Quality Assurance Through Observation of Service Delivery

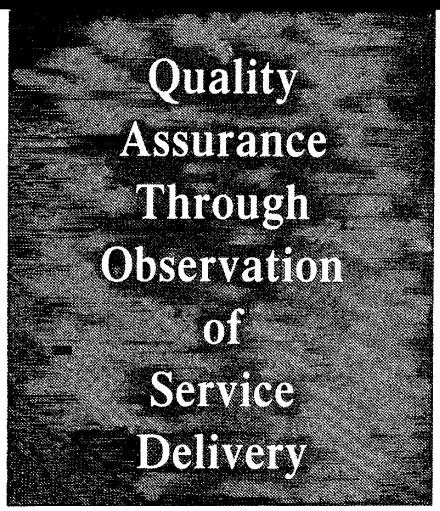
A PRACTICAL APPROACH UNDERTAKEN IN MID GLAMORGAN

Mid Glamorgan County Council
Social Services Department

Mid Glamorgan Health Authority

In conjunction with the King's Fund College

MID GLAMORGAN
mental health services



Mid-Glamorgan Social Services Department/ District Health Authority

Quality Assurance in Mental Health Services

Quality Assurance Action Planning and Standard Setting Through Observation of Service Delivery (ENQUIRE)

Final Report Phase I

Sept 1991 – Feb 1992

Mid Glamorgan County Council
Social Services Department

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Contents

Acknowledgements

The Enquire Quality Assurance Project has been carried out with the support of the Central Joint Planning Team (Mental Illness), with funding from the Welsh Office and Mid-Glamorgan Joint Training Strategy.

The CJPT (MI) wishes to thank the team of eighteen staff who carried out the work over a period of three weeks. They brought to the project a questioning and enthusiastic attitude which helped overcome some of the difficulties of working within very tight time scales on a major piece of evaluation.

In particular special thanks are due to the users and staff of services and units that were visited who gave their time to the Quality Assurance Team.

The material in this report brings together the Interim Report presented to managers at the Seminars (January 1992) and the Case Study of a single unit. The complete visit reports are available as a companion volume, by six Districts and by functional areas visited.

Report prepared by Gordon Jones, Peter Wakeford and members of the Quality Assurance Team, with support from Kings Fund College faculty, Chris Heginbotham and Huw Richards.

INTRODUCTION

section 1

The Mental Health Services within Mid-Glamorgan are in a period of considerable change and renewal. The Joint County Plan for Mid-Glamorgan sets out strategic planning objectives to achieve these changes, reflecting the views of service users, statutory agencies and voluntary organisations. Contained within the Plan is the commitment to develop quality assurance methods which can assess the degree to which objectives of the Service are being met.

The Central Joint Planning Team (Mental Illness) in conjunction with the Kings Fund College, and with funding support from the Welsh Office has now carried out, using the Enquire System, the first phase of a quality assurance programme. This method of appraising the quality of service uses direct information obtained from people at the point of service transaction. This is the point where resident and care worker, patient and nurse or day service user and worker meet.

2. The Scope of the Project

The Quality Assurance Team visited 58 units and recorded 870 validated observations. These observations are summarised in this report; the complete data set is available by both District and function in the reference papers submitted to the project sponsors.

The visits covered all 6 Districts, with a concentration in the Merthyr district where one particular unit was visited on three occasions in order to write an in-depth case-study. User views were gathered from material produced at user conferences, and by interviews with users and user led organisations. In all 10 types of services and sources were identified and visited.

Table 1 **SERVICE TYPES VISITED BY DISTRICT**

SCOPE 10 SERVICE TYPES	MERTHYR	RHONDDA	TAFF ELY	OGWR	RHYMNEY	CYNON	TOTALS
SERVICE USER	19						19
RESIDENTIAL	4	1	1	1		1	8
HOSPITAL WARDS	4		1				5
CPN TEAMS	1						1
DAY SERVICES	3	1	2	3	1	1	11
SOCIAL WORK SERVICE	1	1					2
HOSPITAL PATIENTS	2						2
USERS ORGANISATIONS	2						2
USERS CONFERENCE	1	1	1	1	1	1	6
EMPLOYMENT PROJECT	0				1		1
TOTALS	37	4	5	6	3	3	62

The Quality Assurance team working in pairs validated processed, and fed back 870 observations which produced 103 Action Plans agreed with agencies across the country.

Table 2

AGENCY/SERVICE USERS VISITED OBSERVATIONS RECORDED ACTION PLANS WRITTEN BY DISTRICT

	AGENCIES	OBSERVATIONS	ACTION PLANS
MERTHYR	37	555	42
RHONDDA	4	60	12
TAFF ELY	5	75	15
OGWR	6	90	16
RHYMNEY	3	45	9
CYNON	3	45	9
TOTAL	58	870	103

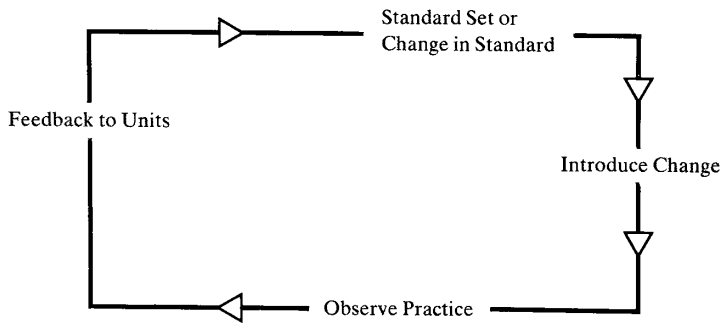
3. Design of a Quality Assurance System for Mid-Glamorgan

The project is seen as an ongoing part of a quality assurance cycle which now involves:

- repeated observational visits
- agreed Action Plans
- standards setting
- controlling standards, and implementing Action Plans
- reviewing and learning from the process

An integral part of this process is establishment of Action Plans, which form part of the Quality Cycle. Quality Assurance Cycles can be shown diagrammatically.

CYCLE OF QUALITY ASSURANCE/ QUALITY REVIEW TEAM



It will be clear that some important work has been done in Phase I to establish such a system. This includes ensuring a team is drawn together, is properly trained, undertakes effective observation, validates and analyses observations, feeds back such observations to staff and generates action items, obtains management support, effects change, and then reviews the service.

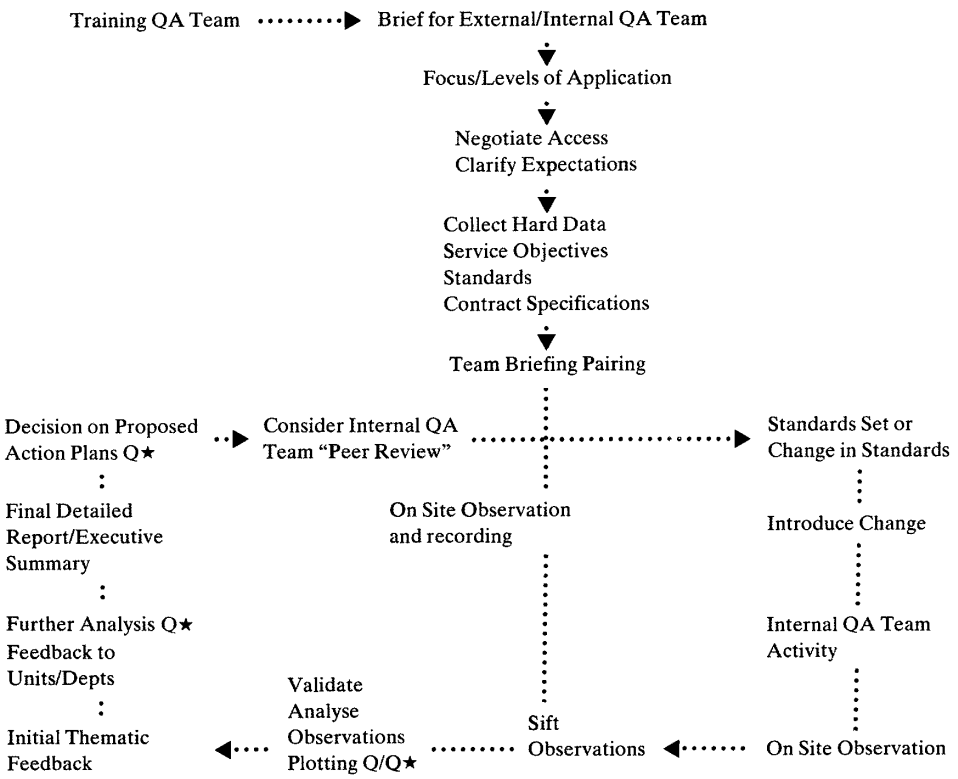
A brief description of the approach used will assist in understanding the system which has been established.

4. Mid-Glamorgan Quality Assurance Process

The following steps were taken to establish the project.

1. An 'external' team is created from staff of the service (the Quality Assurance Team);
2. The Quality Assurance team visits and observes the service;
3. In observing the service the Team looks carefully at structure, process and outcome information, discussing the service with managers, staff and service users;
4. Observations of the service (seen, heard) are analysed;
5. Action Plans are developed with and for both staff and management;
6. The process is audited by an in-depth case-study and the Phase I findings are presented;
7. Quality Review Teams are established to monitor implementation of Action Plans and set standards;
8. The Team re-visits and re-observes the service, measures changes and improvements, and formulates Phase II Action Plans.

Quality Assurance Cycle



Complete quality assurance cycle using the ENQUIRE system

5. The Quality Assurance Team

The Quality Assurance Team was set up in September 1991 and consists of members of staff from the Health Authority and Local Authority Social Services Department.

The Team undertook a three day training programme with Kings Fund College facilitators which included an overview of audit and quality assurance systems, and comprehensive training using the ENQUIRE System. As part of this process, a pilot study was carried out on 10 wards at a local psychiatric hospital. Briefing material about the sites was provided in advance and the Team split into pairs in order to carry out this work. One member of the pair observed and made notes whilst the other interviewed staff and service users. Following these visits, each pair discussed and considered their observations and then prioritised them into 20-25 statements before deciding on the most significant 15 observations. Each observation was coded using the Enquire matrix and Quality Star systems. As a training exercise, three observations were chosen on which to base a proposed action plan. The pairs also prepared a'site note' on each unit visited. All the findings were discussed in depth with the team afterwards.

Towards the end of the training period, the Team agreed that each member would be responsible for a specific role or tasks. Some members agreed to act as *facilitators* or *team leaders*, whilst others undertook to *brief* the services that would be visited and to ensure that adequate information would be made available to the Team. Another small group agreed to be responsible for *data processing* and presentation of findings at the Management Seminar.

Observation began with the Quality Assurance Team undertaking visits to 20 facilities within the county. This is referred to as obtaining a "snapshot" of the service — gaining information from a range of service units in a comparatively short period of time. These visits took place over 4 days and involved each pair in visiting two or three sites, and a feedback session to the staff and users of the services visited during the assessment. Three action plans were agreed with staff and service users who had been involved and who would be responsible for undertaking tasks related to action plans.

One site was visited by three pairs on two occasions one month apart in order to test the consistency of observations and use of the plotting instruments. The detailed findings of this audit are contained in the Case-Study included here.

All the information gathered by the Team was collated at the end of this Phase, and is available in the complete visit reports. The findings were processed by computer using the 'Enquire' software package. This was undertaken by the Kings Fund College.

The second stage of this first phase took place in October when the team made in-depth visits to assess a wide range of services in the *Merthyr District*. They visited eleven facilities, met with fifteen groups of users and conducted twenty five sessions with individual service users. This information was processed and an analysis made. It was possible at this stage to highlight certain key issues and to focus on action items which could be resolved by staff, and those which needed to be addressed by service managers.

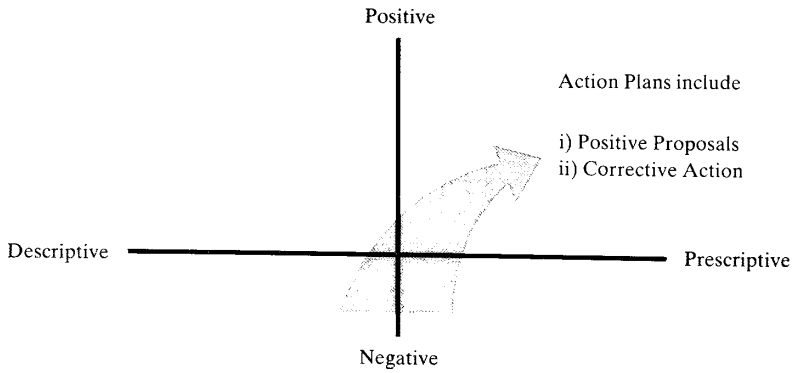
6. Action Planning

Having processed the observations the Quality Assurance team met with the service providers to agree an Action Plan consisting of three to five items. The Action Plan itself has 3 parts — an intended preferred outcome; a statement of the processes required to achieve the outcome; and any structural inputs or resources needed. The Action Plans are written using the matrix, as shown in the following example (only part of the matrix is shown for the purposes of this example).

ACTION PLANNING: Quality Matrix

	STRUCTURE	PROCESS	OUTCOME
Community			
Users Life			Weekly meetings with staff to ensure user has forum to voice opinions, air views. Forum also to offer opportunity for relevant exchange of information
Treatment/Care		Patients interest in meetings to be sought via questionnaire carried out over an 8 week period	
Services Case Management			
Project/Unit	Ward Manager to identify two members of staff to: 1. Compile questionnaire 2. Collate information 3. Set up first meeting by January 1992 if outcome of questionnaire is favourable		
Agency Organisation			
Culture Environment			

Action planning in this way using the observational material will enable negative aspects of the service to be expressed positively and improvement to be measured on the 'star' instrument as illustrated.



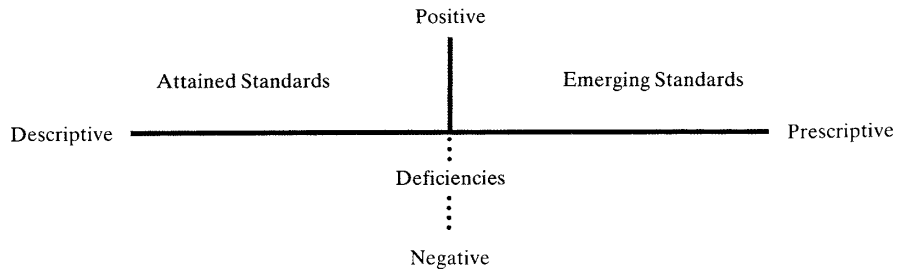
Negative Observations — Service Deficits — Movement through Action Plans and Change to Positive Prescriptive Service Feature

7. Standard Setting Using Observational Material

In addition to creating action plans at agency level the aggregate observational material is analysed and standards written. Standards were written for the following functional areas.

Hospital Wards and Patients	(87 Observations)
Residential Units	(120 Observations)
Day Services	(165 Observations)

The observational material is restated as standards on 3 levels by the following system:



Observations are plotted on the Quality Star. Those above the line are considered to be positive standards that the service has either achieved (attained) or is committed to achieving (emerging). Those observations below the line indicate deficits in the service that need to be addressed, usually by the formulation of action plans.

The analysis of the observations has been grouped into four areas as explained below.

- Attained Standards: for the purpose of the report attained standards are formulated from observations plotted as 'Positive Descriptive'.

- Emerging Standards: emerging standard are drawn from all the observations within the Positive Prescriptive part of the 'Star'.

- Service Deficiencies: these are derived from observations that have been identified and described from all observations plotted as negative on the 'Star'.

- Action Plans: these have been discussed and agreed with service personnel. They are responses the individual unit will endeavour to make in seeking to overcome service deficiencies or improve existing practice. They are set out in full at the end of each section.

8. Quality Review Teams

It is planned to take the work forward by establishing three Quality Review Teams.* They will provide a Quality Assurance Service in the following areas:

i) **Day Services** — all mental health day services throughout the County except Merthyr

ii) **Residential Services** — all mental health residential services including hospital in-patient services throughout the County except Merthyr.

iii) **Merthyr District** — all mental health services in the Merthyr District.

Each Quality Review Team will receive training and support from the project manager and the Kings Fund College.

The tasks of each Quality Review Team will includes to:

1. Review action plans for all Units.
2. Liaise with the Quality Assurance Team on second and subsequent visits to Units.
3. Provide members to the Quality Assurance Team.
4. Develop 'peer' review of services — and a sharing of ideas.
5. Generate ownership of areas under change.
6. Identify items for further consideration.

* (QRT) Each QRT will comprise six or seven local staff and user representation including some members of the QAT. The QRTs will act a catalyst for further activity and monitor the implementation of Action Plans.

9. Resume of Findings

Of the 870 observations, 490 were negative, reflecting the extent and scope for development of the service. One hundred and ninety three negative observations were rated at a level which suggests the need for some urgent remedial work.

The converse is of course true of the 380 positive observations made about the service. This reflected the extent of good quality services that have achieved a high standard.

The observations relating to each individual service or unit are confidential to its managers and staff and have not been divulged to other services or teams without their agreement. Local Joint Planning Teams will have access to observations relating to their geographical area.

When the observations are classified by their subject matter they show a clear focus on matters of treatment and care which directly effect users lives and provided by direct service projects.

RANK ORDER OF OBSERVATIONS BY TOPIC

Initials.	Description	Count
TC	Treatment / Care	242 (28%)
U	Users Life	209 (24%)
PU	Project / Unit	169 (19%)
SC	Services / Case Management	117 (13%)
AO	Agency / Organisation	95 (11%)
Cy	Community	23 (3%)
CE	Culture / Environment	15 (2%)
	Total =	870

When the observational material is classified by its positive or negative aspects the following overall picture emerges;

Quality Star of All Observations (807)

	Descriptive	Prescriptive	
Positive	272 (31%)	108 (12%)	380 (44%)
Negative	297 (34%)	193 (22%)	490 (56%)
	569 (65%)	301 (35%)	870

Considerably more data processing has been undertaken in order to use the material effectively. Feedback to units provided 103 Action Plans. Standards are being set for functional areas and the next series of visits will have a sharper focus and assist change and implementation. The 'audit trail' established in the enclosed Case-Study shows the consistency of observations between pairs and the basis for further development.

10. Preparation of Reports and Time Chart

The findings from the processed observations for the purposes of this report have been analysed by service function:

1: Hospital Services
2: Residential Services (including an in-depth Case-Study of a Hostel)
3: Day Services
4: Users Perspectives

For the purpose of the First Phase Quality Assurance Programme some service areas have not been included in this summary. These include visits the Quality Assurance Team made to Community Psychiatric Nursing Services, Social Work team and Employment Services. There is scope in future quality assurance work to undertake an in-depth analysis of these and other services and details of these smaller visits are available in the reference papers.

As is indicated in the following timetable, it is hoped that the second phase of the Quality Assurance Programme will take place during the late Spring of 1992.

Time Chart

1991	September	'Snapshot' visits across county
	October	In-depth visits to Merthyr Tydfil
	November	Data Processing Action Plans commence
	December	Q.A.T. Review

Time Chart

1992	January	*Review Seminar*
	May	Q.R.T. Training Q.R.Ts. commence first regular meeting (quarterly)
	September	Q.A.T. Refresher Training
	October	Q.A.T. second set of visits to identified units (Residential, Day Services, Merthyr, general).
	October — December	Follow on action items Q.A.T. third visits (12 monthly regular review visits from then on)

Note:
Q.A.T. = Quality Assurance Team (ENQUIRE)
Q.R.T. = Quality Review Team

Information for both hospital patients and ward visits has been combined to give an overall picture of quality issues, affecting hospital services and are taken from 97 observations. These observations relate to one in-patient facility within the County.

Attained Standards

Attained standards account for 25% of the observations obtained and can be summarised as follows:

There was a general consensus among patients that ward staff were friendly, approachable and helpful. Ward staff listened to patients concerns and were quick to respond. Staff attitudes were generally respectful toward patients who felt that if they requested information about their care this was freely given (eight observations).

Patients also reported that the service was generally good, saying that the atmosphere and ward regime were more relaxed than they used to be, that they felt secure and that they felt that they had benefited from their stay in hospital. There was a general feeling that things are changing for the better, albeit slowly. (Seven observations).

With respect to the nursing staff, morale was felt to be generally good, they were open to new ideas (three observations) and had a good working relationship with Consultant Psychiatrists (one observation). Nursing documentation was felt to be of a high standard and care plans are regularly reviewed. (Two observations).

These observations demonstrate that although only a quarter of the reports show that this in-patient service can provide features of security it also offers care planning backed by documentation in a relaxed and respectful way.

Emerging Standards

Emerging standards accounted for only 7% of the observations obtained and can be summarised as follows.

It was acknowledged by staff that kitchen areas should be accessible to patients although this would require refurbishment. (One observation).

A need for more group work was recognised by nurses who felt that the current inflexibility of job descriptions prevented this from taking place. (One observation). A need was also expressed for more qualified staff to be employed on the wards. (One observation).

In order to maintain a 24 hour helpline it was felt that staff with a specialist counselling role should be employed. (One observation).

Both patients and staff recognised a need for more quiet space to be provided on wards. (Two observations).

It was felt that more leave of absence from hospital would facilitate re-adjustment to normal living. (One observation).

Deficiencies

Deficiencies (negative observations) accounted for 68% of the observations obtained and can be summarised as follows.

Safety and Security:

A great deal of concern was expressed regarding ward safety and security, especially the difficulty of observing the movement of patients both in and out of the unit and on the unit itself mainly due to the large number of access points and situation of nursing office. (Twelve observations).

Privacy:

There was concern about lack of privacy for patients. More specifically the following points were raised: lack of curtains and screened off areas; no quiet area to speak to visitors; no access to sleeping areas during the day, "no quiet room, nowhere to go if you want to be on your own, not allowed to use your bedroom during the day, can't lie down in the afternoon"; lack of interview rooms; no locks on bedside lockers, which are too small anyway, "clothes were observed strewn around and hanging from curtain rail". (Seven observations).

Ward Decor:

The ward decor was reported as dreary and the environment clinical — "lacks homely atmosphere, basic functional furniture, lack of colour, ornaments and personal touches". (Eight observations).

Repairs:

Urgent repairs were not being undertaken, e.g. a bathroom and a shower-room were out of action, chairs needed repair. As one member of staff said, "I am waiting for one of the patients to hurt themselves, then something might be done". (Six observations)

Normal Daily Living:

A very common complaint was that patients do not have access to kitchen facilities to make snacks and hot drinks. One user noted that, "there is a sign on the door that the kitchen is not safe for patients to use". This is aggravated by complaints of the food being repetitive and the lack of choice. Drinks are served at set times and the last meal is at 6.00 p.m. (Four observations).

Activity Programmes:

A lack of stimulation and recreational facilities was expressed. No structured activity on the ward was evident. "If I don't go to therapy (the O.T. Unit) I just fall asleep" . . . "we just shuffle around . . . we wander from one room to the next". Many patients complained of boredom. There is no occupational therapy on the wards and the O.T. Unit itself is only part-time. There were complaints that the Occupational Therapy Unit itself was not dynamic, "activities include flower arranging, woodwork, knitting and basket making". (Eight observations).

Therapies:

Nursing staff also complained about the lack of alternative therapies which was attributed to a shortage of qualified staff and an emphasis on office chores. The ratio of qualified staff to learners was as high as 1 to 6 and a nurse who had been employed to undertake group work had also been absorbed into administration and away from direct patient care. Another related complaint was the absence of staff replacements for staff on courses. (Six observations).

Staff Patient Contact; HIV; Complaints:

More specific issues included the inappropriate use of psychiatric wards for H.I.V. sufferers and people with alcohol problems, (one observation), no organised meetings between staff and patients or any formal system of registering patients concerns (two observations) and the lack of availability of medical staff "seeing a doctor once a fortnight by request" was less frequent than he (the patient) would expect. Several patients also complained of only having 3 or 4 minutes with a Psychiatrist when they had a lot more that they had wanted to say. (Three observations).

There are here a range of key issues affecting the general quality of life for both staff and patients. Some issues are structural but others involve flexibility in daily routines and availability of therapeutic and leisure activities.

Action Plans

The hospital wards and the QAT agreed the following Action Plan items. A resume is given here and they are fully set out in the reference papers. There were 11 Action Plans covering the following topics:

1. to bring the issue of patients privacy to the attention of Senior Managers and to identify funds for curtains, screens and more suitable lockers.

2. to explore ways of ensuring that patients have a forum to voice their opinions and air their views.

3. to review ward security with a view to reducing the amount of nursing time spent physically observing patients around the ward and increase the amount of more meaningful contact with patients.

4. to raise the issue of ward decor with Senior Managers and try to identify funds for repairs, furnishings and redecoration.

5. to discuss with Senior Management options for making the kitchen area safe for patient use.

6. to explore with Senior Managers options for improving observation and safety to back corridors on wards.

7. to provide an information booklet for patients and their relatives to improve their awareness of the service.

The implementation of a number of these issues will require consultation with senior managers but many of the issues can be taken forward immediately.

Measure of Quality Improvement

When the Action Plans are implemented the balance between positive and negative aspects of the service should improve. The result shows further scope for improvement.

Table A — Quality star for hospital wards.

	Descriptive	Prescriptive		
Positive	24 (25%)	7 (7%)	31	(32%)
Negative	44 (45%)	22 (23%)	66	(68%)
	68 (70%)	29 (30%)	97	

Table B — Quality star for hospital wards and patients when action plans are implemented.

	Descriptive	Prescriptive		
Positive	35 (36%)	7 (7%)	42	(43%)
Negative	39 (40%)	16 (16%)	55	(57%)
	74 (76%)	23 (24%)	97	

Standard Setting

Using all the observations the QAT has proposed the following standards for hospital wards:

The service currently provides care to the following standards:

1. Hospital staff will make themselves accessible to patients and treat them with courtesy and respect.

2. Hospital staff will provide patients with as much information as possible appropriate to the individuals care and wellbeing.

3. Hospital staff will endeavour to create a relaxed and informal atmosphere in their units while maintaining a safe and secure environment for the patients. Rules and regulations should be kept to the minimum necessary to maintain personal safety.

4. Managers will be aware of staff morale in hospital units and identify and improve issues that may reduce staff morale.

5. Patient documentation will be of a high standard and regularly reviewed. In order to achieve a high standard there must be a direct correlation between documentation and patient satisfaction.

The service will endeavour to meet the following standards:

6. Facilities for patients to make snacks and hot drinks will be provided on wards and units.

7. Staff will deliver a range of therapeutic interventions to meet the needs of patients in their care and be qualified and competent to provide such services.

8. Staff will be given the necessary counselling skills to maintain telephone counselling services.

9. Patients who have identified rehabilitation needs will be reintroduced into the community in a planned and phased way.

10. Hospital staff and Managers have a responsibility to ensure that patients privacy is respected at all times. This will be reflected both in staff attitudes and the physical provision of suitable furnishing and fitments.

11. Hospital units will be maintained and decorated in order to provide a clean and attractive environment in both which to work and receive care.

12. The choice and frequency of meals will reflect the expressed preferences of the patients.

13. Diversionary activities will be available for patients who are unable to leave the unit.

14. The ratio of qualified staff to learners will not be such as to prevent qualified staff having direct contact with patients nor to prevent learners from having a good learning experience.

15. People who suffer from H.I.V. or drug or alcohol related problems for which there is no mental illness consequence will not be cared for in psychiatric hospital units.

16. Hospital Doctors and psychiatrists interview time with patients will be relevant and satisfy their individual needs.

17. Appropriate occupational therapy input will be provided.

18. Team building programmes will be provided for staff of Community Mental Health Teams.

This section uses the 120 observations concerning residential care. The latter part of this section is a Case-Study of a Hostel which illustrates the work of the Quality Assurance Project in depth in all its facets: observation, action-planning and standard setting. The Case-Study is also an audit of the use of the Enquire System by the Quality Assurance Team.

The residential units visited included:

a) Rehabilitation Hostels
b) Housing Association Projects
c) Group Homes

Attained Standards

There were thirty-two observations (27% of total) that indicated positive features of Residential Services. These related to the physical ambience and location of units that were visited. Service users felt positively about the settings in which they were living — eleven observations, for instance, stated positive views on the residential settings. As well as the physical features of the unit, the internal regime and philosophy of units also figures highly in observation. Ten observations suggested that attained standards of treatment and care had been achieved. They noted the good relationships that existed between staff members and service users, and also between the Residential Unit and other services. In particular it was noted that there was an understanding of the relationship between residential units and day services.

Out of the total number of observations (120) made about residential units, 40% were positive and 60% negatives.

There were several main themes which emerged from the positive statements made about residential units. These provide instances of good practice which could serve as examples to be followed throughout the service.

Rehabilitation Hostels

Open referral systems are used in the residential units and prospective residents may refer themselves, however most referrals come from professionals such as CPN's, General Practitioners, Social Workers and Psychiatrists. There is an active involvement by residents in their own assessments and they attend assessment and review meetings. These meetings are only attended by the residents and staff who are directly involved.

There were many positive comments by service users about the location of the residential units and about the actual physical surroundings. The units were generally considered to be pleasant places to live in and were thought to be both well emerged and well monitored.

Many of the service users felt there was a pleasant and relaxed atmosphere in the residential units and that the staff were friendly, approachable and helpful.

A keyworker system was in operation which appeared to be working well, with residents being given a choice of keyworker. Some of the staff had been on PASS (Program Analysis of Service Systems) courses and the Team observed that this appeared to have influenced their work in a positive way. Good staff/ resident interaction was observed by the Team who felt that staff showed genuine respect for the residents.

Regular meetings are held in one of the Residential Units which both staff and

residents attend. Positive feedback was received about these. A residents council in one of the units runs with no staff input. It deals with complaints and the organisation of social events. Service users felt this was functioning well.

Users of the service commented that they were consulted about the choice of furniture and equipment in the Residential Unit.

An active social skills programme is in operation in one of the residential units and residents were responsible for their own cooking, cleaning, laundry and budgeting. Service users are actively involved in community activities such as voluntary work and attendance at day services.

The observations indicate that there was good communication between residential unit staff and field social workers and that problems were resolved effectively.

There are facilities for residents with hearing impairment at one of the residential units which has been designated for this purpose, and staff then attend regular sign language classes to B.S.L. standard.

Good follow up is provided for service users of the residential unit on discharge from the unit. An outreach worker is available and staff continue to provide support to ex-service users who are living in the community.

Housing Association Projects

At one of the housing projects a social worker and a housing association representative met fortnightly at the house, but residents were ambivalent about this, seeing the meetings as an interference. The social worker thought the meetings brought balance preventing dominance by some residents.

Group Homes

The general layout of the homes visited was spacious and the environment pleasant. The residents stated that they were happy living in the house.

Emerging Standards

Care management observations indicated the need to centre the development of close links between field social workers and residential units.

Sixteen observations were grouped as emerging standards. They indicated the impact that continuing improvements in the residential settings have on users lives. Support services and the financial implications for users of residential services was noted.

Observations suggested the need to continue the development in residential settings which have a direct and significant impact upon users lives. It is apparent also that there is an awareness of the importance of information services and systems which inform service users of their rights and also local information that is relevant to them.

Rehabilitation Hostels

There is a need for residents to be provided with information about the service and in one of the units a brochure and information booklet are being produced for this purpose. There would appear to be a need for more locally based residential units as at present the existing

units provide a service for people whose home is a considerable distance away. Although the residents do make some use of the local facilities, i.e. pubs and leisure centres, there is scope for this to be increased. Some service users in residential units expressed a need to have more frequent contact with their Social Workers than they have at present.

Housing Projects

In one unit plans had been made to involve residents in consultation regarding the future of the project. They would be given a choice over whether they wanted to continue living in the project or move to housing association accommodation. There were plans at another housing project for a voluntary organisation to take over management, thus giving it a rehabilitative function and supplementing the existing residential unit.

Group Homes

Although some residents expressed satisfaction with the group homes several problems emerged which need to be addressed. In one home the residents were concerned that local authority repairs had not been carried out and that other problems regarding the heating and cooking facilities needed to be dealt with.

One of the group home supervisors worked up to and beyond the time she was contracted for, and the residents stated that they would not be able to manage without her. It was clear that a system should be adopted whereby 'out of hours' cover could be provided for the residents (i.e. evenings, weekends and holidays).

Deficiencies

72 observations (60%) identified deficits in residential services. These are summarised as follows:

Rules and Regulations

The largest area that indicated the need for a strategic approach involved service users and their daily lives. Nine observations were critical of the rules and regulations that have to be followed in the unit. Some residents accepted the need for safety guidelines, whilst other rules seemed to have little relevance to the needs of users. Action plans for the units would indicate the need to address this area. Rules and regulations that reduce individual choice and autonomy of residents need to be examined.

Other observations noted issues about the institutional management of some units. For example, the difficulty for a unit of a large organisation to break away from bureaucracy. A number of observations noted how staff were bound by regulations that made innovation and change difficult.

The observations indicate the need to re-examine the user perspective of the service.

Rehabilitation Hostel

Ten observations highlighted deficiencies in the users lives of the rehabilitation hostel. In the main these related to some of the current rules and regulations. For example:

> "Programmes must be followed" "you can't do things at your own pace. Things have to be done when the staff want."

It is apparent from these observations that the rules and regulations in residential establishments can be seen as an intrusion into the personal autonomy and independence of users. There is the conflict highlighted above between safety led rules, e.g. fire regulations that may dictate where and when people can smoke, and the individual rights of users.

Agency/organisational observations indicated a need to review referral and admission policy in hostels. Admission policies need to be clearer and more focused, although this could in some instances constrain relevant admissions. The changing use of the hostel indicated a need to review staffing levels in particular the need for night cover. At present night cover is arranged on a sleep-in basis. There is no separate night staff, with cover being provided by day staff, and this can put extra pressure on staff.

Housing Association Projects

There were eleven deficit observations noted in the housing project. They clearly indicated a project that is in some difficulty as there were negative features in all areas. These highlighted the need for close, sustained co-operation and co-ordination between agencies in the arrangement of housing projects which aspire to provide specialist accommodation and residential services.

It was stated, "the Housing Association is a general housing association with no experience in special needs". There is no written operational policy for the housing project, with predictable results; set up on a misconception, that simply putting people together with difficulties would help them overcome their problems."

Group Homes

There are twenty negative observations on group homes, highlighting the conflict and difficulty that arise in the management of small family units by a large organisation. A number of observations show how large organisations find it difficult to respond quickly and sensitively to the individual needs of people living in such units. For example, one observation states:

> "Although interiors redecorated annually, communal rooms have few personal belongings in evidence. Furniture is utilitarian and institutional, lacking comfort and homely appearance."

The tension between the management of the units by the Local Authority, and personal wishes of residents is apparent. Problems with external appearance of group homes featured with observations relating to the problem of maintaining gardens which become overgrown and neglected. This leads to situations where a group home becomes more than obvious in a street.

Professional support to group homes identified are in need of review. The impact of social workers felt to be sometimes inappropriate and that staff with other more practical skills would be more appropriate e.g. social care worker.

Action Plans

The action plans agreed can be summarised as follows:

Rehabilitation Hostels

1. Review of policies on residents right to entertain friends and visitors in their own room.

2. Review of right of residents to consume alcohol in Unit.

3. Consultation and review regarding access to communal area after 11.30 p.m., to reflect individual choices.

4. Review of referral, assessment and individual programme system.

5. Review of night cover arrangements.

6. Establishment of closer links between residential units and hospital.

7. Providing guidelines on Respite Care Services.

Housing Project

1. Provision of operational policy offering guidance on allocation criteria, rehabilitation function and possible move on strategy.

2. Review of future management options.

Group Homes

1. Review of budget procedures to ensure a reduction in bureaucracy.

2. Establishment of procedure to ensure maintenance of garden and buildings.

3. Production of clear written guidelines regarding policy and procedures.

4. Review of support services.

Measure of Quality Improvement

When these action plans are implemented the balance between positive and negative features of the service will be significantly changed from 40% to 59% positive aspects. This can be shown as follows:

Table A — **Quality star for residential units at present.**

	Descriptive	Prescriptive	
Positive	32 (27%)	16 (13%)	48 (40%)
Negative	35 (29%)	37 (31%)	72 (60%)
	67 (56%)	53 (44%)	120

Table B — **Quality star for residential units when action plans are implmeneted and achieved.**

	Descriptive	Prescriptive	
Positive	55 (46%)	16 (13%)	71 (59%)
Negative	29 (24%)	20 (17%)	49 (41%)
	84 (70%)	23 (30%)	120

Standard Setting

The standard setting for residential units produced 13 standards and the Case-Study produced 18 for the specific unit.

The 13 overall standards were as follows:—

1. Residential Services will involve service users in preparation of individual programme plans and be consulted about developments that affect their daily lives.
2. Regard must be had to the environment and ambience of services. Services should be homely and welcoming in nature, blending in with the neighbourhood in which they are located.
3. Services need to be developed that cater for the needs of users with special needs; an example are those with hearing impairments.
4. Good communication between professional groups is recognised as an essential ingredient of services.

5. Good communication between service staff and service users is important.

6. Service users should be treated with respect and dignity with an awareness of their individual needs.

7. Service staff need to have personal development programmes that enable them to examine the value of services, (for example attendance on P.A.S.S. courses).

8. Attention must be paid to the layout and interior decoration of residential units. These must be chosen by the users of services, and not dictated by bureaucractic procedures.

9. Group homes and residential or accommodation schemes must be staffed to provide cover to adequate levels.

10. Services should provide information about their service.

11. Services should be locally based and available.

12. Fieldworkers, for example, CPN's and social workers will maintain frequent contact with clients who are in residential care.

13. All accommodation schemes should be co-ordinated and planned to prevent clustered developments.

Case Study: Mental Health Hostel Visited by Teams 1, 2, 3:

Consistency of Observations Standards Setting and Action Plans

1: DESCRIPTION OF UNIT AND TEAM BRIEF

2: METHODOLOGY FOR AUDIT STUDY

3: 3 ACCOUNTS OF HOSTEL

4: SUMMARY OF COMPARISON BETWEEN TEAMS 1 & 2

5: COMPARISON OF TEAMS 1 & 2 (lst PASS) & TEAM 3 (2nd PASS)

6: STANDARD SETTING, RATING AGAINST AIMHS STANDARDS AND ACTION PLANS

7: CONCLUSION

8: APPENDICES: 1:3 ACCOUNTS OF THE HOSTEL/THE VISIT REPORTS

2: COMPARISON OF OBSERVATIONS BETWEEN TEAM 1 & 2

3: COMPARISON OF OBSERVATIONS BETWEEN TEAMS 1 & 2 (lst PASS) & TEAM 3 (2nd PASS)

4-7: ALL SOURCES OF OBSERVATIONS FOR TEAMS, AND BY 'STAR' EVALUATION

8: SPO COMPARISON OF TEAMS PLOTTING

9: RANK MATRIX COMPARISON OF TEAMS PLOTTING

10: ENQUIRE OBSERVATIONS EXPRESSED AS STANDARDS

11: STANDARDS RATED ON AIMHS

12: ACTION PLANS FROM TEAMS 1, 2 & 3

Case-study Examining the Constituency of Observations Between 3 Observer Pairs; Standards Set and Action Plans

Unit Studied — Mental Health Hostel

The Unit

The unit studied has 16 places and two more are in a semi-detached house which is used for residents with special needs eg a mother and child. It caters for people with mental health/ illness problems who are aged 18 or over and is part of a network of services preventing unnecessary admission to hospitals and providing resettlement for discharged patients in particular from the local psychiatric Hospital. The unit operates an 'outreach' service to support previous residents. Its aims are to promote and sustain independent living in a non-clinical environment.

Clients rights are reported and respected. Residents are encouraged to take a full part in decision-making in the unit and are consulted about changes which may take place. Suggestions and complaints can be taken up via the "box" or through Keyworkers, weekly meetings of the 'Clients Council' or directly to the Officer in Charge.

The building has a large lounge area which is the hub of the building. The building in general is regarded as attractive and well appointed. Two main residential areas of 8 single rooms each branch off the main lounge. Dining, Kitchen and Leisure areas are shared by residents.

The Quality Assurance Team Brief

The above unit description is that reported by all three teams (pairs) who visited the unit for half a day for each visit. The description given to the teams was provided by the unit itself to the "briefing" members of the Quality Assurance Team. The visits took place as follows: Team 1 — 9.9.91 and a further visit by Team 2 — 10.9.91; Team 3 on 8.10.91, one month later. Each visit was independent and the processing of the material was also undertaken independently by the teams. This study illustrates the work of 3 pairs working within a QAT and represents approximately 30% of its membership. It is an "audit trail" through the Quality Assurance Project itself.

Methodology

The unit was visited by three pairs of observers in order to assess the consistency of the accounts given by the QAT members on a single occasion. The design for such a test on the Quality Assurance Team is set out elsewhere(2). The method employed is qualitative and compares the content of accounts given in 15 observations per pair on a four level scale of

- "agreement": where the subject matter of observations is close in content;
- "related": where the subject matter is related to an extent that the observations could be joined together and complement each other;
- "different": where the subject matter has no direct clear connection with other teams observations;
- and "disagreement": where the subject matter is at variance (in fact or opinion) with other teams observations.

It should be noted that qualitative material may properly contain reported variance or inconsistencies particularly from different sources, for example staff and residents. Consistency is thus measured between pairs not within pairs of observers. Consistency between observing pairs can be understood as levels of

agreement or disagreement in observational content.

Further comparisons between pairs are also possible in terms of the sources recorded for their observations from the scoring on the 'Star' instrument for all observations from users, staff or managers. Comparison may also be made of the rank order of components of the "quality matrix" by team.

The main purpose of this case-study is to provide the QAT (and the project sponsors) with an indication of the validity and consistency of the accounts given of a single hostel (in a county-wide study) and an initial sense of reliability of observations over time and with different observers.

No attempt was made to control any agency variables at either time. A significant difference noted by Team 3 against Teams 1 and 2 was that contact with the manager was greater and this is reflected in the 'source' counts. Also, because the system promotes change, by a method of feed-back of the observations to the unit being observed, this creates an added dynamic; the unit gained information between visits 1 + 2 and 3 and learning, action-planning, new sources (eg manager) and other factors therefore make the unit a 'moving' rather than a 'static target'.

The method adopted in extracting standards from the observations is illustrated in the text. The emerging standards are also rated against AIMHS (3) Standards for comparison and finally the Action Plans are considered in terms of impact on the unit, when implemented.

The Three Accounts of the Hostel

At this stage the three separate accounts (15 final observations each) should be read (see Appendix 1). An initial comparison of the 'positive' and 'negative' plotting of their observations shows considerable similarity between Teams 1 + 2 at time one and slight variance by Team 3.

Table 1

Time one		Time two
Team 1	Team 2	Team 3
6 | 0 = **6**	4 | 2 = **6**	6 | 2 = **8**
8 | 1 **9**	2 | 7 **9**	2 | 5 **7**

Adoption of the action items from time one and the positive managerial comments may have influenced the improved evaluation at time two.

We may now turn to the 4 level analysis of content between the pairs at time one. This is set out in detail in Appendix 2. Of the 30 observations scrutinised, consistency was as follows:

Table 2

Consistency between team (pair)1 + 2

Agreement	Related	Different	Disagreement
16	4	10	0

No disagreement was found. 33% of the accounts differed in subject matter. 66% of the observations showed agreement or closely related subject matter.

The sources of observations were similar but with Team 2 having no managerial sources but having 53% of its material sourced to users as compared to 40% user sources for Team 1.

Table 3

Source of observations

	Team 1	Team 2
Staff	13 (43%)	7 (47%)
Consumer	12 (40%)	8 (53%)
Manager	3 (10%)	0
QAT (Self)	2 (7%)	0
	30	15

A significant difference between the teams emerged from the number of corroborative sources. Each observation may have multiple sources save the use of the QAT as a source which is only recorded if it is the exclusive source. Team 1 have twice as many sources for the same number of observations, ie a higher level of corroboration

Both teams recorded high levels of negative observational content sourced to users, but Team 2 recorded more positive aspects sourced to staff than Team 1. The full tables will be given later when Team 3's material is added (for comparison of sources, and by quality star — see Appendices 4, 5, 6, & 7).

The focus of observations in terms of outcome material, and process and structural aspects also shows some differences. Common to all 3 teams is the low level of outcome material. Team 2 recorded more structural aspects in their account and Team 1 recorded almost exclusively process issues. (For detailed breakdown see Appendix 8).

Table 4

Classification if oberservations by structure, process or outcome

	Team 1	Team 2
Structure	1	9
Process	13	4
Outcome	1	2
	15	15

When the matrix plotting is compared and the vertical service dimensions are compared, it can be seen that both Team 1 and 2 reported most of their observations within 3 (4) dimensions.

Table 5

		Team 1	Team 2
1	Project unit	4 (27%)	6 (40%)
2	Users life	5 (33%)	4 (27%)
3	Treatment/care	6 (40%)	2 (13%)
4	Services/Case-Management	-	2 (13%)
5	Agency/Organisation	-	-
6	Community	-	-
7	Culture/Environment	-	-

This shows a consistency of focus on the unit being visited and less concern with the local community, the local culture and environment and with the parent (purchaser/management) organisation. This is a sound starting point for the initial stages of a quality assurance exercise, as it focuses on the internal aspects of the agency. (For detailed tabulation See Appendix 9).

Summary of Comparison of Team 1 and 2 on the First Visit

1. The site description which the teams gave, based on the briefing material was identical. The material focused attention on the unit itself and gave few pointers to the network of services within which the hostel functions. The brief provided no information on length of stay, turnover, unit costs, on dependency levels of residents or staffing levels. These factors may be added to the QA team brief for the next Quality Review Team visit.

2. The comparison of observational content showed a sound level of agreement or relatedness at a 66% level and no frank disagreements between the visiting pairs were identified.

3. On the crude measure of two axes of the

quality 'star' ie positive and negative features of the unit, the two Teams produced an identical evaluative score, marking the unit as having negative features on a ratio of — 6:9 ≡ 1.5. Team 1 observations were almost wholly descriptive whilst Team 2 reported more prescriptive material.

4. The sources of the observational material showed that most of it derived from contact with consumers and 'front-line' staff. The extent of corroboration of observations by multiple sources was markedly different, Team 1 having greater source corroboration. Few observations relied only on the team members themselves.

5. Most of the material was 'process' and 'structure' oriented as would be expected from the first visit to a unit; outcome data was low at the 10% level.

6. The comparison of matrix plots shows a focus on the unit and its internal activities rather than on its related agencies or external environment. This is to be expected at the early stage of observational audit.

7. Feedback to the unit agreed 3 action items for each team (see Appendix 10), these focused on choices of individual programmes; choice of bedtime; duty staff at night, permission to consume alcohol; permission to entertain visitors in rooms; and flexible bedtimes and night staff cover. There was consistency in action plans in terms of the focus on increased resident choice, in use of rooms, in night-time facilities.

Comparison of Teams 1 + 2 (Time One) with Team 3 (Time Two)

The area in which there might be a greater divergence in accounts is from a separate team (pair of observers) at a much later point (one month later) after feedback from Team 1 and 2 and identification of action items. Also Team 3 established contact with the manager of the unit.

The method used for comparison was to take the results of the first stage (comparing Team 1 and 2) and to consider the extent to which the observations of Team 3 were consistent with either Team 1, or with Team 2 or with both on the 4 level scale of agreement/disagreement outlined above. At this stage it might be helpful to refer again to the 3 accounts and in particular to Team 3 and to view the comparative exercise results set out in Appendix 3.

The following table sets out the levels of agreement between Team 3 and the two other teams, and produces a final global level of agreement using the levels of agreement from the above reports on Teams 1 + 2 above.

Table 6a

Comparison on Observations between team 1,2 + 3. (Obs. = 45)

	Agree	Related	Different	Disagree
Team 3 cf 1	1	0	0	1
Team 3 cf 2	1	3	0	0
Team 3 cf 1 and 2	4	3	2	0
Team 3 cf 1 or 2	6	6	2	1

Table 6b

Global score of teams 1, 2 and 3	22 (49%)	10	12	1
	71%		28%	

The table shows that almost half of all Team 3's observations were in agreement or related to both Team 1 and Team 2's material. When the looser criterion of either Team 1 or 2 is used the consistency increases to 12 of 15 observations.

The global score of consistency between teams is calculated on the criteria of agreement with either of the other two teams.

When Team 3 sources are compared with Teams 1 + 2 in respect of the 'star' Team 3 reported a significantly more positive view from users but from no greater number of observations from users.

Conversely Team 3 had few observations sourced to staff but reported a more negative material from that source. As already noted Team 3 had more material sourced to managers and it was 71% positive.

Team 3 had 22 sources for 15 observations and taking all three teams together they provided 67 sources for 45 observations.

The global measure of agreement shows that 49% of observations from the three teams showed agreement in content and that adding related issues this rises to 71%. Frank disagreement or conflict in content occurred in only one case but just under 28% of the material gathered in 45 observations was unique to the team that made the observation.

Standard Setting, Action Plans and Implications for Quality Review Teams Undertaking the Second Visits (2nd Pass) in the QA Cycle

Apart from giving an indication of the performance of our visiting pairs (Teams 1, 2

and 3) the content of their observations, and their consistency this audit has also shown the dynamics which QRTs will face in the next cycle of visits.

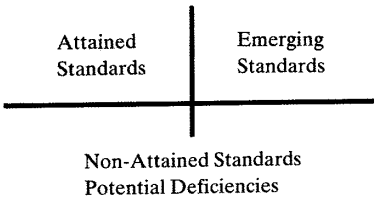
The factors which have emerged show that —

a) The Action Plans from the first visit became part of the second visit brief and are a required focus for observations. In other words 3 of the 15 observations at the second visit will have addressed the action plan items agreed at the first visit.

b) QRTs will also begin to formulate standards from the observational material. The 'Star' is a useful guide in developing standard statements — which can be collated on a functional basis (eg for Day Care, Residential) across the country. The method adopted here begins by considering the observational material plotted on the Q Star as follows —

Table 7

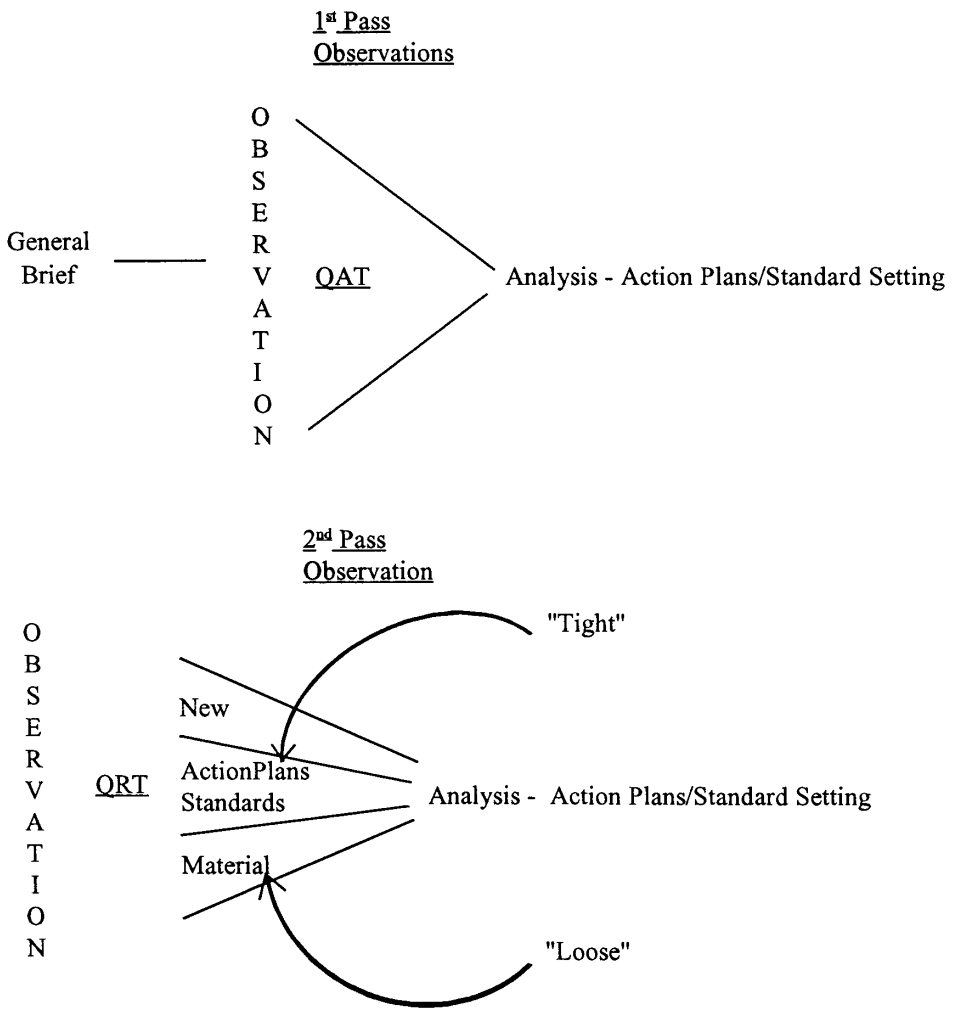
Observations Plotted on the Star Expressed as Standards



Both these processes (action planning in standard setting) if kept under close control will create a 'tight-loose' aspect to observation at the 2nd pass. Observations will be more focused ("tighter") on action plan items and on areas where standards have been formulated from the first set of observations. Observation will continue however to range throughout the service bringing in new material and opportunities for improvement, on a "looser" basis.

This can be expressed diagrammatically as follows —

Table 8



The material from team 3 in this case-study illustrates this feature. Team 3 observation 1/3/8 is derived from teams 1 + 2's observations and refers to 6 previous action plans.

The action plans from Team 3 are based on new material which was shown as "different" in this comparison of consistency eg 1/3/1 and 1/3/15 — which develop the referral system from the

local hospital, which had not featured in any depth in the team 1 + 2 observations.

This approach to the cyclical nature of change and quality enhancement strikes a balance between the need for validity and consistency in observation and the way in which focused observation can take place alongside a more open search for new service areas where change may be needed.

The fact that each team will have a level of unique material (team 1 + 2 differ in one of every three observations) means that the search for valid new material about a service which can be agreed with the agency at feedback is an achievable goal. The levels of consistency over time by (the same) or different observers will be influenced firstly by a learning factor through feedback, and by the dual focus, 'loose-tight' approach to observation which action plans and attained and emerging standards provide.

Standard Setting Using Plotted Observations

As noted above the 45 observations from 3 teams were plotted on the Star. A 3-way distinction between attained standards, emerging standards and deficiencies can be made (see Table 7 p.6). An exercise identifying these observations and expressing the material as standards was undertaken. Following this exercise the standards were rated using appropriate sections of the AIMHS Standards (3).

Attained Standards from Enquire Observations

The 16 observations in the quadrant were combined with the 4 emerging standards to form a group of 20 positive aspects of this service.

The service provides care to the following standards:

1: An open referral system and access through all appropriate professional groups. (1/2/6).

2: A pleasant physical environment of domestic size which is secure and safe and where night cover is rigorously monitored. (1/1/1, 1/3/2, 1/3/12, 1/3/8 & 9).

3: An active social skills programme with external links to classes; shopping, cooking, cleaning, laundry and crafts. (1/1/2, 1/1/12, 1/3/5).

4: Facility for special needs in a self-contained flat e.g. for mother and baby. (1/2/7).

5: A Keyworker System by agreement with residents, who work with staff on a partnership basis and whose wishes are respected. (1/1/14, 1/1/4, 1/2/15, 1/3/13).

6: Individual programmes and care plans, which are regularly reviewed. (1/3/4).

7: A weekly communal meeting and resident only meetings. (1/2/11).

8. An active outreach and support service which establishes and maintains clients independence in the community — possibly on a long-term basis (1/2/2, 1/1/3, 1/2/3, 1/3/7).

9: Negotiated retention of residents' place on re-admission to hospital (1/2/1).

The observations on which these standards are based are set out in Appendix 11).

The 25 observations recorded as negative allow the formulation of a required standard in respect of the subject recorded.

Non or Partially Attained Standards:

The service will seek to attain the following standards:

1: A clear and detailed prospectus of the hostel's services should be prepared and made available to referring agencies and prospective residents. (1/3/15, 1/3/1) A

2: Individual call plans should clearly state the agreed activities to be undertaken by both residents and staff. A shared method of recording completion and progress should be agreed. (1/2/13, 1/2/14, 1/1/6, 1/3/14) (A).

3: Physical facilities for the maximum participation by residents in programmes should be reviewed. (1/3/11).

4: A self-medication programme should be considered, with advice from prescribing medical practitioners, for appropriate residents. (1/1/10).

5: Entitlement to, and claiming of welfare benefits will become part of the budgeting training module, with the aim of maximising skill and income and lessening stigma by emphasising the right to benefit, the value of saving and the means for obtaining benefit. 1/2/5, 1/3/3(A).

6: Rising and bed times should be flexible and by individual resident choice within the agreed requirements of individual resident choice within the agreed requirements of individual plans. (1/2/8, 1/1/9, 1/2/9, 1/1/7) (A).

7: Access by residents to personal rooms should be flexible and guided by an agreed policy between staff and residents 1/2/12(A).

8: Policies on smoking, consumption of alcohol, use of transport, and private entertaining in rooms should be reviewed and a policy agreed 1/1/5, 1/1/11, 1/1/13, 1/2/10.

9: Staff deployment and significant changes in personnel should be discussed with residents. Night cover should be reviewed with a view to maintaining residents' security and lessening demands on staff. (1/2/4, 1/1/5, 1/3/10) (A).

A complete list of observations from which these non-partially attained standards are derived is set out in Appendix 10. It is significant that 7 of the 9 below standard activities were identified in Action Plans from the teams.

These attained and non (or partially attained standards) can be rated within the AIMHS system. The Enquire observational material is appropriate for use with AIMHS.

The Enquire derived standards for a single unit were rated against AIMHS sections C and D. C is ongoing management/rehabilitation; D is long-term follow-up. For the complete rating see Appendix 11. It should be noted that the AIMHS system is concerned with area services provided by a range of agencies. The full

application of the AIMHS system to Mid-Glamorgan can be taken forward by the Quality Review Teams as they also monitor the implementation of the action plans.

D. Long-Term Follow-up

On preparedness to follow-up, tracking systems care-management and confidentiality, of 22 standards —

12 were attained
10 were not applicable to this individual unit
2 were partially obtained

In this use of the Enquire observations some standards were regarded as attained since the Mid-Glam SSD/DHA has certain facilities which conform to the AIMHS requirements but which are not delivered by the single unit under consideration in this case-study. This case-study illustrates the way in which Enquire observations on individual units can be used to provide the material, when aggregated with other units, to enable the AIMHS standards check.

It should be noted for processing data from the 2nd pass in Mid-Glamorgan that the AIMHS Standards (A1 to E13, 29 categories and sub-items) can be included within the Enquire Software Package, and this is an option now available.

The Enquire derived standards from the 3 teams were rated against an illustrative section of the AIMHS System (Section C) under ongoing Management and Rehabilitation. Where information was not available the item is scored N/A (not applicable). The initial results of the rating was as follows:

Table 9

Standard — Teams 1, 2 + 3 Rating

	Total	Attained	Partially Attained	Attainment Initiated	Not Attained	NA
C1: Assessment and Review	28	13	11	1	0	3
C2: Case-Management	56	34	12	0	3	7
C3: Independent Living Skills Programme	50	23	11	4	3	9
	134	70	34	5	6	19

In this selected rating it is clear that the Enquire observations show the hostel to meet the AIMHS standards selected in more than 50% of cases. This rating can be compared with the overall 'star' plotting for the units using enquire which showed a composite score from the 3 teams as follows:

Table 10

$$\frac{6}{9} + \frac{6}{9} + \frac{8}{7} = \frac{20}{25}$$

Standard C:5 Residential Programmes	Attained	Attained Partially	Attainment Initiated	UN	NA
	20	8	0	2	7

This shows that the hostel provides just over 50% of its services to an attained standard.

Action Plans

The non-attained standards (negative observations) set out above show that 7 of them are addressed by the action items from one of the teams. This illustrates the systems ongoing ability to focus on new areas for action.

Each team completed 3 Action Plans and identified the methods for its implementation. If all Action Plans are implemented the hostels star score would improve from —

20 to 29, and of the 18 standards derived from the analysis of observations the hostel would meet 16. The action plans from each Team plotted on the matrix showing how they are to be implemented are set out in Appendix 12.

Conclusion

The material gathered on the hostel has its own intrinsic value and validity and is being taken forward in the context of the Quality Assurance Programme. The discussion here has been to consider the consistency of the observing teams in terms of the accounts which they gave of the unit. At this stage of the programme, after 3 days training at the first 'pass' of an ongoing QA cycle the material reported would appear to have an adequate level of consistency between teams at the first pass (Teams 1 + 2). The dynamics attending the 2nd pass observations of Team 3 have been examined. An adequate balance of consistency with Teams 1 + 2 and the development of new material has been described.

The observational material was adequate for a standards setting exercise to be completed and 18 standards were identified. The Action Plans covered most of the unattained standards and if implemented will show a measurable improvement in the quality of the service. Rated gainst the AIMHS Standards attainment levels were similar to Enquire plotted scores.

REFERENCES:

1: Richards H, Heginbotham C. 'The Enquire System', Kings Fund College, London, 1990.

2: Richards H, Heginbotham C. 'Design of Pilot Study on Reliability of Observations (unpublished 1991).

3: Rosen A, Miller V and Parker G. Standards of Care for Area Mental Health Services (Area Integrated Mental Health Service Standards — AIMHS), Dept. of Mental Health NSW. 1990.

The Quality Assurance project covered day service provision in the county including day centres, day hospitals, and occupational therapy. 165 observations were made.

Attained Standards

Almost one third (51) of one hundred and sixty-five observations fell into this category, of which at least ten observations suggested that good staff care and facilities are provided, along with a wide programme of activities, with the opportunity of user group elections and participation in staff meetings. The advantage of client self-referral was also expressed along with team expansion in other observations.

Five observations related to the advantages of a multi-disciplinary team approach, particularly using the same building. A reference by one team that the care of drug and alcohol dependency cases was problematic could perhaps be inferred by other teams.

There was an indication of the commitment towards OT programmes whilst staff from other units acknowledged that the change from dependency for consumers would need careful facilitation. Once again the advantages of drop-in facilities were recorded.

As for clients, themselves, eight observations reflected the benefits of diversionary activities particularly using resources in the community i.e. community centres, shops where no stigma could be attached. There were particular references to the reliance of volunteers for such facilities.

Emerging Standards

Eighteen per cent of the observations fell into the category, which acknowledged basic needs at unit level, such as budgets to be allocated to specific areas, more staffing both at administrative and caring level, together with an acknowledgement of the need for different facilities to cater for a younger age group of mentally ill people, as well as practical provision for users who suffer everyday transport problems.

At one unit clients felt particular distress because of erratic ambulance service and communal dining facilities shared by a group of users with long term problems. At other units, it was perceived that low staff levels caused difficulties in developing community work; indeed clients felt there was inconsistency in staff availability. The need for appropriately located Lithium Clinics was identified.

The users themselves related the inconsistencies in the waiting time for day centre places and the formulation of detailed individual programmes.

Deficiencies

Over half (51% of observations), fell into this category of which:

Thirteen observations recorded the lack of private facilities in units, together with the need for decoration and renovation; to quote one staff member "it reeks of an institution".

Eleven observations related to poor staffing levels, i.e. at one unit there were at least five vacant posts and at other units it was felt that such high caseloads kept preventative care to a

minimum, whilst acknowledging the need for weekend cover.

Ten observations from clients, suggested limited activities offered by units. One unit was geared more to women than men as there were no male staff, while other observations reflected the need for more social skills programmes.

Four observations from clients related to transport problems, particularly for those disabled.

Three observations from a community mental health team referred to the lack of input of any client or user group in major decisions.

Three observations focused on the role of development posts, together with the use of development budgets.

Particular mention should be made of one unit which had no assessments or plans for clients, whilst the need for more occupational therapy intervention has been a recurrent theme.

Action Plans

In the area of day service provision thirty-three action plans were negotiated, and included the following themes:

- All clients to have a case manager.
- Team building programmes for community mental health teams.
- Availability of staff for more community services.
- More user/client participation.

Measurement of Quality Improvement

When such plans are implemented it is likely to produce a significant change in day service provision as indicated in Tables A and b.

Table A **Quality Star for day services at present:**

	Descriptive		Prescriptive			
Postive	51	(31%)	30	(18%)	81	(49%)
Negative	64	(39%)	20	(12%)	84	(51%)
	115	(70%)	50	(30%)	165	

Table B Quality Star for day services when action plans are implemented:

	Descriptive		Prescriptive		
Postive	79	(48%)	23	(14%)	102
Negative	52	(31%)	12	(7%)	63
	130	(79%)	35	(21%)	165

Standard Setting

The following 13 standards were proposed for day services:—

1. There will be user group elections and participation by service users in staff meetings.

2. There will be an open referral system.

3. A multi-disciplinary teamwork approach will be encouraged and the advantages of staff working from the same team base will be acknowledged.

4. There will be a commitment to relevant OT programmes.

5. There will be a commitment to appropriate drop-in facilities.

6. The use of community resources by service users will continue to be encouraged by staff.

7. It is recognised that volunteers have a valuable contribution to make to the services and efforts will be maintained in recruitment, training and development.

8. Adequate and realistic budgets will be provided for projects together with appropriate levels of staffing.

9. Appropriate services will be provided for young mentally ill people with mental health problems.

10. Transport will be provided where appropriate for service users in order to ensure that they are able to attend day services.

11. Appropriate dining facilities will be provided so that clients of day care services do not have to share facilities with other client groups.

12. Specialist clinical resources will be provided where necessary, e.g. Lithium monitoring clinics.

13. The time between receipt of referral and initial contact with the client should be not more than five working days.

Observations sourced to users were obtained in three ways:

1. People currently using services (two hundred and eighty-six observations).

2. The report of the first Users Conference (held in November, 1990), ninety observations. The report was analysed using the ENQUIRE system to generate a series of 'observations' from the recorded material.

3. User led organisations (thirty observations).

This provided a total of 406 observations. Within this total, 191 observations were categorised as positive, 215 as negative.

One particularly interesting issue that emerges from this data is that users whilst they are in, or using the services, speak more favourably about the quality of the service they are receiving. When they are out of the service system, or no longer need to use it, their comments are far less favourable. In other words their views change with the benefit of hindsight. There are a number of possible reasons for this.

Much of the information elicited is in relation to how the services received impact on users lives or is about the quality of treatment and care being offered.

Attained Standards

Since the first Mid-Glamorgan Mental Health Service Users Conference, much has been achieved in developing user-led groups or forums in each of the six districts. Much of the information describes how important this is for users in terms of giving or receiving support to and from each other, developing skills in representation and committee work and many people seemed to appreciate some of the social aspects. It would seem that quite a number of professionals recognise the important contribution users can make to the development of services and a lot has been achieved to date in facilitating that process.

As services are gradually becoming localised people are finding that the number of options open to them is increasing and they clearly welcome this. The location of services is more appropriate to their needs, although there is much still to be done in this respect, the reduction in travelling time to and from service settings having obvious advantages.

Quite a few people have expressed an interest or eagerness in getting back to work at some point and there is evidence that suggests that the service system is attempting to address this particular issue.

Many users are clearly happy to be receiving 'a service' regardless of expressed quality issues. This would seem to indicate that services are, perhaps, becoming more comprehensive and are reaching a wide range of people, although this still has to be seen in a development context.

Many very positive statements were made about the quality of staff to client interaction. Users, particularly those who have used services for many years are able to contrast new or emerging positive attitudes with attitudes of a more negative kind held by staff in some of the more traditional service settings. Again this must be recognised in its developmental context. There are still inconsistencies when comparisons are made, but it is, nonetheless, a positive aspect that needs to be acknowledged and built on. Many of the people interviewed feel strongly that the service has helped them in

various ways and that they really do not know how they would cope without it.

Emerging Standards

There are a substantial number of observations and comment regarding medication. Whilst it would appear that there is recognition of some of the problems users are experiencing with regard to their prescribed drugs and the need for careful monitoring of side effects and withdrawal in some instances, it would seem that this is still an area that needs closer examination. How people get information about their treatment is still a very 'thorny' issue for many people and there is little, so far to suggest that information is forthcoming, either in written or verbal form. Recognition of a problem is one step in the right direction; what is needed (quite urgently if we are hearing what people are saying correctly) is positive action. One person interviewed has "been on Lithium therapy for 9 years with no monitoring of blood levels!" Drugs are often prescribed by general practitioners and psychiatrists without adequate monitoring, advice and dialogue between doctor and patient. Withdrawal from drugs is often not properly planned and supervised . . . "they brought me off Ativan too quickly".

In one district a 24 hour telephone helpline has now been set up. However, there seems to be a very poor level of information given out to users about this and how to assess this valuable service. Many users, it would seem, would like to see this facility available in all six districts.

Deficiencies

A total of 215 observations in this section relate to deficiencies within the services as perceived by the people who use them.

Six themes emerge which can be categorised as follows:

1. General Practitioners seem to have a poor understanding of mental health issues and so many users felt poorly supported, given very limited choices in treatments and/or therapies. It would seem that GPs (with a few exceptions) are quick to prescribe major and minor tranquillisers to people, giving very little, if any, information about what these drugs do or how they work, and offer little, if any information about side effects, long and short term. They seem reluctant to give much time to patients to listen to their problems. All of the above, it would seem applies equally to consultant psychiatrists (with one or two exceptions). (Fifteen Observations).

2. Many people felt they had received poor to inadequate support when their mental health problems had been compounded by bereavement. (Nine Observations).

3. Chemotherapy of one sort or another seems to be the main course of treatment and many people interviewed feel this is very limited and has major consequences in relation to their overall quality of life and general well being.

   The amount and mixture of drugs that some people were prescribed was quite considerable and this is an area that needs urgent reviews. Users also expressed concern that these drugs were not reviewed regularly. (Seventeen Observations).

4. Whilst there has been progress made in some districts, in the delivery of local services (albeit limited) much still has to be achieved that will avoid people having to make long and expensive journeys to and from services.

5. "Long working hours and little to occupy time, staff often too busy to give time to patients."

   Many people expressed concern about how little there was to occupy them or assist them in the rehabilitative process. Activity that was available, it was felt, was often biased towards women. This issue related to both hospital in-patient facilities and Day Services visited. (Eight Observations).

6. People are not getting information in written from, there being little in the way of printed information packs or brochures for staff to give to clients. Staff were often reluctant to talk to clients about the service they were being offered or the treatment they were being prescribed. (Fifteen Observations)

   Note: Action Plans are not contained within this section as most observations relate to the individual needs of users, and are subject to clinical and social work assessment and treatment.

Standard Setting

The quality assurance team set the following standards. Standards 1-8 are regarded as capable of immediate provision, 9-14 are target standards.

1. The service will continue to encourage and support the active participation of users in all areas of planning and development.

2. The service will promote the development of user-led self help groups in each of the six districts.

3. Services will continue to be developed locally, thus avoiding long, costly and time wasting travel arrangements.

4. Services will seek to offer a wide range of options to its clientele thus maximising choice.

5. The development of employment related projects and services will continue to have a high priority within the mental health service system.

6. Services will ensure that all staff are conversant with and committed to the agreed aims and philosophy of the service as it develops.

7. Staff will adopt a positive and respectful attitude towards clients and what can be achieved for people experiencing psychosocial distress regardless of the individuals level of incapacity.

8. The service will offer a continuum of support to clients, the level of which will be determined by the client.

9. The service will ensure that user groups will receive copies of important policy and planning documentation as part of the consultation process, e.g. Welsh Office Mental Illness Strategy, Local and Central Joint Plans, etc.

10. The service will ensure that clients have all necessary information pertaining to their treatment and support.

11. User and carers will be given all necessary information and advice regarding prescribed medication and possible subsequent side effects and long term implications of accepting these treatments.

12. Professionals involved in the prescription and administering of medications will ensure that regular and effective monitoring mechanisms are in place for all clients.

13. A 24-hour telephone 'Help-line' service will be set up in each district that is adequately staffed.

14. Information about this 'Help-Line' will be distributed to all users of the service and advertised in suitable public areas, e.g. General Practitioners Waiting Rooms, Public Libraries, etc.

Common Themes and Future Standards

section 6

From the observations contained in the preceding Chapters it is possible to identify common themes. From these, desirable future service standards have been identified by the Quality Assurance Team.

1. **Theme**
   Across the services noted there was a lack of consistency in the planning and delivery of services, resulting int he individual needs of users not being met.

   Service Standard
   The services will be responsive and relevant to the individual needs of users.

2. **Theme**
   There was a lack of information available to clients regarding the range of services available.

   Service Standard
   The services will develop good information facilities in the form of brochures and fact sheets that are easily available to service users.

3. **Theme**
   Currently there is inadequate input into the formal planning mechanisms by users.

   Service Standard
   Planning mechanisms will include and involve users of the service.

4. **Theme**
   Many services are not monitored for quality and effectiveness on a regular basis, leading to service inertia.

   Service Standard
   The service will be committed to the establishment of mechanisms that will enable regular monitoring of change, review and standard setting.

5. **Theme**
   There were many examples illustrating a lack of respect for the individual dignity and right of service users.

   Service Standard
   The service will ensure that the dignity of the individual and their rights will be respected at all times.

6. **Theme**
   The observations indicated that many users were in need of individual and independent representation with regard to obtaining the best possible service.

   Service Standard
   The service will be committed to the development of all forms of advocacy e.g. self advocacy, citizen advocacy.

7. **Theme**
   There were many examples of services that were not readily available and accessible.

   Service Standard
   Services will provide facilities that are accessible and available to service users when most needed e.g. crisis services, weekend and evening support work.

8. **Theme**
   The quality of environment was on occasion of a very poor standard both structurally and decoratively.

   Service Standard
   The service will ensure that environmental standards will be of the highest quality.

Conclusions and Recommendations

section 7

This report illustrates some of the positive and negative features of mental health services in Mid Glamorgan. Within the Reference Papers and the Executive Summary there now exists a wealth of rich material that will assist in evaluating and planning services.

The Central Joint Planning Team (Mental Illness) is committed to developing quality assurance methods such as this, which have direct positive influences upon service delivery. The strategic planning and development of mental health services in the county must encompass a vision of quality facilities and services which are relevant to the individual needs of people with mental health problems. If this vision is to be achieved the setting of measurable service standards must be a priority, as must be ways of 'testing' the quality.

The work of the Quality Assurance Team, and Quality Review Teams now needs to be able to move into a second phase of its work. To be able to revisit the services, visit new services, test out action plans and examine and set service standards. This work to be in partnership with managers and service users.

This requires the continued commitment of resources to the project.

Appendix 1:

3 Accounts of the Hostel
The Visit Reports

Team 1

1. Very pleasant physical environment. Well situated, well furnished and equipped, well maintained, spacious, creating a warm friendly atmosphere. T/O/U/Po/D/.

2. Active social skills programmes maintained and appreciate to activities of everyday living, e.g. Residents were responsible for own cooking, cleaning and laundry. CS/P/U/Po/D/.

3. Good follow up support to ex-residents. Outreach worker and hostel staff continue to support ex residents. CS/P/TC/Po/D/.

4. Good staff/resident interaction was observed. Staff showed genuine respect for residents. T/P/TC/Po/D.

5. House rule:— "No drinking on premises except Xmas, New Year with Officer in Charge's permission" — "If you can go out to the pub for 2 pints, why can't you bring a can back to the Hostel?" (Resident) A CSM/St/PU/N/Pr/.

6. House Rule:— "Programmes must be followed" — "you can't do things at your own pace. Things have to be done when the staff want" (Resident). CSM/P/U/N/D.

7. House Rule:— "To ensure that residents are in bed by 11.30pm" — Residents unable to use communal areas after 11.30 pm e.g. watch TV or chat to each other. CSM/P/PU/N/D/.

8. "It's like a hotel here", (Resident). No resident expressed motivation to leave. CS/P/PU/N/D/.

9. Residents not responsible for getting themselves up in the morning. Alarm clock not evident. They (staff) knock on the door and call our names." CS/P/TC/N/D/.

10. Residents not able to take responsibility for self administering medication, as all drugs locked away and administered by staff. CS/P/TC/N/D/.

11. No privacy to entertain friend of opposite sex in resident's own room. Visitors confined to forum (main lounge). A CS/P/U/N/D/.

12. As part of programme on budgeting skills some clients' money is handed out daily by staff. CS/P/TC/Po/D.

13. Although bicycles are provided at the unit, residents are nto allowed to ride them outside the hostel grounds without a proficiency test certificate. CS/P/PU/N/D/.

14. Staff work in teams using a keyworker system and residents can choose their keywork. CS/P/TC/Po/D/.

15. Only one member of staff sleeping in at night. Implications expressed include: Fire and safety, locking building at night, hospital admissions more likely. A S/P/U/N/D/.

Quality Matrix

	Structure	Process	Outcome
Cy			
U		2, 6, 11, 15	1
TC		3, 4, 9, 10, 12, 14	
SC			
PU	5	7, 8, 13	
AO			
CE			

Cy Community
Tc Treatment / Care
PU Project / Unit
U Users Life
SC Services / Case Management
AO Agency / Organisation

Quality Star

	Descriptive	Prescriptive
Positive	1, 2, 3, 4, 12, 14	
Negative	6, 7, 8, 9, 10, 11, 13, 15	5

Team 2

1. The decision whether to retain a bed for a resident who has been hospitalised is made after a multi-disciplinary consultation. We discuss it with the Social Worker and the Consultant in charge of the Residents Treatment.
S/P/SC/Po/Pr/.

2. An outreach facility operates to maintain contact between ex-residents and the hostel staff. Some ex-residents return daily for various reasons, e.g. budgeting, social visits. This allows staff to monitor progress. Staff sometimes visit them at home.
S/P/U/N/Pr/.

3. One ex-resident living locally is independent has full time employment, has no contact with the hostel, "He's doing fine".
S/O/U/Pd/D/.

4. Night cover consists of one sleeping staff member — this causes a great deal of anxiety amongst staff in terms of security of patients, their own security and the building. "A resident could let anyone in and we wouldn't know." A
S/St/AO/N/D.

5. The residents are encouraged to save, however, the process users to ensure their compliance exerts strong pressure on them to conform, e.g. ex-residents are invited back to talk to reluctant residents as regards the remits and demerits of saving.
S/P/TC/N/D/.

6. There is an open referral system and prospective residents may refer themselves, however, most referrals from professionals such as CPNs, GPs, Consultant Psychiatrists and Social Workers.
S/St/PU/Po/D/.

7. There is a self contained house attached to the hostel users for residents with special needs and as a half way facility towards independence. For instance currently being used for two residents one of whom has 2 dogs, also been used for a mother and baby.
S/St/TC/Po/D.

8. Residents are expected to arise at 8.30am during the week, later on the weekend, the 8.30 am rising is dictated by works tasks rota having to be completed by 10am. Some residents felt that they should have the option of rising later.
C/P/U/N/Pr/.

9. Residents must be in their rooms by 11.30pm but are allowed to watch TV there late if they have one. One resident stated that she would prefer to remain in the lounge longer if she wishes. A.
C/St/PU/N/Pr/.

10. There appear to very few rules and instructions, noteworthy however is the fact that residents have got to be in their rooms by 11.30pm since no smoking is allowed in individual rooms, this ensures that no resident smokes after 11.30pm.
C/St/PU/N/Pr/.

11. There is a weekly communal meeting which is open to all residents of individual units. Residents felt that these meetings were useful and effective in achieving some results.
C/St/PU/Po/D/.

12. One resident stated that they were not allowed onto their beds once they got up at 8.30am. If they persisted the doors to their rooms were locked denying spontaneous access.
C/St/PU/N/Pr/.

13. Residents are sometimes expected to attend the Local Day Centre [redacted], one resident was not sure why she was attending and felt she had no choice in the matter. "The staff decided." A.
C/O/U/N/Pr/.

14. A sports group exists which some residents are expected to attend, one resident felt that she had no choice but to attend. "They like you to do something by day — I think." A.
C/St/PU/N/Pr/.

Quality Matrix

	Structure	Process	Outcome
Cy			
U	12	1	5
TC		13	
SC	6, 7	4, 10, 14	
PU		2, 8	9
AO	11	3, 15	
CE			

Cy Community
Tc Treatment / Care
PU Project / Unit
U Users Life
SC Services / Case Management
AO Agency / Organisation

Quality Star

	Descriptive	Prescriptive
Positive	2, 4, 5, 8, 9, 13	7, 12
Negative	10, 14	1, 3, 6, 11, 15

15. Generally the residents were happy with Hostel Service provision and there was an easy relationship between staff and residents, and amongst staff. C/St/SC/Po/Pr/.

Team 3

1. Staff and residents feel that some people transferred there, especially from [redacted] Hospital, undergo traumatic experience and culture shock on arrival — they seem unprepared to assume responsibilities expected of them at [redacted]. A SCM/P/U/N/Pr/.

2. Security paramount at Hostel, to prevent theft/loss of personal effects and abuse of Hostel facilities. It is the only Local Authority Establishment in Merthyr not burgled to date. M/P/PU/Po/D/.

3. Staff totally disillusioned with system re: claiming benefits for young people, when trying to resettle into community. Clients have to be 'stamped' mentally ill to maximise these — many resent this and refuse to apply. A. S/P/AO/N/Pr/.

4. Meetings regularly held between staff/residents to discuss their individual programme progress, feelings, suggestions and complaints. Clients never coerced into co-operation, reasons for non-compliance explored and ways found to stimulate their interest. CSM/P/SC/Po/D/.

5. Links have been established with local College craft class — helping to stimulate residents' interest in making items for their eventual homes. A resident has agreed to participate in supporting Craft Leader in teaching people with learning difficulties. CM/O/U/Po/D/.

6. dRecent staff changes within Hostel units made residents unhappy. They felt they were not consulted in any manner. Residents at satellite houses resent changing of Outreach Project Keyworker every 3 months, but appreciate need of staff to share experience. CM/St/SC/N/Pr/.

7. Clients would like permanent Outreach Keyworker appointed as soon as possible, thus maintaining continuity of care. A worker from Hostel could be allocated to Project on 3 monthly basis to gain training experience and support Keyworker. C/St/SC/Po/Pr/.

8. All six action plans identified from previous visits have been submitted as projects to appropriate management levels. Some have been resolved, others awaiting decisions. M/P/PU/Po/D/.

9. Officer in Charge now monitoring need for extra night staff (sleeping in or waking duty). This done in accordance following request for AP by Residents/ Staff in previous visit. OIC supports this has already made arrangements to provide extra cover. CM/O/PU/Po/D/.

10. Residents feel it unfair to expect staff to be disturbed during the night, then to work as usual next morning. Staff would be too tired to perform duties correctly — may make inappropriate decisions or be unintentionally rude. C/P/SC/N/D/.

11. Staff felt that size and structure of building affected appropriate implementation of individual care programmes, because no more than 4 residents are able to use some Hostel facilities at one time. S/St/AO/N/Pr/.

12. Residents felt that size and structure of building met all their needs. "If it were any larger, then it would feel like a ward. We often sit in the lounge chatting and watching TV in the evenings and it feels very cosy." C/St/U/Po/Pr/.

13. Staff and Residents were observed to interact on a 'partnership' basis throughout the unit. "Staff are available to help us when we are not feeling well and assist us in carrying out our daily programmes", e.g. shopping, cooking, budgeting and laundry etc. C/P/TC/Po/D/.

14. Some residents state: Although management run Hostel on trust, staff continually check whether allocated tasks performed. "I don't feel they believe what I say." Others state that some Residents often claim to have completed tasks when they had not. C/P/SC/N/D/.

15. Staff felt that the referral system was inadequate and that certain residents were being inappropriately placed at the Hostel — where they abused both staff and services offered. A more descriptive and appropriate referral system should be implemented as soon as possible. A. S/P/AO/N/Pr/.

Quality Matrix

	Structure	Process	Outcome
Cy			
U		2, 8,	3, 13
TC	7	5	
SC	15	1	
PU	6, 9, 10, 11, 12, 14		
AO	4		
CE			

Cy Community
Tc Treatment / Care
PU Project / Unit
U Users Life
SC Services / Case Management
AO Agency / Organisation

Quality Star

	Descriptive	Prescriptive
Positive	3, 6, 7, 11	1, 15
Negative	4, 5	2, 8, 9, 10, 12, 13, 14

Appendix 2:

[FIRST PASS]
COMPARISON OF TEAM 1/1 and TEAM 1/2 OBSERVATIONS: THOMASTOWN HOUSE: MERTHYR

Team/Code	Theme	Observation (A=Action Plan)	Agree	Related	Different	Disagree
	REFERRAL/OUTREACH/PLACEMENT/KEYWORKER/LIAISON					
1 /2 /2		An outreach facility operates to maintain contact between ex-residents and the hostel staff. Some ex-residents return daily for various reasons, e.g. budgeting, social visits. This allows staff to monitor progress. Staff sometimes visit them at home. S/P/U/N/Pr/.	✓			
1 /1 /3		Good follow up support to ex-residents. Outreach worker and hostel staff continue to support ex-residents. CS/P/TC/Po/D/.	✓			
1 /1 /14		Staff work in teams using a keyworker system and residents can choose their keyworker. CS/P/TC/Po/D.			✓	
1 /2 /3		One ex-resident living locally is independent has full-time employment, has no contact with the hostel, "He's doing fine". S/O/U/Po/D.		✓		
1 /2 /1		The decision whether to retain a bed for a resident who has been hospitalised is made after a multi-disciplinary consultation. We discuss it with the Social Worker and the Consultant in charge of the Residents Treatment. S/P/SC/Po/Pr/.			✓	
1 /2 /6		There is an open referral system and prospective residents may refer themselves, however, most referrals come from professionals such as CPNs, GPs, Consultant Psychiatrists and Social Workers. S/St/PU/Po/D.			✓	

Team/Code	Theme	Observation (A=Action Plan)	Agree	Related	Different	Disagree
	DAILY ROUTINE PRIVACY AND USE OF ROOMS					
1 /2 /8		Residents are expected to arise at 8.30 a.m. during the week, later on the weekend the 8.30 am rising is dictated by works tasks rota having to be completed by 10 a.m. Some residents felt that they should have the option of rising later. C/P/U/N/Pr/.	✓			
1 /1 /9		Resident not responsible for setting themselves up in the morning. Alarm clock not evident. "They (staff) knock on the door and call our names". CS/P/TC/N/D/.	✓			
1 /2 /12		One resident stated that they were not allowed onto their beds once they got up at 8.30 a.m. If they persisted the doors to their rooms were locked denying spontaneous access. C/St/PU/N/Pr/.	✓			
1 /2 /9		Residents must be in their rooms by 11.20 p.m. but are allowed to watch T.V. there late if they have one. One resident stated that she would prefer to remain in lounge longer if she wishes. A C/St/PU/N/Pr/.	A ✓			
1 /1 /7		House Rule:- "To ensure that residents are in bed by 11.30 p.m." - Residents unable to use communal areas after 11.30 p.m. e.g. watch T.V. or chat to each other. CSM/P/PU/N/D/.	✓			
1 /2 /10		There appear to be very few rules and instructions, noteworthy however is the fact that residents have got to be in their rooms by 11.30 p.m. since no smoking is allowed in individual rooms, this ensures that no resident smokes after 11.30 p.m. C/St/PU/N/Pr/.	✓			
1 /1 /5		House rule:- "No drinking on premises except Xmas, New Year with Officer in Charges permission" - "If you can go out to the pub for 2 pints, why can't you bring a can back to the Hostel"? (Resident). A CSM/St/PU/N/Pr/.			✓A	
1 /1 /11		No privacy to entertain friend of opposite sex in resident's own room. Visitors confined to forum (main lounge). A CS/P/U/N/D/.		✓		

Team/Code	Theme	Observation (A=Action Plan)	Agree	Related	Different	Disagree
	NIGHT COVER					
1 /2 /4		Night cover consists of one sleeping staff member - this causes a great deal of anxiety amongst staff in terms of security of patients, their own security and the building. "A resident could let anyone in and we wouldn't know". A S/Su/AO/N/D/.	✓A			
1 /1 /15		Only one member of staff sleeping in at night. Implications expressed include: Fire and safety, locking building at night, hospital admissions more likely. A S/P/U/N/D/.	✓A			
	FUND MANAGEMENT					
1 /2 /5		The residents are encouraged to save, however, the process users to ensure their compliance exerts strong pressure on them to conform, e.g. ex-residents are invited back to talk to reluctant residents as regards the remits and demerits of saving. S/P/TC/N/D/.		✓		
1 /1 /12		As part of programme on budgeting skills some clients money is handed out daily by staff. CS/P/TC/Po/D/.		✓		
	(PHYSCIAL) ENVIRONMENT					
1 /2 /7		There is a self contained house attached to the hostel users for residents with special needs and as a half way facility towards independence. For instance currently being used for two residents one of whom has 2 dogs, also been used for a mother and baby. S/Su/TC/Po/D/.	✓			
1 /1 /1		Very pleasant physical environment. Well situated, well furnished and equipped, well maintained, spacious, creating a warm friendly atmosphere. T/O/U/Po/D/.			✓	
1 /1 /8		"It's like a hotel here", (Resident). No resident expressed motivation to leave. CS/P/PU/N/D/.			✓	

Team/Code	Theme	Observation (A=Action Plan)	Agree	Related	Different	Disagree
	CARE PROGRAMMES					
1 /2 /13		Residents are sometimes expected to attend the Local Day Centre [redacted] one resident was not sure whey she was attending and felt she had no choice in the matter. "The staff decided". A C/O/U/N/Pr/.	A			
1 /1 /6		House Rule:- "Programmes must be followed" - "you can't do things at your own pace. Things have to be done when the staff want". (Resident) CSM/P/U/N/D/.	✓			
1 /2 /14		A sports group exists which some residents are expected to attend, one resident felt that she had no choice but to attend. "They like you to do something by day - I think". A C/Su/PU/N/Pr/.	✓			
1 /1 /10		Resident not able to take responsibility for self administering medication, as all drugs locked away and administered by staff. CS/P/TC/N/D/.	✓A		✓	
1 /1 /2		Active social skills programme maintained and appreciate to activities of every day living, e.g. residents were responsible for own cooking, cleaning and laundry. CS/P/U/Po/D/.			✓	
1 /2 /11		There is a weekly communal meeting which is open to all residents and a weekly meeting limited to residents of individual units. Residents felt that these meetings were useful and effective in achieving some results. C/Su/PU/Po/D/.			✓	

Team/Code	Theme	Observation (A=Action Plan)	Agree	Related	Different	Disagree
	GENERAL ATMOSPHERE					
1 /2 /15		Generally the residents were happy with Hostel Service provision and there was an easy relationship between staff and residents, and amongst staff. C/St/SC/Po/Pr/.	✓			
1 /1 /4		Good staff/resident interaction was observed. Staff showed genuine respect for residents. T/P/TC/Po/D/.	✓			
	MOBILITY					
1 /1 /13		Although bicycles are provided at the unit, residents are not allowed to ride them outside the hostel grounds without a proficiency test certificate.			✓	
		TOTALS	16	4	10	0

Appendix 3

[SECOND PASS]
COMPARISON OF TEAM 1/1, 1/2 (1st PASS) AND 1/3 (2nd PASS) OBSERVATIONS: THOMASTOWN HOSTEL: MERTHYR

Team/Code	Theme Observation (A=Action Plan)	Agree			Related			Different			Disagree		
	REFERRAL/OUTREACH/PLACEMENTS/KEYWORKER/LIAISON	1	2	1+2	1	2	1+2	1	2	1+2	1	2	1+2
1 /2 /2	An outreach facility operates to maintain contact between ex-residents and the hostel staff. Some ex-residents return daily for various reasons, e.g. budgeting, social visits. This allows staff to monitor progress. Staff sometimes visit them at home. S/P/U/N/Pr/.												
1 /3 /7	Clients would like permanent Outreach Keyworker appointed as soon as possible, thus maintaining continuity of care. A worker from Hostel could be allocated to Project on 3 monthly basis to gain training experience and support Keyworker. C/St/SC/Po/Pr/.						✓						
1 /1 /3	Good follow up support to ex-residents. Outreach worker and hostel staff continue to support ex-residents. CS/P/TC/Po/D/.												
1 /1 /14	Staff work in teams using a keyworker system and residents can choose their keyworker. CS/P/TC/Po/D.												
1 /2 /3	One ex-resident living locally is independent has full-time employment, has no contact with the hostel, "He's doing fine". S/O/U/Po/D.												
1 /2 /1	The decision whether to retain a bed for a resident who has been hospitalised is made after a multi-disciplinary consultation. We discuss it with the Social Worker and the Consultant in charge of the Residents Treatment. S/P/SC/Po/Pr/.												
1 /2 /6	There is an open referral system and prospective residents may refer themselves, however, most referrals come from professionals such as CPNs, GPs, Consultant Psychiatrists and Social Workers. S/St/PU/Po/D.												
1 /3 /1	Staff and residents feel that some people transferred there, especially from St Tydfils Hospital, undergo traumatic experience and culture shock on arrival - they seem unprepared to assum responsibilities expected of them at [redacted]. A CSM/P/U/N/Pr.									✓			
1 /3 /15	Staff felt that the referral system was inadequate and that certain residents were being inappropriately placed at the Hostel - where they abused both staff and services offered. A more descriptive and appropriate referral system should be implemented as soon as possible. A									✓			

Team/Code	Theme Observation (A=Action Plan)	Agree			Related			Different			Disagree		
		1	2	1+2	1	2	1+2	1	2	1+2	1	2	1+2
1 /2 /8	Residents are expected to arise at 8.30 a.m. during the week, later on the weekend the 8.30 am rising is dictated by works tasks rota having to be completed by 10 a.m. Some residents felt that they should have the option of rising later. C/P/U/N/Pr/.												
1 /1 /9	Resident not responsible for setting themselves up in the morning. Alarm clock not evident. "They (staff) knock on the door and call our names". CS/P/TC/N/D/.												
1 /2 /12	One resident stated that they were not allowed onto their beds once they got up at 8.30 a.m. If they persisted the doors to their rooms were locked denying spontaneous access. C/St/PU/N/Pr/.												
1 /2 /9	Residents must be in their rooms by 11.20 p.m. but are allowed to watch T.V. there late if they have one. One resident stated that she would prefer to remain in lounge longer if she wishes. A C/St/PU/N/Pr/.												
1 /1 /7	House Rule:- "To ensure that residents are in bed by 11.30 p.m." - Residents unable to use communal areas after 11.30 p.m. e.g. watch T.V. or chat to each other. CSM/P/PU/N/D/.												
1 /2 /10	There appear to be very few rules and instructions, noteworthy however is the fact that residents have got to be in their rooms by 11.30 p.m. since no smoking is allowed in individual rooms, this ensures that no resident smokes after 11.30 p.m. C/St/PU/N/Pr/.												
1 /1 /5	House rule:- "No drinking on premises except Xmas, New Year with Officer in Charges permission" - "If you can go out to the pub for 2 pints, why can't you bring a can back to the Hostel"? (Resident). A CSM/St/PU/N/Pr/.												
1 /1 /11	No privacy to entertain friend of opposite sex in resident's own room. Visitors confined to forum (main lounge). A CS/P/U/N/D/.												

Team/Code	Theme	Observation (A=Action Plan)	Agree			Related			Different			Disagree		
			1	2	1+2	1	2	1+2	1	2	1+2	1	2	1+2
		FUND MANAGEMENT												
1 /2 /5		The residents are encouragers to save, however the process users to ensure their compliance exerts strong pressure on them to conform, e.g. ex-residents are invited back to talk to reluctant residents as regards the remits and demerits of saving. S/P/TC/N/D/.												
1 /1 /12		As part of programme on budgeting skills some clients money is handed out daily by staff. CS/P/TC/Po/D/.												
	1 /3 /3	Staff totally disillusioned with system re: claiming benefits for young people, when trying to resettle into community. Clients have to be 'stamped' mentally ill to maximise these - many resent this and refuse to apply.A S/P/AO/N/Pr/.						✓						
		(PHYSICAL) ENVIRONMENT												
1 /2 /7		There is a self contained house attached to the hostel users for residents with special needs and is a half way facility towards independence. For instance, currently being used for two residents one of whom has 2 dogs, also been used for a mother and baby. S/St/TC/Po/D/.												
	1 /3 /6	Recent staff changes within Hostel units made residents unhappy. They felt they were not consulted in any manner. Residents at satellite houses resent changing of Outreach Project Keyworker every 3 months, but appreciate need of staff to share experience. CM/St/SC/N/Pr/.					✓							
1 /1 /1		Very pleasant physical environment. Well situated, well furnished and equipped, well maintained, spacious, creating a warm friendly atmosphere. T/O/U/Po/D/.												
	1 /3 /12	Residents felt that size and structure of building met all their needs. "If it were any larger, then it would feel like a ward. We often sit in the lounge chatting and watching T.V. in the evening and it feels very cosy." C/St/U/Po/Pr/.	✓											
	1 /3 /11	Staff felt that size and structure of building affected appropriate implementation of individual care programmes, because no more than 4 residents are able to use some Hostel facilities at one time. S/St/AO/N/Pr/.										✓		
1 /1 /8		"It's like a hotel here". (Resident). No resident expressed motivation to leave.												

Team/Code	Theme	Observation (A=Action Plan)	Agree			Related			Different			Disagree		
			1	2	1+2	1	2	1+2	1	2	1+2	1	2	1+2
		NIGHT COVER												
1 /2 /4		Night cover consists of one sleeping staff member - this causes a great deal of anxiety amongst staff in terms of security of patients, their own security and the building. "A resident could let anyone in and we wouldn't know". A S/St/AO/N/D/.												
	1 /3 /2	Security paramount at Hostel, to prevent theft/loss of personal effects and abuse of Hostel facilities. It is the only Local Authority Establishment in Merthyr not burgled to date. M/P/PU/Po/D/.			✓									
	1 /3 /9	Officer in Charge now monitoring need for extra night staff (sleeping in or waking duty). This done in accordance following request for AP by Residents/Staff in previous visit. OIC supports this has already made arrangements to provide extra cover. CM/O/PU/Po/D/.			✓									
1 /1 /15		Only one member of staff sleeping in at night. Implications expressed include: Fire and safety, locking building at night, hospital admissions more likely. A S/P/U/N/D/.												
	1 /3 /8	All six action plans identified from previous visits have been submitted as projects to appropriate management levels. Some have been resolved, others awaiting decisions. M/P/PU/Po/D/.			✓									
	1 /3 /10	Residents feel it unfair to expect staff to be disturbed during night, then to work as usual next morning. Staff would be too tired to perform duties correctly - may make inappropriate decisions or be unintentionally rude. C/P/SC/N/D/.					✓							

Team/Code	Theme	Observation (A=Action Plan)	Agree			Related			Different			Disagree		
			1	2	1+2	1	2	1+2	1	2	1+2	1	2	1+2
		CARE PROGRAMMES												
1 /2 /13		Residents are sometimes expected to attend the Local Day Centre [redacted], one resident was not sure whey she was attending and felt she had no choice in the matter. "The staff decided". A C/O/U/N/Pr/.												
	1 /3 /5	Links have been established with local College craft class helping to stimulate residents' interest in making items for their eventual homes. A resident has agreed to participate in supporting Craft Leader in teaching people with learning difficulties. CM/O/U.Po/D/.					✓							
1 /1 /6		House Rule:- "Programmes must be followed" - "you can't do things at your own pace. Things have to be done when the staff want". (Resident) CSM/P/U/N/D/.												
1 /2 /14		A sports group exists which some residents are expected to attend, one resident felt that she had no choice but to attend. "They like you to do something by day - I think". A C/St/PU/N/Pr/.												
	1 /3 /14	Some residents state: although management run Hostel on trust, staff continually check whether allocated tasks performed. "I don't feel they believe what I say". Others state that some Residents often claim to have completed tasks when they had not. C/P/SC/N/D/.						✓						

Team/Code	Theme	Observation (A=Action Plan)	Agree			Related			Different			Disagree		
			1	2	1+2	1	2	1+2	1	2	1+2	1	2	1+2
		CARE PROGRAMMES (continued)												
1 /1 /10		Resident not able to take responsibility for self administering medication, as all drugs locked away and administered by staff. CS/P/TC/N/D/.												
1 /1 /2		Active social skills programmes maintained and appreciate to activities of every day living, e.g. Residents were responsible for own cooking, cleaning and laundry. CS/P/U/Po/D/.												
1 /2 /11		There is a weekly communal meeting which is open to all residents and a weekly meeting limited to residents of individual units. Residents felt that these meetings were useful and effective in achieving some results. C/St/PU/Po/D/.												
	1 /3 /4	Meetings regularly held between staff/residents to discuss their individual programme progress, feelings, suggestions and complaints. Clients never coerced into co-operation, reasons for non-compliance explored and ways found to stimulate their interest. CSM/P/SC/Po/D.		✓										

Team/Code	Theme	Observation (A=Action Plan)	Agree			Related			Different			Disagree		
			1	2	1+2	1	2	1+2	1	2	1+2	1	2	1+2
		GENERAL ATMOSPHERE												
1 /1 /4		Good staff/resident interaction ws observed. Staff showed genuine respect for residents. T/P/TC/Po/D/.												
1 /2 /15		Generally the residents were happy with Hostel Service provision and there was an easy relationship between staff and residents, and amongst staff.												
1 /3 /13		Staff and Residents were observed to interact on a `partnership' basis throughout the unit. "Staff are available to help us when we are not feeling well and assist us in carrying out our daily programmes". e.g. Shopping, cooking, budgeting and laundry etc. C/P/TC/Po/D/.			✓									
		MOBILITY												
1 /1 /13		Although bicycles are provided at the unit, residents are not allowed to ride them outside the hostel grounds without a proficiency test certificate. CS/P/PU/N/D/.												

Appendix 4:

Sources of Observations for all Teams and by 'Star' Evaluation

Source	Count
Staff	13 (43%)
Customer	12 (40%)
Management	3 (10%)
Team	2 (7%)

Total = 30

Source	Count
Staff	8 (53%)
Customer	7 (47%)
Management	0 (0%)
Team	0 (0%)

Total = 15

Source	Count
Staff	10 (45%)
Customer	7 (32%)
Management	5 (23%)
Team	0 (0%)

Total = 22

Appendix 5:

Sources of Observations for all Teams and by 'Star' Evaluation
Source: Users

TEAM 1/1. Observations sourced to users

	Descriptive	Prescriptive	
Positive	4 (33%)	0 (0%)	4 (33%)
Negative	7 (58%)	1 (8%)	8 (67%)
	11 (92%)	1 (8%)	12

TEAM 1/2. Observations sourced to users

	Descriptive	Prescriptive	
Positive	1 (13%)	1 (13%)	2 (25%)
Negative	0 (0%)	6 (75%)	6 (75%)
	1 (13%)	7 (88%)	8

TEAM 1/3. Observations sourced to users

	Descriptive	Prescriptive	
Positive	4 (40%)	2 (20%)	6 (60%)
Negative	2 (20%)	2 (20%)	4 (40%)
	6 (60%)	4 (40%)	10

Appendix 6:

Sources of Observations for all Teams and by 'Star' Evaluation
Source: Staff

TEAM 1/1. Observations sourced to staff

	Descriptive	Prescriptive	
Positive	4 (31%)	0 (0%)	4 (31%)
Negative	8 (62%)	1 (8%)	9 (69%)
	12 (92%)	1 (8%)	13

TEAM 1/2. Observations sourced to staff

	Descriptive	Prescriptive	
Positive	3 (43%)	1 (14%)	4 (57%)
Negative	2 (29%)	1 (14%)	3 (43%)
	5 (71%)	2 (29%)	7

TEAM 1/3. Observations sourced to staff

	Descriptive	Prescriptive	
Positive	1 (20%)	0 (0%)	1 (20%)
Negative	0 (0%)	4 (80%)	4 (80%)
	1 (20%)	4 (80%)	5

Appendix 7:

Sources of Observations for all Teams and by 'Star' Evaluation
Source: Managers

TEAM 1/1. Observations sourced to Management

	Descriptive	Prescriptive	
Positive	0 (0%)	0 (0%)	0 (0%)
Negative	2 (67%)	1 (33%)	3 (100%)
	2 (67%)	1 (33%)	12

TEAM 1/3, Observations sourced to Management

	Descriptive	Prescriptive	
Positive	5 (71%)	0 (0%)	5 (71%)
Negative	0 (0%)	1 (8%)	2 (29%)
	5 (71%)	1 (8%)	7

Appendix 8:

SPO Comparison

TEAM 1/1

SPO	Count
Process	13 (87%)
Structure	1 (7%)
Outcome	1 (7%)

Total = 15

TEAM 1/2

SPO	Count
Process	9 (60%)
Structure	4 (27%)
Outcome	2 (13%)

Total = 15

TEAM 1/3

SPO	Count
Process	9 (60%)
Structure	4 (27%)
Outcome	2 (13%)

Total = 15

Appendix 9:

Rank Matrix Comparison

TEAM 1/1

Init	Description	Count
TC	Treament / Care	6 (40%)
U	Users Life	5 (33%)
PU	Project / Unit	4 (27%)
Cy	Community	0 (0%)
SC	Services / Case Management	0 (0%)
AO	Agency / Organisation	0 (0%)
CE	Culture / Environment	0 (0%)

Total = 15

TEAM 1/2

Init	Description	Count
PU	Project / Unit	6 (40%)
U	Users Life	4 (27%)
TC	Treatment / Care	2 (13%)
SC	Services / Management	2 (13%)
AO	Agency / Organisation	1 (7%)
Cy	Community	0 (0%)
CE	Culture / Environment	0 (0%)

Total = 15

TEAM 1/3

Init	Description	Count
SC	Services / Case Management	5 (33%)
U	Users Life	3 (20%)
PU	Project / Unit	3 (20%)
AO	Agency / Organisation	3 (20%)
TC	Treatment / Care	1 (7%)
Cy	Community	0 (0%)
CE	Culture / Environment	0 (0%)

Total = 15

Appendix 10:

Team 1. Attained Standards

1/1/1 Very pleasant physical environment. Well situated, well furnished and equipped, well maintained, spacious, creating a warm friendly atmosphere.
T/O/U/Po/D/.

1/1/2 Active social skills programmes maintained and appreciate to activities of every day living, e.g. Residents were responsible for own cooking, cleaning and laundry.
CS/P/U/Po/D/.

1/1/3 Good follow up support to ex-residents. Outreach worker and hostel staff continue to support ex-residents.
CS/P/TC/Po/D/.

1/1/4 Good staff/resident interaction was observed. Staff showed genuine respect for residents.
T/P/TC/Po/D/.

1/1/12 As part of programme on budgeting skills some clients money is handed out daily by staff.
CS/P/TC/Po/D/.

1/1/14 Staff work in teams using a keyworker system and residents can choose their keyworker.
CS/P/TC/Po/D/.

Team 2. Attained Standards

1/2/3 One ex-resident living locally is independent has full time employment, has no contact with the hostel, "He's doing fine".
S/O/U/Po/D//.

1/2/6 There is an open referral system and prospective residents may refer themselves, however, most referrals come from professionals such as CPNs, GPs, Consultant Psychiatrists and Social Workers.
S/St/PU/Po/D/.

1/2/7 There is a self contained house attached to the hostel users for residents with special needs and as a half way facility towards independence. For instance currently being used for two residents one of whom has 2 dogs, also been used for a mother and baby.
S/St/TC/Po/D/.

1/2/11 There is a weekly communal meeting which is open to all residents and a weekly meeting limited to residents of individual units. Residents felt that these meetings were useful and effective in achieving some results.
C/St/PU/Po/D/.

Team 3. Attained Standards

1/3/2 Security paramount at Hostel, to prevent theft/loss of personal effects and abuse of Hostel facilities. It is the only Local Authority Establishment in [redacted] not burgled to date.
M/P/PU/Po/D/.

1/3/4 Meetings regularly held between staff/residents to discuss their individual programme progress, feelings, suggestions and complaints. Clients never coerced into co-operation, reasons for non-compliance explored and ways found to stimulate their interest.
CSM/P/SC/Po/D/.

1/3/5 Links have been established with local College craft class — helping to stimulate homes. A resident has agreed to participate in supporting Craft Leader in teaching people with learning difficulties.
CM/O/P/Po/D/.

1/3/8 All six action plans identified from previous visits have been submitted as projects to appropriate to management levels. Some have been resolved, others awaiting decisions.
M/P/PU/Po/D/.

1/3/9 Officer in Charge now monitoring need for extra night staff (sleeping in or waking duty). This done in accordance following request for AP by Residents/Staff in previous visit. OIC supports this has already made arrangements to provide extra cover.
CM/O/PU/Po/D/.

1/3/13 Staff and Residents were observed to interact on a 'partnership' basis throughout the unit. "Staff are available to help us when we are not feeling well and assist us in carrying out our daily programmes", e.g. shopping, cooking, budgeting and laundry etc.
C/P/TC/Po/D/.

Team 2. Emerging Standards

1/2/1 The decision whether to retain a bed for a resident who has been hospitalised is made after a multi-disciplinary consultation. We discuss it with the Social Worker and the Consultant in charge of the Residents treatment/.

1/2/15 Generally the residents were happy with Hostel Service provision and there was an easy relationship between staff and residents, and amongst staff.
C/St/SC/Po/Pr/.

Team 3. Emerging Standards

1/3/7 Clients would like permanent Outreach Keyworker appointed as soon as possible, thus maintaining continuity of care. A worker from Hostel could be allocated to Project on 3 monthly basis to gain training experience and support Keyworker.
C/St/SC/Po/Pr/.

1/3/12 Residents felt that size and structure of building met all their needs. "If it were any larger, then it would feel like a ward. We often sit in the lounge chatting and watching TV in the evenings and it feels very cosy."/.

Team 1. Deficiencies

1/1/5 House rule: "No drinking on premises except Xmas, New Year with Officer in Charges permission" — "If you can go out to the pub for 2 pints, why can't you bring a can back to the Hostel?" (Resident) A.
CSM/St/PU/N/Pr/.

1/1/6 House Rule:— "Programmes must be followed" — "you can't do things at your own pace. Things have to be done when the staff want" (Resident).
CSM/P/U/N/D/.

1/1/7 House Rule:— "To ensure that residents are in bed by 11.30pm" — Residents unable to use communal areas after 11.30pm, e.g. watch TV or chat to each other.
CSM/P/PU/N/D/.

1/1/8 "It's like a hotel here" (Resident). No resident expressed motivation to leave.
CS/P/PU/N/D/.

1/1/9 Residents not responsible for getting themselves up in the morning. Alarm clock not evident. They (staff) knock on the door and call our names."
CS/P/TC/N/D/.

1/1/10 Resident not able to take responsibility for self administering medication, as all drugs locked away and administered by staff.
CS/P/TC/N/D/.

1/1/11 No privacy to entertain friend of opposite sex in resident's own room. Visitors confined to form (main lounge). A.
CS/P/U/N/D/.

1/1/13 Although bicycles are provided at the unit, residents are not allowed to ride them outside the hostel grounds without a proficiency test certificate.
CS/P/PU/N/D/.

1/1/15 Only one member of staff sleeping in at night. Implications expressed include: Fire and safety, locking building at night, hospital admissions more likely. A.
S/P/U/N/D/.

Team 2. Deficiencies

1/2/2 An outreach facility operates to maintain contact between ex-residents and the hostel staff. Some ex-residents return daily for various reasons, e.g. budgeting, social visits. This allows staff to monitor progress. Staff sometimes visit them at home.

1/2/4 Night cover consists of one sleeping staff member — this causes a great deal of anxiety amongst staff in terms of security of patients, their own security and the building. "A resident could let anyone in and we wouldn't know." A.
S/St/AO/N/D/.

1/2/5 The residents are encouraged to save, however the process users to ensure their compliance exters strong pressure on them to conform, e.g. ex-residents are invited back to talk to reluctant residents as regards the remits and demerits of saving.
S/P/TC/N/D/.

1/2/8 Residents are expected to arise at 8.30am during the week, later at the weekend, the 8.30am rising is dictated by works tasks rota having to be completed by 10am. Some residents felt that they should have the option of rising later.
C/P/U/N/Pr/.

1/2/9 Residents must be in their rooms by 11.30pm but are allowed to watch TV there late if they have one. One resident stated that she would prefer to remain in the lounge longer if she wished. A.
C/St/PU/N/Pr/.

1/2/10 There appear to be very few rules and instructions, noteworthy, however, is the fact that residents have got to be in their rooms by 11.30pm since no smoking is allowed in individual rooms,t his ensures that no resident smokes after 11.30pm.
C/St/PU/N/Pr/.

1/2/12 One resident stated that they were not allowed onto their beds once they got up at 8.30am. If they persisted the doors to their rooms were locked denying spontaneous access.
C/St/PU/N/Pr/.

1/2/13 Residents are sometimes expected to attend the local Day Centre [redacted] one resident was not sure why she was attending and felt she had no choice in the matter. "The staff decided." A.

1/2/14 A sports group exists which some residents are expected to attend, one resident felt she had no choice but to attend. "They like you to do something by day — I think." A.
C/St/PU/N/Pr/.

Team 3. Deficiencies

1/3/1 Staff and residents feel that some people transferred there, especially from St Tydfils Hospit, undergo traumatic experience and culture shock on arrival — they seem unprepared to assume responsibilities expected of them at [redacted]. A.
CSM/P/U/N/Pr/.

1/3/3 Staff totally disillusioned with system re: claiming benefits for young people, when trying to resettle into community. Clients have to be 'stamped' mentally ill to maximise these — many resent this and refuse to apply. A.
S/P/AO/N/Pr/.

1/3/6 Recent staff changes within Hostel units made residents unhappy. They felt they were not consulted in any manner. Residents at satellite houses resent changing of Outreach Project Keyworker every 3 months, but appreciate need of staff to share experience.
CM/St/SC/N/Pr/.

1/3/10 Residents feel it unfair to expect staff to be disturbed during the night, then to work as usual next morning. Staff would be too tired to perform duties correctly — may make inappropriate decisions or be unintentionally rude.
C/P/SC/N/D/.

1/3/11 Staff felt that size and structure of building affected appropriate implementation of individual care programmes, because no more than 4 residents are able to use some Hostel facilities at one time.
S/St/AO/N/Pr/.

1/3/14 Some residents state: Although management run Hostel on trust, staff continually check whether allocated tasks performed. "I don't feel they believe what I say." Others state that some Residents often claim to have completed tasks when they had not.
C/P/SC/N/D/.

1/3/15 Staff felt that the referral system was inadequate and that certain residents were being inappropriately placed at the Hostel — where they abused both staff and services offered. A more descriptive and appropriate referral system should be implemented as soon as possible. A.
S/P/AO/N/Pr/.

Appendix 11

TABLE 4. OVERVIEW OF THE AIMHS STANDARDS
PHASE OF CARE: A **INITIAL CONTACT AND ASSESSMENT**
STANDARDS A:1. Early Detection of Psychiatric Disorder A:2. Assessment
PHASE OF CARE: B **ACUTE AND SHORT TERM MANAGEMENT**
STANDARDS B:1. Early or Timely Intervention B:2. Settings for Intervention B:3. Range and Choice of Intervention Methods B:4. Improving Co-operation with Interventions.
PHASE OF CARE: C **ONGOING MANAGEMENT/REHABILITATION**
STANDARDS C:1. Programming C:2. Case Management C:3. Independent Living Skills Programmes C:4. Vocational/Work Programmes C:5. Residential Programmes C:6. Family and Caregiver Programmes C:7. Voluntary Services, and Services to Voluntary (Self-Help) Groups
PHASE OF CARE: D **LONG TERM FOLLOW-UP**
STANDARDS D:1. Preparedness to Follow-Up D:2. System of Tracking D:3. Follow-Up for Service Appraisal
PHASE OF CARE: E **EVERY PHASE OF CARE**
STANDARDS E:1. Ethics, and Service User Rights E:2. Medico-Legal and Safety Provisions E:3. Use of Medication and Other Treatments E:4. Communication, Consultation, Continuity and Consistency, (Including Documentation) E:5. Promoting Values of "Normalisation", Autonomy and Mutual Respect E:6. Improving Community Support and Tolerance E:7. Staffing and Staff Report E:8. Service Structure, Management and Planning E:9. Service Accountability E:10. Service Evaluation (Including Quality Assurance) E:11. Counselling and Psychotherapies E:12. Cultural Awareness E:13. Education and Training

Rosen, Miller, Parker; AIMHS STANDARDS PROJECT, 1990.

PHASE OF CARE: D
LONG TERM FOLLOW-UP

PRINCIPLES

The service has a commitment to provide long term, active follow-up, rather than time-limited services. The staff should go out, if needed, to individuals and families who are intermittently or continually at risk due to acute or chronic serious psychiatric disorders.

Not all service users require long term follow-up. Needless, staff-intiated follow-up could be construed as and infringement of privacy, or as an expression of staff over-involvement and difficulty with separation.

Discreet, routine, systematic follow-up of all service users is only necessary for the evaluation of effectiveness of a service, to ascertain whether a case should be closed; or to research the natural history of disorders.

Service users and their families should be assured that the service is stable and enduring over time, in order to provide continuity of care for them, for as long as it is needed.

STANDARD D:1
PREPAREDNESS TO FOLLOW-UP

The service should provide active, long term follow-up to individuals with serious psychiatric disorder and their families, who remain potentially at risk due to that disorder.

CROSS REFERENCE

B:4 IMPROVING CO-OPERATION WITH INTERVENTION
C:1 PROGRAMMING
C:2 CASE MANAGEMENT
C:6 FAMILY AND CAREGIVER PROGRAMMES
E:4 COMMUNICATION, CONSULTATION, CONTINUITY AND CONSISTENCY

RATIONALE

1.i) Long term active follow-up is required for individuals who might otherwise drop out of care, to prevent recurrent relapses, life disruptions and deterioration of function.

1.ii) Long term active follow-up promotes the individual's functional stability, preventing further disability. It provides a back-up for the neighbourhood and enhances the capacity of the local community to tolerate, co-exist and help these individuals.

D:1 INDICATORS

	Rating					Comment
	A	AP	AI	UN	NA	
1.1. For indivduals who remain at risk, the service will clearly delegate staff (eg. case manager) to:						
a) to provide ongoing, rather than time-limited follow-up to service users and their families.	✓					
b) be prepared to go out to meet an individual who remains at risk, who will not attend any services	✓					
c) be prepared to work indirectly through other services (eg. G.P.) if the individual declines direct services, - as long as the individual's essential clinical needs can be met by doing so, (refer B:4, E:4)	✓					
d) be assertive and persistent in offering services to individuals who remain at risk, while taking care not to intrude unnecessarily on their privacy	✓					
e) persist in offfering family support, practical assistance, counselling and access to family oriented programmes, to the families of individuals at risk; where that individual declines direct services					✓	

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained
NA - Not Applicable

STANDARD D:2
SYSTEM OF TRACKING

The service will provide a reliable, non-intrusive and enduring system for maintaining contact with, and monitoring the progress and needs of individuals who remain at risk due to serious psychiatric disorder.

CROSS REFERENCE

C:2 CASE MANAGEMENT
E:8 SERVICE STRUCTURE, MANAGEMENT AND PLANNING
E:9 SERVICE ACCOUNTABILITY
E:10 SERVICE EVALUATION

	Rating					Comment
	A	AP	AI	UN	NA	
2.4. The team continues to be available to the individual at risk and the family in crisis					✓	
AT SERVICE LEVEL						
2.5. Service policy determines that the file is never closed while the individual remains at risk and resident in that catchment area (refer E:9)					✓	
2.6. The service provides an efficient "at risk" case register which is organised primarily to assist professionals and team in the management, review and follow-up of service users, (refer E:8, E:10)					✓	

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained
NA - Not Applicable

STANDARD D:3
FOLLOW-UP FOR SERVICE APPRAISAL

The service will utilise follow-up procedures, primarily to assist in providing direct care to service users, and secondarily to assess service effectiveness in terms of a) adequacy of care, b) quality of outcomes, from the point of view of service users and their families, c) penetration of services to the population in need, d) continuity and stability of the service.

CROSS REFERENCE

E:8 SERVICE STRUCTURE, MANAGEMENT AND PLANNING
E:9 SERVICE ACCOUNTABILITY
E:12 SERVICE EVALUATION

RATIONALE

3.i) As catchment areas vary greatly in demography, social morbidity and corresponding styles of mental health service, ideal service structures and processes cannot be narrowly defined. Hence the "bottom line" for service appraisal for area integrated mental health services, are outcomes and continuity of care.

3.ii) A well organised system of tracking provides the information necessary for service appraisal, which in turn provides feedback to services regarding the adequacy of care, outreach, continuity and outcomes - particularly as seen from the point of view of service users, families and referring agencies, (refer E:8, E:9, E:10)

RATIONALE

2.i) An effective system of tracking must function well at several levels: the personal level, eg. through the case manager taking personal responsibility for follow-up, and maintaining a close working relationship with service users and their families

2.ii) the team level, eg. a method for alerting the team to the need to follow up a service user, through regular peer review activities; continued team availability to that individual and family in crisis

2.iii) the service level, eg. never discharging or closing the file while the individual remains at risk; computerised case register for those service users at risk

INDICATORS

AT CASE MANAGER LEVEL	Rating					Comment
	A	AP	AI	UN	NA	
2.1. Clear responsibility has been given to one person, eg. case manager, for tracking and following up individuals at risk and their families, and for maintaining if possible a personal working relationship	✓					
2.2. A responsible team member, eg. case manager, alerts the service user, family or caregiver, and/or other agencies involved, of difficulty in retaining an individual in care or contact, or the need for combined effort to follow-up, eg. direct personal contact; case register system helps to generate appropriate letters for team member to sign and send to individuals and agencies involved	✓					
AT TEAM LEVEL						
2.3. A reliable system exists to assist the team and the responsible team member, to alert them that an individual is at risk of "dropping out" of the system of care, eg. information is regularly updated and referred to the "active" service user contact list on board or in book; computerised case register print-out; regular peer review activity	✓					

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained
NA - Not Applicable

D:3 INDICATORS

	Rating					Comment
	A	AP	AI	UN	NA	
3.1. There is a system for unintrusive follow-up of individuals, families or carers, and referring agents, either: a) intermittently or b) at set intervals eg. brief phone call or letter; case register system generates a questionnaire for the team member to sign and send	✓					
3.2. At the time of follow-up, a brief assessment is done of the service user's clinical and functional state, needs, and level of satisfaction with the service					✓	
3.3. Attempts are made to ascertain what has happened to those potentially at risk who are not participating in the service in terms of: a) knowledge about the service b) contact with other services or agencies c) clinical and functional needs that were/are not met d) dissatisfaction with the service and how this could be rectified					✓	
3.4. The service can demonstrate to individuals at risk, their families and caregivers, and to referring agencies, that the service provided is consistent, reliable, stable and enduring and will continue as long as it is needed, (refer E:9).					✓	

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained
NA - Not Applicable

PHASE OF CARE:E
EVERY PHASE OF CARE

PRINCIPLES

Certain key aspects of mental health services are applicable to, and provide the foundation for every phase of mental health care - in terms of underlying ethical, legal, safety, clinical, organisational, cultural and evaluation practices, eg. Standard E:11 Counselling and Psychotherapies underlies Standard C:7 Family and Caregiver Programmes.

STANDARD E:1
ETHICS, AND SERVICE USER RIGHTS

The service will ensure that service user's rights are protected. This includes confidentiality of personal information, obtaining informed consent for psychiatric treatment and maintaining a secure clinical record system.

CROSS REFERENCE

B:2 SETTING FOR ACUTE INTERVENTION
B:3 RANGE AND CHOICE OF INTERVENTION METHODS
B:4 IMPROVING COOPERATION WITH INTERVENTIONS
E:2 MEDICO-LEGAL AND SAFETY PROVISIONS
E:3 USE OF MEDICATION AND OTHER TREATMENTS
E:6 IMPROVING COMMUNITY SUPPORT AND TOLERANCE
E:8 SERVICE STRUCTURE, MANAGEMENT AND PLANNING
E:9 SERVICE ACCOUNTABILITY

RATIONALE

1.i) Every person, including those with psychiatric disorders, has several basic rights, a) to be safe, b) to be informed, c) to choose, d) to be heard; and generally to be treated with humanity and respect for the inherent dignity of the human person.

1.ii) The service has a duty to maintain confidentiality in regard to the personal details of service users and their families. Guidelines should be clearly documented for the exceptional circumstances when confidentiality may or must be broken by service providers.

E:1 INDICATORS

CONFIDENTIALITY	Rating					Comment
	A	AP	AI	UN	NA	
1.1. The service ensures the maintenance of confidentiality by:						
a) adhering to the set guidelines	✓					

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained
NA - Not Applicable

	Rating					Comment
	A	AP	AI	UN	NA	
b) clarifying the extent of and limits to, confidentiality (for both service providers and users) eg. whether confidentiality applies to the individual or team; whether the referring agent is included; clarifying professional responsibility to report a serious threat of danger	✓					
c) seeking the service user's permission to share such information with others, eg. family, when appropriate; general practitioners; welfare agencies. Such permission should be given in writing, where possible, or at the least, should be clearly documented in the clinical record	✓					
INFORMED CONSENT						
1.2. Informed consent has been sought, given and documented, regarding every form of psychiatric treatment (even with emergency treatment or when under an involuntary order, where possible) (refer to E:3)		✓				
SECURITY OF INFORMATION						
1.3. Security of clinical files and case registers has been assured, eg. locking, and restricted access codes					✓	
ETHICS COMMITTEE APPROVAL						
1.4. The service ensures that any research, or evaluation project, or case register system portraying or transmitting details of individual service users, has satisfied the requirements for privacy or ethics committee approval.					✓	
PERSONAL ACCESS						
1.5. The service ensures reasonable and ready access:					✓	

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained
NA - Not Applicable

PHASE OF CARE: C: ONGOING MANAGEMENT/REHABILITATION

PRINCIPLES

Every individual with serious mental disorder has the potential for rehabilitation.

The service should ensure that there is continuity of care while the person remains intermittently or continuously at risk.

This should be an on-going rather than time-limited commitment to service-users and caregivers.

Co-ordination of clinical, functional and interpersonal facets of care should occur on a consistent basis whether in a hospital or community setting.

The service should ensure that programmes fit individuals' changing needs according to their stage of rehabilitation, rather than merely fitting individuals into generic programmes. This involves: providing individual programme planning for service users and their families; offering a wide range of options within each intervention category (eg. residential, vocational, life skills); and applying programmes flexibly in a recurring sequence of assessment, planning, implementation and review.

Rehabilitation should occur in the most culturally valued environment possible to help the service-user to retain or regain full membership of a living community and to enhance personal dignity and self-respect.

The use of local community resources, whether public, private or voluntary, should be integrated into the rehabilitation of the service-user and work with their families.

Rehabilitation efforts to develop or redevelop life skills should take place in a setting which is as near as possible to that of the service-user's every day life. In this way life skills training is most likely to generalise from the treatment environment to other life situations.

Ongoing mental health management and rehabilitation necessarily involves a wider definition and view of longterm psychiatric disorder. This encompasses pathological, clinical and functional impairments, disabilities in the course of everyday life, and consequent handicaps in society, depending on the adequacy of community response, levels of discrimination, etc. All these aspects must be tackled in a mental health service rehabilitation programme.

In this phase of care there should be an emphasis on the identifying and improving of strengths and abilities as well as impairments and disabilities.

There is a shift of emphasis from detecting and treating
labile acute symptoms and signs, to assessing and assisting with ongoing or residual levels of functioning
and symptomatology.

STANDARD C:1 PROGRAMMING

The service will provide a range of specific programmes from which to choose those that meet the individual needs of service users and caregivers for ongoing support, treatment and rehabilitation. Such programmes should be applied in a recurring sequence of assessment, planning, implemention and review.

CROSS REFERENCE

A:2 ASSESSMENT
B:3 INTERVENTION METHODS (RANGE AND CHOICE)
B:4 IMPROVING CO-OPERATION WITH INTERVENTION
E:1 ETHICS AND SERVICE USER RIGHTS
NOTE: For specific content of implementation see C:2 - 7

RATIONALE

1.i). The intention of this standard is to ensure that the programme is tailored to fit the needs of the individual rather than fitting the individual into inflexible programmes and facilities. Hence the need for individual programme planning and the availability of a wide range of options within each programme category eg. residential, vocational.

1.ii). A programme is defined as a definite plan and clear descriptive notice of any intended formal series of proceedings, (Shorter Oxford Dictionary, 1968). In this context, programming will be most effective if it is systematically planned, applied, reviewed, and clearly documented. In this way the intent and direction of the programme are made explicit, and can be modified according to the progress and changing needs of service-users and caregivers.

1.iii) Programmes should be planned, implemented and reviewed in partnership with service-users and caregivers.

1.iv) Given adequate programmes and resources, the service user should progress through rehabilitation. Such progression will vary for different individuals and may take place in minute steps, rapid leaps or even seemingly discontinuous spurts, interspersed by long apparently dormant phases. Arguably there should be no such thing as a maintenance stream in programming, where service users are streamed into routine programmes and just left there indefinitely.

C:1 INDICATORS

ASSESSMENT AND REVIEW	Rating					Comment
	A	AP	AI	UN	NA	
1.1. Assessment and review of the individual should be comprehensive and should therefore include the following:						
a) clinical factors (health and disorder) - psychiatric - physical - investigation results	✓					

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained NA - Not Applicable

AIMHS STANDARDS: ROSEN, MILLER AND PARKER, 1990
PHASE OF CARE: C: ONGOING MANAGEMENT/REHABILITATION

	Rating					Comment
	A	AP	AI	UN	NA	
- medication (effectiveness, toxic effects) b) functional components (strengths and impairments) - cognitive eg. can't concentrate - affective - behavioural - personality	✓					
c) functional performance factors (abilities and disabilities) - self care eg. grooming - communication and expressive - relationships - family, social - vocational and educational - leisure and recreation - finding and keeping suitable accommodation - finance and budgeting - attitudinal and motivational (including co-operation with programming)	✓					
d) socio-cultural and environmental factors (advantages and handicaps) - effect of social context on behaviour eg. able to modify social roles to the demands of different situations - response to life stressors, present and past - sense of mastery or control over the external environment (human & non-human) - effect of cultural background, values and norms on functional performance, eg. how the individual and family respond culturally to perceived stigma, social exclusion and isolation - current handicap due to society' response to the service user's disability eg. lack of access to employment					✓	
1.2. The assessment and review process should be :						

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained
NA - Not Applicable

	Rating					Comment
	A	AP	AI	UN	NA	
d) planning the most appropriate setting for that particular programme in terms of: i) cultural value, dignity and self-esteem (normalisation) ii)where skills will be used (ie best setting to facilitate generalisation of skills learnt) e) a clearly stated and documented "agreed plan" of management negotiated individually between service provider and service user, and where appropriate involving family or caregivers, (refer A:2.10)		✓ ✓ ✓				
IMPLEMENTATION						
1.5. Programmes should be implemented systematically. a) There is systematic assessment, planning, implementation and review of the programme. b) Time is structured into the programme to allow for all stages of a)	✓	✓				
1.6. Only programmes with demonstrated effective outcomes for service users are implemented, that is: a) There is evidence that the particular programme results in effective outcomes. b) If there is no substantial evidence, then steps are being taken by the service to evaluate the programme. c) The programme is subject to formal review.	✓ ✓		✓			
1.7. The programme is practicable in terms of resources ie. sufficient trained						

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained NA - Not Applicable

	Rating					Comment
	A	AP	AI	UN	NA	
a) prompt following referral (ie. for assessment) and reviewed at set intervals	✓					
b) structured and systematised	✓					
c) actively involving of service users, family and caregivers	✓					
d) regularly compared with previous assessments and reviews	✓					
1.3. Programmes are initiated, updated, modified or terminated according to the results of the assessments and reviews of service users needs and progress, and of the programmes themselves.	✓					
PLANNING						
1.4. Programme planning should be systematic and comprehensive including:						
a) individual programme planning ie. systematically employing an explicit method for linking each service user's individual needs to specific goals which are in turn linked to particular activities, interventions or facilities.	✓					
b) ensuring that service users participate in planning of any programmes in which they involved - as an individual - as a group - as a family		✓				
c) offering "real" choices (albeit within reasonable limits) from a range of activities, interventions or facilities within specific programmes, eg. within a residential programme, there may be a choice between graded levels of supervision in group homes or hostels.		✓				

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained NA - Not Applicable

	Rating					Comment
	A	AP	AI	UN	NA	
staff and material resources are available.						
1.8. The service user is provided with information, education and explanation regarding the rehabilitation programme, prior to making a commitment to participate. This includes seeking informed consent for any technological intervention, (refer E:1)		✓				
DOCUMENTATION						
1.9. Assessment,planning, implementation and review must be adequately documented regarding: a) consistently listing service users' strengths and impairments, and their corresponding problems, goals and plans in order of priority		✓				
b) severity rating of problems		✓				
c) setting provisional time-scales for implementing plans and achieving goals		✓				
d) setting next review date in advance		✓				
e) key participants signing the assessment/review					✓	
1.10. Programme planning is clearly documented for each individual, family or group, and incorporated in the overall treatment plan.	✓					
1.11. Educational written materials and audio-visual aids are available for use by service users in conjunction with the programme.					✓	

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained
NA - Not Applicable

STANDARD C:2
CASE MANAGEMENT

The service will formally assign a case manager to each service-user to ensure that all aspects of that service- user's needs are met. The service will recognise the case manager's primary responsibility for working with the service-user to draw together into one coherent system, all services necessary to meet these needs, whether in hospital or in the community.

CROSS REFERENCE:

A:4 ACCOUNTABILITY/CONTRACTING
B:5 IMPROVING CO-OPERATION
C:1 PROGRAMMING
D:1 PREPAREDNESS TO FOLLOW-UP

RATIONALE

2.i) Case management can be understood as a "net" or "web" drawing together all necessary services for a service-user, into one coherent local system. It can be seen as a microcosm of the standards of care prevailing in the whole Area Mental Health Service.

2.ii) Although relevant to all phases of care, the case management function is central to the ongoing management phase. A case manager bears the primary responsibility for ensuring that within the mental health system, the clinical and functional needs unique to each service-user are met consistently. This entails ensuring that the full cycle of assessment, planning, implementation and regular review occurs for that individual. It includes co-ordinating the use of resources to meet these needs from both within the mental health system and from the wider physical, social and cultural environment.

2.iii)The case manager's role is active in anticipating and meeting service-user needs. This includes: maintaining contact and visiting service-users while they remain at risk, rather than allowing them to discontinue treatment or only responding to service-user needs when acute episodes occur; attending to some practical needs (eg. domestic care) alongside service-user, in order to accurately observe, to model relevant skills, to train the service-user in those skills and to help bridge gaps until necessary support services are arranged.

2.iv) The interaction and relationship between the case manager and the service-user is an important therapeutic tool ensuring effectiveness and continuity of care. The case manager is counsellor, mentor and advocate on behalf of the service-user.

2.v) Ideally all case-management functions for one service-user should be assigned clearly to one service-provider, although in some complex circumstances joint case management may be preferable.

2.vi) The pivotal role and primary responsibility of the case manager should be formally recognised within within both community and hospital components of the service, and its legitimacy promoted by the service among relevant doctors, other health professionals, community agencies, service-users and families.

2.vii) Case management ability is not a natural consequence of being a mental health professional. It requires special professional training, practical skills development and experience.

C:2 INDICATORS

ASSIGNMENT AND NOTIFICATION	Rating					Comment
	A	AP	AI	UN	NA	
2.1 a) The service clearly assigns a case manager (or joint case managers) to each service-user.	✓					
b) The functions of the case management system and the name(s) of the case manager(s) of each service user are notified to that service user, family or caregivers, members of the Area Mental Health Service team, referring medical practitioner and/or other services involved.						
c) The name of the case manager(s) are clearly marked on the service-user's clinical record or file in a psychiatric case register.	✓					
CASE MANAGEMENT FUNCTIONS						
2.2. The case manager undertakes or ensures:						
a) comprehensive assessment of all needs of each service-user, their family or caregivers.		✓				
b) an adequate plan, including individual programme planning and identifying resources required to meet identified needs.	✓					
c) a clearly negotiated, documented "agreed plan" of management, stating what the service user and service provider should expect of each other, (refer A:2.10, C:1)		✓				
d) monitoring and regular review of progress	✓					
e) updating and modifying of plans according to progress, and implementing changes.	✓					

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained NA - Not Applicable

AIMHS STANDARDS: ROSEN, MILLER AND PARKER, 1990
PHASE OF CARE: C: ONGOING MANAGEMENT/REHABILITATION

	Rating					Comment
	A	AP	AI	UN	NA	
f) involving the the service-user. family and caregivers in all planning. or changes of plans.		✓				
g) liaison (both orally and in writing) with relevant health and other services, in planning or changes of plans.	✓					
h) co-ordination of all services required by the service-user in the community and in hospital.	✓					
i) identifying and ensuring gaps in services and resources are filled eg lack of social network, lack of housing.		✓				
j) assistance for the service-user with mundane tasks (eg. self or household maintenance) if this is beyond the functional capacity of the service-user alone, or if no one else is available to provide this assistance.	✓					
k) provision of necessary information and education regarding the disorder and its management, to the service-user and family, (refer C:6, E:13)		✓				
l) specific, structured, practical and necessary skills training for the service- user and family.	✓					
m) counselling of the service-user.	✓					
n) advocacy to maximize the service-user's rights and access to clinical and community resources, and to minimize exploitation of the service-user.	✓					
o) provision of direct access for the service-user to the prescribing doctor(s) and other specialised health or welfare professionals on a routine and a crisis basis.	✓					
p) availablility and mobility to assess						

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained NA - Not Applicable

	Rating					Comment
	A	AP	AI	UN	NA	
and work with service-users where they live and work.		✓				
q) crisis availability, including access to case manager or designated substitute (eg. rostered team member) at all times.		✓				
r) continuity of case manager services for as long as they are needed, ie. as long as the service-user remains at risk due to psychiatric disorder.				✓		
s) full consultation with the service-user, caregivers, area team and any team likely to take over care prior to referral, transfer and discharge.	✓					
t) prompt documentation and filing of all relevant transactions.	✓					
SERVICE-USER NEEDS						
2.3. The case manager identifies and ensures that attention is given to all aspects of client needs:						
a) reducing psychiatric symptoms	✓					
b) improving physical health (in conjunction with the service user's psychiatrist and general practitioner)	✓					
c) improving co-operation with treatment eg. improving attendance; decreasing medication side-effects.	✓					
d) economic	✓					
e) housing	✓					
f) domestic skills	✓					
g) transport				✓		
h) education					✓	
i) work		✓				

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained NA - Not Applicable

	Rating					Comment
	A	AP	AI	UN	NA	
j) recreation		✓				
k) family relations		✓				
l) self-care, grooming	✓					
m) personal dignity and self- esteem	✓					
n) social network, fellowship, acceptance, tolerance	✓					
o) sexuality/intimacy				✓		
p) sense of purpose, religion, spirituality					✓	
q) creative and self expression of thoughts and feelings	✓					
r) cultural (or sub-cultural) group contact					✓	
s) emotional dependency		✓				
CASE MANAGER/SERVICE-USER RELATIONSHIP						
2.4. Attention should be given to maintaining the relationship between the case manager and the service-user:						
a) the case manager establishes and maintains trust and rapport.	✓					
b) the case manager achieves an appropriate balance between being actively and assertively involved (while the service-user remains at risk), and being non-intrusive in the individual's or family's life.	✓					
c) the case manager uses the therapeutic relationship as a means to ensure co-operative endeavour with the service-user and continuity of care.	✓					
d) the case manager involves the minimum number of staff required, all of whom know the person(s) needs and goals.	✓					

RATING KEY:

C:3 INDICATORS

SETTING	Rating					Comment
	A	AP	AI	UN	NA	
3.1. The setting for living skills training is the most familiar and/or the most appropriate for the generalisation of skills, and learning from the service-users own experience eg. in own home, local shops, banks, club.						
3.2. Location of the living skills programme: a) the team-base should be in a non-institutional location, central and well integrated into the local community	✓					
b) where the programme is centre-based, the centre should be: - a small scale informal, welcoming environment	✓					
- easily accessible to service-users by public or private transport	✓					
c) where the programme is based on outreach teamwork, the team should: - be mobile,	✓					
- have the time and the capability to provide assessment and skills training for service-users in the environment in which they most need to use the skills.		✓				
d) all centre-based programmes should also provide an outreach component of living skills assessment and training	✓					
e) where the programme is based in an institutional or sheltered setting a living skills programme is provided to prepare the service-user for a progressively less restricted life in an appropriate community setting.	✓					

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained
NA - Not Applicable

SCOPE AND BALANCE	Rating					Comment
	A	AP	AI	UN	NA	
3.3. The living skills programme provides sufficient scope and balance to develop and ensure the competance (of the service-user) in the skills of everyday living, in order to meet that person's everyday needs, including:						
a) improving cognitive skills, eg. cognitive, concentration, when impaired		✓				
b) improving psychosocial skills, eg. interactional skills	✓					
c) improving sensorimotor skills						
d) being engaged in meaningful activity and use of time, whether structured or unstructured	✓					
e) meeting self-care needs, eg. grooming, general health, nutrition	✓					
f) meeting economic or consumer needs and activities, eg.budgeting, banking, shopping	✓					
g) meeting social and group needs eg. network building and maintenance, drop-in facilities, interaction across generations and with both sexes			✓			
h) meeting needs for family contact and support, eg. counselling and education, (refer C:6)					✓	
i) meeting domestic needs eg. cooking, cleaning	✓					
j) meeting accommodation needs eg. house-hunting (refer C:5)	✓					
k) meeting pre-vocational and vocational needs eg.time keeping, working with and alongside others, (refer C:4)	✓					

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained
NA - Not Applicable

	Rating					Comment
	A	AP	AI	UN	NA	
e) service-user has the right and the opportunity (if necessary) to change their case manager.		✓				
SYSTEM MAINTENANCE						
2.5. In order to ensure that case management functions continue to provide the best care possible for the needs of the service-user, the case manager should:						
a) consult regularly with colleagues of all relevant disciplines and with team members of the Area Mental Health Service, concerning: the service-user's problems, plans for treatment, and the service-user's requirements when the case manager is off duty.	✓					
b) be familiar with all relevant service-providers and facilities in the catchment area.	✓					
c) organise help with case management by sharing tasks or where necessary arranging joint case management, eg. if the service-user needs more services than one case manager can realistically provide, or if the client has more than one type of serious disability.	✓					
d) attain specific knowledge and skills through training, relevant to the duties of case manager.	✓					
e) seek and ensure adequate expert supervision and advice on cases managed.	✓					
2.6. The management and staff of the Area Mental Health Service should:						
a) recognise as legitimate, the case manager's responsibility for the care of the service-user at every stage of care. No other professional makes					✓	

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained
NA - Not Applicable

	Rating					Comment
	A	AP	AI	UN	NA	
substantive changes in the management and treatment of that service-user without consulting the case manager.					✓	
b) promote and give clear support to the role of the case manager in terms of responsibility for the service-user's care, and in terms of the case manager's own career development and further training.					✓	
c) ensure that the ratio of service-users per case manager is appropriate according to: i) number of staff available, ii) complexity of needs of the service-user, (refer E:7)					✓	

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained
NA - Not Applicable

STANDARD C:3
INDEPENDENT LIVING SKILLS PROGRAMME

The service will provide a programme for service-users, of practical training or retraining in those skills necessary to live independently in the community. These skills comprise both basic survival skills and more complex self sustaining and interactional skills, which maximise functioning in, and enhance the quality of every-day life.

CROSS REFERENCE

C:1 PROGRAMMING
C:5 RESIDENTIAL PROGRAMMES
C:5 FAMILY AND CAREGIVER PROGRAMMES
E:7 NORMALISATION

RATIONALE

3.i) Living skills will generalise more readily if taught in the actual physical environment in which they will be used, or one similar. This applies particularly to more complex skills or tasks, eg. learning to cook in the service user's own kitchen. However even if the setting is necessarily institutional or sheltered for the time being, rehabilitation efforts should be orientated towards preparing for (or trying out in) the appropriate community setting.

3.ii) Experiential methods of learning should be emphasised, where service-users actively participate in learning and improve upon living skills.

3.iii)As service-users become more independent in living skills they are more able to meet their own needs - needs that range from basic survival to the achievement of a subjectively satisfying life.

	Rating					Comment
	A	AP	AI	UN	NA	
d) family group (nuclear and/or extended family)					✓	
e) large group	✓					
f) participation in a crowd, eg. football match, mass meeting, or communal activity					✓	
CHARACTERISTICS						
3.5. The living skills programme:						
a) is available at flexible times - day - evening - weekday - weekend			✓			
b) is organised in such a way as to allow staff time away from the implementation of programmes, to assess, plan and review programmes, and for further staff training		✓				
c) is goal-oriented for the service-user, and activities used to achieve these goals are: - directed towards developing specific skills - sequenced according to level of difficulty, complexity, priority, etc., (activities are used as graded learning experiences)	✓					
d) encourages and expects service-users to work towards achieving their goals (goals may be achieved by very small or very large steps, over a flexible time span)	✓					
e) provides activities/groups which are streamed and chosen according to service-users': - rate of progress - needs - interests	✓					

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained
NA - Not Applicable

	Rating					Comment
	A	AP	AI	UN	NA	
l) meeting educational needs eg. upgrading schooling, learning about relevant clinical issues and treatments, (refer E:13)			✓			
m) meeting recreational and leisure needs eg. sport, relaxation,	✓					
n) meeting creative/expressive needs eg. music, public-speaking					✓	
o) meeting geographic mobility needs eg. use of public transport, holidays, moving house				✓		
p) meeting sexual and intimacy needs eg. privacy for intimate relationships				✓		
q) meeting spiritual and religious needs, eg. organised religion, private meditation					✓	
r) meeting security and self-protection needs, eg. self defence training, attending to household locks	✓					
s) meeting needs for personal rights and responsibilities, eg. avoiding exploitation as a worker, and as a mental health service user	✓					
t) meeting needs for a sense of self-worth, coherent identity, purpose and membership of a community (see C:3.7)	✓					
INDIVIDUAL OR GROUP METHODS						
3.4. The appropriate individual or group method is used,according to the aims of the programme.						
a) individual	✓					
b) dyads or couple					✓	
c) small group (approx. 3 - 12 people)	✓					

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained NA - Not Applicable

ACTION PLANNING: Quality Matrix

1/1	STRUCTURE	PROCESS	OUTCOME
Community			
Users Life			1/1/5 Residents should have the choice of consuming alcohol on the hostel premises.
Treatment/Care			Refer to non-attained Standard 8
Services Case Management		1/1/5 Officer in charge to consult with senior management to change policy on consumption of alcohol on premises	
Project/Unit			
Agency Organisation	1/1/5 Senior management to change county policy on consumption of alcohol on county council premises.		
Culture Environment			

ACTION PLANNING: Quality Matrix

1/1	STRUCTURE	PROCESS	OUTCOME
Community			
Users Life			1/1/7 Residents should not have to stay in rooms after 11.30 pm. Should have greater access to communal areas at night
Treatment/Care			1/1/7 To have extra staff cover available at night
Services Case Management			Refer to non-attained Standard 7
Project/Unit		1/1/7 Extra staff cover to be negotiated by officer in charge	
Agency Organisation	1/1/7 Department to increase establishment at unit		
Culture Environment			

APPENDIX 12: ACTION PLANS FROM TEAMS 1, 2 & 3

AIMHS STANDARDS: ROSEN, MILLER AND PARKER, 1990
PHASE OF CARE: C: ONGOING MANAGEMENT/REHABILITATION

	Rating					Comment
	A	AP	AI	UN	NA	
f) provides programmes that have been field tested to demonstrateevidence of their effectiveness				✓		
STAFFING						
3.6. a) Staff are given sufficient training (in-service, continuing or post-graduate education) to provide living skills programmes.					✓	
b) The living skills programme is supported by sufficient clerical and administrative staff.					✓	
c) sufficient staff to efficiently implement the programme, ie. a practical staff/service-user ratio			✓			
SERVICE-USER ATTITUDES AND SELF-CONCEPT						
3.7. Service-providers give sufficient attention to improving and consolidating service-users' self-sustaining attitudes and self-concepts, such as:						
a) self-image, self-worth, self-esteem		✓				
b) autonomy, self-control or mastery over the individual's own life		✓				
c) coherent and consistent sense of self-identity		✓				
d) willingness to attend programme, actively participate, carry out tasks or undertakings		✓				
e) reliability		✓				
f) co-operation, alliance or working partnership with service-providers and co-workers		✓				
g) sense of purpose and/or commitment		✓				
h) sense of belonging to, or full		✓				

RATING KEY:

A - Attained AP - Attained Partially AI - Attainment Initiated UN - Not Attained NA - Not Applicable

ACTION PLANNING: Quality Matrix

1/1	STRUCTURE	PROCESS	OUTCOME
Community			
Users Life			1/1/11 Residents will have the rights to entertain friends and visitors in their own rooms
Treatment/Care			Refer to non-attained Standard 7
Services Case Management			
Project/Unit	1/1/11 The unwritten policy on entertaining friends and visitors in residents rooms be changed	1/1/11 Residents and staff will have further meeting to discuss and amend policy on entertaining in rooms	
Agency Organisation			
Culture Environment			

ACTION PLANNING: Quality Matrix

1/2	STRUCTURE	PROCESS	OUTCOME
Community			
Users Life			
Treatment/Care			1/2/4 A waking member of staff to be on duty each night
Services Case Management			Refer to non-attained Standard 9
Project/Unit			
Agency Organisation		1/2/4 The officer in charge to write to principal assistant (Mental Health)	
Culture Environment			

ACTION PLANNING: Quality Matrix

1/2	STRUCTURE	PROCESS	OUTCOME
Community			
Users Life			1/2/9 Bed time should reflect individual choices
Treatment/Care			Refer to non-attained Standard 6
Services Case Management		1/2/9 Residents staff to discuss the issue at the next community meeting	
Project/Unit			
Agency Organisation			
Culture Environment			

ACTION PLANNING: Quality Matrix

1/2	STRUCTURE	PROCESS	OUTCOME
Community			
Users Life			
Treatment/Care			1/2/13+14 Each resident needs to be made aware that they have a choice in what constitutes their individual programme
Services Case Management		1/2/13+14 Key - worker to ensure that the residents are fully aware of their choices. When the contents of their I.P. are being discussed	Refer to non-attained Standard 2
Project/Unit			
Agency Organisation			
Culture Environment			

ACTION PLANNING: Quality Matrix

1/3	STRUCTURE	PROCESS	OUTCOME
Community			
Users Life			
Treatment/Care			
Services Case Management			
Project/Unit			1/3/15 To produce a more comprehensive referral system Refer to non-
Agency Organisation	1/3/15 Senior hostel staff to attend M.D.T meetings where such referrals would be discussed	1/3/15 To develop a new holistic referral form enabling all relevant information to be gathered	attained Standard 1
Culture Environment			

ACTION PLANNING: Quality Matrix

1/3	STRUCTURE	PROCESS	OUTCOME
Community			
Users Life			
Treatment/Care			1/3/1 Develop closer working links between hostel and Hospital to enable future referrals have the necessary skills and information available prior to transfer
Services Case Management			Refer to non-attained Standard 1
Project/Unit			
Agency Organisation	1/3/1 Team managers at hostel to discuss setting up of closer links with other units with their managers	1/3/1 Potential referrals to be identified at earliest opportunity and discussed at M.D.T, which would include staff from hostel	
Culture Environment			

ACTION PLANNING: Quality Matrix

1/3	STRUCTURE	PROCESS	OUTCOME
Community			
Users Life			1/3/3 To maximise income without categorizing individuals as being mentally ill
Treatment/Care			Refer to non-attained Standard 5
Services Case Management			
Project/Unit			
Agency Organisation	1/3/3 Staff at hostel to discus with Line managers their letter. Contact to be made with local interest groups	1/3/3 Letters to be sent to local M.P. the Local Community Health Council. Local mind group to be asked to become a pressure group	
Culture Environment			

Appendix 13

Mid Glamorgan Source Count for All Observations (870)

Source	Count	
Customer	596	(65%)
Staff	255	(28%)
Management	33	(4%)
Team	27	(3%)

Mid Glamorgan Rank Order of Components

Init	Description	Count	
TC	Treatment Care	242	(28%)
U	Users Life	209	(24%)
PU	Project/Unit	169	(19%)
SC	Services/Case Management	117	(13%)
AO	Agency/Organisation	95	(11%)
Cy	Community	23	(3%)
CE	Culture/Environment	15	(2%)

Total = 870

Mid Glamorgan Quality Matrix/Star for All Observations (870)

	St	P	O	
Cy	3	2	5	10
U	6	18	52	76
TC	5	54	39	98
SC	7	29	9	45
PU	20	8	6	34
AO	2	3	1	6
CE	2		1	3
	45	114	113	272

	St	P	O	
		2		2
	2	7	11	20
	13	15	10	38
	1	5	1	7
	11	10		21
	10	6	1	17
	1	2		3
	38	47	23	108

	St	P	O	
Cy	2	1	1	4
U	5	13	64	82
TC	7	36	30	73
SC	10	14	4	28
PU	35	21	14	70
AO	23	8	4	35
CE	1	2	2	5
	St	P	O	

	St	P	O	
	4	2	1	7
	8	6	17	31
	7	21	5	33
	19	14	4	37
	33	10	1	44
	24	12	1	37
	1	3		4
	St	P	O	

Cy	Community
TC	Treatment/Care
PU	Project/Unit
CE	Culture/Environment
U	Users Life
SC	Services/Case Management
AO	Agency/Organisation

Appendix 14

Quality Assurance Team Members

Lee Lanciotti	Community Psychiatric Nurse, Rhymney
Sonia Jones	Glyn Cynffig Senior Care Officer
Alan Williams	St Tydfils Hospital, Merthyr
Bunny Thomas	East Glamorgan Psychiatric Day Hospital State Enrolled Nurse.
Gwen Davies	Glanrhyd Hospital Occupational Therapist
Robert Young	EMI Unit, Maerdy Hospital Charge Nurse
Alison Tindall	Senior Social Services Officer Ty Draw, Pontypridd
Ian Cutler	Co-ordinator, Ty Draw, Pontypridd
Janet Thomas	Senior Social Services Officer, Merthyr
Phil Ashford	Mental Health Development Officer Rhymney Valley District
Sue Whitson	Social Worker, Cynon
John Mathias	Mental Health Development Officer Ogwr District
Margaret Cresci	Senior Nurse, Taff Ely
John Squire	Charge Nurse, Resettlement Team, Penyfai Hospital
Martin Herbert	Clinical Psychologist Gwaelodygarth House, Merthyr
Verton Daniel	Senior Social Services Officer Ogwr District
Sheila Davies	Social Care Worker, Thomastown House
Gayle James	Nurse, Parc Hospital, Bridgend

Appendix 15

Project Manager/Co-ordinator and Quality Assurance Team Managers

1. Gordon Jones: Principal Assistant (Mental Health)
2. Peter Wakeford: Joint Training Co-ordinator

Kings Fund College. Consultants and authors of Enquire System.

1. Chris Heginbotham
   Fellow Kings Fund College

2. Huw Richards
   Visiting Fellow Kings Fund College

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