03203675v1/document.

to allow 'the taking into account of a diversity of existing situations and profiles of people'.

The second example is detailed in an article published in the journal *Pensée Plurielle*.[63] The authors, researchers in educational sciences, conducted two evaluations of residential homes for people with disabilities and dependency. Within the framework of these evaluations, they were particularly attentive to supporting the participation of the people being cared for and the staff in the evaluation. Indeed, they intend to contribute 'to the development of a practice of co-training and evaluation as an alternative to standardised and managerial approaches in social and healthcare settings'.[64] They call for an evaluation centred 'on the search for shared knowledge of the meaning of practices and the specificity of institutional issues, in order to produce a work of self-evaluation while contributing to the training of professionals'. Instead of 'prescriptive evaluation approaches', they prefer 'research methods capable of combining a scientific approach, uncertainty and the clinical issues that are specific to social and healthcare settings,' and 'the system supports the participation of residents and professionals in evaluation practices in an unprecedented way'. The authors 'took the decision to create conditions of trust through a constant presence and the deployment of spaces/forums for shared discussion and work, likely to enrich the approaches and reflections of each person. All subjects could be addressed, questions asked, scenarios and their options discussed'. These forums were intended to act as 'time and space for work, feedback, discussion and in-depth analysis', but were also intended to raise awareness and enlist the support of the settings' pilot actors, so that they could take up the approach and 'integrate its contributions into the school project'. The evaluation process was thus conceived 'as the crucible of a 'collective researcher', addressed to professionals but also to residents (especially during the initial data collection and feedback).

After a phase of presentation of the approach during an introductory seminar, the investigation was first composed of 'clinical presentations', 'ethno/anthropological' field observations, a literature review, informal interviews and analysis of computerised care plans. Working groups were then set up with professionals in order to examine in greater depth the themes identified in the first data collection phase. In-depth interviews were then conducted with each professional, before a final feedback session with professionals, residents and their families, which led to in-depth discussions and recommendations for the future.

However, the main limitation of these studies is that they were designed and conducted by academics and cannot be extended, if only because the pool of academics willing and able to conduct assessments is small. Although these initiatives certainly encourage the appropriation of the reference framework and methods by the teams of the services evaluated, it would be impossible to reproduce such an approach in all the organisations in the country. Currently, then, the only practice likely to encourage a large-scale appropriation of the CRPD guidelines might be the Cap'Handéo certification scheme described above. However, we must recall here its main

[63] Ponnou and Lemoine (2021), pp. 53-75, https:/www.cairn.info/revue-pensee-plurielle-2021-1-page-53.htm.

[64] This proposal is shared by other authors such as Dominique Fablet (2011), 'The internal evaluation of an innovative parent-child fostering service', *Connexions*, 2011/2, pp. 143-159, and Baptiste Lodéon (2017) 'Should social action evaluation evolve?' *Empan*, pp. 139-144.

limitations: the association offers national certification to service providers who self-evaluate under the distant (and partial, as the impact study mentioned above noted) supervision of other service providers.

It would therefore be a good idea to promote cooperation between university research and the certifying associations around the design of the evaluation procedures, and to ensure closer monitoring of the certifying associations, in particular to make sure that there is not too great a gap between the stated principles and what is actually evaluated.

5 Recommendations

5.1 Recommendations for France

- Developing piloting tools aligned with the UN principles in the elaboration and implementation of quality frameworks for social services. Strengthening the consideration of the CRPD principles and EU-level guidance. Bringing together not only evaluation professionals and facility managers, but also service professionals, service users (people with disabilities and carers) and their representatives, as well as academic research to define the quality of social services. Clarifying the difference between quality assurance and control, while establishing precise indicators to assess the actual implementation of the CRPD.

- Reducing the separation between mainstream and disability-specific sectors. Strengthening the quality assessment of personal support services, in particular the criteria likely to concern users with disabilities, and bringing it closer to the evaluation of ESSMSs. Developing the assessment of service accessibility beyond the material dimension: it is a question of assessing the opportunities that the services give to people with disabilities to participate in society.

- Taking into account workplace realities in the performance of quality assessments. Developing a quality assurance system that, rather than increasing the burden on employees of social and healthcare services, actually equips them to improve their practice in order to meet the needs of people with disabilities, respecting their rights and supporting their independent living. Ensuring that the working conditions and remuneration of staff are such that they can meet the objectives set.

5.2 Recommendations to the European Commission

- Supporting upskilling and reskilling processes in the social and healthcare services sector. Encouraging the development of training plans (for evaluating authorities, to deal with forms of participatory evaluation; for management functions, to integrate the participation of supported persons and their entourage; for supported persons, to structure their knowledge from experience), but also supporting, through working conditions, the transformation of professions in the social and healthcare services sector towards an approach centred on the pathway of the supported person.

- Encouraging the financing of projects that support systemic transformation of services towards quality coherently with UN CRPD principles, instead of focusing solely on evaluation procedures. Supporting the systemic transformation of services by avoiding focusing solely on the improvement of the reference systems and evaluation methods in isolation. Ensuring that the conditions of practice of the personal service professions, the funding mechanisms and the reception of evaluation reports by the authorities are also in line with the UN CRPD principles.

- Discouraging segregation between disability-specific services and mainstream services when monitoring policy developments in the sector of personal support services across the Member States. Giving priority to the assessment of the level of accessibility of service providers. Accessibility, in its broadest meaning, is related to the enabling effect of services provided. This enabling effect refers to the effectiveness of the rights persons with disability can access to as defined by the UNRPD. It includes also the effectiveness of persons with disabilities' participation opportunities in mainstream society.

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