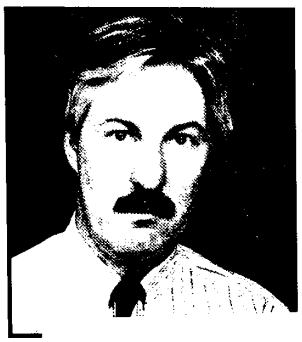
The ENQUIRE SYSTEM

A Workbook on Quality Assurance in Health and Social Care.

Huw Richards
Chris Heginbotham

King's Fund College

THE AUTHORS



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A WORKBOOK ON QUALITY ASSURANCE IN HEALTH AND SOCIAL CARE

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PREFACE

The materials in this workbook are copyright to the authors; however the authors are willing to give their permission for their use and application following consultation. The value of these tools and approaches is in their comprehensive application. Any use which dilutes the basic structure of the approach is liable to lead to incomplete or inaccurate quality assurance procedures, which will not achieve the desired outcomes of an improving and improved service.

An **ENQUIRE** Casebook is in preparation together with computer guidance on data analysis. Further advice and guidance on the application of the **ENQUIRE** System can be obtained from the authors.

ACKNOWLEDGEMENTS

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HUW RICHARDS
CHRIS HEGINBOTHAM

LONDON 1989

CONTENTS

Wherever possible, visual aids and conceptual diagrams are used to aid understanding of the **ENQUIRE** process. We hope that the **ENQUIRE SYSTEM** outlined in this workbook is sufficiently explanatory, even in dealing with difficult areas, such as the validation of observations to encourage readers to consider the potential for a practical Quality Assurance Programme in their area.

INTRODUCTION

This workbook outlining the ENQUIRE System is intended to be a practical guide to establishing and running quality assurance programmes (QAPs) for health and social care. The workbook is based on a number of conceptual tools, which provide both a framework for quality assurance, and assistance in appreciating its full potential.

The primary aim of this workbook is to provide managers, front-line workers, external and internal "inspectors", informal carers and service users, with a shared framework for consultation and evaluation of the quality of services.

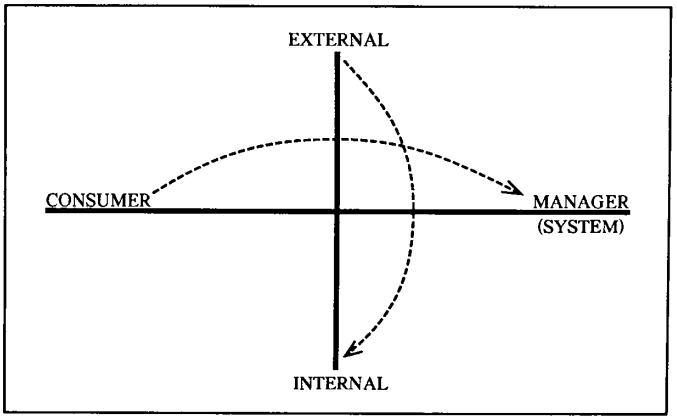
This workbook is predominantly concerned with community care - that is with health and social care provided by a range of agencies to people requiring long term support. However it has applications in acute and community services and can be used in residential and hospital provision. The ideas contained in the book can therefore be used in a variety of ways, and it will be seen that the basic concepts are relevant to a wide variety of health and social service applications.

The initiative in setting up quality assurance programmes is likely to come from professional staff or management and may be extended to include carers and users. Sometimes the stimulus will come from suggestions or complaints procedures, or from service users themselves or their advocates.

It is important that the skills required in setting up quality assurance programmes should not create a competence test or barrier to the full involvement of carers and service users. Indeed, it is the contention of this workbook that the involvement of service users at all levels in the planning, development and management of care can be promoted by an effective quality assurance package. We shall also see that quality of life outcomes for the users of services is an important component in the development of quality assurance.

Since it is intended to be a workbook, theoretical concerns have been kept to a minimum, though some key principles are considered. However, the tools used can be extended with some theoretical additions and create powerful mechanisms for tackling quality issues. The main emphasis of the workbook is on evaluation and acting upon reported observations about services to people. The workbook builds on the simple schema shown in Figure 1.

Figure 1



Using external or externalised observations of a service, internal changes can be promoted. Front line workers, and consumer views translate into management action through the use of quality cycles and the judicious application of both internal and external observation brought together in composite approaches. More will be said about this below.

The **ENQUIRE** System is an "umbrella" under which many kinds of Quality Assurance Programmes can take place. A wide range of existing tools and some other developed systems can be used within the **ENQUIRE** cycles providing that they can be shown by the designers of the QAP to be consistent with the basic tenets of **ENQUIRE.**

The term quality assurance is used in this workbook to encompass quality measurement and quality enhancement. Quality asssurance is more than controlling for set standards but requires an active search for constant improvement in the quality of the service.

SECTION 1

QUALITY ASSURANCE

SECTION 1
QUALITY ASSURANCE

Quality assurance has explicit criteria for evaluation and promotes effective communication

QA is a method by which service providers, be they front-line staff, managers or inspection or monitoring staff (either internal or external) can assess the degree to which the objectives of the service are met to a level which is likely to provide satisfaction to the users of the service. A QA programme (QAP) is therefore a regular process and cannot rely wholly on "one-off" visits or inspections. It also provides a framework and content, which enables communication between managers, staff and users and the evaluators of the service. Criteria for the evaluation are made explicit and shared, which thus increases the potential for the findings to be agreed at all levels as action plans.

The Language of Quality

INSPECTION	Quality by Regular Monitoring Quality by Checklists
ACCREDITATION	Quality as Standards Quality by Volume
MANAGEMENT	Quality through Staff Appraisal Quality of Service Quality by Case-Management
CLINICIAN	Quality as Good Practice Quality by Clinical Audit Quality of Care Quality as Effectiveness
PATIENT CLIENT USER CONSUMER CITIZEN	User Satisfaction Quality of Life

Figure 2

Quality assurance can be a peer review exercise, whereby units, services, wards or projects can undertake reciprocal evaluations. Involvement of the staff from different components of a service in a quality assurance team may enable a form of "externalised" review to be made, whilst rooting that review in the services under consideration. A QAP introduced correctly will create a positive climate of evaluation, which can be self critical without being threatening, and allow external monitoring on the basis of explicit criteria.

Quality assurance addresses the quality of what?

The language of "quality" in health and social services is now common. In setting up a QAP however, it is important to be clear as to the quality of which components of the programme it is intended to address. Here it is important to consider the language of "quality". Figure 2 demonstrates the various approaches taken to quality and some of the language used to describe those approaches.

Following Figure 2 we can visualise the language of quality as operates in six basic domains as shown in Figure 3.

The Language of "Quality" Can Be Summarised as Follows:

Figure 3

Quality from Regulatory Inspectorates (Standards Setting)	Quality from the Application of "Norms" Contract Specification	Quality by addressing Accreditation Registration
Quality from measuring Inputs against Outputs Cost / Benefit Medical Audit	Quality from Care and Service	Quality of Life User Satisfaction Assessments Measures of "Wellbeing"

Definitions of quality

Maxwell defined six dimensions of quality as follows:

Maxwell's Six Dimensions of Quality

Acceptability

Effectiveness

Access

Equity

Efficiency and Economy

Relevance

We have already seen Maxwell's definition of quality as having six dimensions. We shall discuss these six dimensions further, but at this stage it should be noted that these are not unrelated terms. Whilst they indicate the scope of what might be understood by the term "quality", these features are not mutually exclusive and the inter-relationship between them must be considered carefully.

The MIND/Richmond Fellowship Study Team on Quality and Community Mental Health Care suggested that quality could be defined as follows:

"Quality is excellence in the deployment of skills, abilities and capacities, leading to the attainment of a service, which provides care, support and treatment in a way which is relevant, accessible and responsive to individual and community need." (MIND / Richmond Fellowship : 1990)

It will be seen that Maxwell's relevance, accessibility and responsiveness criteria are included, but that the MIND/Richmond Fellowship are concerned with the notion of excellence and in the deployment of skills. In this definition the processes by which staff use their skills are of paramount importance.

On the other hand, the Audit Commission in its Action Guide on performance review in local government (1988) suggests that service effectiveness includes getting to the right customers, by the right methods and organisation, with the right levels and quality of service, and is concerned about final results and outcomes. They see quality as being within the third of these - effectiveness - with the right levels and quality of service and considers quality as concerned with such things as delays or waiting times, inspections and audit, consumer surveys and in-service staff training and motivation. This is perhaps a narrow way of viewing quality, when so much of their view of effectiveness is concerned with what the present authors consider to be quality, expressed in one way or another (see Figure 4).

Figure 4

Structure - Outcome
Issues in Service Effectiveness & Quality

Structure

Getting to the right customers	By the right organisation	With the right levels & methods of delivery
Some services are statutory, eg. education. Others are unavoidable, eg. child protection. Others are discretionary, eg. generic social services.	How the service is structured -Centralised or decentralised -Divided eg. - by customers - by age - by area - by specialism - by a combination of these	Type of service -General or specialist Quantity of service -opening hours -stock levels -numbers dealt with -delivery times
Where appropriate, define client groups -who are the customers -are we getting to the right ones -how do we know	Community or facility based will depend on the type of service given: -mobile or central libraries -community or residential care for -the elderly	Measurement -delays, waiting time -inspection services -consumer surveys -in-service staff training / motivation
Reaching more / different customers, by -marketing -pricing differently -providing better quality -using resources more efficiently	Alternative methods, such as -publicity v enforcement -use of voluntary organisations	
Targeting scarce resources -enforced action		
Reducing the need for services eg. -home support to young parents -drug abuse prevention		

Outcome

Concerns about final results & outcomes

Public protection
eg. fire service, police:
-fewer deaths
-greater public safety
-approved social works

Better environment
eg. planning environmental services:
-valued settings
-improved appearance
-safe & efficient transport systems

Services for economic or personal development
eg. education, libraries ;
-employability
-cultural awareness
-personal growth & happiness

Safety nets
eg. housing, social services:
-support for those in need
-good housing at affordable costs

Source : Based on Audit Commision Action Guide 1988

In the same booklet, the Commission demonstrate the inter-relationship between needs, outcomes and quality on a chart which also relates the population of "customers" (ie of services) and the quantity of the service actually provided. As can be seen from Fig 5, the relationship of needs to outcomes is shown as adding value to people's lives. The relationship between needs and quality is that of service sufficiency, but the relationship of quality to outcomes is one of effectiveness. It will be noted that this relates to the point made above about the effectiveness of services being the achievement of the objectives set by both staff and service users.

Figure 5

Source: Performance Review in Local Government: Action Guide (Audit Commission 1988)

Definition alone is probably unhelpful in that quality assurance is a multifaceted and all embracing approach to ensuring that services achieve their objectives set, constantly informing the process of change to improve those services. Quality assurance is part of a change management system. By involving staff and service users at all levels, it is possible to change services over time in a way which is accepted by staff and users. Thus changes are made easier because they are "owned" by the management and staff concerned.

Quality assurance links quality of service to quality of life

Quality assurance programmes introduced here are designed to create a link between the quality of services, the quality of care, support and treatment, and the likely outcomes for service users. The focus on service outcomes enables us to consider how these outcomes impact on users quality of life. It is this linkage that is complex, as yet not fully developed but yet so important.

Most staff effort is expended at significant cost on direct care and treatment intended to create good treatment and thus health outcomes, and by extension, improved quality of life outcomes for the users of the service. It is this point at which managers usually target maximum resources - the National Health Service and Social Services spend by far the largest bulk of their resources on staff, principally staff involved in 'front-line' work. The quality procedures suggested here enable managers and staff to consider carefully whether the targetting of those resources is indeed achieving the quality of life outcomes which they or the service users would wish to see.

The relationship between services, care and quality of life is nevertheless always problematic. Not all aspects of the user's quality of life will be attributable to the quality of care, support and treatment. Measures of quality of life and wellbeing provide an important bearing on the effectiveness of a service, and the same factors may determine the outcome from a more focused use of the measurement of "user satisfaction" with services.

However, they are not able to provide the "final word" on the value of a service any more than services permeate and determine all aspects of a user's life.

A number of direct user satisfaction measures can be included in quality assurance programmes and some of these will be outlined later. It is important to recognise the interplay between quality in the processes of a user's life and the quality of life outcomes for the service user. Sometimes these two features are intimately inter-related, and we shall discuss this further later on in the section.

There are a variety of approaches to quality, which are focused in such a way as to be only an indirect indicator of outcomes for users. These can be helpful in conjunction with the approach outlined here, but must be regarded as preparatory briefing materials for a quality assurance programme, rather than conclusive measures themselves. These materials might be:

a) Socio-demographic information about the environment of the service;

b) Results from the application of "standards" or "norms" in the service, or results of checklist approaches which may have been undertaken in the past, based on some bureaucratic requirement;

c) Input information, such as the number of beds, numbers of staff with particular qualifications and so forth;

d) Fulfillment of accreditation criteria for training purposes;

e) Clinical audit procedures established independently of a wider concern for the overall service;

f) Specific cost benefit analysis studies or those which consider the relationship between "input" and "output" for example, bed usage, patient throughput, numbers of attendances at outpatient departments.

These materials are helpful but must be seen as preparatory. They tend to be of a quantitative nature, whereas the quality assurance programmes outlined here are concerned with qualitative approaches to evaluation, using perceptions, observations and reports from people close to and at the point of service delivery. The tools demonstrated in this workbook enable this information to be used in as effective a way as possible, bringing together existing quantitative data, newly derived qualitative and validated observational data, and newly established quantitative data based on locally derived quasi-quantitative approaches following the development of quality assurance programmes.

The quality assurance programme is centrally concerned with the effectiveness of a service and its impact on the service user. Effectiveness is usually defined in the literature as the relationship between the outputs or outcomes of a service, measured against the objectives set. In other words, the most important question to address is to what extent has the service actually achieved what it has set out to achieve ?

There has been considerable emphasis in recent years on what have become known as the three (and sometimes four) "E's"; Efficiency, Economy and Effectiveness, to which is often added the term Equity. The approach outlined here sets out to link quality assurance to an appraisal of effectiveness - that is the extent to which service or activities achieve their objectives as established by the front-line workers and the users of the service.

Any service must pay attention to matters of economy - that is to meet its objectives with the smallest practical input; and to be efficient - that is to get the greatest output for the least practical input. The avoidance of unproductive expenditure addresses the matter of whether the service needs to be there at all.

The service must also address the volume of service it can provide, the number of people served, for how long and at what cost. The service should be aware of its responsibility in the context of relatively scarce resources and address matters of equitable distribution to its target population. Most of these concerns are dealt with by management, policy makers and in resource allocation and are generally approached and pursued by quantitative methods.

The quality of a service will largely be dependent upon resource availability and the way in which those resources are deployed But it is that deployment, especially the processes in that deployment which matter most.

The intention of the **ENQUIRE** System and this workbook is to add to these components a qualitative appraisal of the effects of practice in terms of the outcomes in the lives of the service users, and whether those outcomes are valued and desired personal futures for those users.If this can be achieved through QAPs then qualitative understanding and effectiveness can be set alongside quantitative measures within the process of management and resource allocation, thereby giving a 'voice' to front-line workers and service users in that process. We believe that the **ENQUIRE** System creates such a framework.

Quality Assurance Is Systematic

An effective quality assurance programme will enable practitioners to review their activity systematically, in partnership with users within a framework which can be the basis for continuing collaboration with managers and resource providers. The quality assurance programmes outlined in this workbook are concerned with the valued and desired personal outcomes for service users within their social and community context. The QAP's thus provide an evaluative bridge between perspectives of service providers and those of service users.

Quality Assurance In Community And Long-Term Care

Quality Assurance in community care (community health and social care), especially for people in the so called 'priority" groups - people with mental illnesses, learning disabilities, physical disabilities and elderly people - is very different to acute health care.

Two key differences can be discerned. Firstly, that needs for long-term care may be such that medical (or more broadly health) care is a relatively small component; and secondly the recognition that such services aim to improve the ability of a person to function independently within society - rehabilitation, enhanced social functioning. In long term care improvement and autonomy may fluctuate, and may be harder to discern and promote, requiring a different approach to quality assurance to that undertaken in acute care.

A further important difference is the changing pattern of long-term care. Traditional hospital based services are being replaced with localised, decentralised community services, and dispersal and diversity present a major challenge to quality assurance and quality enhancement.

The last few years have seen an increasing emphasis on quality in community health and social care. Various approaches have been taken and are reviewed briefly here. In community care settings it is essential to consider the linked relationships between quality in 'acute' in-patient services, and emergency care, rehabilitative services, and social and long term support. In other words one services' outcomes can be a linked services "inputs".

Traditional quality assurance has focused on three service components of **structure**, **process** and **outcome** (Donabedian 1966), and we shall use this scheme in developing the Quality Matrix (Q#) later in the workbook. Structural issues should not be confused simply with inputs - there will be inputs to each aspect of structure, process and outcomes; and outcomes should not be confused simply with outputs. The outputs may be a measurable result, for example, numbers of patients treated, but tells us little about the outcome of that treatment or what happens to the service itself.

Adverse Patient Occurrence (APO) systems have been used extensively in acute medical and surgical care. They are helpful in settings (e.g. acute hospitals) where outcomes are relatively predictable and

variation from a mean prognosis can be determined. In long term and rehabilitative care "health" may fluctuate in less easily defined ways. A relapse or adverse reaction to treatment may not be an adverse occurrence in the traditional sense but simply be part of the ups-and-downs of overcoming distress, learning social skills or developing independence after illness.

In the paragraphs below we briefly consider structure, process and outcome issues as seen by a variety of authors and organisations and note the main QA measures or tools in each section.

Structure

The structure of 'priority' services is often the major concern of accrediting agencies. Performance indicators (PI) (Department of Health, 1989) are almost wholly concerned with structural issues - for example, numbers of staff, by professional group employed, number of beds, number of day places, etc. The Health Advisory Service (HAS), local authority registering offices, nursing home registration by health authorities are all concerned mainly with structural concerns.

The "Home Life" code, part of the Registered Homes Act 1984 is predominantly concerned with structure - fire regulations, kitchen cleanliness, book keeping, numbers of trained staff, etc. HAS reports however consider environmental quality - a key component where it influences and affects the quality of care for residents.

Process

The quality of processes in community health and social care have taken a higher profile in the last two or three years. Sometimes these have been concerned with processes of organisational change (Koch 1989) but more importantly the processes of staff management and training, staff-team interactions and staff-client interactions. These are covered in publications on quality measurement (Huxley 1986) and to some degree in publications on multi disciplinary team organisation (Oretveit 1986).

One of the most important process-oriented QA systems is QUARTZ which has been developed by the National Unit for Psychiatric Research and Development (NUPRD)[*Now Research and Development in Psychiatry*] and is intended to ensure a review process containing elements of both internal and external review of the processes of care / treatment which take place within a unit. This system, placed within a framework of environmental quality and external community links, is highly centred on the staff of the service and on assisting them to achieve improved ways of working. It is shown in simple diagrammatic form at Figure 6.

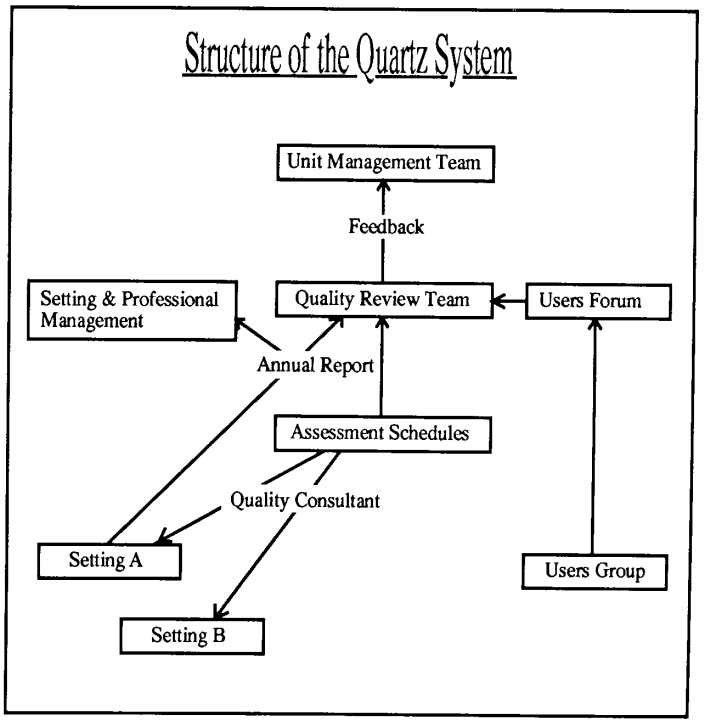


Figure 6

Outcome Measures

Most quality assurance systems contain certain output measures and some outcome measures. QUARTZ, for example, will produce information on outcomes of the care process.

Few systems, however, concentrate on quality of life outcomes for service users. Increasing emphasis on this area is leading to wider concern for consumer involvement and in finding ways of measuring consumer satisfaction (Perry and Deeble, 1989; Camden Consortium/GPMH, 1988; Avon Mental Health Alliance, 1989). These approaches emphasise the views of service users on choice, "empowerment", attitudes of staff, privacy, attitudes towards consent, etc. The distinction between choosing as a process and choices as an outcome is difficult to define and is rarely made explicit. Consumer satisfaction survey instruments have been developed (Perry and Deeble, 1989; Raffael 1977) but appear to be less often used than process systems.

Comprehensive Quality Assurance

The distinction between structure, process and outcome has value in demonstrating the main emphasis of many quality assurance schemes. However, such a three-way distinction is insufficient for the analysis of complex systems such as those found in health care. This workbook builds on Donabedian's three levels to create a Quality Matrix (Q#) of 21 cells. (See section 4 below). Other authors have made recent attempts to draw these levels together (e.g. Rosen, Miller and Parker 1989). The Quality Matrix (Q#) helps both as a conceptual framework for thinking about quality, as a tool for analysing validated observations of a service, and in pin-pointing a range of available mechanisms for tackling quality issues in specific parts of service.

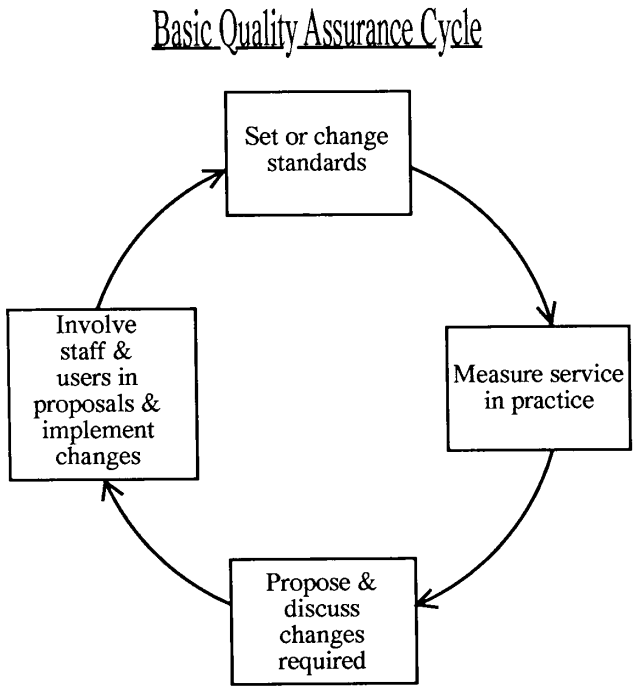


Figure 7a

However, a comprehensive quality assurance system must be part of a cycle of assurance and quality enhancement. Quality measurement is concerned to find indicators which reflect management, staff and user concerns with specific ideas of quality. Quality Assurance, however, is that measurement allied to a stated aim to use the measurements to assist in moving towards some stated objective of improved quality. A simple cycle of quality assurance is shown in Figure 7a. The practice of a service is compared with expectations, changes implemented, the new practices observed and then again compared with expectations. All quality assurance systems must have such a cycle as an underpinning approach to be effective and, as we shall see, it is possible to describe that cycle with greater richness, covering the constituent components subsumed within the general headings shown in Figure 7b.

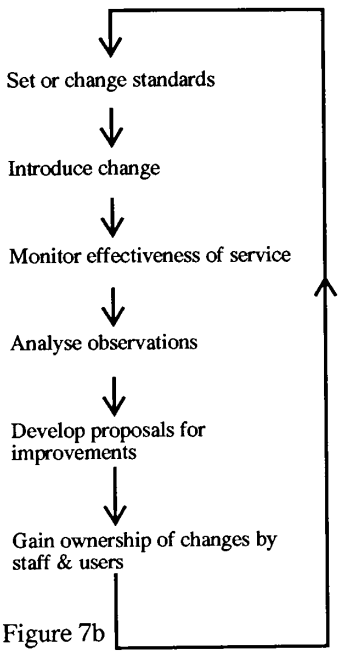


Figure 7b

Standards

Some systems whether they focus on structure, process or outcomes are based on developed schedules or standards. QUARTZ, for example, has refined a series of schedules based on piloting across a range of settings. The Queensland (Rosen et al) system proposes a wide range of standards based on life skills profiles and listings, including for example, proposed standards for area integrated mental health services. Such approaches have advantages and disadvantages. Providing checklists and agreed worked-out standards enables rapid application to a particular service or unit. Conversely slavish application of such check lists may not be accepted fully by staff.

One well known quality analysis system is provided by PASS (Programme Analysis of Service Systems), and is based on the concept of normalisation - that services for people who have been devalued (e.g. people with learning disabilities) should be developed in settings which are valued in the community as a way of enhancing and establishing valued life styles. The PASS system rates a service on the basis of a wide variety of factors which reflect the normalisation goal. One key component however draws together outcomes, structures and processes in what is known as "model coherency".

This assists in relating service objectives to results in a way which demonstrates both past failures and future potential of the service. Whilst PASS does not measure quality of life outcomes for service users it nonetheless offers an approach rooted in a belief in dignity and the human worth of each client and is thus outcome-oriented (as contrasted with the process orientation of QUARTZ, for example).

In a wide ranging review of quality assurance for long term care Chambers (1985) described a range of strategies initiated from outside service facilities. He enumerated nine approaches including external criteria set by accrediting bodies, basic education for care providers, advanced training in quality assurance for service staff, financial incentives to improve quality, certification of services or programmes, mandatory review of facilities and voluntary peer group review. Each of these approaches will have a place in quality management. (Figure 8).

The general tone of the literature however suggests an increasing emphasis on concern for the individual patient or client and thus on the quality of care processes and quality of life outcomes. This in turn has lead to increased emphasis in the literature on consumer orientation and consumer involvement both in the management of care facilities and in quality measures.

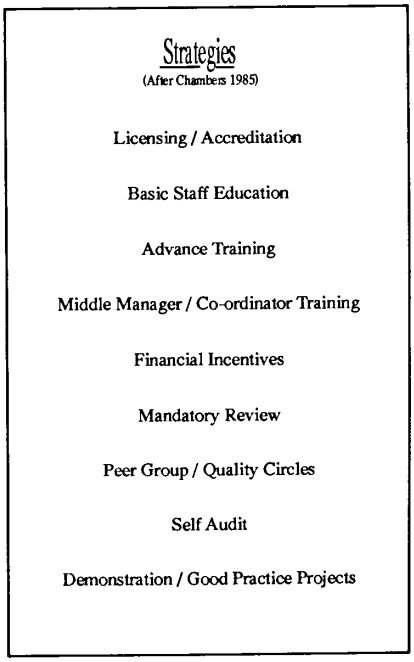


Figure 8

At the same time human resource discussions are beginning to place a greater weight on the staff-client interaction and on team building incorporating client feedback. Whilst standards and checklists are necessary to obtain quasi-numerical data for comparative purposes over time, there appears to be a widening interest in creating learning environments in which staff and service users can interact more fully for the long term benefit of the client.

Quality and Cost

Concerns about quality have become more focused since the Government announced its intention that all health authorities will develop contracts (planning agreements) between the Health Authority and its provider units. Similarly, the "enabling" local authority will purchase a range of services from the private and voluntary sector to meet assessed need. (Caring for People, 1989). Such contracts or planning agreements must set out the service which is to be provided (Service Specification) and which will incorporate the number of episodes of care, the type of care and cost (See Figure 9). Inevitably such specifications must make assumptions about the quality of care. As a very minimum the number of episodes of care and such issues as waiting times must be considered; but any effective contract will specify more detail about quality - and that quality will be related in both direct and indirect ways to the resources made available for the service.

Figure 9 Quality in Relation to Service Definition & Cost

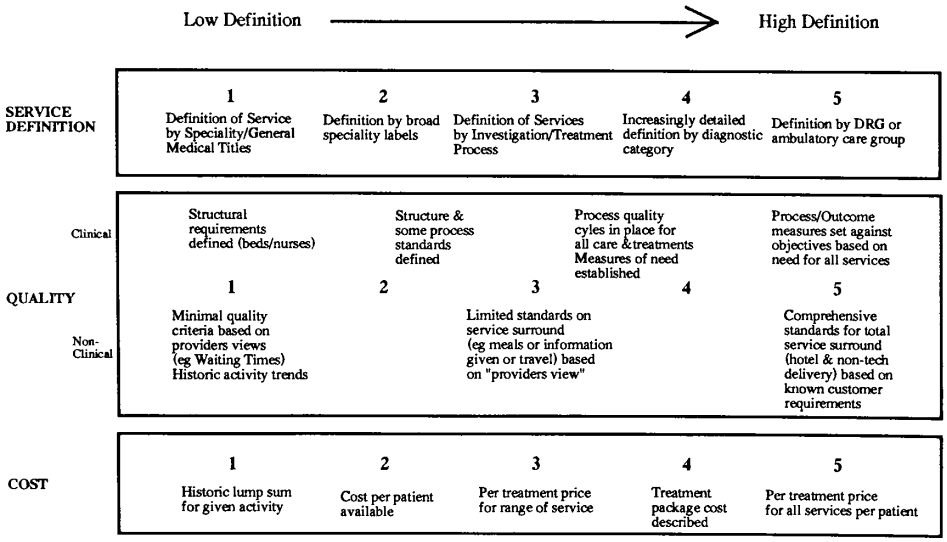
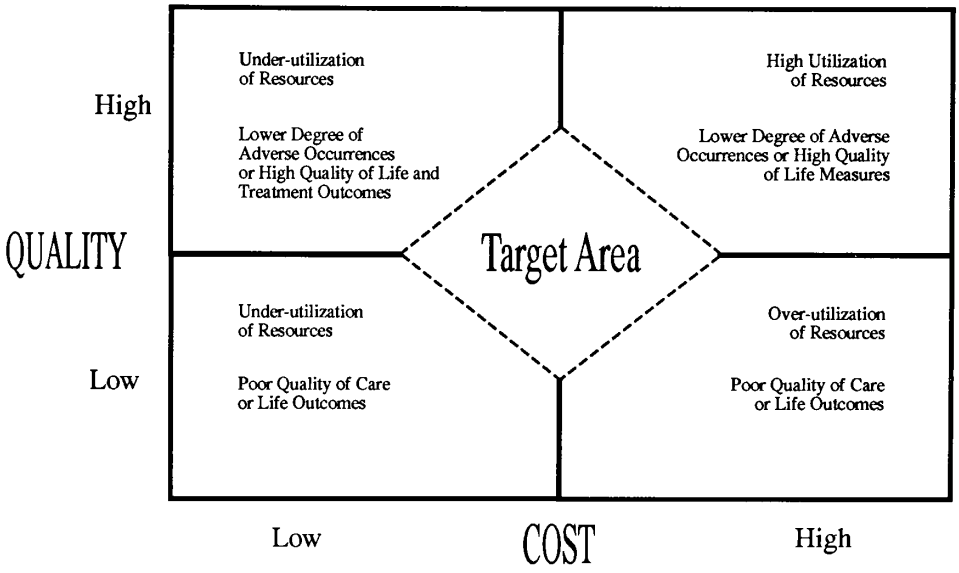


Figure 10 demonstrates that high cost does not necessary equal high quality. Even low levels of resources can be used effectively to create a quality service; but there will be a limit to the amount of that service - some users may get a good quality service when others get no service at all. On the other hand, large amounts of resources can be badly used and squandered leading to over-utilisation and poor quality outcomes. Somewhere in the middle is an area of reasonable cost at appropriate quality. Trying to increase quality beyond some (fairly high) level will begin to increase cost dramatically. The challenge is thus to achieve high quality at realistic cost without QA being used inappropriately to cut resources or to enforce changes which have not been agreed with staff and service users.

Figure 10

Cost / Quality Variations



SECTION 2

QUALITY ASSURANCE PROGRAMMES

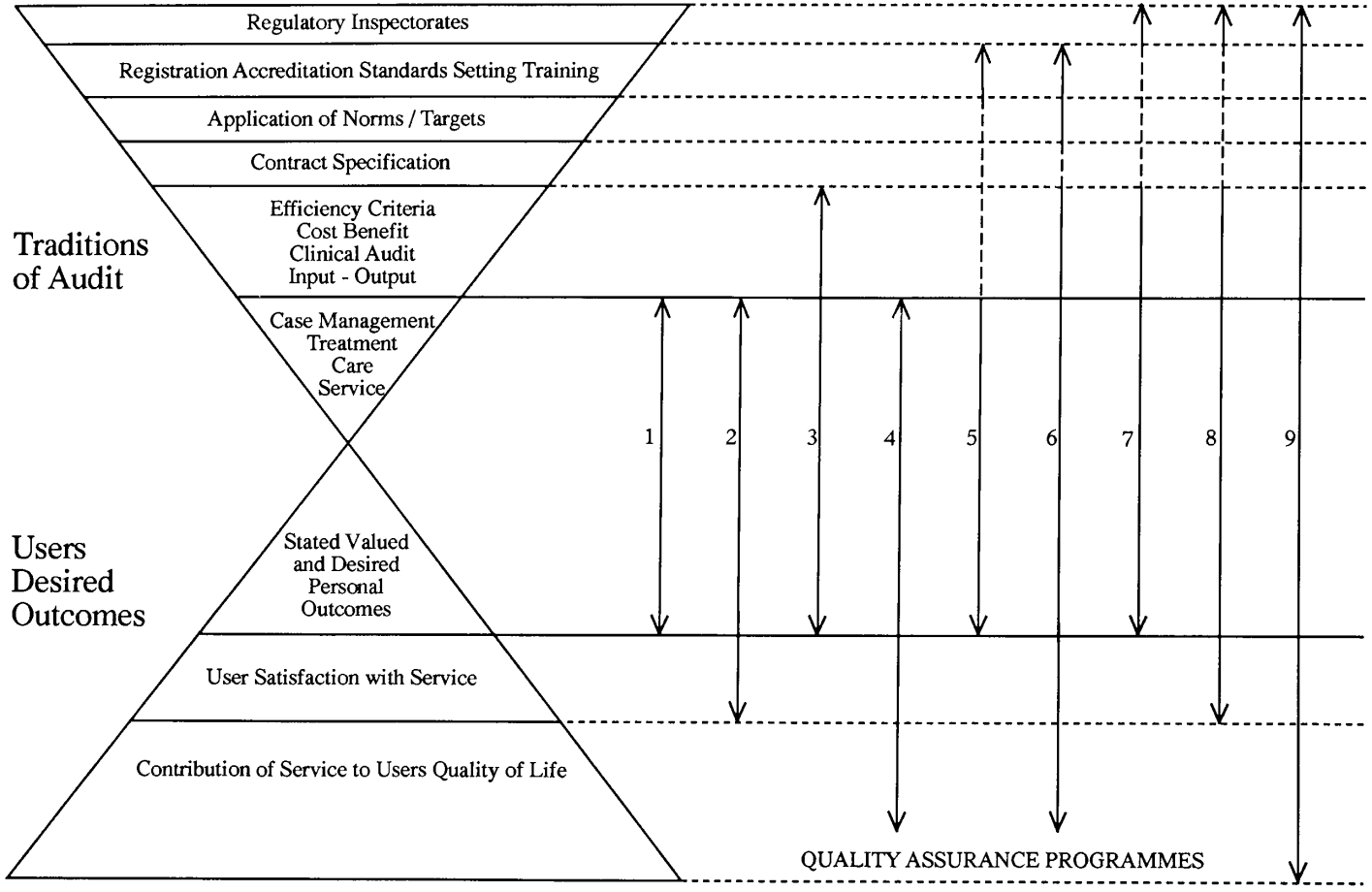

Regulatory Inspectorates
Registration Accreditation Standards Setting Training
Application of Norms / Targets
Contract Specification
Efficiency Criteria
Cost Benefit
Clinical Audit
Input - Output
Traditions of Audit
Case Management
Treatment
Care
Service
1
2
3
4
5
6
7
8
9
Users Desired Outcomes
Stated Valued and Desired Personal Outcomes
User Satisfaction with Service
Contribution of Service to Users Quality of Life
QUALITY ASSURANCE PROGRAMMES

Figure 11

SECTION 2
QUALITY ASSURANCE PROGRAMMES

Quality assurance, as we have seen, is the measurement of quality with the stated intent to use the information to amend and enhance the service. A quality assurance programme can be more or less encompassing of a range of factors applicable to a service. At its simplest, quality assurance will be concerned to ensure that the treatment and care provided to a patient or client, service user or customer achieves valued and desired personal outcomes for that service user. At its most encompassing, a quality assurance programme will cover a complete range of interventions and actions from regulation and inspectorate approaches to investigations of the contribution of the service to the quality of life of service users. This can be seen in Figure 11 where the "hour glass" demonstrates the relationship between different traditions of audit, contrasted with the desired outcomes and quality of life measures for the users of the service. On that diagram we indicate nine possible Quality Assurance Programmes (QAP) (from the wide variety of possible programmes) which take in a range of these traditions of audit set against three levels of user outcome measures (Fig 12).

In Figure 12 some examples are given which would be involved in each of QAP's 1 to 9.We can thus apply the QAP to a varying number of elements in the whole framework. Later we will show that communication between participants in a quality assurance programme can be achieved by adopting standard instruments.

As an introduction to QA programmes however, it is important that all those undertaking such programmes are involved in deciding what matters within a service and do not slavishly apply checklists or schedules developed elsewhere. Even though quality assurance programmes can be developed with an increasing number of participants, they will all use the same framework for evaluation and thus share a common approach.

The simplest quality assurance programme is that undertaken by frontline staff only and is a form of self-assessment or reciprocal peer review (which can also be between units if desired). Sometimes this is undertaken as quality circles, sometimes through structured discussion on a weekly or monthly basis. One advantage is that it builds confidence and familiarity with the approach proposed here. Essentially this is QAP 1 as shown in Figure 12. At this level the staff are making decisions about whether they believe the service achieves valued and desired personal outcomes for users. QAP 2 then builds on this basic programme to involve the users, who are then consulted and included in the programme. Their comments and observations are recorded, or in some cases user satisfaction instruments can be developed.

Where the basic programme is linked to specific audit tools, such as cost budget analysis and clinical audit, then external research evaluators or professional quality assurance practitioners may be involved in gathering specific data. This, as we shall see later, is useful briefing and background material for a quality assurance programme, and may be commissioned by the quality assurance team itself.

In other words, the QAP undertaken by frontline staff can be enriched by having wider information about the environment in which they work and quantitative information from clinical audit. This is shown as QAP 3.

Extending QAP 2 (the basic staff review of quality enhanced with user satisfaction surveys) to include global well-being measures (for example, Lehman's quality of life measures, or Oliver's recent work) creates some theoretical problems which are discussed further in Sections 5 and 6. These should be considered carefully, but nonetheless the importance of developing effective user outcome measures particularly quality of life outcomes - is extremely important. This is shown as QAP 4.

When registration officers of local authorities undertake their registering and monitoring functions, either as "arms length" inspectors of an "internal" service or as external accreditors, they usually limit themselves to contact with service providers. This is thus a variant of the basic quality assurance programme.

Figure 12 **Quality Assurance Programmes (QAP)**

QAP	1	2	3	4	5	6	7	8	9	
Regulatory Inspectorates							*	*	*	
Registration / Accreditation Standards / Training					*	*			*	
Application of Norms / Targets						*			*	
Contract Specification			(*)						*	
Efficiency Criteria Cost Benefit Clinical Audit Inputs / Outputs			*			*			*	
Case Management Care Support Treatment	*	*	*	*	*	*	*	*	*	Core of all programmes
Stated Valued and Desired Personal Outcomes	*	*	*	*	*	*	*	*	*	
Other Satisfaction Studies		*		*		*		*	*	
Service Contribution to Users Quality of Life				*		*			*	

Involving registration or accreditation staff brings an additional perspective on quality and becomes a distinct programme if that level is linked to QAP 1. This is shown as QAP 5 (where the dotted line in Figure 11 is meant to demonstrate that those levels are not involved in this programme). QAP 6 is intended to demonstrate that there will be times when a basic programme involving the users of services will wish to take note of information on registration and accreditation and other efficiency criteria, but not to participate in undertaking formal studies.

QAP's 7 and 8 are intended to recognise that regulatory bodies (the Health Advisory Service, Mental Health Act Commission, Scottish Mental Welfare Commission, Social Services Inspectorate) may undertake short-term visits which can be seen in the light of Quality Assurance Programmes and which might be done in collaboration with peer review and / or consumer involvement surveys as in QAP 1 and QAP 2. It may be helpful for such regulatory bodies to consider adopting the approach set out in this workbook; the "inspection" perspective is not necessarily incompatible with quality assurance programmes. Adopting the framework set out here may greatly enhance observations, communication, evaluation and feedback to the services being scrutinised. Such regulatory activity, because it is external, is given a separate category as programmes 7 and 8.

Finally, QAP 9 is intended to convey the full potential scope of the **ENQUIRE** System. The system offers a framework for using all levels in the traditions of audit and the three levels of user outcomes. It can be seen in figure 12 that the system builds on each of the earlier quality assurance programmes to create an encompassing approach.

The complete diagram (Figure 11) demonstrates the scope of quality assurance programmes and illustrates the increasing number of perspectives which can be generated as the number and type of participants increases. The core quality programme is QAP 1.

This is the simplest and easiest to control and manage. It also generates "ownership" by the staff (and users) involved. QAP 1 involves frontline staff and informal discussion with users and is the essential core of any quality programme. QAP 2 involves frontline staff and a structured questionnaire to users regarding service; QAP 5 involves frontline staff, internal inspectors (e.g. registration officers) or external accreditation visitors (or an "externalised" team drawn from the service but encouraged to take an objective view of components of the service) and discussions with users reported by staff; QAPs 7 and 8 are programmes involving external regulators, inspectors and open up wide ranging contacts, communication and feedback systems. Such visits must be planned in detail to utilise the approach outlined here, and will work most effectively with a regular commitment by staff to quality assurance. QAP 9 includes a consideration of quality in contracts. Obviously if a service believes this to be important a QAP might be devised which links QAP 1 (the core programme) to contract issues - we might designate this QAP 1A.

Reference has been made to the linkage between quality assurance programmes and in - service training. Training of staff is crucial to promoting, supporting and sustaining quality assurance programmes. Learning how to set up a quality programme is indistinguishable from undertaking such a programme at the outset. Some internal management monitoring and inspection arrangements may also be closely associated with training for the staff undertaking such programmes.

The scope of quality assurance is determined by the range of participants and by the degree to which such programmes can be extended beyond "life outcomes" created or sustained by the service itself.

It is essential to bear in mind that quality of life measures will address issues beyond and outside the service. For example, one service user said that a good quality of life outcome would be to cease to be a service user at all! That will not be possible for all, but demonstrates the importance that the service be able to look outwards. Thus Quality Assurance Programmes must be concerned with those who may have to use a service but who may be unwilling or unable to do so, or for whom recovery or independence means disengaging from the service.

These variants of quality assurance programmes are not the only ones available. Other combinations could be developed and indeed we shall see that the development of a quality cycle requires the use of different approaches at different times, in different settings. There is no reason why a programme must progress from QAP 1 to some more embracing approach. The core of staff-user interactions involving the ownership of staff in the development of their care support and treatment service is the one which is most empowering of staff and service users. As staff and user confidence increases, so should their ability to improve the quality of their service. As this happens, managerial internal arrangements and regulatory systems might be invited to join a programme and to gradually extend the scope of the programme to include other levels within the diagram. Alternatively, managers may wish to encourage a quality assurance programme but might chose to use a training input rather than a monitoring or inspection channel through which to introduce it.

SECTION 3
VALUES AND PRINCIPLES

SECTION 3
VALUES AND PRINCIPLES

Any system of inspection and quality assurance is "value driven", and this is just as true for the ENQUIRE System outlined here.

The importance of the ENQUIRE system however, is that it is not based on values that some other group of people felt were important at some other time. Of course, many workers in the human services will wish to use the values enshrined in such instruments as PASS, the principles of "an ordinary life" and a range of human rights principles - for example, that each person shall be treated according to their human worth, without discrimination on the grounds of race, gender, disability and other factors, and shall not be subject to any form of degrading treatment. We can multiply these principles at great length. The point to note here is that the tools outlined here and the further analytic work which follows from them enable the values which staff and consumers believe are important to become explicit and influence action planning. In other words the instruments can be tuned to the demands of staff and consumers and the service.

So often 'off the peg' systems such as PASS make a set of assumptions which have to be accepted as part of the package. That is not to say the authors feel there is anything much to disagree with in PASS and similar instruments; rather that the ENQUIRE System encompasses such other instruments which can then be used appropriately as part of the overall approach to quality assurance.

A number of authors have defined sets of principles and statements of good practice. Seedhouse proposed an Ethical Grid with 5 key principles as shown in Figure 13, on the other hand Brandon in developing notions of good practice suggests the key features shown on the right hand side of Figure 13. We can see that Seedhouse's principles become Brandon's practical lifestyles. For example respecting autonomy will enable real choices, always assuming that the consumer or client is capable of the autonomy that is to be respected and thus of making such choices. Similarly respecting people equally (if this is taken seriously) leads to good relationships. The table thus has been completed by incorporating in the centre a number of key functions which must be undertaken to enable the principles to be put into practice.

Figure 13

Principles +	1 Justifying the Limits 2 Tension of Interactive Principles	= Good Practice
Respecting autonomy	Listening to wishes Best interests Balance of care & control (Informed) consent	Real choices
Respecting people equally	Promise keeping Truth telling Non-discrimination Taking seriously Status, stigma & value Power sharing Educian duty Recognition of personal worth	Good relationships
Promote social integration	Balance of specialist & generic services Establishing opportunities for social interaction	Increased participation Real mixing
Creating conditions for autonomy	Sufficient resources Information Education Access Opportunity structures	Personal development
Beneficence	Doing no harm Minimising iatrogenesis	(Healthy lifestyle)
(SEEDHOUSE) Ethical grid	(H RICHARDS / C HEGINBOTHAM)	(BRANDON) 5 accomplishments of normalisation

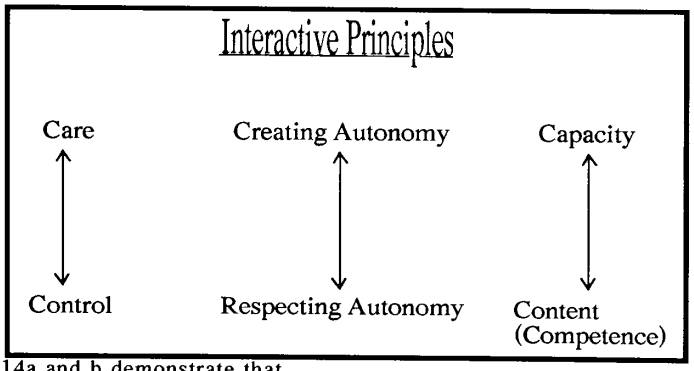
A further example might be helpful. Respecting autonomy can be turned into real choices only if the consumer is listened to, is treated in accordance with his or her best interests, his or her (more or less informed) consent is obtained for any intervention or treatment, and there is an effective balance of care and control. Similarly, respecting people equally requires the points shown in Figure 13.

It can be seen that the promotion of social integration requires an effective balance of specialist and generic services which establish opportunities for appropriate social interaction; but creating conditions for autonomy requires sufficient resources, information, education, access and opportunity structures; whilst beneficence, which leads to truly healthy lifestyles and thus quality outcomes for users lives demands the principle of doing no harm and of minimising any iatrogenic disorder which may occur - using iatrogenic in the broadest sense to include any professional intervention which leads to a harmful outcome.

The importance of considering the principles involved in any quality assurance system is to recognise the inter-play between the processes which go on within a care or treatment environment and the outcomes which result. For example the process of choosing leads to choices; but the very ability to choose is itself an outcome, particularly in mental health care.

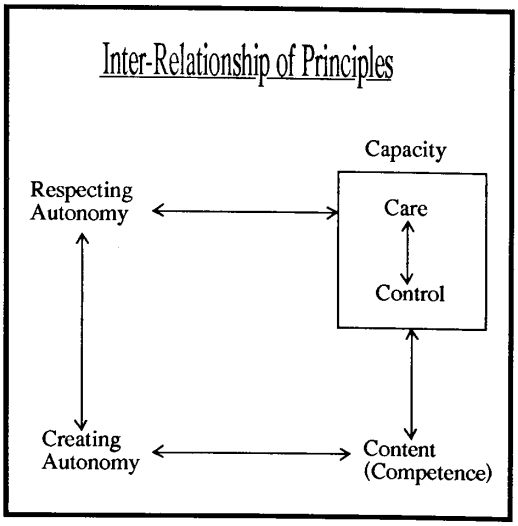
What is the difference between the process of choosing and the choices made? Even a bad choice may be a good outcome if it is the first time the person has been able to make a choice at all. In order to tease this out further a number of interactive principles are drawn from the chart. Figures 14a &14b takes 3 interactive principles; respecting autonomy versus creating autonomy; care versus control; and the key concern within care/control, that is capacity and its relationship to content (which includes the notion of competence).

Figure 14a



Figures 14a and b demonstrate that respecting autonomy requires an effective balance of care and control which in turn is rooted in our approach to an individual's capacity; creating autonomy requires the generation of competence on the basis of some capacity and thus affects the content of the decisions made by both staff and users. This will be true of any form of long term or community care service which deals with people who have more or less impaired capacity at some time - people with mental illnesses, people with learning disabilities and elderly people particularly those with mental health problems in old age. It is thus essential that the values underpinning the use of the **ENQUIRE** System, if it is genuinely to respect the consumer, will attempt to achieve a balance between the three pairs shown in Figure 14a. In order to aid further consideration using the matrix these values are shown super-imposed onto the quality matrix Figure 14c.

Figure 14b



Quality Matrix

PRINCIPLES UNDERLYING DESIRED PERSONAL OUTCOMES FOR USERS

	Structure	Process	Outcome
Community		Respecting People Equally	Real Mixing
Users Life			Real Choices
Treatment / Care		Respecting Autonomy Balance of Care & Control Beneficence Do No Harm	Good Relationships Best Interests Decisions
Services Case Management		Creating Conditions for Autonomy	Personal Development Increased Participation
Project / Unit		Balance of Specialist & Generic Services	
Agency Organisation			
Culture Environment		Promote Social Integration	Real Mixing

(SEEDHOUSE) (BRANDON)

Figure 14c

AUTONOMY:
CREATING AUTONOMY AND RESPECTING AUTONOMY

Creating personal autonomy depends upon and requires the possession of the physical ability to carry out chosen tasks in reasonably suitable environmental circumstances. A degree of knowledge based on available information is required to permit a person to pursue some end, and an understanding of the routes and means to that end and possible pitfalls is also necessary. Finally, the rational ability to select ends appropriate for the person must be present. Autonomy requires some ability to choose, a capacity and a competence, and thus information. On the other hand respecting autonomy pulls us in another direction suggesting that the person's chosen directions shall be respected whether or not we (staff or managers of the service), approve of the specific direction.

This tension is crucial in community and long - term care. The exercise of choices by users - eg the choice to work, will constantly challenge the services' ability to create conditions for such autonomy and sometimes challenge staff to give approval. Many services work towards the creation of autonomy amongst their consumers only to undermine it by not respecting the autonomy created. Although it might be seen as a simple objective of psychiatric services to help a person to be able once again to make independent choices, sometimes the very nature of the treatments and the settings in which treatments occur negate the opportunity to then make such independent choice.

CARE AND CONTROL

There are times when users choices are not respected and justified on care grounds. The distinction between care and control turns on the issue of capacity. Care is the provision of a service by right which does not stigmatise or create unnecessary dependency, which preserves and enhances autonomy, and indeed respects that autonomy. Control on the other hand questions respect for autonomy. This can occur in three ways:

a. In cases where choices will lead to self harm;

b. In cases where one is sure that a decision has been based on a belief that is false; (and this of course is a most difficult area in mental health care)

c. Where a decision will lead to harm to other people.

These matters of control can be both 'soft' and 'hard'. The distinction moving from soft to hard might include moving from persuasion to protection, from security to coercion or from constraint to containment. It can be seen too that the three cases listed also define the first limb of most mental health legislation which is usually written in terms of 'dangerousness' criteria - self harm or harm to others. Some authors have suggested a "best interests" test should be written into control criteria in mental health legislation.

CAPACITY , COMPETENCE AND CONTENT

Decisions about the balance between the principles of good care and adequate and necessary control or constraint often turn on answers to a further set of questions concerning client capacity, their competence in exercising choice and the relationship to the content and outcome of that choice.

Quality Assurance Teams and other forms of inspectorates are often expected to assess the degree to which a service provides a "least restrictive environment" or maximises autonomy and choice amongst its users and often need to be on guard against the persuasiveness of protective paternalist regimes and equally the crudest forms of "normalisation". In order to make such appraisals we suggest (in Figure 13) that not only is this a process of translating abstract ethical principles into everyday activities but also evaluating them by the limits to which they are taken and the balance thus achieved in relation to interacting principles.

There are clear distinctions between certain legal capacities eg for testamentary capacity where the tests applied may be low as opposed to the competence in practice to undertake certain social tasks which require skills rather than legal status. This arises in the notion of "rights" for people with disability and whether some rights are, in effect, performance related.

The first problem to be faced is whether the patients / clients are or are not incapacitated in respect of certain decision making capacities. The generally accepted distinction here is between "substitute judgements" and "best interests" judgements and has been usefully stated as follows.

'..two principles may come into conflict - the need to promote the welfare of the dependent person and to respect her / his right of self-determination. These principles are reflected in the two different standards that have traditionally guided decision-making for incapacitated people - "substituted judgement" and "best interests".

Under the first standard, decisions made for an incapacitated person should attempt to arrive at the same choice that person would have made if competent to do so. Under the second, decisions would be made to promote the welfare of the hypothetical "average person" in the same position as the incapacitated person, which may not be the same as that person would have made. The "best interests" standard has been widely discussed in the context of decision-making for children in family and child care cases where it has come in for a great deal of criticism. In the case of decision-making for an adult, who may once have been capable, but is no longer able to manage her / his own affairs, it is argued that the "substituted judgement" standard should be applied , according to the known values and beliefs of the dependant person when he / she was still competent. For those who have never been competent, this standard can still be applied, albeit to a more limited degree, and perhaps may inevitably be influenced by the "best interests" standard.' (P. Letts. 1988)

This distinction makes clear that "best interest" decisions are difficult to avoid in cases of incapacity even when well established. What happens in care settings where incapacity functioning is not clearly established or not relevant? Here Quality Assurance Teams are faced with appraising the degree to which a service is clear about tests of capacity, distinctions between "substitute" and "best interest" decisions and also contains a further difficulty. This is whether they arrive at judgements of incapacity or overrule a decision made because the outcome of a choice would be in their view against the best interest of the client. Appraising services where many decisions are made on behalf of patients or clients requires careful observation. We should look for confusion between "best interest" discussions on behalf of incapacitated users and "best interest" decisions which overrule and constrain capable and autonomous people. We must be particularly alert to the "persuasive definition of self- determination" (McDermott 1979) which allows for the recognition of capacity or for action to be made by clients only where care staff or "the public" endorse them; in short "you as a client are only capable and / or self determined when you do things that I / we approve of..." ; hypothetical ' average persons' maybe more cautious and constraining than is necessary.

The distinctions between these points lead to the practical, sometimes difficult, questions related to for example, powers of attorney, guardianship and other similar legal procedures. All these require professional staff to face the set of three interactive principles and challenges them to be clear about the moral justification for actions and interventions. This requires iterative consideration and assists in the understanding of the distinction between process and outcome.

The discussion here is intended to highlight the importance of stating explicitly the values and principles upon which any inspection, regulation, monitoring or quality assurance programme is derived. It is essential, for example, that creating and respecting autonomy underpins the way in which human services are delivered. Any set of observations must be rooted in that principle (and the other principles set out in this Section) unless those undertaking an inspection have decided for some carefully considered reason that such a principle is not essential or relevant to the particular service in hand. The authors would be surprised if there are any effective human services which do not require careful consideration of the principles outlined. Thus a Quality Assurance Programme inspection or monitoring team is encouraged to clarify their principles and values and those of the service before undertaking any on site activity, and to enquire closely into the kinds of decisions that are made by patients / clients and users and which kinds of decisions are made for them.

NEEDS AND WANTS

One perennial problem in human service delivery is the distinction between needs and wants. Assessing an individual's needs for some form of care, support or treatment service will always be predicated on the type of service which can be provided, the budget for that service, the objectives of the service as well as the needs of the individual.

There is, too, a distinction between a person's needs which cannot easily be met other than by interventions from professional or volunteer workers and those needs or wants which the person can still satisfy for themselves or which it would not be deemed appropriate for intervention by the (local or national) state. Bradshaw suggested a distinction between four types of needs: **normative, comparative, felt** and **expressed.** The importance of this will become clear as the matrix is developed in sections 4 and 5. At this stage it is worth noting these four descriptors of needs and how they relate to the scheme used in this workbook.

Normative need is clearly that which would be seen by most people as relevant to a person's requirement. This is a structural issue in the person's life and is a general expectation of the needs that any individual will have.

Comparative needs however express those normative needs in relation to others. Some peoples needs will be greater than others because of disability, vulnerability, illness or disorder and invite greater intervention. Comparative need is therefore a structural issue in relation to the assessment and case management procedures.

Felt need is a personal consideration related to an individual's own circumstances and will influence how the individual perceives the outcomes for him or herself of any care or treatment intervention.

Not all felt needs however will be expressed. **Expressed** needs are those which the individual will demand to be met and will be a complex of a normative view (the individual having some view of what is generally accepted), comparative (in other words the individual's view of his or her desert in relation to other people whether or not based on an understanding of what services are available), and felt needs not all of which will be expressed for one reason or another.

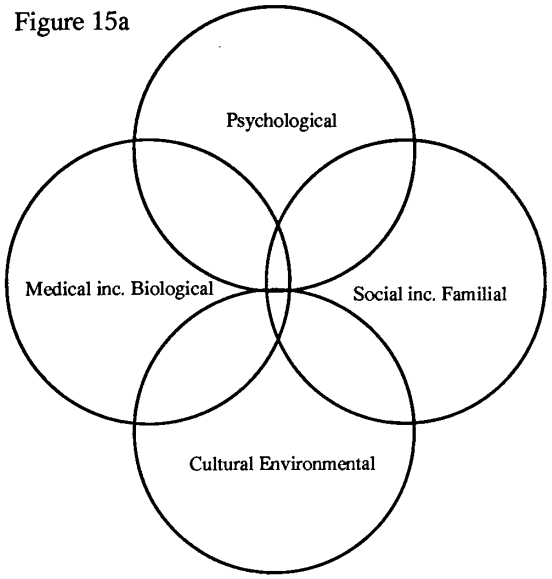
The difficulty of assessment in the social and health field is in ensuring that genuinely felt needs are properly expressed in a way which, in relation to normative and comparative criteria, can make a justified claim for service by a potential user. As we shall see in Section 7 on further analytic work the Quality Matrix (Q#) and Quality Star (Q*)can help in determining whether a case management and assessment system is working by the extent to which it appears to produce consumer satisfaction in its determination of needs met within a comparative framework against those expressed by the client. Expressed needs will, by definition, be those which the consumer makes explicit to staff, especially care managers. If those needs are not met this "expression" will be negative - that is a complaint about inadequate service

A Comprehensive Model of Need and Service Delivery

We have seen above how Bradshaw defines four types of need. Without exploring in too much detail different models of service to meet that need it is worth stating that the **ENQUIRE** System is intended to encompass different models of meeting need. Figure 15a suggests four approaches: medical, psychological, environmental and social. The medical is rooted in biological approaches to illness or disease; the psychological in psychodynamic interventions; the environmental (or cultural) considers issues such as housing, urban stress, the effects of racism, and other cultural denominators in the etiology of disorder; and the social considers personal and familial interactions within the community.

Various agencies take differing approaches to these models. Social Services departments often use a social model of intervention considering the inter-relationships of an individual within his/her family social networks to be most important. Medicine on the other hand will generally take a more biological approach seeing the disorder as determined by genetic or physical factors over which the individual may have little direct control. The Health Service tends to take a medical / psychological model; Social Services

Figure 15a



departments to take an environmental or social model. This is not to say, of course, that there is no overlap between these approaches, or that psychosocial models are somehow unimportant. Rather it is to demonstrate that the interplay between the two key agencies involved in providing services for long term care in particular Social Services departments of local authorities and NHS provider units may be based on broadly different approaches.

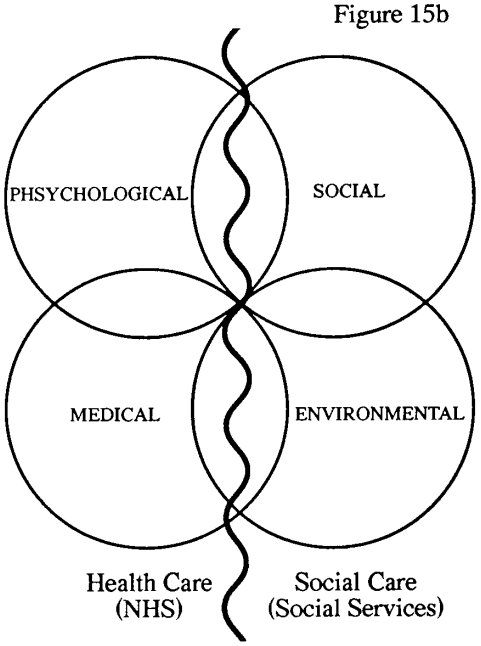
Any person involved in a quality assurance programme as either a member of staff or a service user will bring particular views about these models. If these remain implicit assumptions, not only may the criteria for evaluation remain obscure (or even hidden), but the clarity of the observations may be clouded. Just as staff and users may occupy different positions within the service so they will have different perspectives on quality. The central purpose of a quality assurance programme is to create a framework and terminology which can accommodate and express these different perspectives and apply collective forms of analysis and evaluation.

Prior to any form of analysis is the clear and systematic statement of the data derived from observation. Observations of what is happening in a service can be rendered léss useful if they are determined by a commitment to one particular theory or explanation, or service solution. Skills in making useful observations are discussed below. In this short discussion we attempt to show that theories and explanations in community care services particularly, need not be exclusive or competitive.

In order to be an effective evaluator either in peer group exercises or as an external evaluator it is necessary to recognise that the exercise is value laden and concerns other peoples view of health and welfare. At the same time this system does not state criteria on which observations will be made but rather analyses those observations using the matrix which has *a priori* dimensions. The values which are inherent are those of the *observers* and evaluators however, if the service is evaluated by one professional group with one dominant ideology or approach to service provision then the appraisal becomes a self fulfilling projection of their orientation.

It is thus important that any quality assurance team taking an "externalised" view of the service (even if members of that team are drawn from inside the service) should reflect a range of professional backgrounds and may include service users. This latter point is somewhat contentious in that it is the quality of life of the users of services which is most important to test and the team must focus on those issues. Whether having service users within the team will aid or detract from that process is a matter for individual services.

Figure 15b



SECTION 4
THE TOOLS OF QUALITY ASSURANCE

SECTION 4
THE TOOLS OF QUALITY ASSURANCE

In the first section the idea of quality assurance has been outlined, and the pursuit of quality has been shown to be a "value-driven" ethical enterprise. Before moving on to a systematic application of a programme in practice we will first outline the instruments we have found most helpful.

BUILDING A MATRIX (STRUCTURE PROCESS & OUTCOMES)

Firstly let us consider Donabedians three dimensions of human services; **Structure, Process** and **Outcome.**

Structural aspects of services are easily identified; buildings and the physical environment are obvious examples at a literal level. Structural factors can be thought of as 'givens'; for example inescapable requirements for a service to comply with certain legal regulations or statute; its physical location some distance from its user population; and even the characteristic of its users in terms of age, sex and perhaps levels of disability. Structural aspects of a service will tend to be factors which often make the service recognisable and entail resources without which it would struggle to survive. Within the notion of structure we therefore include resource 'inputs', and aspects of the environment which impinge upon it, for example, serving an inner city area or a multi-cultural population will determine some structure aspects of the service and its context. In summary the structural aspects of services range from physical characteristics, through the nature of the population it serves, the socio-economic context, its remit to the given characteristics of its users and the resource inputs which determine its size and scope.

Processes are the way in which the services direct and indirect caring activities are performed. Processes happen over time and may or may not always be present. They are identified by movement, activity and dynamic energy. Processes are the methods by which the resources of the service are put to their uses; not necessarily "best" uses since some activity may be ill-focused, misdirected and wasteful. Relationships between staff and users may be structural in respect of role relationships, but interactions, care, treatment and service entail activity and engagement The way in which this occurs, by counselling, therapy, group work, consultation and communication are the processes of the service.

Process matters are actions, planned and unplanned, which can be identified as methods, movements or means towards outcomes. Clients may have to go through a waiting list or assessment process; some agencies have to undertake budgetary, audit and grant application procedures. Services are subject to a wide range and variety of processes of client involvement, accountability and of decision making activities which may involve aspects of participation by users and internal and external democratic processes. Process aspects are the "how" and "when" features of a service.

Outcomes are ends or products, goods and services which may or may not impact upon the users. Outcomes are consequences intended or unintended whether experienced directly by the user or not. Outcomes can be good or bad for the user, effective or ineffective but they are caused by the service and mediated by its structures and processes. Outcomes are not "outputs" which are volume measures more appropriately considered as structural aspects such as the number of users served, number of meals provided by a meals on wheel service or the bed occupancy rate of a ward. Outcomes are not synonymous with achieved goals since, for example, building a new hospital structure may be a structural goal, or maintaining a crisis communication system a process goal. Both are indirectly concerned with outcomes for service users.

An outcome of a service is an observed effect which can be understood as intended or otherwise, desired or not. Service outcomes for people must be differentiated from the user expression of their experience of them (often referred to as user satisfaction) and furthermore from measures of general quality of life of people who happen to use the service in question. There are likely to be relationships between these three measures; service outcomes, user satisfaction and quality of life.

Making distinctions between them will enable these measures to be brought into a potentially causal explanatory relationship at a later stage.

Structures, processes and outcomes are therefore linked together in services, often in clear causal chains, for example, the given remit and statutory duties of an agency (structure) gives rise to a claim for service by a client and a delivery method by staff (process) which results in resources being allocated (process - outcomes) and given directly to the user or client (outcomes).

DIMENSIONS OF HEALTH AND SOCIAL SERVICES

We have noted that services as well as having these three aspects operate in a cultural, socio-economic and environmental context. We have also noted that the local community in which the agency functions will have certain characteristics and that a particular unit may be accountable to a parent organisation. We have referred to counselling and treatment and more general matters of services and the users engagement with them. Central to to our concern is the users life and the impact that the service makes upon him or her and the social relations that that person has in their local community. How are we to bring these diverse factors into some systematic relationship with the concepts of structure, process and outcome?

DESIRED PERSONAL OUTCOMES IN THE COMMUNITY

Our fundamental concern must be with the health and welfare of the person who is entitled, chooses, or has to use a particular service. We are concerned about the "users life". The first ring around that person is a support system which will be made up of family, friends, neighbours and proximate strangers, loosely described as "the community". Engagement with a service brings particular care and treatment and more diffuse service aspects, all of which are co-ordinated in some form of "case management", "treatment and care". "Services and case management" can act as the next concentric ring around the person at the centre. These facilities will be provided by a unit or project, such as a day centre or ward, which may be component parts or branches of a larger organisation or agency. These can be viewed as the next two rings - which we can refer to as "project / unit" and "agency / organisation". Finally our cultural, physical, environmental, socio-economic and political landscape lies behind all our health and welfare services. This final ring of our imaginary diagram we have called "culture/environment".

If we remain committed to this central value of the "person/users life in a community" then we can express these various aspects of health and services vertically:

- Community
- People / users life
- Treatment / care
- Services / case management
- Unit / project
- Agency / organisation
- Culture / environment

We can also apply these seven dimensions to three basic concepts of structure, process and outcome and in doing so create a matrix of 21 cells. (Figure 16)

THE QUALITY MATRIX (Q#)

Our task is to be concerned with the description and analysis of quality. We have thus called this the Quality Matrix (Q#). The horizontal dimensions have been adopted from Donabedian's concepts; the vertical dimensions have been established *a priori* and endorsed as a comprehensive set of valued factors in health and welfare services by debate and discussion with professionals in this field and users themselves.

DEFINING THE CELLS AS A TRAINING EXERCISE

In order to explore whether this matrix has provided us with a useful 'conceptual map' we can attempt to locate our concerns and practices within the matrix cells . (Figure 17)

Figure 16

Quality Matrix

	Structure	Process	Outcome
Community			
Users Life			
Treatment / Care			
Services Case Management			
Project / Unit			
Agency Organisation			
Culture Environment			

Figure 17

Quality Matrix

	Structure	Process	Outcome
Community	Deprivation Indices Statistics / Area Profiles Strategic Plans Epidemological Data Health / Welfare Services Infrastructure	Democracy Representation Participation	Belonging Discrimination Tolerance Stigma
Users Life	Age Expectations Sex Hopes Educational Aspiration (Dis)ability Personality	Motivation Budgeting Planning Learning Skills Testing Reality Seeking Help	Satisfaction Happiness Autonomy Income Well-Being
Treatment / Care	Security / Protection / Constraints Guardianship Behavioural Programme Probation	Counselling Injections Consent Information / Communication	Clinical Improvement Effectiveness Side-effects Agreement to Treatment
Services Case Management	Generic / Specialist Balance Access Availability Distance Single Rooms / Decor	Advocacy Relationships with Workers Service Style Workload Management	Personal Touch Trust Needs / Wants Engagement Privacy
Project / Unit	General Hospital Day Hospital Day Centre Staffing and Skill Mix	Waiting Lists Key Workers Supervision / Staff Support Recruitment	Open / Closed Case Consistent Contact Job Satisfaction Worker Commitment Availability of Staff
Agency Organisation	Requirements of Registrations Statutory Duties Remit Plans Objectives Management Hierarchy Fire Regulations	Claiming Entitlements Budgetary Decisions Personnel / Job Description Audit / Inspection	User Rights Resource Allocation Work Practices Staff Appraisal System
Culture Environment	Job Market Religion Housing Estate Multi-cultural Communications	Church / Mosque Attendance Security Street Lighting Rent Collection Transport / Travel Times / Access Vocational / Occupational Opportunities	Concessionary Travel Dampness Pollution Isolation Disincentive for Attendance Productive Day Time Activities

This can be undertaken as a exercise between any or all participants implied in the vertical axis of the matrix by asking respondents to give a description of their services. In order to assist this we provide an example of the issues which have been located in the various cells during extensive use of the matrix with service professionals, managers and users. These are abstract concepts and should not be confused with recorded observations.

What will be immediately clear is the way in which certain issues might be located in a number of cells and do not fall neatly into a single cell. The cells are not 'water tight' but there are two aspects which help us in solving such dilemmas. Firstly by a close examination of the intended meaning and use of the issue in question by the person suggesting it and secondly by discussion and negotiation between those involved in the exercise. This is of course an abstract exercise and though it can be used to familiarise members of the QA teams with the instrument it is no substitute for the descriptive material derived from observation of an actual service. This examination of meaning and negotiation between observers will emerge later as important aspects of QA teams analytical activity using the Q#.

Having established this Q# and suggested a group exercise to familiarise the QA team we can begin to explore some of its characteristics in practice.

Q# PLOTTING, TRACKING, SOURCING AND SCORING

The Q# is essentially a 'map' which shows us the major concerns of a service. The techniques of observation, the collection of raw materials and the validation of data from QA teams visiting and appraising a service will be dealt with in detail below; at this stage it is sufficient to appreciate the Q# as essentially a descriptive tool where concerns falling in any cell can be or become a legitimate focus of activity and goals for the service. In other words the Q# is not designed to show that some concerns are "right" or "wrong", "good" or "bad" but simply to assist us in knowing and understanding what is happening in a service on its own terms in relation to its own objectives on the basis of observations made from the ' inside ' by a QA team .

The QA team should make strenuous efforts to make these observations at the critical point of the service where transactions between 'front-line' staff and users occur: the 'hot-spot' of the service. If observations from that area are excessively 'structural' we may be concerned either about the emphasis within the service or about the focus of the QA team's enquiry, or both; but we will be reluctant solely on the basis of the Q# to draw final conclusions. The reported concerns that will show up on the Q# tell us many things over and above the substantive content of the observation.

By 'plotting' within the Q# we will be able to assess what features of the service are attracting energy and resources, and where the emphasis is being placed by managers and staff. In order to assess the balance in a service between structural, process and outcome matters, the QA Team must take an observational approach which is itself balanced and not excessively skewed towards certain features. Many inspectorates and appraisal systems are very concerned with buildings, fire regulations, and measurable quantitative aspects.

These concerns have an indirect relationship with outcomes for users, tend towards the 'measurable', often become the subject matters of 'checklists' and tend to drive out spontaneity between 'inspectors' and staff during an inspection. They constrain the inspectors from describing the service as a whole and many of its apparently intangible qualities.

The Q# is capable of illustrating the major concerns of the service. We have already noted that matters recorded in the cells, and sometimes straddling cells, can all represent or be the basis of legitimate future goals for the service. If however observations fall in the structural and process areas and are not explicitly outcome comments then these observations can be 'tracked' across the Q# by the QA team in discussion with chosen key actors (users or clinicians, or managers, or combinations thereof) in order to consider what the likely outcome of this activity will be. These emerging goals will include not only specific service outcomes but may also set standards. They in turn also require to be 'quality assured' in a later part of the cycle if they are adopted as service goals within an action-plan.

It will be clear from the earlier part of this section that the Q# can be used in the "classroom" in order to stimulate thinking about services as well as "on-site" in a QA programme gathering and plotting real observations. Teaching and doing QA are closely linked in the ENQUIRE System because the system itself is committed to the development of QA skills by front-line staff and to 'peer review' by these methods. Therefore there is a dual use of all the instruments and techniques and a considerable amount of 'learning by doing'.

SIMPLIFIED Q#

The Q# vertical dimensions may for certain purposes be conflated. The 'users life in the community' can become a single, dimension, the clinicians / professionals concern with "treatment and care" and "services/case management" can become a single dimension - staff / clinician, and the 'project / unit' and 'agency / organisation' can be expressed as a managerial dimension leaving aside, as given, the cultural and environment context. This simplified Q# therefore has this shape (Figure 18).

	Structure	Process	Outcome
Users / Consumers			
Staff / Clinicians			
Managers			

Figure 18

We shall see below one way in which this simplified structure has been developed recently by Mathew for acute care

This Q# can be used initially in teaching to describe the different perspectives of those actors shown in substantive structural, process and outcome terms. It introduces the QA team to the notions that their observations will have a source which entails a set of perspectives, views and values and that the dynamic inter-relationships between these actors (on the issues plotted on the Q#) will have a crucial bearing on the ability of the service to apply QA and introduce planned change. It should be added that the QA team will itself be a source of observations. After work on site with the Q# it can be fruitful to colour code observations by source when 'plotting' on the Q#; this for example may show that users, clinicians and managers differ in the extent to which they focus on explicit overt outcomes of this service and conversely whether their concerns are more structural and process focused with outcomes assumed rather than recorded.

The inter-relationships between users, staff and managers on issues arising in the Q# are best left until the next instrument, the Quality Star (Q✱) has been completed because this provides us not just with an understanding of different perspectives but with the actual proposals for change which will have to be negotiated between these actors.

SCORING ON THE Q#

The Q# although a descriptive tool which shows up a range of issues in the 21 cells has an underlying thrust towards outcomes either by plotting them explicitly or by 'tracking' across from structural and process dimensions towards likely outcomes. The ENQUIRE System is essentially a qualitative approach; however a 'scoring' system can be used with the matrix on the following assumption. If "desired personal outcomes for users in the community" is central to the value and objectives of the service and outcomes generally more highly valued than the processes and structures, then the cells can be numbered from the top right to the bottom left. This not only introduces a weighting to outcomes (over and against processes and structures) but also creates a hierarchy in the vertical column.

If a scoring system is to be used, consideration must be given to the specific objectives of the type of service being studied and its context. The matrix as it stands is applicable in a wide range of health and welfare services. In specific and highly specialised settings it is important not to weight the vertical dimensions (by using the scoring system) without further thought about what the best intended outcomes of the service are. For example, in a terminal care context 'community' may be moved lower down the list if the QAP is focused on internal treatment and specific outcomes such as 'pain controls'; or in a multi-racial area the culture and environment dimension, would move up the list.

The scoring system in general contexts enhances the Q# in certain respects.It allows the QA cycle to show improved or worsened scores. Such a use is better left to the 'peer review' part of the QA cycle so that consistency in observers can be achieved and thus controlled for. The scoring system also allows for comparisons between similar units, and for comparison of scores within the matrix by different sources; ie do managers, staff and users have markedly divergent patterns and scores.

The fact that the next instrument the Quality Star, (Q*), can also be scored and is designed to deal with prescriptive, as well as descriptive data, has led the authors to leave the introduction of scoring the Q# to a later stage in the chosen QAP.

PRINCIPLES INTO PRACTICE ON THE Q#

Most agencies and their policy statements begin with espousing a set of 'Principles'. These vary considerably in coherence and in levels of abstraction. They often bear little relationship to practice and are not used within the service to make decisions by stimulating debate about how principles interact.

The Q# can assist us here by considering the degree to which statements of 'principle' in a service relate to actual outcomes and we have illustrated this above in Section 3, Figures 13 and 14a, b and c

The Q# illustrates the way in which such general abstract statements of principle are in many respects 'process' focused. Whilst helpful and legitimate in that form, they clearly benefit from being expressed as outcomes in a more practical way.

The Q# can be used in training to assist staff to undertake this exercise and then to specify service processes and outcomes which exemplify both an abstract principle and the operationalised principle in the outcome column.

For example when do 'best interest' decisions get made and what is the process and the outcome for the user? These matters can be plotted on the Q# and should specify the actual decisions which are taken for the user, in terms of their structural, process, and outcome characteristics.

CREATING OPERATIONAL OBJECTIVES USING THE Q#

The above use of the Q# also applies to objectives as well as principles. The statements of objectives for a unit or a client can be plotted on the Q# and expressed as outcomes (by tracking across from the structure and process columns, if that is where the objective has been plotted) and then being more specific in the outcome column about what outcomes are intended, and more specific in the 'process' column as to "how" and "by whom" the outcomes will be achieved.

It will be clear that the Q# can enable the QA Team to have a clear idea of the principles and objectives of the service from materials available at the briefing stage.

The 'outcomes' which the QA Team find on a site visit within the QAP can be compared with the stated principles and objectives of the service. This is of considerable value at the feedback point in the Quality Cycle (Q∞) (Stage 2).

We will return to a number of further applications of the Q# but now let us consider the Quality Star (Q*)

THE QUALITY STAR (Q*)

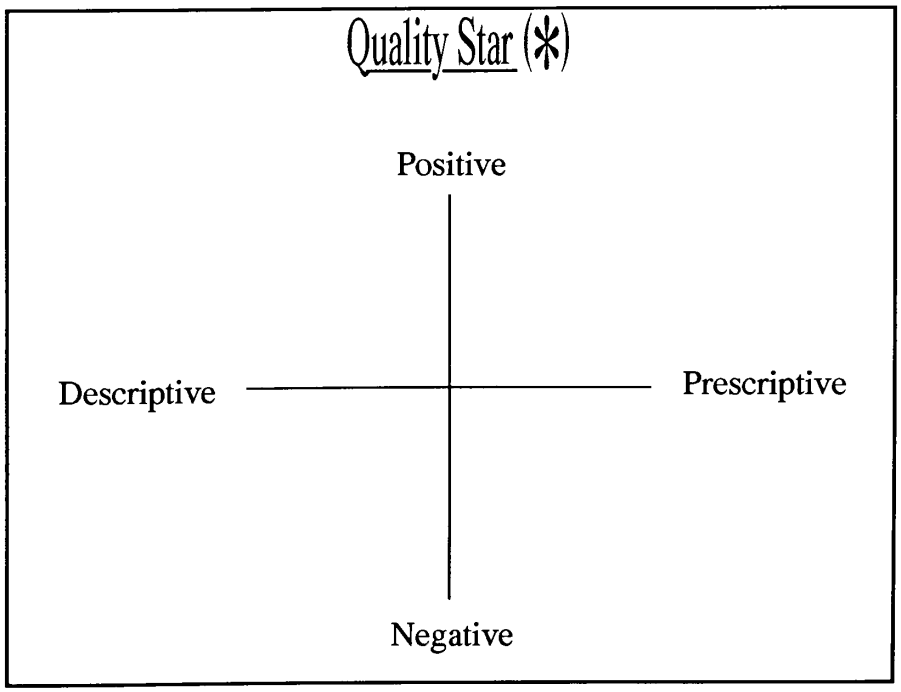
The Q# as we can see is essentially descriptive but capable of analytical use in considering the extent to which emphasis on outcomes in a service are, or can be made overt and explicit. We can use the same observations which we have 'plotted' on the Q# and analyse them further. Firstly we ask to what extent the QA Team report / observation expresses 'positive' or 'negative' aspects of the service. Diagrammatically we express this as a vertical dimension. We then ask to what extent the report / observation is a 'description' of the service and whether it contains any 'prescriptive' features. This can be expressed as a horizontal dimension.

Here we must note that relationship within the QAPs between the 'value-driven' aspects of QA and the nature of value laden 'prescriptive' reports and observations. QA is an ethical enterprise because services are based on principles and values and a QA process must include these aspects. We show above how the Q# instrument can assist us in considering how abstract principles such as 'autonomy' for users can be expressed not only as a structural 'given' and embodied in processes but must have a simply understood outcome as 'choice'. A QAP allows us to assess the extent to which the service outcomes exhibit the stated principles of the service but the method of observation we adopt cannot therefore entail the imposition of the service principles or our own values on what we see and experience on site in a QAP in the descriptive phase of the QA cycle.

In summary therefore there are three areas where principles, values, and prescriptive observations operate. Principles underlying the service may be more or less overtly expressed in the service objectives and the QA Team will be well versed in these matters. Values in practice will be observed and reported by the QA Team avoiding the crude imposition of the observers values and opinions. Some of these values in practice will emerge as 'prescriptive' reports and observations when faithfully recorded.

The Q* makes use of the distinction between 'descriptions' and 'prescriptions' precisely, and notes their 'positive' or 'negative' nature. Thus far we have established the following diagram (Figure 19).

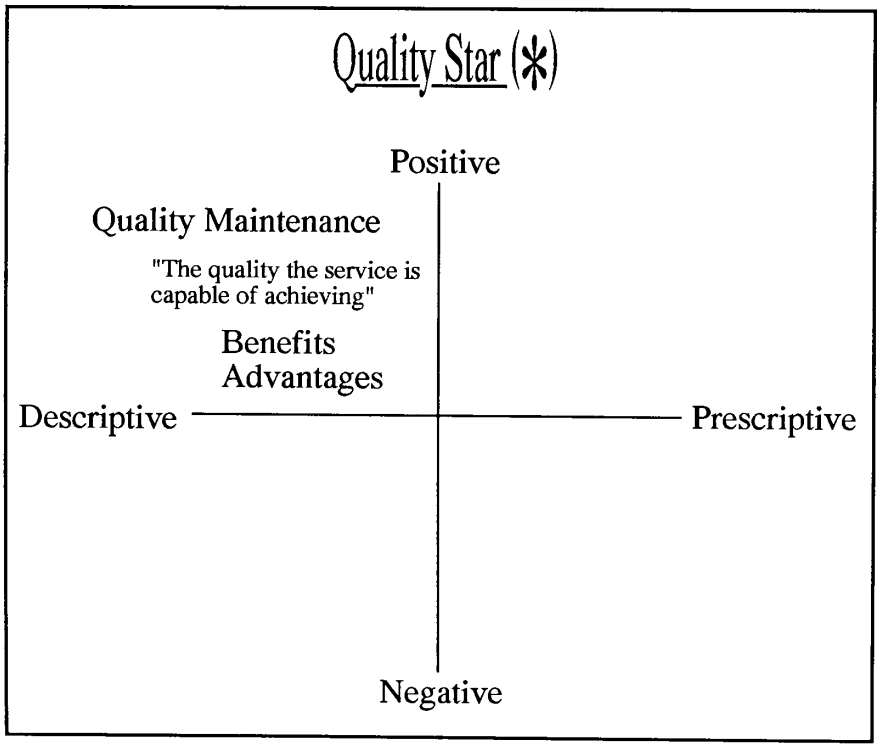
Figure 19



The next stage is to 'plot' the same observations / reports used on the Q# within the quadrants of the Q✱. This is undertaken by the QA Team in discussion and this will be described below in the Quality Cycle (Q∞), our purpose here being purely to introduce the instruments.

Observations / reports which are straightforward positive descriptions of the service belong in the top left hand quadrant and these will express 'benefits' and 'advantages' to the users of the service. This is the quality of service the unit/agency is capable of achieving and is therefore expressed in terms of future action by the QA Team as 'quality maintenance' (Figure 20).

Figure 20



Observations and reports with a negative description of the service are plotted in the bottom left quadrant. These will express actual or potential 'disadvantages and diswelfares' for the user / client. These are matters which the service may seek to improve and to consider framing as future objectives. The QA team will express these items as methods for improvement in quality performance and requiring to be framed as future objectives' in order to become operationally viable.

We now turn to observations which have prescriptive characteristics. These are observations which contain words and phrases such as 'ought', 'must', 'imperative', 'essential that...'.

QA team members are not excluded from making such observations but as we will outline below this should only occur if: firstly the observational technique has been careful and other sources when possible have been established; and secondly, the validation of the observations as qualitative data has been applied by the QA Team at the de-briefing stage (see below). This way the QA Team adhere to the approach of reflecting back to the service its own concerns (albeit by way of an informed response and certainly not a 'gut' reaction) rather than imposing its own perspectives.

Positive prescriptive observations will be plotted in the top right hand quadrant of the Q✱, and these will express 'future objectives' for the service. These are items which the service wants to provide but is presently unable to do so.

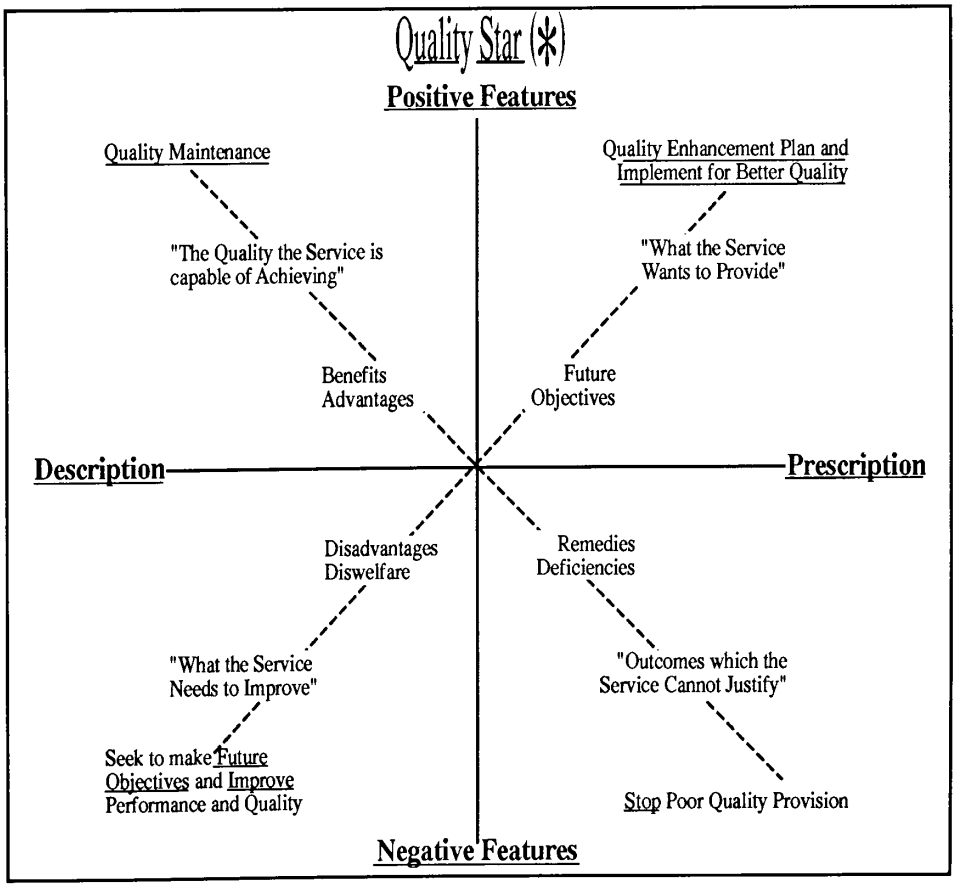
The QA team will express these items as 'action plans for the creation of a better quality service', simply 'plan and implement for better quality'. These items are candidates for quality enhancement.

Finally 'negative prescriptions' are plotted in the bottom right quadrant. These will express 'deficiencies' of the service for which remedial action is imperative. These are 'outcomes which the service cannot justify' and are likely to be at variance both with accepted 'good practice' and also be intended or unintended consequences inconsistent with the principles and objectives of the service. The QA Team will express these items (policies, practices and outcomes which should cease), simply as 'stop poor quality provision'.

The QA Team will consider the extent to which the positive prescriptions, if implemented, would do just that, and emphasise them, rather than simply to "blow indignant moral whistles" and direct the agency into immediate fire-fighting activity. This quadrant can be important if the QA Team is, or is linked to some formal inspectorate function. Matters of registration of units, accreditation, disciplinary or even legal action may derive from these items. The QA Team must face these matters at the outset in the QAP brief, it cannot seek to exclude such matters but it may set limits on what the QA Team can do about them.

It may agree that such matters are brought to the attention of the managers of the service alongside all other reports and further action will rest with them. This must be stated explicitly to the services and staff taking part in the QAP. In summary the Q* now looks like this (Figure 21).

Figure 21



In concluding this introduction to two major tools for Quality Assurance, we will now touch upon the range of applications of the tools before proceeding to locate their use within a Quality Assurance Cycle. It should be stressed that the Q# and Q✱ are not information gathering tools, but are analytical tools for dealing with observations which have been processed to stand as qualitative data.

LEVELS OF APPLICATION OF THE Q# AND Q✱ (PERSONAL / UNIT / AREA)

We have noted that the tools in their various forms operate as analytical tools within the QAP and for QA Teams observations and as teaching tools for training the QA Team in the first instance. These applications will allow for 'peer review' by the services themselves having experienced and learned from the external QAP (particularly from feedback to units and agencies by the QA Team).

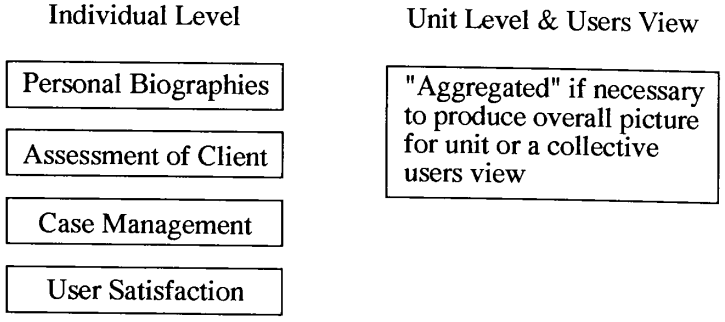
In teaching the Q# we have often adopted a personal biographical approach. We refer to this as 'A day in the life of ..' This Q# application invites the potential user of the instrument to make observations about his or her own daily life with a focus on a particular area such as "work", "recreation" or "social supports". The Q✱ can then be applied to the same observations.

This personal use can be used in conjunction with other self-appraisal methods for staff themselves, in particular 'domainal mapping'. It leads us to the application of the Q# and Q✱, in: assessment and case management

These are complementary methods of applying the Q# and Q✱ at the individual client level. The assessment application will show where client needs and demands are located in the matrix and the Q✱ will provide an action plan which may be contractual with the user/client/patient.

Case-Managers in using the outcome of the assessment application of the Q# and Q✱ may return to the matrix with the action plan and by plotting their intentions as outcomes for the client, track back into the process and structure dimensions to specify 'who' has to do 'what' to achieve these client outcomes.

The assessment applications can also be used to 'question' all or a sample of users of a particular service and aggregate the findings to give the users perspective of the service, particularly on the Q✱. The Q# and Q✱ are therefore also capable of application as consumer / client satisfaction tools. The applications of the Q# and Q* identified so far can therefore be diagramatically expressed as:



Moving on from the level of the individual, the Q# and Q✱ can be applied to a set of functional services, for example: community mental health services for a particular geographical area or population.

This provides a QAP for individual agencies and projects serving an area and allows for appropriate comparisons between similar types of services over time and by 'peer-review exchange'. The latter approach trains a small QA Team in each agency, perhaps 2 or 3 people to use the tools and then to apply them to a neighbouring agency and thereby create the longitudinal QA cycle.

Such simple units or agencies can be hostels, day centres, hospices, community nursing services or wards of hospitals, or several components of a service with the same objectives, for example, an elderly care scheme which has residential and domicilliary components. A short example of Q# and Q* applications to single units is given in the next section.

Area QAPs are built up using combinations of the qualitative data from units with overall aggregated data from the user satisfaction application. The area appraisal can be expressed as a single Q* showing the observations (coded for unit source and QA Team) in each quadrant and expressing them as a percentage, for example (Figure 22a)

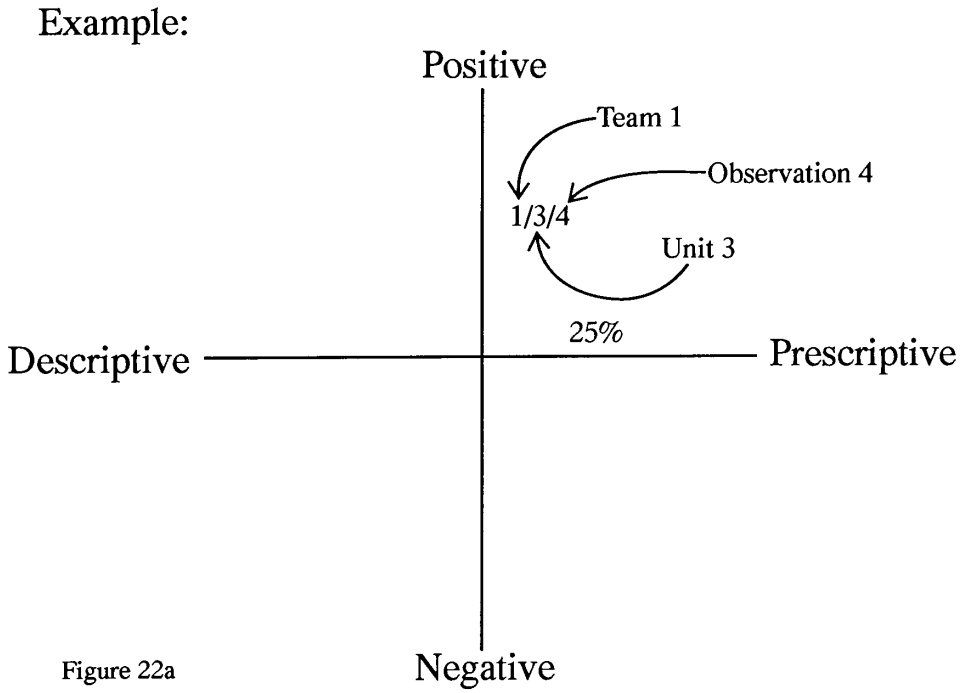


Figure 22a

These observations can be grouped thematically in each quadrant, for example, those that refer to communication, to third party agencies or to staff attitudes. The code may also carry, a further source identified showing whether the observations derived from a consumer (C), a staff member or case-manager (S), from management (M) or from the QA team (T).

The Q* can deal with up to 100 observations (10 agencies) for an area service. If the area is large and will produce more than a manageable number of observations, then a geographical or functional boundary should be sought and established to create a manageable scale for the QAP.

In making area appraisals using both the Q# and the Q* it will be clear that every observation / report made by a QA Team can be coded by it's characteristics or variables. We have noted the 21 cells of the matrix and the four quadrants of the star and the source of observations. We have suggested that an area appraisal of service quality can include up to 10 or more projects or units. We can now bring these characteristics of the observations into play with one another by superimposing the Q# on observations falling in each quadrant of the Q*. (A qualitative " cross - tabulation")

In summary each observation can be coded to express the following characteristics after initial plotting

			EXAMPLE
Team, location & Sequence Code	Team 1 - 6		1
	Unit visited 1 - 10		2
	Observation number 1 - 20		10
Source Code (not mutually exclusive)	Consumer	Co	C
	Staff Member	S	
	Manager	M	
	QA Team	T	T
# Matrix Code	Structure or	St	
	Process or	P	
	Outcome	O	O
	Community	Cy	
	Users Life	U	U
	Treatment / Care	TC	
	Services / Case Management	SC	
	Project / Unit	PU	
	Agency / Organisation	AO	
	Culture / Environment	CE	
✱ Star quadrant code	Positive	Po	PO
	Negative	N	
	Descriptive	D	D
	Prescriptive	Pr	

The example here shows that we have an observation which has been plotted and can now be described in terms of all the possible variables of the **ENQUIRE** System as follows :-

The observation was made by QA Team 1, in Unit 2 and is the 10th in the sequence; the observation concerns outcomes (O) in the users lives (U) and is a positive (Po) in the description (D) of the service sourced to both consumers (C) and to the QA Team (T)

Since every observation can now have an 8 to 11 symbol code (the non - exclusive "source" code making the difference in number) codes can be used in creating an area appraisal rather than in full written observations. From the patterns of these plotted codes we can refer back to the content of the observations. Our code is therefore **1/2/10/C/T/** at the pre **Q#** and **Q✱** stage and **1/2/10/C/T/O/U/Po/D** after data analysis

If such coding is used it makes dealing with up to 100 observations fairly straightforward. A standard computer programme (eg SPSS) will enable further analysis of data by any variable by producing the required lists eg outcomes, all negative descriptive processes or all consumer statements with reference to remedial outcomes.

In order to achieve such detailed analysis of an area service it is sensible to begin by a small scale manual attempt. The steps are as follows :-

1. Ensure that observers code observations (up to a 5 symbol code)
2. Complete the **Q#** and **Q✱** for each agency
3. Complete the code for each observation (up to the final 8 to 11 symbols)
4. Create a diagram of the **Q✱** with a **Q#** in each quadrant. See (Figure 22b).
5. The observations have already been plotted once and the aggregated data replotted on this area **Q#** and **Q✱** will show all the code variables associated with that data processing visually, so only the first 5 code symbols need to be typed into the final figure.
6. Plot all observations on the final figure from computer generated or manually created lists.

Figure 22b: The Enquire Quality #*

Positive

	Structure	Process	Outcome
Community			
Life			
Care / Treatment			
Services Case Management			
Project / Unit			
Organisation / Agency			
Culture			

	Structure	Process	Outcome
Community			
Life			
Care / Treatment			
Services Case Management			
Project / Unit			
Organisation / Agency			
Culture			

Descriptions

Prescriptions

	Structure	Process	Outcome
Community			
Life			
Care / Treatment			
Services Case Management			
Project / Unit			
Organisation / Agency			
Culture			

	Structure	Process	Outcome
Community			
Life			
Care / Treatment			
Services Case Management			
Project / Unit			
Organisation / Agency			
Culture			

Negative

The final figure now shows the visual patterns for the whole service and brings the integrated power of both the Q# and Q* together.

We can now assess the degree to which positive or negative (Q* variables) outcomes (Q# variable) are concentrated in care and treatment areas (Q# variable) and whether there is a "cluster" of such observations and the extent to which that is a users view. Once patterns and clusters emerge the content of those observations can be referred to in the data already collated by its code.

This area Q#* is therefore, if used correctly in terms of focus (eg functional aspects of a service like day services) and level (all units providing a particular service for a population or community) a powerful form of aggregate qualitative appraisal. There is still much interpretive work to be undertaken once patterns emerge but key strengths, weaknesses, tensions and problems in an area service show up readily. For example if the clusters of observations in the positive prescriptive quadrant of the Q* cluster around "agency processes", then since these observations suggest future planning objectives the pattern can be compared to the service as it is in the quality maintenance quadrant of the Q* (top left) Do the future objectives of the area service diverge significantly from the patterns which the service has already established? Furthermore, do these potential future actions address the remedial patterns in the bottom left quadrant ?

This kind of further analysis can give clear indications of the performance of an area service and its likely future stability. As structures and processes continue to change with developments in legislation and social policy such an appraisal can enable a stabilising focus to be created and an evaluative picture to be gained in respect of service outcomes for users.

The unit and area applications of the Q# and Q* as components of a QAP will have implications for national external inspectorates and there are clear benefits to be gained from consistency if not uniformity in tools and methodology of national and local inspection systems.

We can now illustrate the levels and focus of application on the QAP using the Q# and Q* as follows: Action planning which emerges from the QAP will strive to achieve congruence between these levels (Figure 23).

Individual Level	Agency Level	Area Level	National
Personal Biographies Assessment of Client Case Management User Satisfaction	Single Units Grouped Units (functional & geographic) Principles / Objectives of Service	Aggregated data from agency (& individuals)	Relationship of QAP methodology to Community Care Plans / National Inspectorates

Figure 23

This configuration in the application of the tools for QAPs mirrors the variety of QAPs 1-9 (Section 2 above) and it is essential that the appropriate tools are adopted to fit the QAP chosen.

There are a number of further applications of the Q# and Q* at the individual, area and national level.

The **ENQUIRE** System produces findings and is is not designed to create recommendations or prescriptions. The QAP will produce action plans, and hopefully ownership of the QA process itself.

EVALUATING INSPECTIONS USING ENQUIRE

Scrutiny systems should strive to have the capacity to be self-appraising and to interface with other systems. By sourcing observations to the QA Team and reviewing progress over time it is possible to assess their progress across the Q# towards our central concerns with client / user outcomes. Other QA systems and particularly inspection, accreditation and registration activity can be subject to 'audit' by the ENQUIRE System. Most such inspection systems produce written reports and recommendations. These recommendations or specified requirements can be plotted on the Q# and Q✻ to assess the degree to which they are concerned with user outcomes and produce positive prescriptions. This can act as an appraisal of a proposed or an imposed system and thereby may enable its focus to be adjusted.

CONTRACTING FOR CARE

Some agencies, but more commonly area based structures such as District Health Authorities and Social Service Departments, will wish to introduce QAPs in a "multiple provider" and "contracted" system of provision. In building up contract specifications and subsequently quality assuring the contract, the Q# can provide a framework which links contracting for care with the vertical components of the service and the horizontal dimensions of Structure, Process and Outcome.

The contract may be negotiated to be more outcome oriented by using the Q# and the choice of processes for contracting can also be examined. The following Q# illustrates and considers contracting for care and treats the "project unit" dimension as the provider and the 'agency' dimension as the purchaser. The application illustrates an added element of the QAP for managers concerned with contract specification. (see figure 24)

Figure 24

Quality Matrix

CONTRACTING FOR CARE

		Structure	Process	Outcome
	Users Life			Ordinary Life Objectives
	Treatment / Care	Indicative Dimensions	Care Process / Packages	Adverse Occurances
	Services Care Management	Required Service Arrangements	Non Clinical Quality Determination of Targets Client Group	Range / Choice "Efficient" Vertical& Horizontal Screening Low Complaints Level
Providers	Project / Unit			Retains / Obtains Contract Agreement on Desired Outcome Flexibility for Provider
			Iterative Negotiations	
Purchasers	Agency (DHA, SSD)	Contract / Specifications	Open Tendering / Select List Preferred Provider Surveys of Need; Info; Screening etc	Inspection Monitoring / Cost Control Quality Control Contract Let / Renewal Flexibility
		Overall Budget General Needs	Accountancy Audit	Inspection
	Community			Ordinary Life Objectives Number / Type of Contracts Local Organisations Benefit
	Culture Environment		Market Ideology Competition "Enabling Authorities"	Community Involvement

QUALITY ASSURANCE AND QUALITY OF LIFE

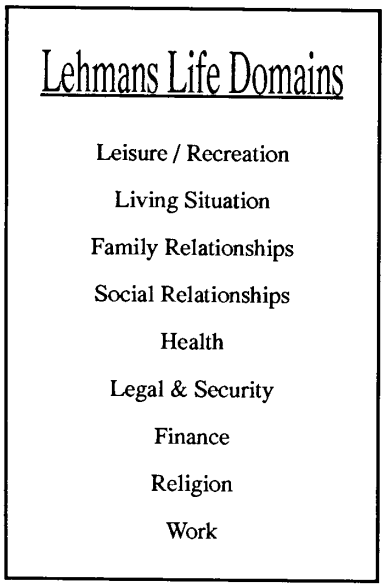
At the individual level the QAP has the capacity to address outcomes for users and express users views. It can and must interface with other approaches which measure the uses of the service general quality of life.

There is an assumed relationship between service outcomes and the users quality of life. It is a matter for further empirical study as to whether user satisfaction statements can be shown to be consonant with such any causal relationship established between service outcome measures and quality of life measures. However, a perspective on service outcomes from changes in the quality of life of the user may be of considerable value.

It is highly unlikely that a QAP will have the resources to extend the exercise to gather independent quality of life measures unless it can attract research funding and appropriate academic support. Nevertheless, we note the importance of this interface here and give an example of the connection.

The nine life domains in which levels of satisfaction can be measured giving a quality of life assessment have been established by Lehman (Figure 25). At the individual case management level the outcomes from the Q# can be set against the levels of satisfaction in nine life domains established by separate interviews.

Figure 25



This sets 'service outcomes' against 'quality of life'. A group of users of a particular service could be interviewed using a quality of life measure and their aggregated scores set against the aggregated outcome measures of the service as established by the Q#.

The objectives of the service and its outcomes are intended to enhance quality of life and therefore the QAP findings may provide a hypothesis that for example an occupational component in a service should, if effective, show an impact on the life domains of work or leisure / recreation or both.

A QAP can therefore create a context in which connection between service outcomes and quality of users life can be made. We are as yet at an early stage in health and welfare services in establishing these more complex relationships between service outcomes, user satisfaction and quality of life, but this remains a considerable challenge and is noted here as a research application within the ENQUIRE System.

ACTION PLANS SETTING STANDARDS AND OBJECTIVES USING Q# AND Q*

As we noted in the **Assessment** and **Case Management** applications of the Q# and Q*, the instruments are used not only for analysing observations but will give an indication by the Q* of items for further action. These specific action items expressed as intended outcomes of the service will be part of a potential set of objectives.

The recorded, plotted and analysed observational data will show what the service can or should do to maintain or enhance quality of service or to minimise or expel deficiencies. These are real objectives and action plans and may contrast somewhat with the more abstract statements of principles and objectives to which the service previously said it was committed. The Q# and Q* therefore encourage participants to be realistic about change and improvement.

Action planning is undertaken by restating the action items which the unit wishes to implement (derived from the Q*) as OUTCOMES for the users in that column in the Q#.

These statements begin to combine as STANDARDS which the unit can and will set itself and attempt to adhere to. They may or may not fulfill some externally imposed standards. These can therefore be added to the matrix and will alongside the units realistic ACTION PLANS, combine to become the focus and concern of an ongoing QA cycle.

TOOLS FOR CHANGE IN AND BEYOND QUALITY ASSURANCE PROGRAMMES

The QAP will also provide through the Q# an overview of the other tools which can be used in instituting change, change which the QAP is designed to measure at a later date. The following simplified Q# illustrates the range of interventions which can bring about change. (Figure 26a) The focus is mainly in the 'means' and process area, but structural and outcome factors will clearly impinge on the methods and tools chosen to continue QA within the overall **ENQUIRE** System.

Figure 26a

Quality Matrix : Tools for Change in QA Programme

	Structure	Process	Outcomes
Life (Users)	User Councils Visiting Hours	Quality of Life Measures Customer Satisfaction Surveys Consultation Confidentiality Recognition of Independent Advocacy Participation in Planning	Rights Exercised Explicit Value & Goals of Service Understood Communication Avoidance of "Tokenism"
		Respect Effective Listening Communication Standards	
Care / Treatment (Clinicians)	Info Systems Policies Protocols Procedures Statutary Requirements PI's Skill Mix	Case Management Clinical Audit Peer Review (Repeat QM & Q*) Q Circles MHAC / SSI / HAS Inspections	Complaints Procedures (Litigation) "Health" Outcome Measure Agreed Care Plans "Homes are for Living in" Criteria
		Disciplinary Grievance Procedures Staff Appraisal IPR Communications / Standards	
Service (Managers)	Finance Skill Mix etc, Staff Levels Capital Assets Pop Stats Other Resources Legislation	CM. Budget Setting Process Staff Attitude Surveys Training Effective Communication Strategies eg Team Briefing Personnel Practices Process / Strategies (QUARTZ)	Throughput Measures Budget Targets Met Set Standards Met Staff Satisfaction Recruitment / Retention Staff

The matrix also suggests some of the factors which operate between managers, staff/clinicians and users in enabling the ongoing QAP to be effective. Another way of thinking about this is shown in Figure 26b, based on work done by Mathew (King's Fund College)

In summary therefore, the **ENQUIRE** System is a comprehensive Quality Assurance Programme which uses its two central tools, the Q# and Q* to generate qualitative data at various levels, personal, unit/agency and area. The **ENQUIRE** system can interface with other inspection systems, has future research potential, and a wide variety of instruments and methods for ongoing QA can be used within the framework.

The Quality Matrix

Figure 26b

	Structure	Process	Outcome
Service User Focus	* Good environment * Good access * Good appointments * Good position in performance league * Open visiting * Good information / brochure	* Respect from staff * Caring, supportive responsive staff * Empowerment from staff * Goes as expected * Seen by appropriate staff * Good liaison with Community Care	* Feel good about -Outcome -Delivery * Feel supported in community * Understanding the future
Clinical Focus	* Good equipment * Good staff skills & qualifications / training * Good systems / emergency support * Good support for staff * Good prevention & health promotion	* Good referral * All staff -do right things -do things right * All support systems work effectively * Complications dealt with smoothly * Efficient system for processing patients appropriately	* Best clinical outcome reviewed through Audit * Optimisation of care * No long term complications * Mortality * No iatrogenisis
Management Focus	* Resources best placed for - effectiveness - efficiency * Placed well in market * Lean costs * Comnet with GP's * Good suggestions / complaints system * Customer awareness systems	* Low "Cost of Quality" * High productivity * Work to CQI plan * Good systems operation * Good teamwork * Good moments of truth * Treatment / retention	* High "value" care * High patient satisfaction score * Sophisticated cost / outcome measures * Equitable service * Service relevant to needs * High throughput

Source: Mathew D. (informal communication, King's Fund College)

The relationship between the Q# and Q✱ shows their complementarity and capacity for analysing extensive and detailed descriptive material.

The Q# and Q✱ and the ENQUIRE System as a whole operates as a training pack for QA Teams, provides analytical tools for processing observations from site-visits and is sufficiently explicit in its methodology to create a QA 'peer review' capacity for continued internal QAPs. The Q# and Q✱ will also provide ACTION PLANS. A checklist of the applications of the Q# and Q* is as follows:

1. Personal Biographies
2. Assessment of client/user
3. Case-Management plans
4. User Satisfaction
5. Single Unit - Observation and Action Plans
6. Grouped Units (functional/geographic) Observations and Action Plans
7. Service Principles/Objectives
8. Evaluation of external national inspectorates
9. Area level data derived from 5 and 6 Observations and Action Plans
10. Care Contracting
11. Potential research interface with quality of life measures
12. Tools and methods for change

SECTION 5

THE QUALITY ASSURANCE CYCLE

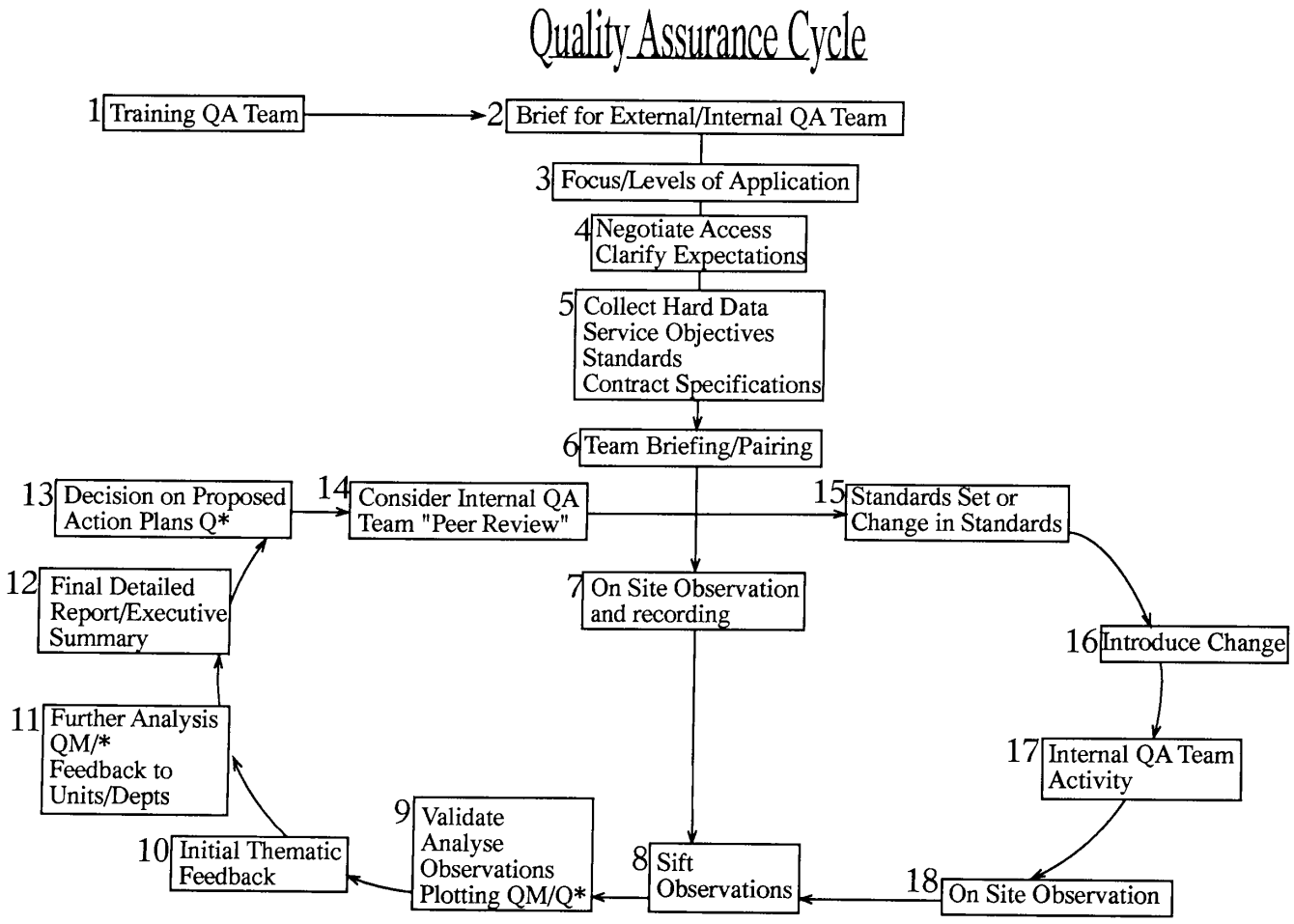
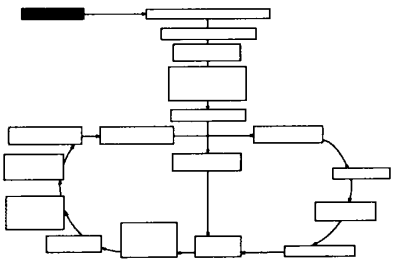

Quality Assurance Cycle
1 Training QA Team
2 Brief for External/Internal QA Team
3 Focus/Levels of Application
4 Negotiate Access
Clarify Expectations
5 Collect Hard Data
Service Objectives
Standards
Contract Specifications
6 Team Briefing/Pairing
7 On Site Observation
and recording
8 Sift
Observations
9 Validate
Analyse
Observations
Plotting QM/Q*
10 Initial Thematic
Feedback
11 Further Analysis
QM/*
Feedback to
Units/Depts
12 Final Detailed
Report/Executive
Summary
13 Decision on Proposed
Action Plans Q*
14 Consider Internal QA
Team "Peer Review"
15 Standards Set or
Change in Standards
16 Introduce Change
17 Internal QA Team
Activity
18 On Site Observation

Figure 27

SECTION 5
THE QUALITY ASSURANCE CYCLE

A systematic approach to quality assurance through qualitative observation, validation and action planning, the complete **ENQUIRE** Quality-Assurance cycle is set out in Figure 27. A brief look at the outset will give a sense of the overall picture. Here we provide a short commentary on each of the 18 stages.

1. Selecting and Training a QA Team

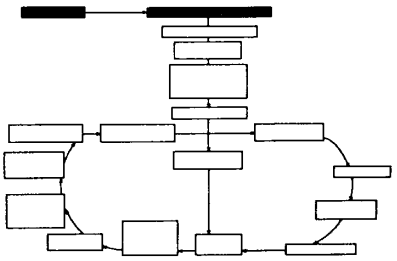


The development of a QAP may begin at staff or user level but its effectiveness will be achieved by the full involvement of the managerial level. Many small changes take place to improve quality in organisations which are within the compass and responsibility of staff and clinicians. Quality Circles, and User Satisfaction surveys are relatively common. Our concern here is to assist in creating a QA programme within the organisation which has the capacity to be an ongoing cycle and brings the three levels of the managers, staff and users into negotiation about planned change.

Managers will therefore have to decide on who and how many people undertake to introduce a QAP. This decision is crucial to the success of the programme. Is QA linked too closely with external inspection? Is QA linked too closely with a particular discipline? Is the 'lead' person sufficiently senior in the organisation? These are all questions which must be addressed.

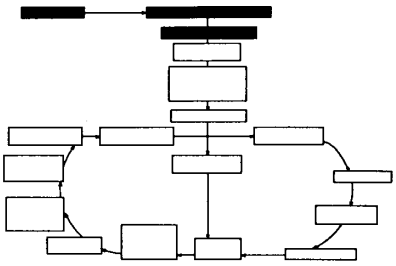
One model which has been adopted successfully is to set up a Quality Assurance Team (QAT) which has access to senior management structures and includes on it all sub-unit 'stakeholders' in the QA process. Such 'stakeholders', whose sections, units or departments will take part in the QAP, also create Quality Review Teams (QRT) at their department level. External trainers are needed to train the QA panel members and they have the responsibility to see that the cycle is completed. External trainers work alongside the panelists in training the QRTs. The initial part of the cycle to stage 13 is then undertaken by a Quality Assurance Team made up of QAT and the QRT. The balance between external and internal QA is thereby made. The external trainers enable the internal QA Team to undertake the programme. The first part of the cycle can still involve external trainers since QA is best understood and applied in practice. At stage 14 the QA visits between units become possible. In time QA Teams can be put together for specific activities but continuity of membership between initial observations (8) and later observations (18) should be borne in mind.

2. Brief for QA Team



The brief will outline the time scale for the stages 2 - 12/13 and specify dates by which each stage must be completed. Sufficient time must be allowed at stage 2 for analysis and for feedback to the participating units. Space and time has to be given to allow for discussion and agreement on the Action Plans (13) and the changes which are to be introduced (15). This time-scale section of the brief will enable the QA Team to be clear about their time commitment and that QA does not begin and end at the stage of site observation (7). The brief will also include items 3-6 below

3. Focus and level of QAP



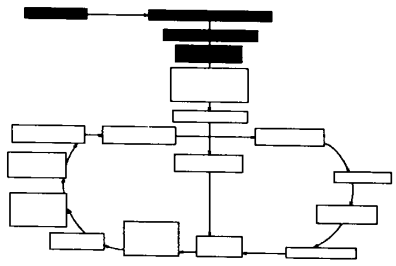
Here decisions are made on the scale of the QAP to be undertaken by the QA Team. The blend of individual contact and unit level contact and choices of a functional or geographical nature must be made. If an Area approach is being taken clearly a sufficient number of units / projects must be included and the emphasis on individual assessments may be less. Such decisions are assisted by considering what "human scale" makes sense to the users of the services being considered. The QA Team will wish to locate itself at the point at which services transactions take place and it is these places and times which will determine the scope of the site visit, its focus and level.

We have noted above in our discussion about the tools for quality assurance, that the Q# and Q* star are capable of use at a unit level and at an individual assessment and case management level. If it is the intention of the QAP to consider a particular kind of service for users, for example day services in a particular geographic area and for a set population, then that picture will emerge best from the aggregated data taken from the Q# and Q* for a range of units providing day care within that area. This does not entail extensive use of the instruments for individual interviews with users. If however, the scale of the service to a significant population is relatively small because of the particular and special nature of the service then the area picture will be determined by many fewer units results. In this instance the use of the instruments at an individual level with users of a single agency providing a service to an area becomes practicable and valuable.

Undertaking a quality assurance programme which includes a perspective of the outputs of particular services and also an understanding of the service - use patterns of those clients who use it, is, in itself, sometimes problematic. The service may produce only a small proportion of the components of the overall care which the user requires to deal with a problem or disability.

An example of this difficulty is the creation of a quality assurance programme to consider residential care services for the elderly in a particular area. These residential services may be located in units which provide respite care and day care for different groups of people as well as the main core of residential care. Staff in the units may have a range of linkages with home help services, meals on wheels, community nursing and sheltered housing units as well as with geriatric and psycho-geriatric provision. The use of a quality assurance programme which entails only residential care services for an area needs careful thought. In short the focus of a QAP is best made by considering the unit or area based functions of particular services in relation to the composition of the user group and their patterns of service use. Here once again we are making the focus of the QAP the 'hot spot' of services where the transactions between staff and users take place.

4. Negotiate access and clarify agency expectations



If a QA programme is to be successful in the first part of the cycle between stages 7 and 13 then the reasons for the visit must be clear to the agencies and units which are participating.

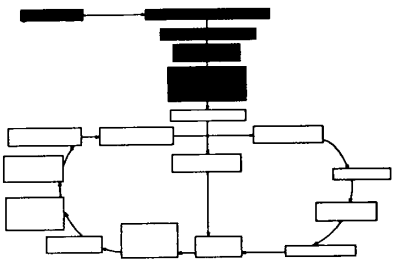
It is particularly difficult to recruit from amongst the service providers and staff in a particular unit to a 'peer review' quality assurance team if they have not fully understood the process that they have taken part in in the first cycle of quality assurance. Clearly staff are unlikely to be committed to action plans if they are not clear about how those action plans have been drawn up and are not reasonably familiar with the straightforward use of at least the Q* instrument. Part of the process of negotiating access and clarifying expectations is to design the programme for the small team who will come to the unit itself.

Unfortunately such site visits often begin by meetings with management and tail off into an assisted and accompanied walk around the plant with occasional contact with service users. Much energy in these kinds of site observations is taken up in hearing the views of middle managers about their service, and do not always involve junior staff in the unit and are likely to become concerned with hopes and aspirations for the service and at the same time in checking hard data information which should have been provided at the briefing stage

It is therefore at stage 4 in the cycle that these matters are dealt with and the items at stage 5; hard data and service objectives, standards and contract specification are collected. The members of the QA Team who undertake the writing of the brief and negotiation of access have a vitally important task to complete. They will determine the extent to which the programme on-site brings the QA Team into direct contact with users of the service and front line staff in a sensitive and productive way. It will determine the structure of the day so as to provide a balance between observation and recording for the QA Team.

This first contact between the QA team and the agency is therefore of considerable importance. The opportunity to take part in an initial feedback meeting with other agencies visited should be outlined, the further opportunity at stage 11 of being able to correct any obvious factual inaccuracies in the observations made by the QA Team should be made explicit. Front line staff and users will also want to know of the material that will go through to the detailed final report at stage 12 and form the basis of action plans at stage 13.

5. Collecting quantitative data, service objectives, standards and contract specification



The ENQUIRE System and the particular tools, the Q# and the Q* are essentially qualitative analysis systems. They allow for detailed observations to be made within quality assurance programmes and conclusions to be drawn from them in the shape of action plans.

However, the context in which such qualitative measures are taken is one in which there are clearly important quantitative aspects of the way in which services operate. The on-site observation by the QA Team will be diverted into the gathering of facts and information if that data has not been provided for them as briefing and collected some considerable time before the visit to the service. Most units of management and social service departments have research information units which will provide much of the hard data ranging from census data, materials derived from the general household survey, more local indices of need and deprivation, the application of norms and other such materials. Matters of population, composition, density, the rural and urban nature of the area to be visited, housing stock, ownership, income levels, family size, age structure of the population are all matters which need to be provided for the QA Team as preparation for the visit. The QA Team will therefore already be aware of a good number of the structural / input 'givens' of a service. A second level type of material which the quality assurance team requires is access to policy statements and planning statements that have been made in respect of the area and the services which are being quality assured.

These documents will contain valuable information about the direction in which services are heading and the degree to which people working in those services have been part of consultation exercises in respect of their future, and the degree to which joint and multiagency planning has occurred in relation to that particular service.

Further hard information which should be gathered and provided to the QA Team at this stage concerns standards, matters of registration requirements and issues concerning contract specification. The service being visited may have externally imposed requirements associated with registration or have already established and set certain minimum or optimal standards. These matters may even have been explicitly stated within the terms of a contract of service provided by the unit.

It is important that the QA team should not have their focus and level of application in stage 3 of the cycle thrown off course by being trapped in considering only what is explicit in terms of statements of standards, conditions of registration or contract specification. However, these matters can be included within the activity of the QA Team and can be sought and identified in terms of structure, process (and outcomes) in the Q# and Q* analysis which will result from the use of these instruments.

In short if matters of standards, objectives, and contract specification fall below the horizontal line in the Q* there are reasons for supposing not only that issues of quality need to be addressed in the service but that the service may also be falling short of the specified and explicit criteria which have been stated in the policy documents governing their activity.

At stage 5 the quality assurance team should be encouraged to learn as much about the area and service before going on-site as possible. A knowledge of the names of managers and staff, the functions of the units, and the area covered all contribute to a sense of concern and value expressed by the QA Team to those who are taking part at the service level.

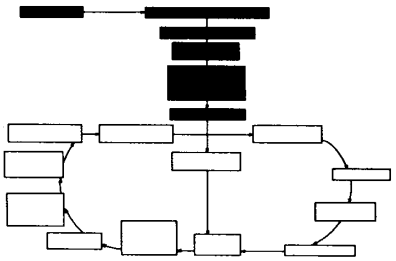
There are occasions on which it may be helpful to suggest to the QA Team that they do not take the hard data briefing materials on-site because it has been our experience that in the more general flexible approach to qualitative observational activity, there are times when members of the QA Team sometimes encouraged by the service providers themselves can be diverted into discussions of a purely informational nature which have already been contained in the briefing materials.

It is also possible for the QA Team to misuse hard data briefing material as a form of checklist and to use the time on-site simply to ask questions arising from the material concerning matters like catchment areas, relationships with other agencies, numbers of users, turnover of beds and other matters which will therefore tend to locate observations, debate, discussion and therefore reports much more within the structural areas of the matrix and skew the picture gained from the visit.

One of the central aspects of qualitative analysis is to attempt to appreciate by describing and understanding outcomes in terms of quality of services to users rather than to specify the volume and level of outputs from the service. Some hard data provided for QA Teams will include materials which can give rise to the application of targets in volume terms for a service. These, if used on-site, sometimes result in a discussion about resource inputs in relation to the volume of outputs of the service rather than any matters of quality, quality being concerned with outcomes for users from the use of existing resources.

6. Team Briefing

As we noted earlier in paragraph 1 the initial team may well be the quality assurance panel (QAP) who operate as a form of an external quality assurance team in order to build future internal teams made up of some of their members; that is people recruited from service level quality review teams plus others who may at stage 14 be considered for a 'peer review' quality assurance team. However, at this stage there are various roles to be performed within any quality assurance team whatever its composition.



Leadership of the team is something that requires careful discussion with management and the leader should, to be most effective, concern him or herself with the content of the visit and avoid activities surrounding the structure and process of the visit. This associates leadership of the team with the substantive content that will result from action plans and locates the content of the outcome of the visit with a senior position within the quality assurance panel and therefore ensures a greater likelihood that the findings will result in new action plans and new objectives agreed at all levels and particularly supported by management at point 15 and 16 in the cycle.

We have already referred within the cycle to a range of activities which are of a preparatory briefing nature and concerned with the process of the quality assurance cycle. This can be an administrative task but will involve visiting the agencies at stage 4 and is therefore best completed by someone who has a sound

grasp of the configuration of services for particular client groups. They will need to work closely with the team leader and ensure that the team are well briefed in matters of focus, time scale, transportation and all other aspects of the cycle, especially communications. These persons may not themselves go on-site at point 7 except in a central, coordinating, administrative capacity and may not need to be closely associated with the content of action plans that arise at point 13. A successful quality assurance team will have a close bond between the leader and the person undertaking the preparatory work and the briefing.

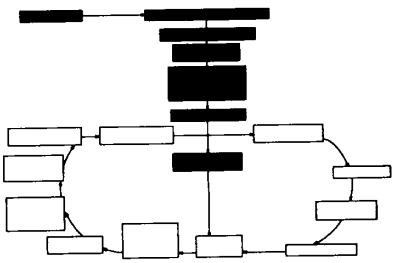
Finally the team requires somebody who will facilitate the discussions which occur at stages eight and nine. In the first part of the cycle the external trainers would be best used as facilitators to enable people to sift observations at stage eight and to validate these and plot them on the instruments. Stage ten is coordinated by the team leader and eleven, twelve and thirteen are coordinated by the person who has undertaken the briefing.

The facilitator's job is therefore linked to the use of the particular instruments, but also to enable the QA Team to negotiate amongst themselves about which observations are deemed valid or otherwise. This person is likely to be a member of the quality assurance panel and have experience of being a full member of a QA Team, but who may not have been an active on-site observing participant in this particular QA programme.

In summary therefore, we can see team briefing is important not only for the team to get together and to get to know each other but also in order that the roles of leader, facilitator and briefer are clearly defined. The hard data briefing can be presented in a short lecture format to the team. The final and most important aspect of team briefing is to establish the pairs who will visit particular services and units. It is fundamental to the ENQUIRE System and for accurate on-site observation that this should be undertaken by pairs of the team operating together.

The pairing of team members with each other is a sensitive and important issue which is related directly to the leadership of the team as a whole. Considerable thought and discussion will have taken place between the person undertaking the briefing and general administrative tasks for the QAP and the leader of the team as to how the team members should be paired. A range of criteria come into play at this point; a skill mix is important, male and female divisions may be important, background and professional discipline of the persons concerned may be of significance and even friendship or long term knowledge of each other can work towards less creative differences of view than would otherwise be the case. Pairs should be invited to work together by the leader and this is best set up before the team briefing meeting so that there is no doubt about what the pairings are and who is working with whom. Therefore the team briefing also has a team building aspect in terms of consolidating the pairs by asking them to undertake small preparatory exercises together and building those pairs into an effective QA Team.

7. On-site observation and recording



By using the word "observation" the ENQUIRE System does not limit this activity to simply 'looking' in a literal visual sense.

Observations are informed responsive reflections that the QA Team make, having absorbed a considerable range of factual information concerning the service, but having then immersed themselves in the world of that service in order to describe and understand, before making any form of analysis and conclusion. Observation in this broader sense therefore includes listening, literal seeing, asking open questions, discussing and also recording.

There is a tendency once introduced to the analytical tools such as the Q# and Q* to allow them to structure and determine the way we observe, collect information and record. This should be avoided. The analytical function of the tools should be stressed at the team briefing and they should not therefore be taken on-site and "filled in" at that point. Rich and meaningful on-site observations emerge from pairs who can

work together, one recording and one entering into dialogue and observation with those directly concerned with the service, without 'reading on' too many presuppositions and assumptions or "known answers" to the issues or problems in the services which are being observed.

We noted earlier the relationship between a quality assurance system being "value driven" in the sense that it gives considerable emphasis to the principles which underline a service, and an awareness of these principles and objectives at the point of analysis in order to assess the degree to which the service exhibits and embodies those principles. The QA Team therefore is not going on-site to solve problems in some "trouble shooting" way and should therefore hold back from didactic activity even when a particular problem or situation has a very obvious solution which is known to them. It is a short step from didactic discussion and prescription to making management decisions about the way in which a service should be conducted and that clearly diverts the quality assurance process into executive decision-making rather than into appropriate feedback for those who in the long term are responsible for making such decisions. In short it is undermining of both front line staff and managers. The **ENQUIRE** System suggests to those members of the QA Team who are going on-site that they consider operating in the following five ways:

a. That they try and capture what occurs at the point at, or nearest to, the delivery of the service in question.

b. That they attempt in their observations to be as descriptive as possible and to avoid (unless they feel it is absolutely necessary) prescriptions for the service. However, in being descriptive they will wish to reflect quotes, opinions, facts and values from a number of sources, users, and services in particular, and these as we have already noted may well contain prescriptions for the service.

c. That the pair work closely together, observing and recording in turns and that they regard themselves as two separate points of observations rather than one single point of observation. They must decide as a pair on whether to source the observations as they record them or not. This dynamic between the diad who are undertaking the on-site work becomes increasingly important when they, as a pair, process their observations from a particular service. Processing observations is inevitably a matter of negotiation and an attempt to find agreement on what should be finally recorded. The observations are not just what has been recorded by the person who happened to be recording during the visit. There are "fieldnotes" and "headnotes" which contribute to the final observation. This is related to the point made above that the pair are separate sources of observation whilst working as a pair. The recording and observing functions do not prevent this from happening. It allows for corroboration or otherwise between the pair about what they have observed. They can then discuss the matter as a potential observation to be expressed in final recorded form.

d. The pairs are encouraged to see the user and the service in its social context and to have a real awareness of what that entails. This concerns the social distance that may exist between those in the QA Team and the people, both users and staff within the service. It may seem an obvious point but what is acceptable and relevant to people within a QA Team may be very different from what is acceptable or relevant for people in a particular community or using a particular service. Here Maxwell's six dimensions of quality are important to bear in mind, they have been noted earlier and the particular ones that we have in mind here are relevance and acceptability.

e. The pair are encouraged to have a dialogue with the people within the service, to ask, where possible, if asking questions at all, open questions and to participate in activities where invited, falling short of adopting any direct therapeutic roles or management functions.

There are therefore a number of skills involved in undertaking observations on-site. Some of these skills derive from interview techniques, some derive from group work approaches and some are simply being able to capture in a very few words what one sees. There is considerable skill balancing ones own professional knowledge and experience, being well informed about the factual aspects of service, having a number of committed preconceptions about the functions of these particular types of services and then allowing the free flow of views, attitudes and experience of users and frontline staff to form a fuller and richer picture of what is going on. This is difficult to achieve but can be greatly improved upon by practice.

If this commentary on site observation appears to be full of 'though shall nots' then it is because it is

an attempt to free up the QA team members to be open to a dialogue, to try and create understanding about the operational outcomes of the services' objectives and principles and to record these faithfully and accurately in order that the material is as sound as possible for later analysis.

We will come, in stage 8 when observations are sifted, to look at matters of significance and reliability but at this stage it is important to create a sense of openness, exploration and dialogue, and not to allow QA Team members to go for a form of "closure" in their observations by linking them either with "checklist" ideas which have emerged from the hard briefing material or by using the analytical tools in order to gather the data in the first place, or by "reading on" their own preconceptions on to a service.

As we noted earlier the QAP is an ethical enterprise in that it recognises that subjective views, personal values, feelings and moral ideas are at the very heart of human services and their evaluation. It is not therefore an endeavour which tries to drive out values and subjectivity, as if this will get us nearer 'real truth' or a 'single truth' which is in some sense more 'factual' or more 'objective'.

There will be critics within any organisation of quality assurance programmes. Some of the criticism may be well informed and helpful, others may be from people who resist the introduction of quality assurance for a variety of reasons. Some of the arguments that are used against such evaluative techniques and qualitative methods will be familiar to readers of this workbook. They often include an over-reliance on apparently factual material, a paradigm which refers to experimental design and natural science methodologies by contrast in order to cast qualitative data as being in some sense arbitrary, less reliable and therefore less true.

The limitations of a qualitative, analytic approach must be fully understood by the QA team. The systematic approach outlined within the **ENQUIRE** System enables the process to be controlled and managed in such a way that the system does not claim for itself and, QA Teams do not find themselves recording and by implication, supporting insupportable proposals or action plans which have no basis in the accurate reflection of the activities of the services they have visited. It is expected and required that a QA Team will be comprised of people with appropriate training, professional skills and sapiential authority in fields or health and social welfare. The QA Team will have been clear about its focus, scope and level of its activity and it may be aware of some pre-determined evaluative criteria in the sense outlined in section 5, for example contract specifications. But the QA team will not allow itself to be lead entirely by these criteria.

The QA team members will be aware of the importance of seeing principles and values in action and with reference to our previous section on interactive principles will reflect in their observations the way in which not only staff skills but attitudes and values are key determinants of quality in the service. The expert knowledge base of the QA Team is in a sense kept in reserve for the further analysis of observational data rather than used to structure the observations at stage 7 in the cycle. It should be noted however, that it is not necessary for all QA Team members to be able to perform all the data analysis tasks to be able to make full, rich and accurate observations.

The purpose of a quality assurance programme (QAP) is to provide all the participants with a better understanding of the service. This clearly may entail the use of information which is of a quantitative nature. This kind of information is of value, but only within the context of the services actually provided to the users of those services. It is not sufficient to know that the socio-demographic characteristics of the area in which the service is located are such that there are many elderly people living alone, or high unemployment rates or that the available resources are below some national guideline norm of provision.

This hard information becomes of value when the service responds to it, clarifies what is within its power and responsibility to change and what is not, and determines and reviews the level of quality they are capable of providing, and for whom, within the available resources.

Most service personnel in any event do not have ready access to many of the hard data sources, to policy documents and strategic plans, and in any event it is not always properly their concern since their primary task is to provide a direct service to a user.

We have stressed the need to make qualitative observations at the point of the service transaction where front line staff exercise their skills and feel valued and introducing hard data in this process of

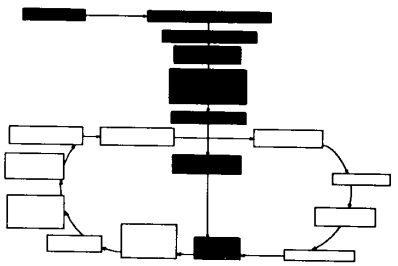
observation and dialogue can sometimes have a negative and disabling affect on staff and users.

It sometimes provides a focus for discontent and apathy and encourages general discussion such as "we have a lower ratio of services / beds / places / resources to users / potential users than anyone else in the region / county / country"! This diverts attention from the focus on the actual quality of the service being delivered even when it is true. Therefore the intrusion of hard data as an evaluative criteria at this point in the service and at this stage of quality assurance exercise can be confusing to both the QA Team and those taking part in the exercise and may make the service feel disempowered.

If however the staff and managers of the local service do have very significant concerns in the policy and resources areas, then these will show up in reported observations and find their way into structural and process areas of the matrix which will reflect that that is where much of the energy locally is going, rather than into direct service provision.

In summary, qualitative evaluation by observations made on-site which are recorded in an appropriate way by one of a pair of the quality assurance team is a technique which requires patience, application, practice and to a large extent acceptance by those who are being observed. The concept of observation is not a literal visual concept but includes a variety of activities including discussion, interviewing, listening and of course visual observation.

Observations are not simply reactions, they are considered and reflected responses which are made overt by the member of the pair in the process of recording. The enterprise is inevitably value driven in two senses. First of all that the observations contain material which relates to the operationalisation of the service principles and values themselves and also the decisions to pursue a particular line of enquiry and to record it is in itself a value judgement. Skilled quality assurance team members in pairs will also quickly be able to avoid becoming a "messaging system" between different parts of a service or agency. We will now move on to the process of sifting and reflecting on the recorded observations from an on-site visit.



8. Sifting and Processing Observations

It is essential that the small diad teams within the overall quality assurance team undertake this activity as soon after making the observations on-site as possible and leave themselves sufficient time to produce an overall description which they can take back the to whole QA team at stage 9 in the cycle. It may be the case that the pair have inevitably had to split up during the visit, in particular if an individual interview with a user has been required. If so then there is a dialogue to be had between the pair themselves with one talking the interview through with the other in order to decide on the observations to be recorded from that activity undertaken singly.

In a visit to a project or unit for example there may be up to 40 or even 50 basic observations that have been made or noted in some form in shorthand or recalled or remembered by the pair from the morning or afternoon's work. The first stage of reflection is simply to list the basic reported observations and to clarify their syntax, grammar and meaning in the form of a single sentence if possible.

The next step is to exclude any which either member of the pair feels they cannot endorse. The next step is to look for observations that appear to be the same or similar or which can be conflated into one single observation. This process generally will reduce the number of observations fairly significantly.

Let us, for the purpose of this example, imagine that the observations have now been reduced from 40-50 to approximately 20-25 which is the general ratio that has emerged in practice to date. Whilst retaining a written copy of the 20-25 observations the pairs next task is to agree which of these are the 10 or 12 most significant. This introduces a clear evaluative element into the recording process for the first time in an explicit way.

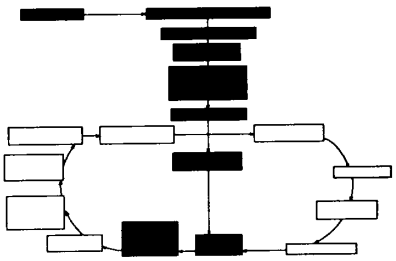
It will be clear from the earlier section on the tools of quality assurance that for any unit or individual it would be possible to fill in every single cell of the 21 cell matrix with a descriptor of the way the service operates. This is simply akin to making a basic model of the service and similar to taking a photograph of it as it is. If all cells in the quality matrix are filled up in a purely descriptive way no pattern of significance will emerge on the matrix to show where energy is being expended and where emphasis is being placed within the service and the degree to which it is directed towards outcomes, processes and structures.

Once again the pair should not be influenced in any way by their knowledge of the analytical tool (the Q# and the Q*) in seeking and noting the most significant observations from their on-site visit. The ability of the Q# to show whether there is an emphasis on and a concern with outcomes as opposed to process or structure is determined by both the nature of the service as accurately reflected by the QA visiting team, but also by the focus of that team and this is a dynamic interaction.

The balance will be struck by experienced QA Teams between their own concerns with quality at the point of service delivery, implying a concern with outcome and the accurate reflection of the service providers and users concerns in so far as they are concerned with outcomes, processes or structures.

In short it is not intended within the ENQUIRE System to train QA Team members increasingly, and only, to focus on matters of outcome at the point of observation. The analytical tools which will reflect the concerns of the service in terms of structure, process and outcome can only be effective if used on sets and series of observations which cover a wide range of the services activities and accurately reflect those which concern service delivery.

9. Validation and analysis of observations and plotting on the Q# and Q*



The team leader and briefing personnel for the quality assurance team must ensure that sufficient time is made available for this stage in the quality assurance cycle, otherwise a great amount of important material will be lost and not captured by the analytical tools and will not have been validated before it is subjected to analysis.

It is at this point that the pairs may turn to the whole QA Team as a group and the leader steps aside and requests the facilitator to take over.

Considerable discipline, in terms of time management, is required to get through the amount of material, for example a QA Team of eight people is four pairs who have seen four or five units in an area each pair will have 10 or 12 x 4 or 5 observations and the QA Team have a very significant work load to get through if all of them are going to be appropriately validated.

It is unlikely however that the whole QA Team is going to need to discuss all the observations from each pair, spend time validating, and then analysing after plotting on the Q# and Q*. All the observations should be heard, i.e. read out, but the pairs only request discussion on any which are unclear.

It is important to note at this point that the observations will be in the form of sentences and that these will be brief. Behind these stated observations will be considerable detail which the pair who have made the observation will know about.

It should also be noted that as the observations are read out by the pairs other QA Team members may want to seek clarification of the observation. The process here is therefore not only validation of the observations and a check on meaningfulness but also "ownership" by the whole QA Team.

It is not a helpful process to give a pair's basic observations to another pair in order that they can plot them on the Q# and Q* because knowledge of the background to the observation is essential to getting the appropriate positioning of those observations.

This process that is continued by the pair also links to stage 11 in the quality assurance cycle where it is required that the pair who made a visit to a service return to the service for feedback, using the analysed observations.

The first task for the facilitator in this meeting is therefore to invite the pairs to read out their ten or twelve key, and most significant, observations and open them for questioning to the whole group. The whole QA Team can therefore seek clarification of these observations and these are therefore rendered meaningful as a result. Questions can be asked of the pair, and cross referring between the pair and other people with other sources to clarify the observation can take place. Reference can be made here to other related observations, to the source of those, and to the briefing materials and to data of a quantitative nature.

This process is not primarily concerned with the "truth" or "falsity" of the observations but with their meaning and clarity.

The facilitator at this point summarises with the QA Team as a group the salient initial thematic points for the functional or area service.

As this proceeds the themes from the whole quality assurance visit, (providing the focus of the visit has been appropriate and thought out) will begin to emerge. For example, in respect of a quality assurance programme for a community mental health service, themes may emerge across and between units visited by pairs concerning crisis intervention, medication adherence, access to general practitioners, vocational rehabilitation opportunities etc. It is these broad themes which will assist in providing the section headings for a final report which will then use the detailed material from individual units and observations by pairs as supportive material to address the overall qualitative issues which the area service faces.

This initial thematic feedback can therefore be used to give agencies participating in the quality assurance cycle a fairly immediate initial verbal feedback which is usually welcomed by those agencies, rather than for them to wait some considerable time for the further more detailed feedback from their visiting pair. This also assists in structuring the final report in terms of its themes, and greatly assists in producing an Executive Summary for managers of a whole service which avoids providing them with a vast amount of detailed observation and analysis.

These steps are effective methods of controlling the large amount of material which will be flowing through stage 9 and assists in validating and analysing observations.

It gives the leader of the QA team a very important "overview" whilst freeing the facilitator to work with the group as a whole in pairs to take forward the analysis of their observations.

It should be clear therefore that stage nine has a number of levels. The validation of observations is linked to the further analysis by pairs and plotting on the Q#, but the overview of the themes emerging from all pairs is simultaneously being taken forward by the QA team leader. Time management for both the leader and the facilitator may be undertaken by the briefing personnel who are primarily concerned with the actual process of a quality assurance cycle.

The further analytical activity can take place at the same meeting, at stage 9 in the cycle, or can be undertaken by the pairs on their own, at a more leisurely pace. If the latter option is taken it is essential that the pairs return their materials to the briefing coordinator of the quality assurance cycle soon as possible. On either basis the tasks that are undertaken here are broadly analytical. The pair will take the 10 or 12 key agreed observations and they will plot them in the Q# cells.

This is a technique which can be learned through training with the ENQUIRE System and is a negotiated procedure between the pair who have made the observations. Reference here can be made to the previous section which outlined the operation of the Q#.

Once the observations have been plotted in the matrix cells or straddling them depending on how the pair have ultimately decided to locate the observations, they can then concern themselves with considering the legitimacy of the goals that flow from the plotted observations.

They will also be able to consider any pattern that emerges from the plotted observations as to whether the service has its energies flowing into structural and process concerns or into the area of outcomes and whether observations are clustered around any particular part of the matrix giving an emphasis to certain features.

The pair will be concerned to note the extent to which these observations show that the service is primarily focused on outcomes for users lives in the community.

The pair will also refer to the techniques of scoring the matrix and providing a source for the observations and consider in relation to the latter whether any further patterns emerge as to whether sourced observations from managers, staff or users show markedly different concerns within the matrix.

Having considered the way in which the service goals are likely to flow from these observed concerns plotted on the matrix, the pair will then "track" across the matrix from any observations which are not plotted in the outcomes column and spend some time considering the most likely outcomes from the structural and process observations which have been plotted.

These reflections on the matrix itself should not be plotted on the actual instrument, but rather kept as an extrapolation from the observations which can be used for discussion at the feedback session to the particular units in stage 11 of the quality assurance cycle.

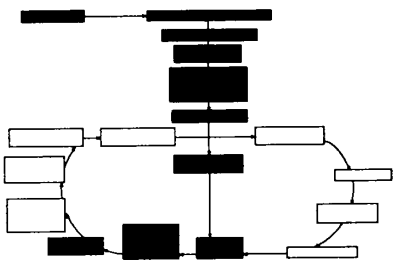
This once again promotes dialogue with the agency by the pair and also stresses the need to focus on the outcomes of the service.

At this point the pair will move on from the matrix to the Q* and using the key 10 or 12 observations will then place them in the appropriate quadrant on the star.

If this task has been completed in association with the rest of the QA team at the same time then copies of all the matrices and stars will be coordinated by the facilitator and the leader of the QA team. They will then be able to undertake any aggregation of data by types of units or by area or by population in order to generate an area perspective as well as detailed observations on individual units.

Similarly if the quality assurance programme is focused on one single unit then the matrices and stars will be associated with individual people using that unit and once again can be aggregated to give a picture of the whole unit.

10. Initial thematic feedback to agencies



This is a stage in the quality assurance cycle which may be influenced by geographical distance, - cost or responsiveness of the units which have been visited.

In a multi-provider, multi-agency context it may well be that the initial thematic feedback to all agencies in a single meeting may have to be general so as to avoid discussing matters which properly belong to the internal concerns of a particular unit. Some units may be in a provider / purchaser relationship with each other or they may be accountable or under contract to them. However, as noted above if the focus of the quality assurance programme has been appropriate on a functional or geographic basis it should be feasible and productive to have an initial thematic feedback meeting with all those agencies and personnel who participated in a focussed quality assurance programme.

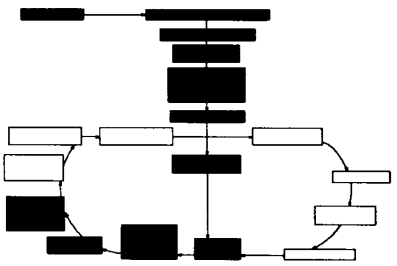
Feedback also provides an opportunity for the leader of the QA Team to establish contact with local people, some of whom will be staff within the agencies visited who either already make up a local quality review team (QRT) or who may be potential members of one and who may be the future members of 'peer review' quality assurance teams between the agencies represented at the meeting.

It is therefore an opportunity to establish, if it is considered feasible, the 'peer review' inter-agency quality assurance cycle which can perform stages 15 through 18 in the figure outline at the beginning of this section. The leader of the QA Team may wish to gain agreement from those agencies that they will take part in a future quality assurance cycle on the basis of inter-agency 'peer review' at this meeting.

If however the quality assurance cycle will always involve either completely external QA Teams or QA Teams drawn from outside the agencies to be quality assured then the 'peer review' issue would not arise at stage 10 in the cycle.

As also noted above if matters of geography and time and service commitments mean that the meeting cannot effectively take place, it may be possible to omit this stage, but serious thought should be given to this before taking that option.

11. Further analysis using the Q# and Q* and feedback to units and departments



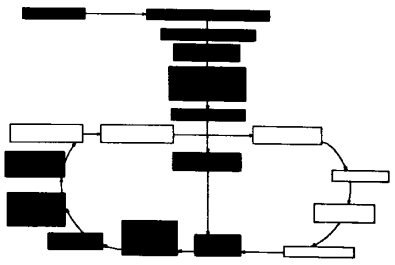
Clearly, sensitivity and skill is required by the pair from the QA Team in feeding back the findings of the quality assurance exercise to the staff and first line management of the individual unit. Critical observations, negative prescriptions and descriptions from the quality star may be difficult for the unit and its staff to accept and own. The committed and systematic nature of the quality assurance programme should be sufficiently explicit to enable the unit staff to hear the content of these observations however critical because they respect the methods and the skills that will have been used in their compilation and analysis. However, the objective of feedback is not only to let the unit know of the findings but also to enable the pair to check on matters of fact and any major corrections which the unit would want to make to their observations. It still remains a matter for the pair to decide finally on any corrections they make.

As noted above in the previous section the **ENQUIRE** System has the capacity to interface with other quality assurance measures that have been used within services and these will have been picked up at stage 5 in the collection of hard data available to the team. At the point of feedback the consistency of results from these alternative systems can be viewed alongside these specific instruments within the **ENQUIRE** System.

The **ENQUIRE** System, is capable of a parallel action in training as well as quality assuring. Stage 11 within the quality assurance cycle enables the pair from the quality assurance team to explain the methodology of the **ENQUIRE** System as well as dealing the actual substantive results. It therefore will assist in the recruitment of staff from units to any future 'peer review' quality assurance team in the future.

A critical "spin-off" from the further analysis stage eleven in the cycle is that the unit can begin to consider what will emerge and be endorsed by their managers at stage thirteen in the cycle. It should be emphasised that analysis and feedback at stage eleven to the agencies is not intended to provide them with an opportunity to preempt the action plans that will be agreed by management, but simply to prepare the ground for discussion and agreement about what changes may be possible and be introduced at stages 15 and 16 in the cycle.

12. Final detailed report and Executive Summary



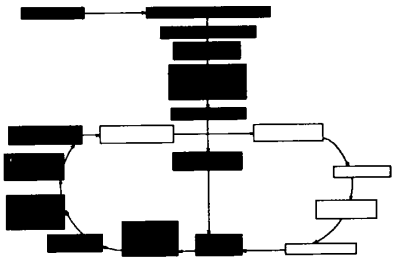
At stages eight and nine the leader of the QA Team is responsible for providing an Executive Summary, and the briefing administrator for the QA Team is responsible for compiling the Final Report. The Final Report will require further analytical work in terms of aggregated unit findings and observations up to completed **Q*s** for either a set and series of functional units or for diverse units which serve a

particular geographical area. The Executive Summary will avoid detailed material, but on the basis of the items put forward at stage 10 in the initial thematic feedback will use the Q* materials aggregated and coded in the way described in the previous section to produce items for inclusion in action plans on an agency basis, a client group basis or an area basis or all three.

The Executive Summary will also refer to the overall scores that have been achieved by the use of the Q* when all aggregated data is placed on one single star. This gives an indication of a whole service's performance in terms of its quality by the quadrants within the star.

The Final Report should avoid such things as written recommendations as such and ensure that copies of it are provided appropriately to the units which took part in the quality assurance programme.

13. Discussion and decision on proposed Action Plans

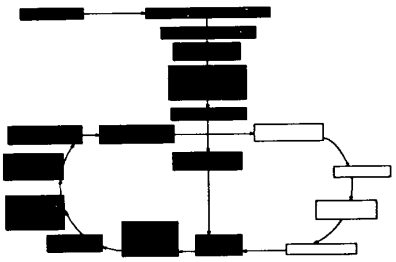


The final report and Executive Summary having now been shown to participants in the QAP, stage 13 requires that the leader of the QA Team return to the quality assurance panel and to senior management and contribute to discussion on possible action plans which have emerged from the quality assurance exercise.

Senior management may or may not wish to have sub-unit heads present at such a meeting and may or may not wish to have the managers of the specific services visited present at such a meeting. These are clearly matters for senior managers in the way in which they wish to utilise the materials emerging from a QAP. It is however, critical that senior management executives are as open and responsive as possible to the proposals and expectations of a QA programme which they have sanctioned in the first place.

The tendency to allow a final report and action plans to languish on desks or for the decision on proposed actions to exclude those who will have to implement them should be considered very carefully. On the basis that the ENQUIRE System works most effectively with the maximum participation it may well be that the senior managers may wish to deal with action plans in the most participative way in terms of operational aspects having had an opportunity to consider such activity within the terms of strategic policy.

14. Consider internal quality assurance teams and 'peer review'



The first wheel of the cycle is now almost complete as can be seen from the figure.

The final report has gone to senior management, action plans have been considered and decisions are therefore being taken about specific items within those plans which can contribute to a review of objectives, the introduction of changes and definition of standards at stages 15 and 16 of the cycle. However, whatever the Action Plans produce in terms of changes, whether they are small or much more significant shifts in policy and practice within units or even within areas, the future quality assurance cycle should be considered at stage 14. It may well be that up to this point there have been external trainers involved with the quality assurance team and external input into the facilitating at stage 9 in particular. However, from this point onwards the ENQUIRE System envisages that the quality assurance process becomes part of the culture of the organisation and becomes built in.

The characteristics of quality assurance as described here, suggest that the composition of a quality assurance team (QAT) includes the highest level of management among its members and that the quality review teams (QRT's) are recruited from operational and unit level.

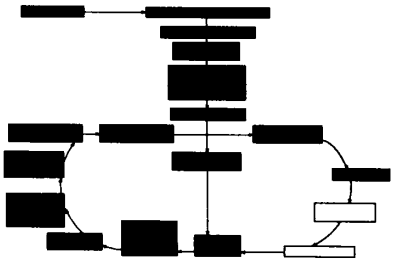
The first wheel of the cycle will have contributed to their skills and knowledge, and to the

deployment of tasks amongst members particularly those of the quality review teams. The internal and external balance therefore in the quality assurance team will have been established by stage fourteen of the quality assurance cycle. The internal nature of future quality assurance is assumed.

However, the ' peer review ' features and characteristics may not be fully worked through. A choice is included within the quality assurance cycle, alongside the future internal QA activity, for a 'peer review' function. Other linkages may be envisaged also between the internal quality assurance team and "arms length" inspectorates, registration functions and training and standards functions of the organisation. It may well be the view of senior management that it is these vertical linkages that need to be taken forward rather than to pursue more horizontal 'peer review' activity within the overall quality assurance programmes which are likely to be adopted. Alternatively it is possible to pursue both by expecting small scale 'peer review' quality assurance activities to go on between units of similar type and units serving the same geographical area or client group, and these reporting to the quality review teams and then to the quality assurance panel.

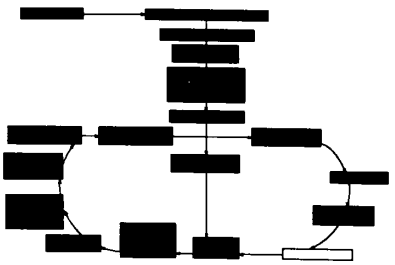
These are matters which have to be decided at this point in the cycle but can wait until the culture of quality assurance is well established, for example until the third wheel of the cycle is complete. On this longitudinal basis stage 14 in the second cycle will become stage 25 in the third and so on. Nothing is therefore lost by ommiting the 'peer review' component in the second cycle and introducing it at a later stage.

15 & 16 Reviewing objectives, changing standards and introducing change



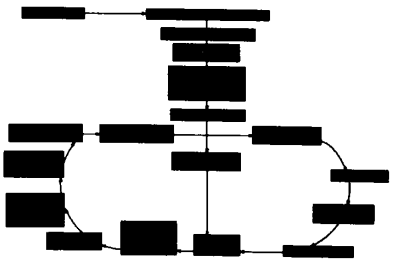
These activities are included in the figure of the quality cycle. It is these matters which are going to be quality assured in the second on-site observations at stage 18. They are matters for the managers of the service and not for the quality assurance team and the leader of the quality assurance team needs to be clear and particularly with the members of the team that they are not undertaking managerial or executive functions in pursuing changes as a quality assurance team. They have facilitated a discussion and completed the cycle to stage 14. They must then allow the line management and day to day managerial and executive functions to pursue their activities in the way they think best.

17. Internal QA activity



Stage 17 must also include of course stages 2 to 6 over again for the team which was going to repeat the first cycle. However, it should be noted that where action plans have been proposed and where changes have been introduced that these become the focus of the QA activity by the team at stage 17. Consistency in team membership is of a considerable value in assessing the impact of change.

18. On-site observation



This clearly operates very similarly to the initial stage 7 in the figure, however, much of this original work will have been done and action plans will have been drawn up and change introduced. As noted above consistency in pairs may be of value and also the on-site observation in the second part of the cycle stage 18 will clearly have a dual focus in that it will want to relook at the matters which showed up on the Q# and Q*, and assess the degree of change and movement in those items as well as undertaking the broader descriptive activity described at stage 7 in the

cycle. The quality review teams in conjunction with the quality assurance panel have to be clear about the timing of activity in stages 17 and 18 in order to allow change within the organisation to be fully worked through. This is a matter for discussion within the quality assurance panel who will be coordinating quality assurance programmes within the organisation as a whole.

The internal QA Team will have three sources of briefing materials at this advanced stage. They will be; the initial general material from the first cycle updated; the results of the Q# and Q* from the first cycle; and a knowledge of the action plan and changes that have been introduced. It is important for observational purposes that the latter two sources do not preempt the continuing freshness and breadth of the ongoing QAP.

SUMMARY & CONCLUSION

This section has briefly taken us through the complete quality assurance cycle (Q∞) which is the **ENQUIRE** System. Whilst there are a variety of other instruments which can be used and interfaced with the **ENQUIRE** System during the Q∞, the figure represents a series of stages which must be considered before they are omitted from any quality assurance programme. We have referred to some of the danger areas in the cycle where because of time constraints or lack of skill and commitment on the part of those in the quality assurance team corners may be cut, observational data may be of less value and the chances of making poor action plans and undertaking faulty analysis will be increased. It is therefore important to note that the stages of the cycle need to be completed before the cycle can move on and thereby create momentum within future quality assurance programmes. The following section will give some brief illustrations of material which can be gathered at stages 7, 8 and 9 of the Q∞.

SECTION 6

BRIEF UNIT LEVEL CASE EXAMPLE

SECTION 6
BRIEF UNIT LEVEL CASE EXAMPLE

It will be clear that the ENQUIRE System is a QA cycle which allows for flexible local or area applications and allows many other instruments to be accommodated within the system consistent with the Q# and Q*. It will also be clear that the system encourages parallel action in terms of training for QA and undertaking QAPs. This balance is often struck between the balance of internal and external QA Teams. The general assumption is that QAPs will become part of the culture of the organisation and begin to reflect local requirements.

Learning to introduce and undertake QAPs by the ENQUIRE System is therefore not a didactic process of absorbing and adhering to a set of verities or the creation of a rigid orthodoxy. Learning, introducing, and undertaking QAPs are therefore initially simultaneous activities. In short the ENQUIRE QA System has no given 'content' other than your observations and is only learned by implementation; much qualitative evaluation has this experiential quality.

Finally the system is intended to empower participants in QAPs to set their systematic and valid findings, on quality of practice and service, alongside other policy making criteria such as cost, efficiency, value for money and other quantitative aids to managerial decision making. The system assists in quality assuring care 'products' in the light of values and good practice.

The following brief (unit based) case of a psychiatric rehabilitation ward illustrates the kinds of negotiation which occurs at stages 8 and 9 of the cycle, and plotting the Q# and Q*. We then illustrate how an action plan emerges from the analysis (stage 13) and how standards and objectives are set for review. This short illustration is in the health field, however, it is clear that the ENQUIRE System can be used across all health, welfare and community based services.

We have limited the observations in the illustration to very short phrases and sentences for simplicity. As experience with the system develops QA Team members tend to produce fuller sentence descriptions as observations. They also develop skills in linking two or more single descriptions into a more powerful statement / observation. There are major limitations in attempting to learn the ENQUIRE System only from the written text or indeed from other peoples tersely expressed observations. We suggest that the way to get a 'feel' of the system is to begin with the Q# and Q*. Written observations are the 'tip of the iceberg' of the experience of the observational process. Any written case examples will suffer therefore from these limitations.

CASE EXAMPLE: REHABILITATION WARD IN A PSYCHIATRIC HOSPITAL

The Quality Assurance Team visited the rehabilitation ward for a morning and an afternoon of one day. There were 2 members of the Quality Assurance Team and they had the opportunity to speak to the nursing staff on two shifts and were able to sit and observe activity going on in the day area as well as a general tour of the ward, an opportunity to watch some ward-based activities and enter into conversation and discussion with 8 patients.

This case example provides 20 of the raw observations which the 2 members reported back to the QA Team at the end of the day. (Figure 29) As noted in the previous section some initial sifting work may be done by the visiting pair before returning to the QA Team, however in the early stages of introducing QAPs it is instructive to use the whole QA Team as a 'sounding board'.

The 'raw' observations are made up of comments, observations and replies given to and made by our 2 members of the QA Team. The table shows the way in which such 'raw' observations are categorised by the source from which they came. We now illustrate the process by which the pair who visited the ward negotiate with each other or in this case with the whole QA Team as to whether these observations should go

Figure 29

Raw Observations

	Observations	Source	Validity
1	8 men watching TV at 11am		
2	Nurses on tea break		
3	Cracked window pane	QA Team	3: not reliable
4	Smell tobacco & food	Members	4: not reliable
5	One man wearing no trousers - (into 8)		5: into 8
6	Dining area clear - (into 19)		6: into 19
7	One third patients only out at OT & other therapies	Staff	
8	Cubicled bed areas, little privacy	QAT	
9	No toilet doors		
10	No written ward policies		
11	Infrequent ward meetings		
12	Lack of staff liaison with outside agencies	Staff Reply	
13	Patient mix not consistent with rehabilitation ward function		
14	No easy access to town	Patient Comment	
15	Length of stay unknown		
16	Several consultants admit to ward (into 11)	Staff Reply	16: into 11
17	It's Ok but I can't get out enough		
18	Not enough money for cigarettes	Patient	
19	I can't cook my own food	Comments	
20	They make us do our own laundry		

forward to be plotted on the Q# and Q✱. As we noted in the previous section, this is done by asking the following questions

"Can the comment, topic, reply, or observation be established as having been made?"

"Can this comment or topic, reply or observation be accepted by the pair and the QA Team as a whole, as a meaningful statement?"

It is essential to see the distinction between accepting that an observation is meaningful, was made and should be taken forward to be plotted on the Q# and Q✱ and attempting to make a decision as to whether that observation itself is "true" or "false". At this stage we are primarily concerned to establish the descriptive meaning of the raw observations; truth, falsehood, or prescriptivity are matters for later processing at the stage of feedback to the individual agency on the basis of the Q✱.

We now illustrate the kind of dialogue and negotiation that went on between team members about these raw observations. There are essentially two ways in which these raw observations can"make it" across the dividing line into our column of valid observations to be plotted on the matrix. First of all a team member reports the observation to the group, makes a claim that the observation is reasonable, meaningful and valid and, if necessary, negotiates with the rest of the team to have that observation plotted on the matrix. The second and complementary way of negotiating is that the raw observation can be corroborated by other replies and observations from the list of raw observations 1-20 above. Confirmatory observations illustrate our negotiations about observation 1. Team member B is the single source of observation 1.

Team Member A

" I notice here that you said that 8 men were watching TV at 11 am. Is this particularly significant or important in the ward activities?

Team Member B

"Yes, I believe it is important. This is supposed to be a rehabilitation ward and I would not expect men to be sitting watching the television at 11 o'clock in the morning"

Team Member A

"Doyou have any other information about the kind of activities that they should have been attending at this time, for example, is there a rule in the ward that people would go to therapies during the morning? Do you think this might be because these people refused to go, or do you think that therapies were not available, or is there some other reason, because I am beginning to be convinced that you are right, that we should record this?"

Team Member B

"I do not know whether there were therapies available that day. The ward rota for rehabilitation showed that normally patients would be undertaking some sort of rehabilitation session in the mornings. We were not told that there was a problem about the lack of therapy on that particular day."

Team Member A

"Okay. How does everyone in the group feel about that? It seems to me that we are really approaching a point at which we can agree that we ought to take this forward as an important observation. "

It is clear therefore that the raw observation 1 is something that, after some negotiation, Team Member B has convinced both Team Member A and the group as a whole it should move forward now to be analysed. The negotiation about this raw observation also illustrates another very important point. Team member B clearly decided to record that 8 men were watching television at 11 am because as a skilled visitor he would normally, going into a rehabilitation ward, have been struck by that very fact.

He is likely to have automatically checked the rehabilitation programme on the ward rota to follow-up his assumption that this was an unplanned and possibly unscheduled activity which may not be contributing to the rehabilitative task that the ward is intended to fulfill. It is important that Team Member B can be quizzed by the Team because they can then be confident that the observation is based on professional assumptions about the function of rehabilitation wards.

The QA Team want to work with observations which are reliable reports which can lead to constructive discussion, rather than a negative, prescriptive view that people should not be undertaking this activity in a rehabilitation ward. This kind of value judgement would not be appropriate as we have noted earlier at an observational stage of a visit.

We do not want to check at this point solely the veracity (in an explanatory sense) of the observations made, but to achieve a meaningful description and to exclude some from being plotted on the matrix if they are unreliable, cannot be validated by corroboration as having been said or seen or are value judgements which are obviously pre-emptive prescription.

We are reliant upon the skills of the Quality Assurance Team to minimise any prejudice in making observations. The negotiations concerning the raw observations as to whether they should go forward on the matrix is precisely to tease out what the value base is that may be implicit, in the observation. We have noted that values come into play in a later process of analysis by the Q*.

It should be noted that it is only prescriptive, value laden, or potentially biased observations by the QA Team pair / member which are scrutinised so closely. Reported statements from staff, users or managers are simply recorded as observations, rendered meaningful in discussion, and are taken forward for matrix plotting without extensive changes.

We now move on to illustrate the second raw observation which is that the "Nurses were on tea break" at the time of the visit to the ward. Team member B made the observation.

Team Member A

> *"Why do you believe that this is an important point. Were the nurses obviously having a tea break or were they simply in the office together at that particular moment"*

Team Member B

> *"I am not quite sure about this. At first I thought that in fact there was a patient also having a cup of tea with them and my response to that was somewhat different. I have recorded that nurses were on a tea break because it was not a shift transfer meeting and it seemed to me that there were, as we noted in observation 18 men in the ward involved in very passive activity ; the nurses may well have been better scheduling their own individual tea breaks rather than sitting as a group of, I think 3 of them at that stage in the morning. "*

Team Member A

> *Yes, l accept the point that you have made. My only other question would be for how long they were together in the office; whether this seemed along time or whether it was just a very brief interlude. "*

Team Member B

> *"I think this is something we should check out. I think we should record it and plot it. My claim for wanting to do that is because I think we ought to be clear about what kinds of tea breaks nurses do get. I think we need to understand the kinds of stresses that they are under in the job and clearly they need to have a break in the morning It also relates to the need to have time to meet brief incoming staff to have a staff meeting and to cover the therapeutic requirements in the ward. "*

Team Member A

> *"I accept that, and I think we should retain it as an observation , but I think we should make a point in the feedback of checking that with the staff tomorrow morning."*

Team Member B

> *"I think we should put this to the group and see whether people agree with you. I do agree with you I have to say. "*

The group agreed that this probably was a helpful observation to take forward. It clearly had occurred, had been observed and was going to give rise to some useful discussion and the feedback session. It will be noted of course that these two raw observations were ones that in our table we have sourced to a QA Team member. Let us now look at the kind of negotiation that goes on if a Team Member is reporting what either a staff member or a patient said to them. Let us now look at observation 19, which is a patient comment which is "I cannot cook my own food." This was a comment made by a patient and recorded by one of the team members. In the negotiation team meeting at the end of the day team members made the following observations about it.

Team Member A

> *"It seemed to me strange that a patient would say that he could not cook his own food on a rehabilitation ward where, I would have thought, domestic skills were quite important . I put my*

head into the room which was used by staff to make late evening cups of tea and toast, and it did not seem to me that it was an area that was being currently used by patients at all. So I think it is worth taking this forward as a matter of concern for us. "

Team Member B

"Yes, I am sure that this is right. I think what I was uncertain about was whether the patient was saying that he personally was not able to cook his own food or whether he was not allowed to or whether all patients were not allowed to or, possibly even another option which was that for some reason on that particular day there were no facilities or there was no food available or something else. There are a number of options and we have not really teased that one out."

Team Member A

"I think that this is an interesting development of what we might get into with ward staff at feedback. But I am pretty sure that he was really saying that he wanted to cook his food and he was capable of doing so and that maybe he was hungry from time to time and wanted food. I do not actually think he was saying that he was not getting appropriate rehabilitation, I think he was just saying" when I am hungry I cannot get food". That leads me to consider whether or not we are really talking about a patient not having enough to eat or whether we are really talking about a service, in a sense at ward level, by which patients can maintain their domestic skills and I think that is going to be a very interesting discussion.

Team Member B

"I agree,and we need to find out from the ward staff exactly what the situation is about the amount of food available. What I understand you to be saying is that he was prevented by some rules from cooking his own food. That must be the observation we put down but we must also be alive to the "outcome " point that there may not be sufficient food available for patients and that is something we need to check back"

Team Member A

"I agree with you on this and it also reminds me to make a note that we should also ask the question about whether there is a ward-based budget available to the charge nurse to purchase tea, coffee, bread etc.".

As can well be imagined the whole team accepted that this was going to lead to some very interesting further discussions and agreed that as a patient comment it should be taken forward as a valid report and observation.

At this stage by running through every one of the raw observations 1-20, noting where they came from in terms of their source, in other words, who said them and who recorded them we have illustrated the way in which negotiation between the pair and by implication with the whole Quality Assurance Team proceeded.

We can see therefore that we have now at least put raw observations through a 'filter' which makes us feel more confident about them being a reflection of the reality of life within this rehabilitation ward. These become observations which the team, as a whole, can 'own' and can be the basis for a discussion about what is good practice and what may be the best outcomes of good practice within this ward setting. We should note however that in a QAP these observations are only the 'tip of the iceberg', the experience of making them and the detail that is available lies behind them remains with the pair.

In the field as opposed to the illustration it is not possible to transfer the terse final observational statement to someone else to 'plot' and, or, to feedback to the agency, precisely because the detailed basis for the observation remains with those who made it.

We are however now in a position to take forward the 15 of the 20 raw observations which we

consider should be plotted but, before we do that, let us illustrate with one of the 5 rejected raw observations as to the kind of negotiation which will produce rejection by the team rather than acceptance.

The 5 raw observations which the group decided not be taken forward as meaningful observations to be plotted on the matrix were 3, 4, 6 and 16. As far as 3 was concerned it was noted that someone else had heard that the cracked window pane had only been done that morning and that it was about to be mended. As far as observation 4, the smell of tobacco and food was reported by one of the team members, the other team member could not agree that there was a particular smell of either tobacco or food and it was decided to drop it. Concerning observation 5, that one man appeared to have no trousers or was not wearing them it appeared in discussion that this was not a case of the patient not having trousers but that it was much more related to the observation made in 8, about privacy, and it was decided therefore to drop observation 5 and include it, if necessary, in any future discussion arising from observation 8: Cubicled bed areas, little privacy.

Observation 6, that the dining area was clean, was regarded as likely to be an accurate description but not of itself of any particular significance and it was decided to relate it to observation 19 since that appeared to be referring much more specifically to the experience of patients and their ability to cook food. The possibility that there might be some relationship between the dining area being clean and unused in relation to the experience of the patient was left open for discussion. What these examples illustrate is that one can reduce the number of observations that need to be plotted on the matrix thus making it simpler to work with not only by rejecting observations which are not meaningful or valid but also if they are better subsumed into other observations, allowing this as a form of corroboration.

However, let us now consider a straight rejection of an observation on the grounds that it could not either be subsumed into another observation or stand as an independent statement in its own right. This illustration is on observation 16, which is a reply by staff to a question by a visiting team member which was "several Consultants admit to the ward."

Team Member A

> *"The first question I would ask is what do we mean by several: that does not tell us very much. Secondly it is common practice for a number of Consultants in a hospital to admit to a ward and therefore this is a comment which has a bit of structure to it and a bit of process but is really telling us very little about either."*

Team Member B

> *"My reason for recording it was that I was curious not so much with the number of Consultants who might be involved in the ward, although this might be significant, but with the idea of admitting to a rehabilitation ward. It seemed to me that what we are really talking about is transfer from other wards and I was curious to find out whether they were in fact actual admissions to a rehabilitation ward."*

Team Member A

> *"Yes, I think my response is that there is a question of whether the staff member meant admit or transfer. This point I think begs quite a lot of questions which we perhaps need to ask but of itself does not tell us very much, and it might better be checked out against the briefing data or admissions and Consultant cover. In terms of quality of service a variety of Consultants may create a stimulating atmosphere, alternatively it may make rehabilitation as a speciality more difficult to define at ward practice level."*

Team Member B

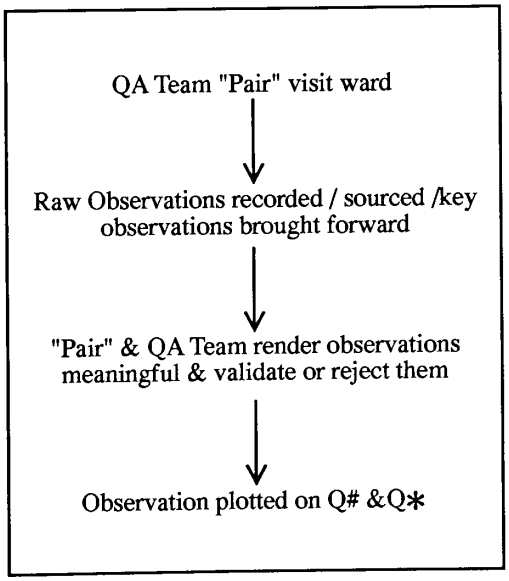
> *" I take the point and I will be guided by the group, I would be happy to accept that this may come up in discussion about written ward policies in our observation 10, or be related to discussions we may get into under "infrequent ward meetings"; but I would not want to have to say what "several" meant in numerical terms or whether the word "admit" was in fact to do with admissions from the community to this ward or just transfers and so I think that two words in my observation are ambiguous."*

It will be clear from this exchange that it was impossible to render that particular raw observation meaningful. It was difficult for people to know or agree what might be meant by 'several' and it was also difficult to know what the word 'admit' meant. However, in rejecting it as an observation, once again it is important to emphasise that it may well be true that 3, 4 or even 5 Consultants do admit to this particular ward and they do admit rather than transfer within the hospital, in other words admit from outside. However, the visiting team was sure that such a matter would emerge in discussion arising from a much more soundly based and validated observation rather than from this particular one. The pair learned from this example that clarity of observation is particularly important.

Two team members A and B came back to the Quality Assurance Team with 20 raw observations. They may have made many more which they themselves had filtered out on grounds that they just were not sure about what they had seen or heard. The 20 that we quote were 20 of a much larger number of observations. One should not at first be deterred from including more raw observations even if, as a visiting number, one is unsure of their validity. We should emphasise that what we are quoting here are selected examples.

We shall now illustrate the discussion which occurs when the observations are ready to be plotted. In summary we have now been through the following stages (Figure 30):

Figure 30



Following this the Q# and Q* form the basis of feedback to the agency, in this case the staff of the rehabilitation ward. The data is then subject to any factual correction or negotiated alteration of the observation and the finalised Q# and Q* go forward into the final report of the QA Team. This illustration ends at the plotting stage with a brief illustration of an emergent action plan

PLOTTING ON THE QUALITY MATRIX Q# AND QUALITY STAR Q* OF CASE EXAMPLE OF REHABILITATION WARD IN A PSYCHIATRIC HOSPITAL

Observation 1 - *8 men watching televison at 11 am.*

We know that our team were concerned to see a significant number of patients in a rehabilitation ward in mid-morning watching the television and we are also aware that there is another observation, which is that only one third of the patients were out at ocupational therapy and other therapies (observation 7). In discussion our pair asked whether there was any special reason for the men to be watching television. We do

not have to cover again the ground that convinced our quality assurance team that this was valid observation. What we now have to do is to see where it can be appropriately placed within the quality matrix. Is this observation an intended service outcome from the service? Our pair decided that it was not and in their view this was probably an unintended process in the users life.

It is clearly a comment on the daily life of the users of the service but these day-time activities should be guided by considerations within a rehabilitation care plan, which is a process aspect of the functions of the ward. The pair agreed to plot it as illustrated on the matrix. Not as a life outcome for the user of the service but as a process issue in "care and treatment" (Figure 31a).

Quality Matrix: Case Example - Rehabilitation ward in a Psychiatric Hospital

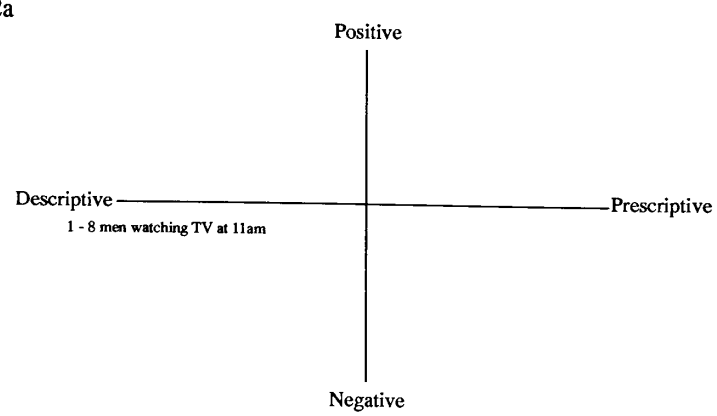
	Structure	Process	Outcome
Community			
Users Life			
Treatment / Care		1 - 8 men watching TV at 11am	
Services Case Management			
Project / Unit			
Agency Organisation			
Culture Environment			

Figure 31a

Turning now to the quality star (Q*) (Figure 32a) this observation would appear to be a negative description of the service. The observation does not seem to contain something sufficiently prescriptive or imperative by suggesting that men should not watch television, although this is slightly implied, but as it stands the pair decided that it would appropriately fit into the bottom left hand quadrant of the quality star as shown.

Quality Star (*) Case Example: Rehabilitation Ward in a Psychiatric Hospital

Figure 32a



We can see already therefore that the plotting of the observation on the two instruments constantly requires us to ask what the quality and functions of the service actually are. The observation tells us nothing about the 8 men but it tells us that a significant number of the patients in the ward were not apparently receiving a service of an appropriate quality given the remit and function of a rehabilitation ward.

The observation clearly raises a number of further questions. It may be that on feedback to the agency the nursing staff do not accept that this was the case on that particular day or are able to convince the quality assurance team that it is very irregular or unusual occurrence, is a result of low staffing circumstances, or a failure of other departments to offer a service on that particular day. Alternatively, during the feedback the staff may accept that this did and does occur on a regular basis and is not an aspect of their service which they find satisfying.

After this stage of feedback to agencies and the final report the Action Plan which may emerge from the Q✱ may, as noted in earlier sections, re-express this observation as a positive prescription in turning it from the bottom left hand quadrant into the top right hand quadrant within the Q✱ expressing it in a positive fashion. It can be re-expressed as a statement about occupations during the day in the ward that have clear therapeutic value. Unless this transition is made the observation remains as a negative description of the service and cannot be expressed positively. A positive expression of the observation assists action planning and also prevents action which in itself is purely negative for example by simply preventing people watching television in the mornings.

Observation 2 - *Nurses on tea break*

This observation was again discussed during the process of validation by our pair with the full QA Team and although there was some lack of clarity about whether this was leading to an issue about shift changeovers or staffing levels, it was seen as a valid observation to take forward in order to pursue this discussion.

Our pair were clear that this was not an outcome of service unless it could be shown clearly to have been a case discussion meeting as opposed to a tea break. Even then there would be a reason for saying that it was a process rather than a specific service outcome. The pair concluded that nurses being in the nurses station alone having what appeared to be a tea break is a process phenomenon which may be determined by the structural nature of the staffing levels in the project / unit or the agency / organisation, and finally concluded that they would plot this observation as a process issue at project/unit level as shown in the Q#. (for the completed Q# and Q✱ see page 74 figures 31b and 32b)

Turning to the Q✱, the visiting pair were clear that as it stands this observation represents a negative description of the service and it is therefore plotted in that quadrant. The pair also noted that it should be clear during the agency feedback that there was a particular but significant period during the visit when all the nursing staff appeared to be having a tea break at the same time and that there was no suggestion that during the whole period of the visit to the unit that nurses were congregated in one place.

Observation 3 - *Cracked window pane*

This observation was not validated and not regarded as reliable and therefore cannot be plotted.

Observation 4 - *Smell of tobacco and food in the ward*

Similarly this observation was not regarded as reliable and is therefore not plotted.

Observation 5 - *One man with no trousers and No 8 cubicled bed areas, little privacy*

In bringing these two observations together they were in fact rewritten by our pair as "cubicled bed areas with little privacy eg; one man clearly visible wearing no trousers." This is an illustration of the way in which observations can corroborate each other and therefore be run together in a sentence which is more helpful and powerful in terms of assessing quality in a unit. Our pair were clear that this was a structural matter in relation to the layout of the ward and plotted it in a project / unit structural cell in the matrix. They were also clear that it was a non-acceptable (Maxwell) practice and probably should stop and therefore plotted it in the negative prescriptive / remedial quadrant of the Q✱.

Observation 6 - *Dining area clear had been associated with observation 19 - a report from a patient who said " I cannot cook my own food"*

The visiting pair suggested that they make observation number 19 " I cannot cook my own food" the significant observation and add that the dining area was clean as a suggestion that it could not be readily used by patients at times and in ways they would like. The observation then becomes "I cannot cook my own food; ward dining area clean." The pair considered that this was a stated outcome of the service for a patient related to the services available to that patient within the ward, rather than treatment or care, even though they could accept that cooking food might be part of a skills programme. It appeared to have more to do with choice and access (Maxwell) than daily living skills, and where a patient might meet his or her needs and wants, and have real choices (see figure 14c page 21).

It was therefore plotted in the outcome column under services. On the Q* the pair decided to place this observation as a negative description of the service.

Observation 7 - *One-third only out at occupational therapy and other therapies*

This observation was reported to the team by staff members. The pair were clear that staff were implying that a considerable number of the patients who could and should be receiving other therapies were not receiving them. The pair regarded this observation as being in the treatment and care dimension of the matrix and really an outcome for those patients who were attending therapy and for those who were not. It is therefore plotted in the outcome column under treatment/care.

The pair discussed at some length whether or not this observation contained a positive prescriptive that more patients should go to these therapies and concluded that it had sufficient prescriptive content to be regarded as a positive prescription on the Q* rather than simply a negative description of the service. The emergent action plan is clear, a re-assessment of the needs of 2/3 of patients for occupational and other therapies.

Observation 9 - *No toilet doors*

This observation is about a basic matter concerning the ward facilities and our pair decided that this was clearly a structural issue in relation to the ward itself, ie; the project/unit and plotted in that cell on the matrix. They also regarded it as a negative prescription of the ward, ie a practice that should cease or a feature that should be remedied.

Observation 10 - *No written ward policies*

The pair discussed this matter and considered that the absence of a ward policy was an absence of a statement of clear objectives for the project / unit itself. They regarded it as having potential effects which may be detrimental to the focus of treatment and care and services and case management. They considered that it might be seen as a structural factor in such a ward and might be plotted under a structural feature of the project/unit. However, on reflection because it was so closely allied to the ward services and the specification of what these should be it was plotted in the structural column in relation to services and case management.

The pair regarded it as an imperative and a negative prescription and a matter which required remedial attention, and therefore plotted it in theQ* in that quadrant.

The pair also discussed whether or not observation 10 - no written ward policies was clearly linked to observation number 13 - *"patient mix not consistent with rehabilitation ward function"*.

They decided that these two could usefully be linked together even at this stage and plotted this as an outcome for the patients under services and case management in the matrix and as a positive prescription for future scrutiny by the ward staffing following the fulfillment of the written ward policies proposal.

Had observation 13 stood alone and given that it came from a staff source it may have been considered a 'structural' given for the ward and plotted accordingly. However the possible link with ward

policies as a determinant suggests an outcome for the patients. It begins to form a qualitative outcome pattern with observations 1 and 7.

Observation 14 - *No easy access to town*

The pair considered this to be an environmental issue given the siting of the hospital and therefore it was inherent in the structure of the service and they plotted it accordingly. They felt that it could be expressed as an outcome in the users life but considered that its causation in their view was so linked to the siting of the hospital, and that it was fundamentally a structural issue. On the Q✱ it was plotted as a negative description of the service.

Observation 15 - *Length of stay unknown*

The pair regarded this as a matter of ignorance on the part of the staff, but relating to the information that would normally be given to patients on admission it suggests that they would not have any indication of the likely length of their rehabilitation programme. It suggested to the visiting pair that it might relate to the absence of periodic reviews of progress of patients and therefore detract from any impetus that the ward might have in moving people back to the community. The pair regarded it as a process issue within the ward relating to services and case management. On the Q✱ it was regarded as a negative description of the service.

Observation 11 - *Infrequent ward meetings*

This was regarded by the pair as a process matter within treatment and care and was plotted accordingly. It was also regarded as of sufficient prescriptive quality to be a proposal for there to be ward meetings more frequently and meetings between staff and patients and therefore was plotted in the positive prescriptive quadrant of the Q✱ as something that could be implemented in the ward.

Observation 12 - *Lack of staff liaison with outside agencies*

The pair considered this to be a process matter between the project / unit and other agencies relating possibly to case management issues as well general liaison.

They placed it therefore on the borderline between the project / unit and case management in the process column

The pair considered that the staff source for this observation contained some degree of intent made it less descriptively negative of the service and more positively prescriptive of future activity, and therefore plotted in that quadrant on the Q✱.

Observation 16 - *Several consultants admit to ward*

The discussion concerning this observation was shown above and it was thought that it related sufficiently to observation 11 and was covered by that and the discussion that will arise in relation to it.

Observation 17 - "*It is OK but I cannot get out enough*"

This observation was felt to relate to observation 14, that there was no easy access to the town but was a patient comment and suggested isolation and a certain amount of constraint, and so was considered to be an outcome in the service users life and was plotted in that cell on the Q#. In the Q✱ it was regarded as a implying positive intent, with a suggestion that things could be better by being able to get out, and therefore was plotted as a positive prescription for the service.

Observation 18 - "*Not enough money for cigarettes*"

The pair in discussion about this observation considered that it was not made by a particularly heavy smoker and they were concerned that it may be symptomatic of difficulties over the management of patient funds. They therefore considered that it may well be an outcome for the patient as regards to the services that the ward provides in terms of budgetary management and plotted it accordingly. In terms of the Q✱ they considered it simply to be a negative description of the service.

Summary

The overall picture that emerges from plotting the observations on the Q# and the Q✱ (See Figures 31b and 32b) begins to show up fairly clearly.

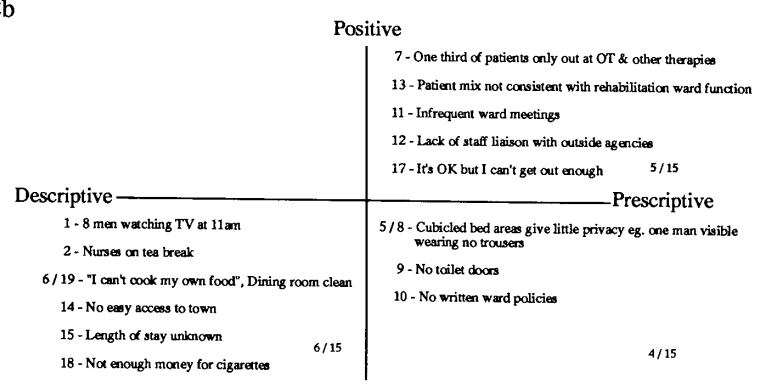
Quality Matrix: Case Example - Rehabilitation ward in a Psychiatric Hospital

	Structure	Process	Outcome
Community			
Users Life			17 - It is OK but I cannot get out enough
Treatment / Care		1 - 8 men watching TV at 11am	7 - One-third of patients only out at OT & other therapies
Services Case Management	10 - No written ward policies	15 - Length of stay unknown 11 - Infrequent ward meetings 12 - Lack of staff liaison with other agencies	6/9- "I can't cook my own food" Dining area clean 13 - Patient mix not consistent with rehab. ward 18 - Not enough money for cigarettes
Project / Unit	5 / 8 - Cubicled bed area gives little privacy eg. one man visible wearing no trousers 9 - No toilet doors	2 - Nurses on tea break	
Agency Organisation			
Culture Environment	14 - No easy access to town		

Figure 31b

Quality Star (✱) Case Example: Rehabilitation Ward in a Psychiatric Hospital

Figure 32b



It can be seen in the outcome column (in which a third of the observations were located) that only two of the outcomes for the users give some positive prescriptive suggestions for the future and two of them remain negative prescriptions of the services and case management.

From the process column observations 1, 2 and 15 were negative aspects of the service and only two of the five observations gave rise to positive prescriptions for the future.

In the structural column four out of the five observations were in the remedial quadrant of theQ✱, and therefore it is reasonable to conclude that there are some fairly basic structural remedial activities that need to be addressed in this particular ward / unit.

As we can see from this pattern on the Q# there are concerns with outcomes coming through from the quality assurance programme and that in conjunction with theQ✱ one can see ways in which the structural and process problems, if addressed, will produce more positive outcomes for the users of the service.

It is along a notional 'diagonal line' between the structural aspects of the organisation (at the bottom left of the matrix which is in the low scoring area) and concerns which fall at the top right hand part of the matrix in terms of users lives in the community, as an outcome, that we will expect to see movement in the Quality Cycle (Q∞).

The Q# together with the Q✱ show substantive issues and practices on which improvement can be made in order to bring the structure and process features of the service into a relationship with more positive outcomes.

It is significant for this ward that out of 15 key observations there were none in the positive descriptive quadrant of theQ✱. There are also four of the 15 observations which require immediate remedial action.

This case illustration shows the power of the sifted and validated observations when plotted on the two instruments and the way in which this gives a substantive content, direction and shape to Action Plans which can emerge from the quadrants on the star. It shows the way in which the two instruments interrelate with each other, the patterns which emerge within the matrix and the ability of the star to move from descriptive activity towards Action Plans which we now consider. Finally, it will be clear that this process of "plotting" on the Q# and Q✱ creates further detailed discussion between the "pair" of quality assurers over and above the validation process outlined at stage 8 and the early part of stage 9 of the QA Cycle (Q∞).

ACTION PLAN

Following the analysis of the Q# and Q✱ data the unit can formulate an action plan which will be made up of the observations from the Q✱ expressed as outcomes back on a new Q#.

We have already noted that the decisions about implementing change are matters for discussion with service managers and not in any way an executive function of the QAP.

There may be Action items which will form part of the ACTION PLAN which are within the scope, compass and resources of the unit to implement immediately or in the near future. The unit is therefore benefiting immediately from the QAP, obtaining a greater control of the quality of service outcomes and contributing to the building of a 'peer review' capacity at inter-unit level.

The following Q# contains an example of seven ACTION items which the Rehabilitation Ward expressed as intended OUTCOMES for the patients. The next stage they will undertake will be to discuss 'structural' and 'process' requirements to bring the outcomes into effect. This is the positive converse of the causal relationship between structure, process and outcome outlined in paragraph two page 36. In other words the ACTION PLAN plots the intended OUTCOME and seeks to explore what can cause these to come into effect.

It would be reasonably straightforward by the point of stage 18, that is to say after the second set of on-site observations have been analysed to see whether there has been significant change in bringing the positive prescriptive material over to positive descriptive list in the Q✱, and whether the structural and process items on the Q# were in fact producing actual better outcomes or outcomes at all. New second time observations falling in structure and process columns can be tracked across the matrix and be shown to produce better or worse outcomes.

Figure 33

Case Example: Rehabilitation Ward Action Plan

	Structure	Process	Outcome
Community	17 / 14 Check vol. org. & mainstream transport services	17 / 14 Check & establish transport system, patients finances & define recreational & therapeutic aspects of visits to town	17 / 14 patients should have sufficient resources & access to the local town & community & information about transport systems
Users Life			
Treatment / Care			
Services Case Management	Are there needs & requirements which patients have that are not met by the current resources available. Can the ward control its intake from other units?	7 Check individual care plus negotiate access / attendance with OT & other units As 7	9 Ensure that patients have access to & engage with OT & other therapies 13 Patients should have clear expectations of their rehabilitation progress.
Project / Unit	5 / 8 / 9 Immediate provision of toilet doors, agreement with management on refurbishment / minor upgrading &curtains.	5 / 8 / 9 Review activity in Day Area, sleeping area, time & activity in ward area. Design toilet doors, screening or bed curtains or increased single accomodation	5 / 8 / 9 Create clear social & private times & places within the ward environment & daily routine. Curtains, screening, minor upgrading & immediate toilet doors.
Agency Organisation			
Culture Environment			

You may wish to complete this emergent Action Plan for the Rehabilitation Ward & consider which items be immediately implemented by ward staff & which require further discussion with managers & resource providers

We have now outlined the essential features of the ENQUIRE System and shown the application of the tools for analysis following on-site observation as componants within a Quality Assurance Cycle (Q∞).

Reference can be made hear to the 12 applications of the tools for quality assurance noted on page 36. These essential features, if applied, are sufficient to complete at least QAPs 1, 2 and3.

What follows in Section 7 is further detailed analytical work for which more specialist skills are required but which lead to total quality management.

SECTION 7

FURTHER ANALYTICAL WORK: NEW DIRECTIONS FOR EXPLORATION

SECTION 7

FURTHER ANALYTICAL WORK: NEW DIRECTIONS FOR EXPLORATION.

So far the workbook has been concerned with description and analysis. Observations made by visiting teams or by participating staff are validated, then plotted on the Q✱ or Q#, and in so doing those tools highlight and depict quality issues which require detailed consideration. We have also shown how all the variables within the analytical system can be brought to bear in the single Q#✱ (See page 51).

This section takes the analytical work further by demonstrating additional facets of the Q✱ and Q#. If the matrix highlights problems in a specific cell then additional techniques can be brought to bear to examine problems in that area. These techniques are additions to the essential processes of the Q∞.

The approaches we shall examine are as follows:

1. The further use of the techniques as part of change management;
2. The further use of the Q# in case management and assessment - and in particular looking at different approaches to "needs";
3. The availability of alternative systems for considering specific areas within the matrix;
4. Staff, management and consumer interaction;
5. Production of local materials relevant to particular cells.
6. Complementary matrix developments
7. Total Quality Management

1. Change Management

Figure 34 shows the standard quality cycle. It can be seen that quality assurance (and quality enhancement) can only meaningfully be given that term if it is part of a management system which enables **changes** to be made on the basis of quality measures. Sometimes an encompassing approach is given the term 'total quality management'. TQM requires the full involvement of management and staff in ensuring that all aspects of a service are regularly monitored, measured, reviewed and amended with the full involvement of those operating the service. The end point must be a focus on the quality of life outcomes for the user of the service - in other words the focus must be towards the top right hand comer of the matrix. If systems and bureaucracy are drawn in red, and person centred issues in green, this can lead to describing user - outcome focussed approaches as "greening the matrix"!

Basic Quality Assurance Cycle

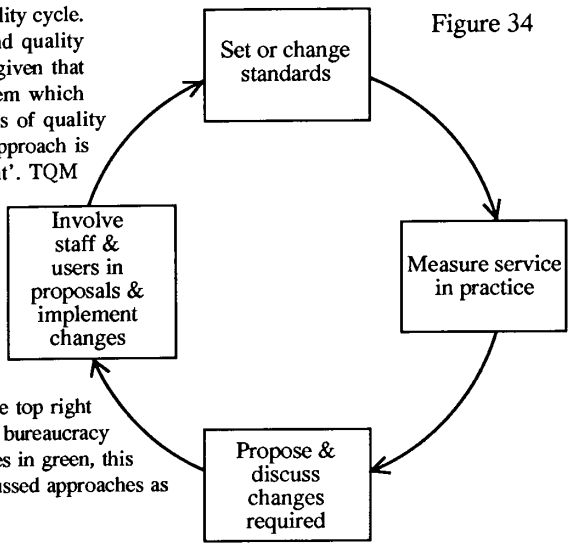


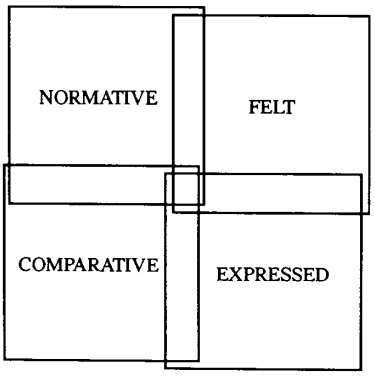
Figure 34

By bringing together a visiting team or panel from the departments or sections of a service a form of internal imposed audit can be established. The team uses the Q# and Q* to highlight the key factors involved for each department. A review team within the department (which may be as few as two members of staff according to the size of the department or section) then works on the issues which have been identified. Over time all staff should be brought more and more into these developments. This is an iterative process and all staff should be informed at each stage as to the extent of the quality assurance programme and its progress. We have referred to these groupings as Quality Assurance Teams (QATs) and Quality Review Teams (QRTs).

2. Case Management and the Assessment of Need

We saw earlier how Bradshaw's four levels of need helped inform our discussion of quality of life outcomes. Bradshaw suggested needs fell into four areas (Figure 35) normative, comparative, felt and expressed. These can be described as overlapping areas as in Figure 35. Being able to put some criteria on the extent to which these areas overlap is essential. In providing care, support and treatment to people with disabilities and disadvantages we are concerned with distributive justice. This requires a matching of individuals to resources to obtain the best possible efficiency in the mix of clients and the mix of services used. Ferlie, Challis and Davies have demonstrated that care management systems are concerned to balance a number of case management tasks, case finding, screening for eligibility, assessment of user need, care planning, monitoring and service development (gap filling) (Figure 36).Their work suggests two simple diagrams in Figure 37a which shows the trade off between horizontal efficiency, in other words, finding cases from the range of disability and disadvantage, and ensuring a balance amongst competing client groups; and vertical efficiency - in other words screening within a particular type of disability or client group. Too high vertical efficiency means many clients will not receive any service at all; too low vertical efficiency will lead to a large number of clients receiving an unfocused service and some clients with high needs will not receive sufficient support. Horizontal efficiency on the other hand requires a balancing across client groups. Offering the service to only one client group will provide that group with a good service to the detriment of others; offering the service to a very broad range of people will lead to dilution of resources and poor targetting. Consequently the assessment of need must be focused to get the right balance of vertical and horizontal efficiency.

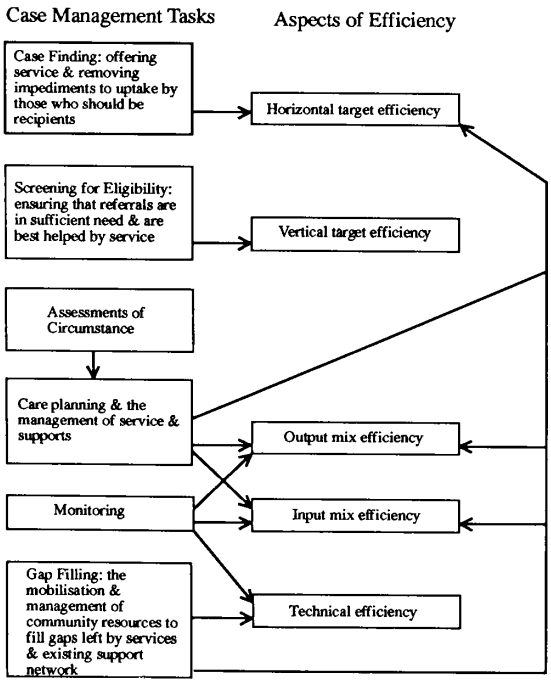
Figure 35



Diagrammatic Representation of Bradshaws Taxonomy of Need

Figure 36

Principal Causal Connections between Case Management Tasks & Aspects of Efficiency



Source: Davis B & Challis D
"Matching Resources to needs in Community Care"

This is related to figure 37b which describes the output 'casemix' of clients provided with a service and the input casemix - the range of clients presenting as requiring a service. This could also be related to the output mix of services used with the input mix of services available. Too few services will automatically lead to a narrow output mix; but even a broad range of services can still be used narrowly. An appropriate balance is required. The challenge is to match the assessment of need with the input casemix in order to obtain a good output casemix, which ensures the right balance of vertical and horizontal efficiency. The available services must then match the output casemix. A mismatch means clients assessed as requiring services unable to obtain the services needed. This can be shown as a cycle in figure 37c.

Figure 37a

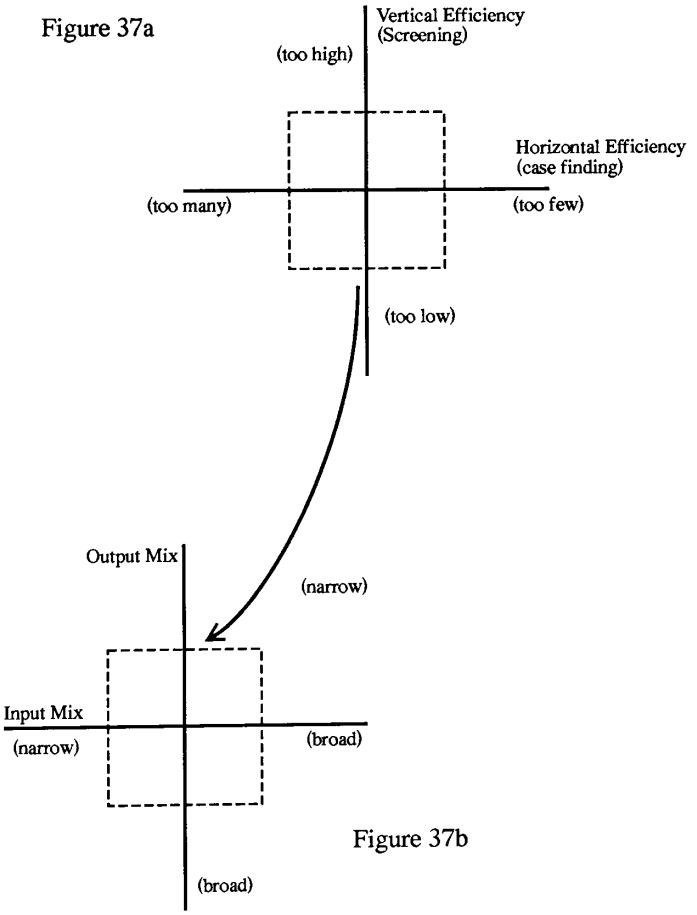


Figure 37b

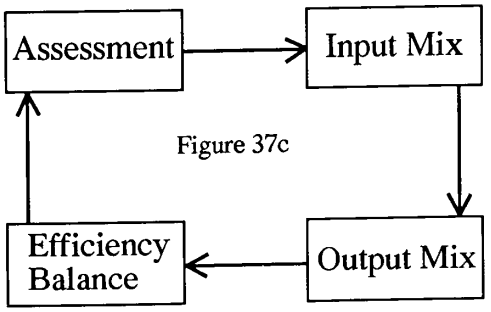


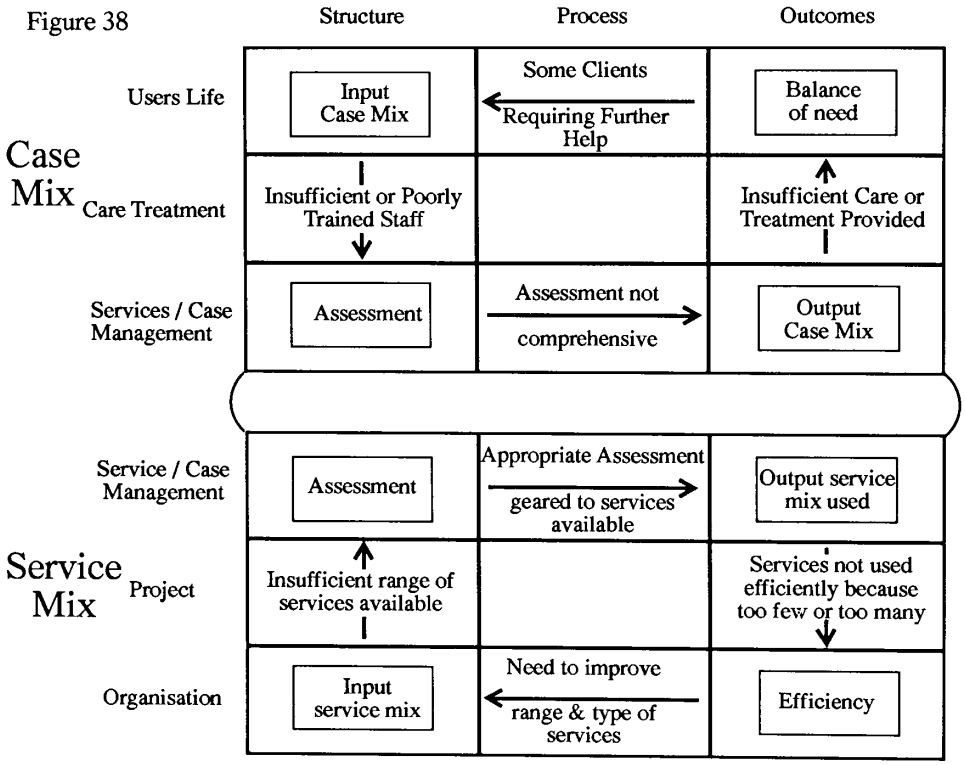
Figure 37c

Figure 37c can then be superimposed onto the matrix. [It is worth noting that we are here concerned with the descriptive side of Q*]. Horizontal / vertical casemix balance is mapped onto the users life / outcome cell of the matrix; assessment is mapped onto the service - case management / structure cell; and input and output casemix correspondingly to life / structure and service / outcome. Similarly, we can map the service input and output mix and the efficiency in useage of services available.

It is worth noting that we are concerned here with the relationship between assessment and case management, and the balance of casemix which results or service useage, but not directly with treatment or quality of life outcomes for service users.

Any observations which are plotted in those four cells can thus be seen as related to our four concerns of efficiency, assessment, input and output mix. It will depend of course, on the nature of the specific observations. However by recognising this relationship we can now take the observations from the descriptive side of the Q* plotting them appropriately in the rows of the matrix and attempt to draw conclusions from this. Figure38 suggests the messages which those observations may be providing depending upon where they fall within the matrix.

Figure 38

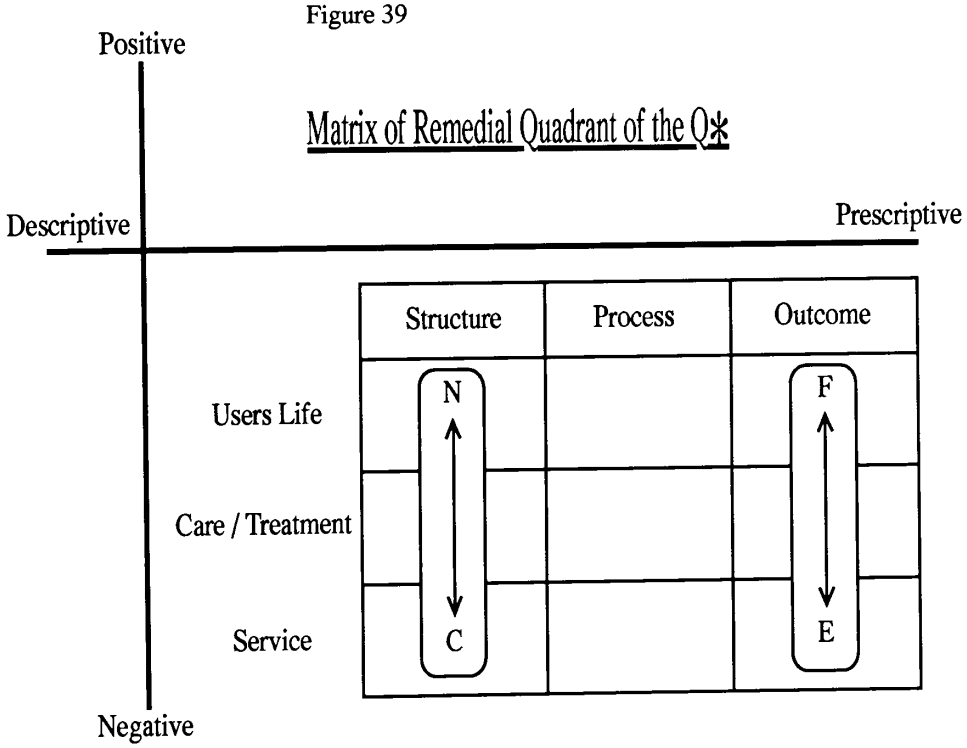


For example, information which falls along the outcome column between the users life and services case management cells is providing information on the relationship between output casemix and the extent to which need in the community has been met. Negative comments would thus indicate that insufficient care or treatment was being provided to some people because the casemix was wrong, thus leading to poorer outcomes

Having obtained some information about the efficiency of the system we can now return to the assessment of need. Figure39 shows how the distinction between normative, comparative, felt and expressed need can also be mapped onto the Q#. In this case however we are concerned directly with the quality of life for the user and the quality of care and treatment provided. Here we shall be interested in mapping the negative prescriptive observations from the Q* to enable us to see to what extent the service is meeting or not meeting individual user need. The 'normative-comparative' axis is mapped onto the left hand column of the matrix, the 'felt - expressed axis' is mapped onto the right hand column.

When the negative prescriptive observations are plotted, figure 39 gives an indication of what is going wrong. For example if there are a large number of negative prescriptive comments in the structure / service cell then it is probable that the needs assessment which has been done for the user is too coarse. On the other hand if there are a large number of negative / prescriptive observations in the users quality of life outcomes cell then, for fairly obvious reasons, it is clear the service is not meeting the users needs as perceived by the user. The value of this approach is to assist in analysing what needs to be done if staff are concerned about problems in a particular cell of the matrix. For example initial work may have shown that attention needs to be given to the processes of care / treatment. This may quite simply be due to inappropriate treatment; but if a large number of negative prescriptive observations appear in that cell it is likely that it is because treatments are not related effectively to user need. In other words the treatments themselves may be perfectly proper and reasonable but are not dealing acceptably with the individuals requirements. The strength of this approach is that it can be done person by person as well as for the whole service. In order to undertake this analysis on an area basis it is necessary to have completed the analysis illustrated in Figure 22b on page 39 .

Figure 39



3.Use of Complementary Measures for Specific Cells

A wide range of complementary measures are available. The QUARTZ system developed by the National Unit for Psychiatric Research and Development (now Research & Development in Psychiatry) is a schedule based approach predominantly concerned with processes; the acreditation - organisation audit book produced by the King's Fund establishes a range of standard measures which can be used appropriate to the particular service involved. Again, PASS (Program Analysis of Service Systems) is a value driven analytic process which relates structures and outcomes together in an approach known as "model coherence". Another approach is that developed by Rosen et al in Australia which uses life skills profiles to measure functional disability in people with mental illnesses. A further example is CRISP developed by Brodie in New South Wales, Australia, which is essentially a client register incorporating assessment evaluations.

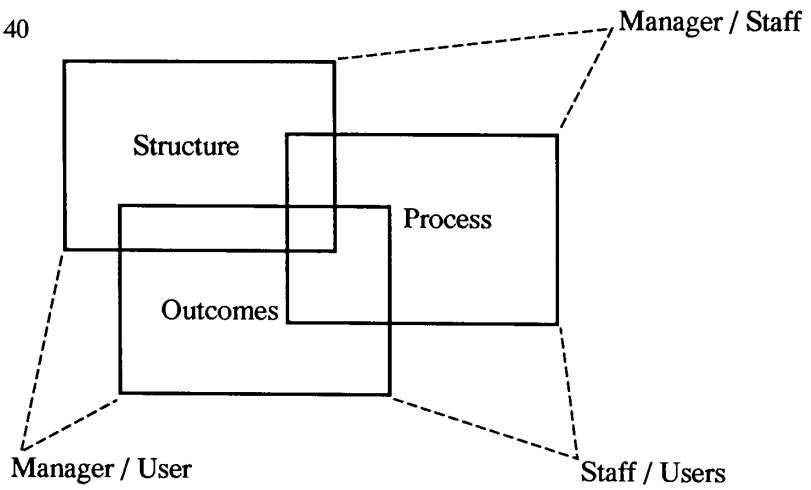
Each of these systems can be used on its own for a service. The problem with doing so however is that each has a focus in one or two cells of the matrix, but does not cover the whole picture. As we saw earlier, Registering Officers of local authorities, or the Health Advisory Service, focus on particular areas in the matrix. It is one reason why these approaches often do not develop full quality appraisals. The other main reason, of course, is that these are imposed external forms of audit which are not "owned" by the staff and users of the service, and are not part of the change management system within that service. Often, too, their responses appear long after the visits, sometimes reflecting changes that were happening anyway.

By using the Q# and Q* it is possible to focus in on those areas of the matrix which require attention and then to use the most appropriate technique or tool to do further work. Too often staff become disconcerted, either because they feel they have to tackle the whole of the service at once, or because the tools they are using do not deal with the problem that they perceive. Only by a rigorous, thorough and systematic approach similar to that described in this workbook is it possible to define the areas which require the most attention

4. Staff Management and Consumer Interaction

A key component of quality assurance is to ensure that staff, managers and consumers talk together about how the service can perform better. Figure 40 shows a simple way in which this can be described. Q# relationships between structure and process issues are largely to do with staff - management interaction. Structure-outcome issues are mainly manager-user concerns (which is why PASS is powerful in bringing managers and consumers together - but sometimes leaves front line staff out of discussion); and staff-user interactions are between process and outcomes. This simple distinction helps to direct staff and managers to the best areas in which discussions can take place.

Figure 40



5. Production of Local Schedules

Once a particular cell of the matrix is identified as an area which requires further work it is possible to involve staff and users in writing schedules or checklists which can be used regularly in the service. The value of doing so is to involve those who will have to implement any change which follows from the information which is obtained in developing the analysis of their service. The more that staff participate in developing those schedules the more likely it is that they will work actively to secure change which can improve the service they offer it. Two examples are given here of the types of schedules which might be written for specific cells.(Figures 41a and 41b)

[These lists are not intended to be exhaustive or necessarily to frame the way in which staff should go about quality assurance; rather they are examples of instruments which might be developed locally to focus on specific matrix cells]

6. Complementary Matrix Developments

A number of authors have developed ideas around the matrix structure. Two in particular are worth noting: A model for the development of a QA system for intellectual handicap services in Waikato, New Zealand (Sian Williams, Assuring Quality in Community Care 1990) and the Social Services Inspectorate ("Homes are for living in" 1990).

The Waikato quality assurance system develops a three dimensional cube from a basic matrix with some similarities to that proposed here. The third dimension is made up of three components - inputs, audits and improvements. This then enables the horizontal "plate" corresponding to a row on the basic matrix to be developed as a matrix of structure, process and outcomes set against inputs, audits and improvements for a particular component of the vertical dimension (eg; client, care / treatment, service and so forth). In the Waikato model however the vertical dimensions of the basic matrix are: client, family, staff, management, community, service and facility.

User Questionnaire

1 General Information

* Did you receive adequate information & advice on all aspects of your care?
* Were you asked your expectations of the service?
* Were your expectations realised?
* Have you been involved in evaluating your care?
* Were you given adequate time with the professional staff?
* Were you asked of any anxieties & if so were these addressed?
* Did you feel that the right individual was looking after your case?
* Did people - staff, managers - seem to care?
* Were your professional differences met?
* Was your consent sought for all treatments?
* Were you (are you) able to obtain leisure & recreation facilities of your choice?
* Have you been offered a range of alternative accomodation when youleave the service?
* Have you been given choice on the use of facilities whilst you have been in this service?

Figure 41a

2 Treatment Information

* Were the aims of treatment agreed with you?
* If yes, how were those aims to be realised?
  - by a reduction in distress?
  - by reduction in symptoms?
  - by maintaining you at a level you found comfortable?
  - by maintaining your independence as far as possible?
* If the aims of treatment were not yours but were enforced, did the treatment:
  - reduce your distress?
  - improve the way you perceived your symptoms?
  - maintain you at a level which you felt acceptable?
  - enhance your independence?
  - make you feel more acceptable to your friends & relatives?
* Do you feel more acceptable to yourself?
* Has the treatment helped in your dealings with other agencies such as social services or the police?
* Was an effort made to maximise your agreement to:
  - admission?
  - transfer?
  - discharge?
  - follow up?

Figure 41b

It is the present authors' contention that this is insufficient for the broader view of quality assurance (especially in the contract culture where the commissioner / supplier relationship must be considered) and in developing the appropriate relationships between each level within the matrix.

Nonetheless, the value of the Waikato system as developed by Williams is to provide a range of action and process points relevant to the development of high quality services for users. One example is shown in Figure 41.

It can been seen that these matrices can be used in the development of a quality programme once a basic Q∞ has been developed from the Q# and Q✱. In essence these are additional ideas and pointers filling out the suggestions made in the basic matrix.

The second model recently published is that of the social services inspectorate. In a booklet entitled "Homes are for living in", a matrix is developed based on two dimension sets - one concerned with quality outcomes, for users lives, and the other with a range of (mainly process but some structure) factors in care. Their proposals are aimed particularly at residential and nursing home care, and thus their lists are tailored to the requirements of that type of care.

The 'quality accomplishments' are privacy, dignity, independence, choice, rights and fulfillment; and the care factors are physical environment, care practices, staff, staff training and development, procedures, case records, documents and meals and meal times. In other words the SSI have developed a matrix which enables registering and inspection officers of local authorities to focus on key aspects of residential provision set in a context of achieving a range of personal rights based criteria (eg; privacy, dignity etc).

The SSI matrix (Figure 42) is completed by listing a wide range of points for each cell of the accomplishments / care factors matrix. Its particular value lies in offering staff and service users helpful detail once it has been established that particular aspects of the service require focused consideration.

Outcome Standards	Structure Standards	Process Standards
Planning Production of a life style plan, not an IPP. Including ideal home / occupation / relationship. Production of an associated IPP which identifies skills needed to progress toward life plan. Production of a health care plan, eg. wheelchair needs / dental needs. Production of a CV.	Advocate available. Client & advocate given knowledge of choices that can reasonably expect. Information centre. Management sanction of reasonable risk taking. Training modules available for client & / or staff. Employment specialist available.	Meeting held at Tokanui or in Community (preferably at information centre?). Staff decide how intrusive they should be in design of plan & actingupon it : use of judgement, eg. consider worst possible scenario if allow client independence. Consultation with appropriate staff.
Action Plan reasserted or modified. Service planners informed if plan cannot be pursued. Satisfaction of client	Communication channel between advocate & Trust. Adequate resources. Flexible staffing arrangements	Trial & error. Written or verbal memo.
System Audit Verification that client has plan, with date, & dated amendments. Verification that this updated plan is known by all relevant people. Verification that financial entitlements taken up - benefits & wages	Filing system held by staff - centrally or at facility. Appropriate details kept at other facilities, eg. vocational. Up to date information on benefits as a result of close liaison with DSW Office. Complaints procedures available.	Checklist used by internal evaluators
Reviews Plan reaffirmed or modified according to client's / advocate's satisfaction. Plan verified according to Trust / National Standards. (Also social audit standards?)	External agency, eg. university, provided with copy of life style plan. Arrangement made to enter home / workplace / meet with family advocate. Possible courses of action known if complaint made	Track client through day & night: work, home & recreation. Client asked if happy. Client observed - subjective judgement. Staff consulted & consensus acheived. Report written. Planners / funders informed.
Improvements Life style plan more specific; higher aims. New opportunities available. More contacts with non IH services. More employment opportunities in "normal" organisations.	Time for staff, clients to talk & plan. Contractual obligation of all staff to take proactive role in developing community understanding & acceptance. Trustees educated in current thinking / models of good practice	Regular meetings. QC set up to identify problem & find & apply solution. Presentations attended by client / other staff - use information centre as neutral base.

Source: William S "Assuring Quality in Community Care" 1990

Figure 41

Undertaking an initial quality assurance programme on the basis of the SSI matrix would probably become too detailed too quickly; yet it offers that additional detail which is so important for staff to feel confident in taking forward quality assurance programmes once they have undertaken the work set out earlier on in this workbook. A further advantage of "Homes are for living in" (especially as a follow up to the approach described here) is that it provides a value driven set of observations forms on which inspection and monitoring staff can record their views about the quality of a service.

The only danger with any formalised checklist system (as we have pointed out on a number of occasions during the workbook) is in being too prescriptive. Minimum standards so often become maximum standards; prescriptive factors often become the only things which 'monitors' look for. Of vital importance is the requirement that anyone undertaking quality assurance keeps an open mind and constantly refreshes their approach so that the quality assurance procedures do not become stale and the service does not settle into a different set of bad habits.

Social Services Inspectorate Model

	Privacy	Dignity	Process	Independence	Choice	Rights	Fulfilment
Physical Environment							
Care Practices							
Staff							
Staff Training & Development							
Procedures							
Case Records							
Documents							
Meals & Meal Times							

Figure 42

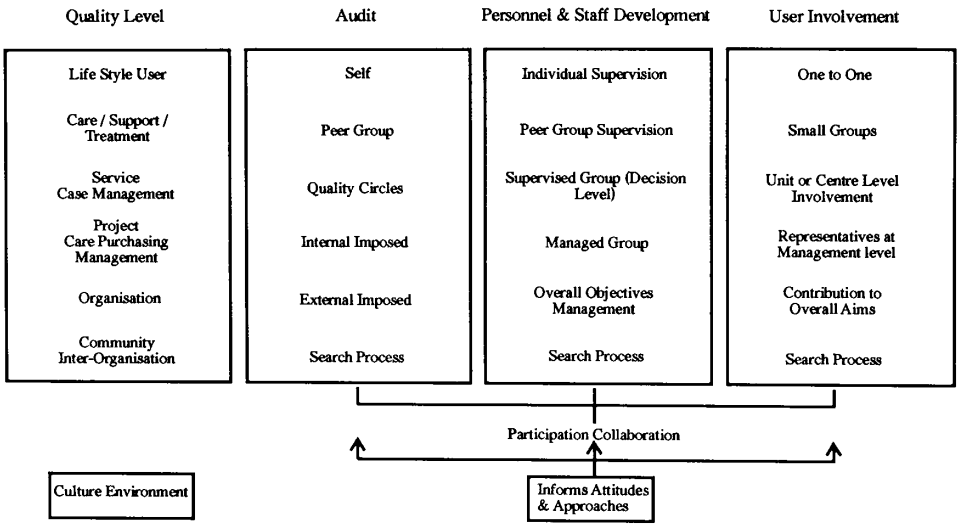
7. Total Quality Relationships

The basic matrix can be extended in a variety of ways appropriate to the needs of a service. The Waikato approach and that of the SSI demonstrate the way in which the method can be extended once an effective quality assurance cycle has been established. Figure 43 shows another set of relationships demonstrating the interplay between the basic vertical dimensions of an user's life, care / treatment and so forth set against audit, personal development and user involvement. Each level within this matrix demonstrates the approach which might be taken at a particular level. For example, at the service level a form of an internal audit could well be established around quality circles linked to supervised group work, linked to involvement of staff and decision making through appropriate participation mechanisms which in themselves involve one or more users of the service.

A further example would be at the level of the individual user. Audit is by an individual a member of staff or service user. This is related to individual supervision of staff which in turn must reflect the one to one relationship between staff and service users.

Figure 43

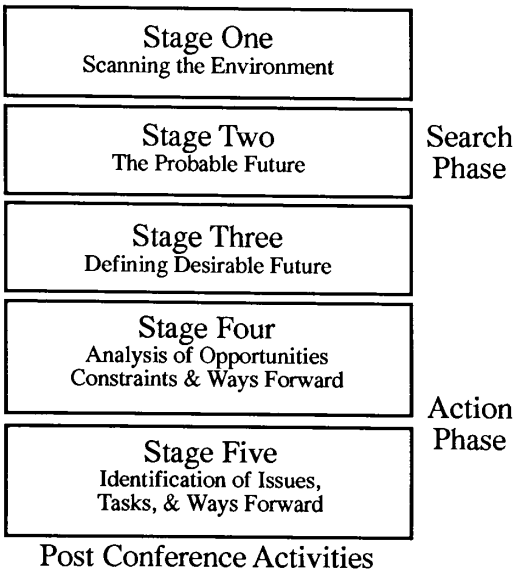
Total Quality Relationships



At the community level the process becomes one of "search" - a technique for iterative and interactive planning which enables all participants or organisations to establish desirable futures for the service and its users and thus to produce a strategy for moving forward from the existing state of the service or the user's life to a new and better state at some time in the future. This is demonstrated in Figure 44 and is described more fully in a Mind / Richmond fellowship publication on quality in community mental health care - " A Search for Quality ".

Figure 44

The Search Process



SECTION 8

Concluding Remarks

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Concluding Remarks

This workbook is intended to be an introductory guide to establishing effective quality assurance programmes in health and social care. It is deliberately focussed on a complete quality cycle requiring participants to undertake rigorous observation and analysis.

The ENQUIRE System is based on a number of important principles. These are :-

- that quality assurance incorporates quality measurement and a stated intention to use that measurement to improve and enhance the quality of the service. It requires managerial sanction
- that no two services are identical and thus individually tailored processes are required.
- that effective QA requires an involvement of staff and service users and is geared primarily to service outcomes and their eventual impact on the quality of life.
- that a good QA system will be based on rigorous validated observation aimed at discovering key concerns about a service.
- that off-the-peg solutions are not always helpful or desireable but can be useful once key issues in a service have been targetted, and
- that checklists and standards must be developed locally and applied carefully.

The ENQUIRE System is encompassing in that it :-

- focusses staff and users on the most important area of service for further consideration, and
- enables a range of specific tools to be deployed appropriately.

A case study handbook is in preparation. This will demonstrate the power of the system in practice. Anyone using this workbook carefully should have no difficulty in developing lasting procedures which offer significant insights into a service and suggest necessary changes. It will have been apparent to the attentive reader that there are many pitfalls, not least being the temptation to cut corners, save time in preparation, observation and data validation. Using the complete system will give good results but requires full support from management and staff.

The authors hope the ENQUIRE System will prove a valuable approach to all who are tackling the difficult but rewarding area of improving the quality of the services, care and treatment and, above all, lives of vulnerable or disadvantaged people.

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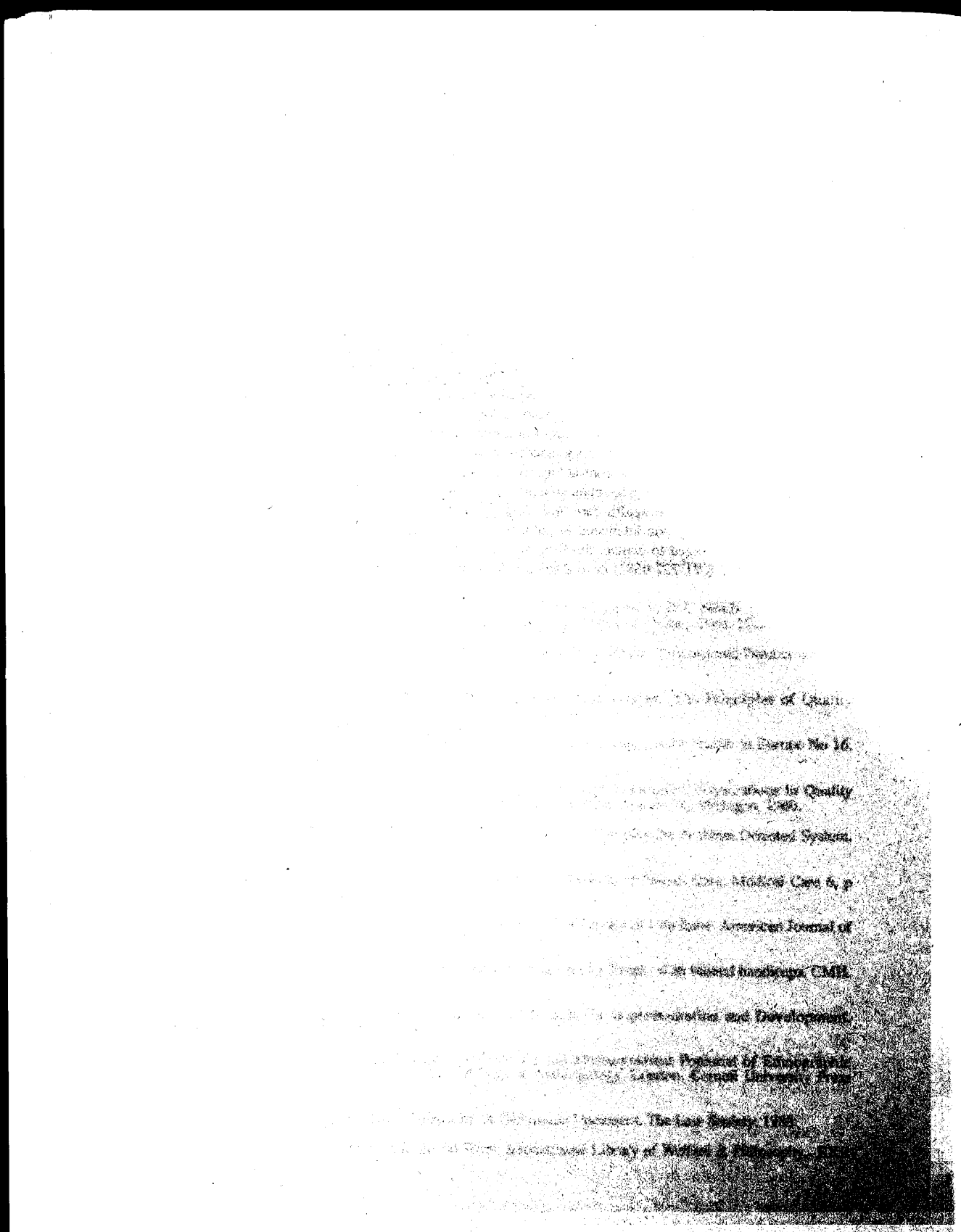
BUILDING COMMUNITY STRATEGIES

The King's Fund College is predominantly concerned with management and organisational development for health and social care. As part of its work a group of faculty within the College run a series of inter-linked programmes and seminars known as "Building Community Strategies" (BCS). The BCS group incorporates community health and social care, primary care and family practitioner services. Programmes in the BCS area include locality management, contracting for the health of the community, quality assurance in the community, health and social care, management development programmes for services to people with learning disabilities, mental health care and elderly people, and publications on a range of issues in community services. Any one interested in publications or management and organisational development programmes is encouraged to contact the Programme Support Unit at the King's Fund College, 2 Palace Court, London, W2 (071-727-0581) or to discuss their requirements with the group co-ordinator, Dr David Towell.

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