Quality Assurance through Observation of Service Delivery

A WORKBOOK

Second Edition

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A great deal of experience has been gained with the use of ENQUIRE during the period since the first edition of the workbook was issued. ENQUIRE has been used extensively in Scotland, in both community visits and hospital studies, and in major applications in three health authorities/social service departments in England and Wales. The authors wish to thank all the staff and users of those services for their involvement and for providing experience on which to improve the operation of ENQUIRE.

A full textbook is now in preparation which sets out detailed research studies on reliability and validity, together with computer guidance on data analysis. Further advice and guidance on the application of ENQUIRE can be obtained from the authors.

Huw Richards
Chris Heginbotham

London 1992

Preface

This workbook outlining the ENQUIRE system is intended to be a practical guide to establishing and running quality assurance programmes for health and social care. The workbook is based on a number of conceptual tools, which provide both a framework for quality assurance, and assistance in appreciating its full potential. The primary aim of this workbook is to provide managers, front-line workers, external and internal "inspectors", informal carers and service users, with a shared framework for consultation and evaluation of the quality of services.

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

The initiative in setting up quality assurance programmes is likely to come from professional staff or management and may be extended to include carers and users. Sometimes the stimulus will come from suggestions or complaints procedures, or from service users themselves or their advocates. It is important that the skills required in setting up quality assurance programmes should not create a competence test or barrier to the full involvement of carers and service users. Indeed, it is the contention of this workbook that the involvement of service users at all levels in the planning, development and management of care can be promoted by an effective quality assurance package. Quality of life outcomes for the users of services are an important component in the development of quality assurance.

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

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

ENQUIRE is an "umbrella" under which many kinds of quality assurance programmes can take place. A wide range of existing tools and some other developed systems can be used within the ENQUIRE cycles providing that they can be shown by the designers of the programme to be consistent with the basic tenets of ENQUIRE.

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

1. ENQUIRE: QUALITY ASSURANCE THROUGH OBSERVATION OF SERVICE DELIVERY

1. Introduction

Quality assurance has been defined as "quality measurement with the stated intention to make improvements". For the purposes of this workbook quality assurance encompasses the idea of quality enhancement and continuous quality improvement. Quality assurance and change management are intimately related and must be continuous to be effective.

Developing good mental health care requires a cyclical process:

- set (or change) standards
- control for those standards (ie. run the service)
- review the service
- learn from the information generated

BASIC QUALITY ASSURANCE OR AUDIT CYCLE

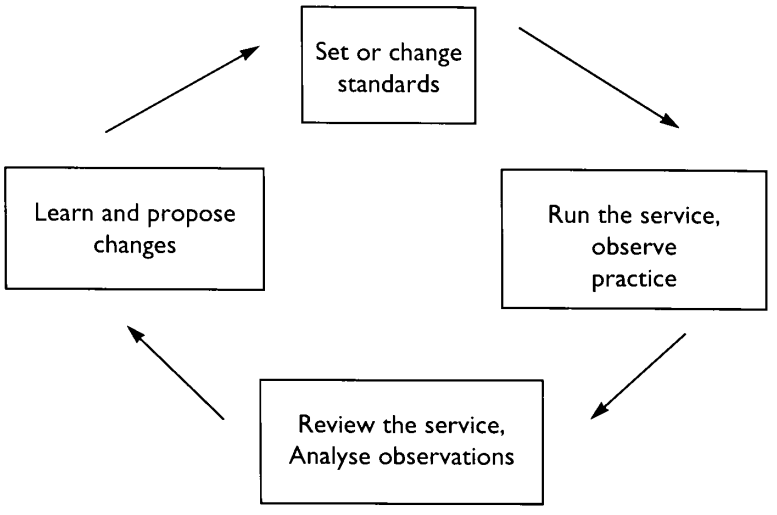


FIGURE 1

Any quality assurance cycle which misses out one of these key steps will be deficient. Too often features of a service are changed without proper review; and even if a review is undertaken little organisational learning takes place. A simple cycle such as this is part of change management. Reviewing and ensuring that all staff agree with changes to be made, and that the organisation has learnt lessons about the way the service is provided, are important components of good service management. Quality assurance thus demands active involvement of staff and service users in monitoring the effectiveness of care, proposing changes and ensuring that such changes are implemented.

It follows that team building and problem solving are two key features of quality assurance. But what matters most is that any quality assurance system gets to the "hot spot" of the service — the point at which direct care is provided to service users. It is how they perceive the service which most matters, how **they** interact with service staff, and their treatment and quality of life outcomes. Yet many quality assurance systems are staff led, involve service users relatively little, and do not focus on personal outcomes. More importantly few systems observe actual practice. Most use standard checklists or accreditation systems, rely on policy statements on on largely structural information about a service.

Observing what goes on in the service, especially at the point of interaction between staff and service users, is crucial to an understanding of that service and the way in which quality might be enhanced. Consequently an observational technique has been developed incorporating two analytic tools for observing practice, validating observations and analysing data qualitatively. Most quality systems either use structured checklist information amenable to some form of numerical analysis, or use ethnographic description only.The ENQUIRE system provides a fully developed observational technique allied to qualitative cluster analysis providing rich and varied data of which service developments may be based.

2. Key Features of Quality Assurance Programme

Any quality assurance system must address a number of key questions. The following list has been devised from experience using ENQUIRE and is drawn from a wide survey of the literature.

1. Does it have a repetitive **cyclical** path and focus on **enhancement** in preference to maintenance?

2. It is highly **participative**, including users and professional staff to contribute to quality management by increasing **communication, shared values** and objectives?

3. Does it take account of user/consumer statements?

4. Does it involve **'peer review'** by staff?

5. It is linked to **standard setting** exercises?

6. Does it involve **observation** of services in operation?

7. Is it **outcome orientated** in applying its findings?

8. Can it complement but stand **independent** of cost data, and other qualitative data.

9. Is it **action oriented** in applying its findings?

10. Does it embody its **values**, principles and make them **explicit** to participants.

11. Does it have a transparent and **learnable methodology**?

3. Traditions of Audit

Audit and quality assurance are intertwined. Audit tends to be unidimensional concerned either with structure, or process, or outcomes and often focused on one professional group or component of a service. Four traditions of audit can be defined: external, internal, consumer (user) and management (hierarchical system).

The **external** tradition is exemplified by regulatory bodies, government accreditation agencies, parliamentary committees, health inspectorates and national advisory services. The **internal** tradition is characterised by professional standards (often established locally), peer review, quality circles and clinical audit. The **consumer** tradition incorporates national and international voluntary agencies, lobby groups, complaints mechanisms and procedures, litigation and local health board/insurance company representations. **Management** audit is often focused on budgetary activity but includes individual performance review, utilisation management, disciplinary procedures and skillmix audit.

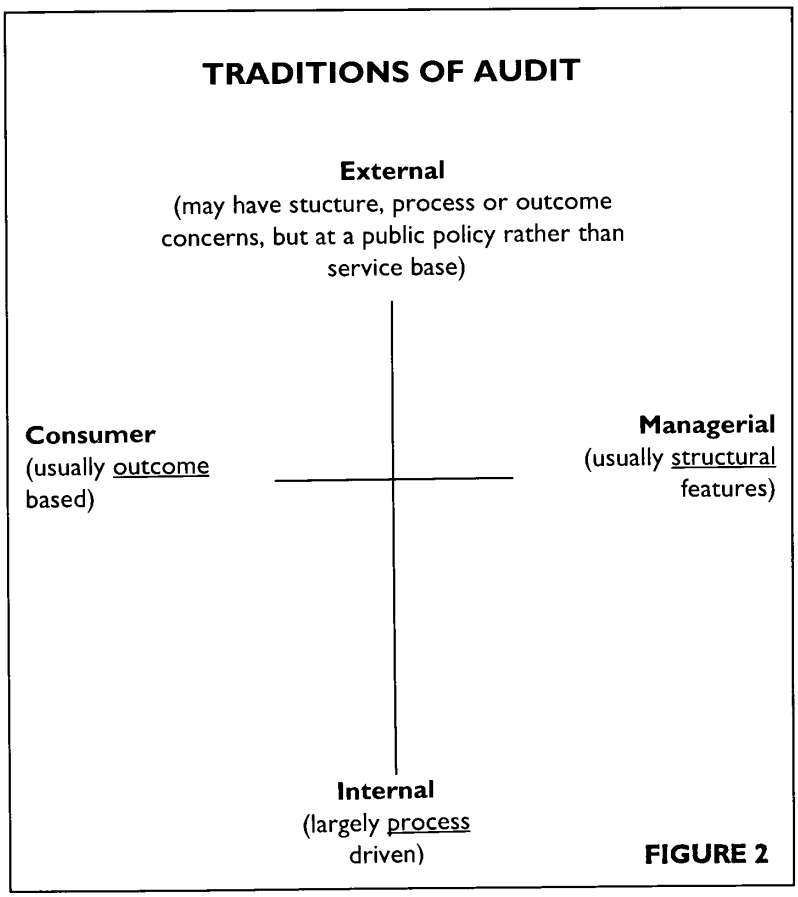


FIGURE 2

Each tradition has a place, yet each has advantages and disadvantages. The external can be objective yet remote; the internal is immediate and detailed but conflicts of interest may arise for individual clinicians. The consumer tradition (user) provides anecdotal and personal information yet by its very nature is often unrelated to systemic concerns; the management tradition provides numerical data largely unrelated to the outcomes of service users. External audit provides an overview of public policy and a framework within which services operate; management audit provides structural information; internal audit provides largely process information but some outcomes; and

user audit provides outcome measures. In developing an effective quality assurance scheme it is important to obtain the best of four worlds — to maximise the advantages and minimise the disadvantages of each tradition.

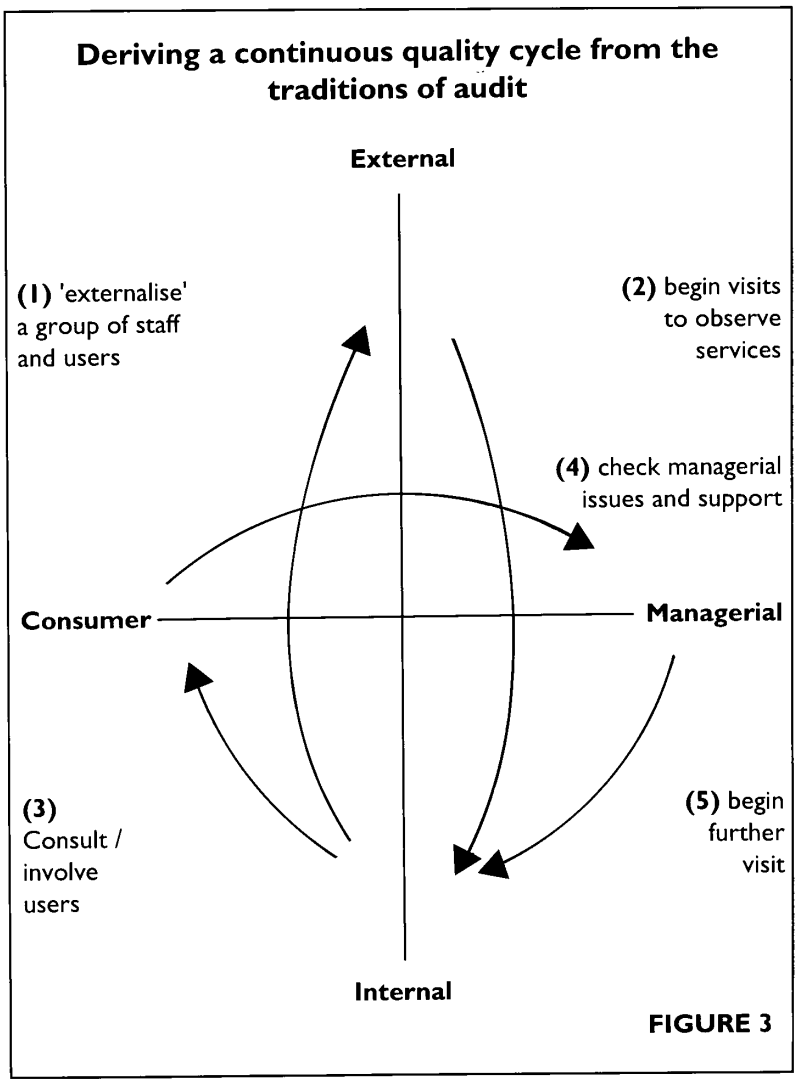
To do so means drawing from each tradition the key feature which we have noted here. It is thus important to:

- externalize (and thus provide some objectivity) any observations of a service without these becoming wholly external to the service;
- to look closely internally at a service and to draw on process information about the way the service operates;
- to involve users of the service to provide personal and quality of life outcome information; and
- to relate this information to the management of the service and particularly structural changes which may be needed.

4. The Quality Cycle

From this we can devise a quality cycle relevant to an observational technique:

1. create an external team from staff of the service;
2. the team to visit and observe the service;
3. in observing the service to look carefully at structure, process and outcome information, discussing the service with managers, staff and service users;
4. organise the observations in a rigorous and validated approach;
5. develop action items with and for users, staff and management;
6. suggest appropriate changes and ensure "ownership" of those changes by staff and managers;
7. re-visit and re-observe the service.



It will be obvious that some important work needs to be done to establish such a system. This includes ensuring a team is drawn together, is properly trained, undertakes effective observation, validates and analyses observations, feeds such observations back to staff and generates action items, obtains management support, effects changes, and then revisits the service.

The ENQUIRE system enables each stage of this process to be undertaken effectively, to obtain data of the quality of the service and to analyse that data qualitatively without spurious numerical interventions.

5. The ENQUIRE system

The ENQUIRE system is thus **encompassing**, based on a complete quality cycle, drawing on four traditions of audit, observing direct service provision, and offering pointers to the use of other tools and techniques appropriate to the specific future needs of a service.

5.1 Quality Assurance Teams

A quality assurance team is created by bringing together staff and users from different parts of a service and from different disciplines and levels of the hierarchy. For example, in an area based mental health service teams may be developed for each major functional area — adult mental health, services to elderly people, forensic psychiatry and so on. Each team will require a minimum of between 8 and 12 members, involving psychiatrists, clinical psychologists, nurses, occupational therapists, social workers and service users. The team is trained in the observational technique (see below) and assisted to understand fully the importance of rigorous observation and analysis. Team training usually takes at least three days.

The team will then design a visiting programme, usually to no more than 8 to 12 wards/hostels/projects in any two or three day period. Because the visits must be undertaken by pairs of observers, a team of 8 can visit 4 facilities in one day. Obviously larger teams can visit more facilities at one time and the load is shared amongst staff. Larger teams, too, enable the ideas of quality assurance to be disseminated more quickly throughout the organisation. The QAT become the "culture carriers", encouraging others and acting as champions of change. Longer visits can be valuable but are expensive in staff time. A realistic balance is needed between the cost of the exercise and the reliability of the information generator.

5.2 Briefing

It is essential that teams are properly briefed. Usually two members of an 8 person team undertake to obtain all basic information about a service including policies, skillmix, the names of key staff, and any special features of the services to be visited. All the visiting pairs are briefed so that they do not have to ask simple, straight forward questions on their visit. The briefing is also an opportunity to ensure that those to be visited are aware of the

nature of the visit, its scope and implications.

5.3 Observational Visits

It is essential that observational visits are undertaken by a pair of observers. There are two reasons for this:

(a) to ensure that whilst one person asks questions or engages in discussion, the other is able to take notes, and vice versa; and

(b) more importantly, that the two observers are able to validate their findings against each others observation, and finally against the full quality assurance team.

The rigour of the system requires that only those observations which the team are certain are correct should be used. An observation may be something which is heard, told to the visiting pair, or which the visit pair themselves saw or heard.

5.4 Validation of Observations

Following a visit which will usually be for half a day, the visiting pair will go through their notes and write between 25 and 50 short statements which encapsulate the key points observed. They will then amalgamate those 50 statements into between 20 and 25 sentences, usually of no more than 30 words. Each sentence is an observation and should be about one aspect of the service. We shall see below that clarity of observation is important or it will be impossible to analyse the observations made. The visiting pair then discuss which of the observations is in their view most significant. usually the result is between 10 and 15 significant observations — points which the pair believe are important about the service that they have visited and which they can justify.

Observer bias has to be considered. The approach uses staff who are experienced and have a professional training, or service users with an outcome oriented view of the service. It is thus not value neutral but that of itself is acceptable. The analytical tools — the quality matrix and the quality star — not only assist in analysing observations, but also in checking on the values of the observers. There is nothing inherently wrong in this approach — indeed it is positively acceptable in that the externalized quality assurance team will take a view of the service which is "objective" and "normative" within the bounds of their training and experience. That of itself means that observations are grounded in common experience; observers tend to be harder on

their own service than on other peoples!

5.5 Initial Data Analysis using the Quality Matrix and Quality Star

The visiting pair then plot their observations on the quality matrix and the quality star (see below). This enables them to analyse their observations by structure, process or outcomes and by 7 dimensions set *a priori* but piloted and developed in relation to mental health services, services for elderly people and other and long term care provision. The quality star tells whether an observation is positive or negative, descriptive or prescriptive. Descriptive suggests some feature which is "happening"; prescriptive denotes those features which may be either desirable, or are happening now and are undesirable.

The rigour of analysis will often require inexperienced observers to rewrite observations, not to change the basic observation itself, but to ensure that it does not encompass different issues from different dimensions or confuse structure, process or outcomes. The initial plot will give an idea of the extent to which the service is demonstrating features which are positive or negative, whether there are things which need to changed about the service immediately or longer term development can be instigated and whether the changes are to basic structural features, to interaction processes or to the outcomes the service is achieving.

The full quality assurance team then meets and checks any observations which any visiting pair feel they are uncertain about or for which they need support from the full team. This may happen if they want to make observations which are substantially critical of the current service, its staff or management. Peer review within the team can be an essential component in ensuring that observers feel comfortable about undertaking the work. Checking with the full team is also a form of triangulation — team, observer 1, observer 2.

5.6 Feedback and Action Planning

As soon as possible after the observational visit the team should feed back their validated observations (the 10 -15 key observations which have been analysed) to staff of the faculty. Feedback should be to the staff who were on the facility at the time of the visit. The feedback will check accuracy of factual information and is not intended to allow the staff of the service to "browbeat" the visiting pair into changing any critical observations. Sometimes observations will be a matter of opinion which the staff may not share — but that does not invalidate those observations.

At this meeting staff should be encouraged to select between 3 and 5 observations on which they wish to take action. Some may be relatively trivial and immediate, others may be longer term and may require management sanction. The items on which the staff which to focus will be recorded and a **quality review team** established with two or three local staff taking responsibility for pursuing the action items. Quality review team training and support is essential and should be seen as an important ongoing part of quality assurance as much as the work of the quality assurance team in visiting services.

5.7 Standard Setting

From the observations recorded it is possible to generate a set of **attained** standards, "emergent" or **desired** standards, and a list of deficiencies which may need remedial action. Some **deficiencies** will be descriptions of poor structures, practice or provision and may be improved over time; some may be so serious as to require early intervention. Obviously **very** serious matters would not be left for the quality assurance process to take its course. However, quality assurance must be seen as a positive development not linked to any form of disciplinary procedure. Although some deficiencies will be observed, rooting out deficiencies is not the main purpose of the exercise. What matters is to decide what is most **significant** at the time of the visit.

'Attained' standards can be developed from the positive service descriptions, by rewriting observations as statements of current service attainment. It is what is happening now — in other words a description of existing acceptable quality. Staff, management and users may have expressed a wish to improve on the existing service or to add new components. These will emerge as positive desirable statements and can be written as 'emergent' or desired standards to which the service aspires. Such emergent standards can form the basis of goal setting and action plans, as well as monitoring during subsequent quality assurance visits.

5.8 Report for Management

Reports on individual services should not be made available to staff other than those of that component part of the service. An aggregated report should be provided drawing together all observations on each component, the action items generated with a full set of quality star and quality matrix analyses. A **thematic** analysis should then be done drawing from all observations the key issues which have emerged under which further management action is required. Some of these will incorporate action items decided on by staff of the service. Those which require management sanction and additional resources should be 'flagged' separately. The thematic analysis will form the

core of the report which may be made available more widely. It must be remembered that a set of observations undertaken by a team of 12 over a two day period to 12 facilities (6 paired visits on each day with full validation) may generate as many as 150 observations.

This is rich data and produces a great deal of qualitative information about a service from which themes can readily be drawn.

Once a quality assurance team has completed a set of visit to all component parts of a service a great deal of change may have been encouraged. It is essential that this is supported and reinforced periodically by further visits from the quality assurance team and by support from management.

6. Quality Matrix and Quality Star

ENQUIRE system uses two simple but powerful and effective tools for analysing observational data. These are the quality matrix (Q#) and quality star (Q*).

Quality Matrix

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

FIGURE 4

The quality matrix is based on Donabedian's structure, process, outcome distinctions. These form the vertical columns of the matrix. The horizontal rows are created by seven dimensions as follows:

1 Community (Note 1. below)
2 Users life
3 Care and treatment
4 Services/case management
5 Project/unit
6 Agency/organisation
7 Environment/culture

Most of the dimensions are self-explanatory. The **community dimension** is the community with which patients live and within which the service operates; **users life** refers to those who use the service and are treated by it. **Care and treatment** is largely the clinical and psycho-social treatment offered by professional staff; while **services/case management** refers to hotel services and the administrative functions of coordinating care, but not the care itself. The **project or unit** level refers to the hospital ward, hostel or other facility, whereas the **agency or organisation** level refers to the organisation within which that service operates — which might be the National Health Service in the UK, or it might be a large private provider in the United States. Finally the environment level reflects the **culture** and wider contextual concerns within which the full service operates.

Each observation is plotted on the matrix. By doing so it is possible to gain an understanding of both the preoccupations of the service and the key features requiring change. This will help in two ways: in identifying cells of matrix where particular work may be needed and where other tools can be brought to bear; and in identifying clearly what that change is. If observations are plotted incorrectly the impression may be gained that structural change is required when it is in fact a process change which is needed. If negative outcomes are discovered in any row these can be tracked back across the matrix to discover the changes needed to processes and structures to achieve the outcome desired. This follows from Donabedian's assertion that every aspect of a service has structure, process and outcome features.

Note 1
Although the usual matrix has seven well mandated dimensions for long term care services, any number is possible subject to reasonable distinctions being drawn between new designations. The ENQUIRE software allows up to nine (9) dimensions to be specified for alternative uses.

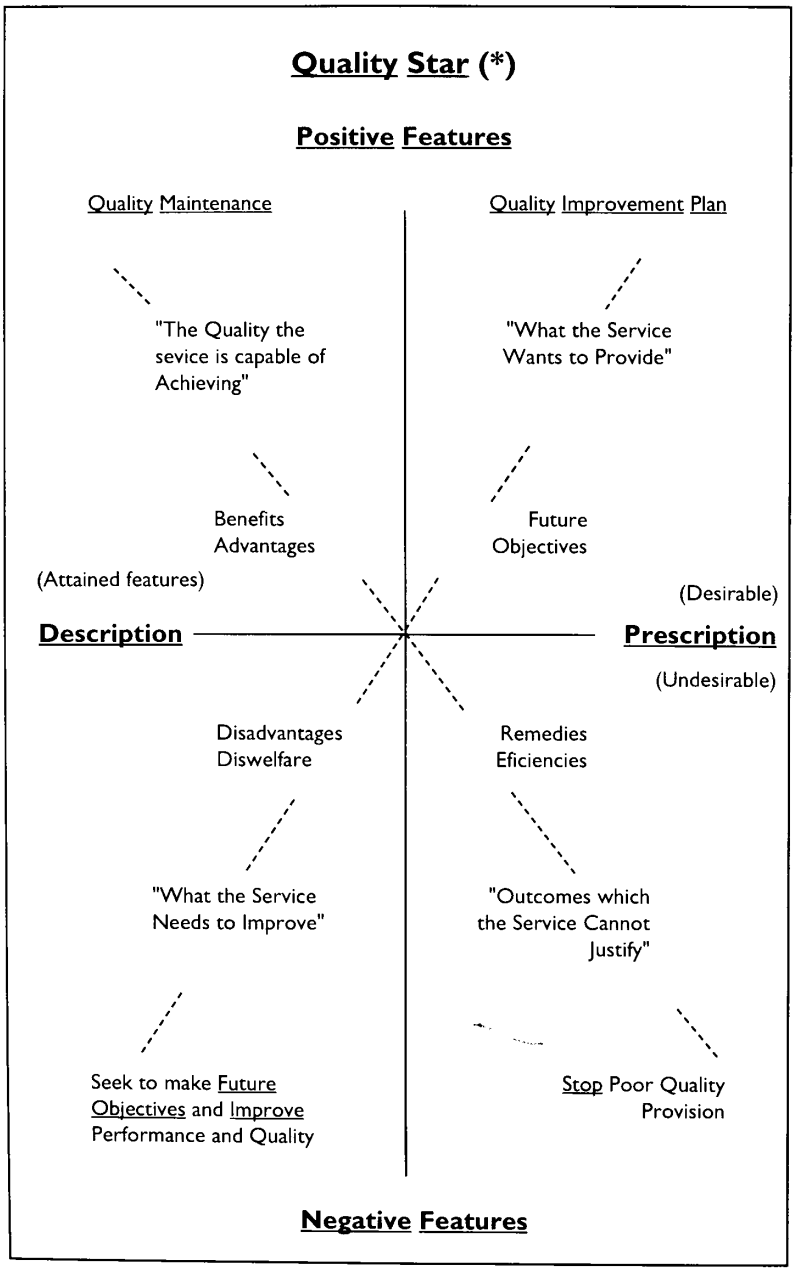

Quality Star (*)
Positive Features
Quality Maintenance
Quality Improvement Plan
"The Quality the sevice is capable of Achieving"
"What the Service Wants to Provide"
Benefits Advantages
Future Objectives
(Attained features)
(Desirable)
Description
Prescription
(Undesirable)
Disadvantages Diswelfare
Remedies Eficiencies
"What the Service Needs to Improve"
"Outcomes which the Service Cannot Justify"
Seek to make Future Objectives and Improve Performance and Quality
Stop Poor Quality Provision
Negative Features

FIGURE 5

The quality star is a simple 4 quadrant map-positive description, negative description, positive prescription (desirable) and negative prescription (undesirable). Quality assurance teams are asked always to write descriptive statements, even if these include a description of what a member of staff or service user had said to the team. However much teams try to write descriptive statements, some observations have a distinctly prescriptive flavour, either because they include a statement where a user or member of staff says that something "ought to be done", or the team itself write an observation in such a way that it contains a prescriptive element.

Consequently plotting on the quality star will usually reveal a range of observations in the positive description and negative description quadrants plus a few in the positive prescription and one or two in the negative prescription. This will indicate a service with both good and bad features, some of which the staff or users themselves would like to see changed (positive prescriptions) and some things which need to be stopped or changed fairly quickly (undesirable). Obviously negative descriptions can be turned into positive prescriptions through action planning and discussion with staff.

6.3 Computer Software

Computer software has been developed to enable all observations to be input to a database with an annotation giving the quality assurance teams designation for each observation. In other words each observation will have a code attached to it which indicates whether it is a structure, process or outcome observation, which of the seven rows it falls within, whether it is positive or negative, attained or desirable/undesirable, and whether it is **sourced** to the user, a member of staff, a manager or to the visiting pair. Ideally observations should come from users and staff, sometimes from managers and only be sourced to the team alone if there is no other corroboration.

Once all this data is placed on the computer it is possible to **enquire** of the system for observations with particular characteristics. For example, we may wish to know all the observations made by pair 1, on facility A, which was sourced to users, and were concerned with the negative outcomes of care and treatment. In a large service following many observational visits there are likely to be at least a few and often some tens of observations in particular cells. Usually there will be not many in the outcomes for the agency or the environment (though it is surprising what can emerge from such visits), and if a briefing has been done well, observations in the structural area of care and treatment in users life are usually fairly thin.

A service with a great deal of resource problems will usually lead to many observations in the structure column around the services, project and agency levels especially on the first cycle. Services where staff are developing ideas often lead to observations in the process area particularly for care and treat-

ment and case management. The service with a great deal of user involvement or where staff are fully aware of the need for the service to meet individual need will provide rich data in the outcome column for users life and care and treatment.

7. CONCLUSION

ENQUIRE can be used in a variety of ways. This brief discussion provides a straightforward introduction to the more detailed consideration set out in this workbook. It has shown how ENQUIRE can be used as a quality assurance system. It can however be used as a basis for external inspectorate, for monitoring, in regulatory activity, and for standard setting. The approach is both a rich and accessible method which involves staff and service users, generates information on which standards can be set and can become a regular review process within an organisation.

ENQUIRE has been used extensively by the Mental Welfare Commission in Scotland as an inspectorate tool; has been used by the King's Fund College as part of service review techniques where it forms one part of an overall approach; and has been used as a straightforward quality assurance system as a monitoring and inspection tool, and in standard setting. Information on these uses is available from the authors.

A software package is available. This enables all observations to be held on the database and to be manipulated using the matrix and star. A maximum of 9 vertical dimensions are available and can be changed depending on the specific requirements of the service. The seven dimensions used here have been found to work well, but specialist situations may call for a different set of dimensions. The **ENQUIRE** mode enables managers and staff to extract specific sets of information and to focus in on certain cells of the matrix demanding information about a visiting pair, or a particular facility, or those features which are positive/negative, or prescriptive/descriptive. In summary the ENQUIRE System is both powerful and encompassing.

2. Values and Principles

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

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

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

A number of authors have defined sets of principles and statements of good practice. Seedhouse proposed an Ethical Grid with 5 key principles as shown in Figure 6; Brandon, in developing notions of good practice, suggests the key features shown on the right hand side of Figure 6. It can seen that Seedhouse's principles become Brandon's practical lifestyles. For example respecting autonomy will enable real choices, always assuming that the consumer or client is capable of the autonomy that is to be respected and thus of making such choices. Similarly respecting people equally (if this is taken seriously) leads to good relationships. The table has been completed by incorporating in the centre a number of key functions which must be undertaken to enable the principles to be put into practice.

A further example might be helpful. Respecting autonomy can be turned into real choices only if the consumer is listened to, is treated in accordance with

his or her best interests, his or her (more or less informed) consent is obtained for any intervention or treatment, and there is an effective balance of care and control. Similarly, respecting people equally requires the points 'show in Figure 6.

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

FIGURE 6

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

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

What is the difference between the process of choosing and the choices made? Even a bad choice may be a good outcome if it is the first time the person has been able to make a choice at all. In order to tease this out further a number of interactive principles are drawn from the chart. Figures 7 & 8 take three interactive principles; respecting autonomy versus creating autonomy; care versus control; and the key concern within care/control, that is capacity and its relationship to content (which includes the notion of competence).

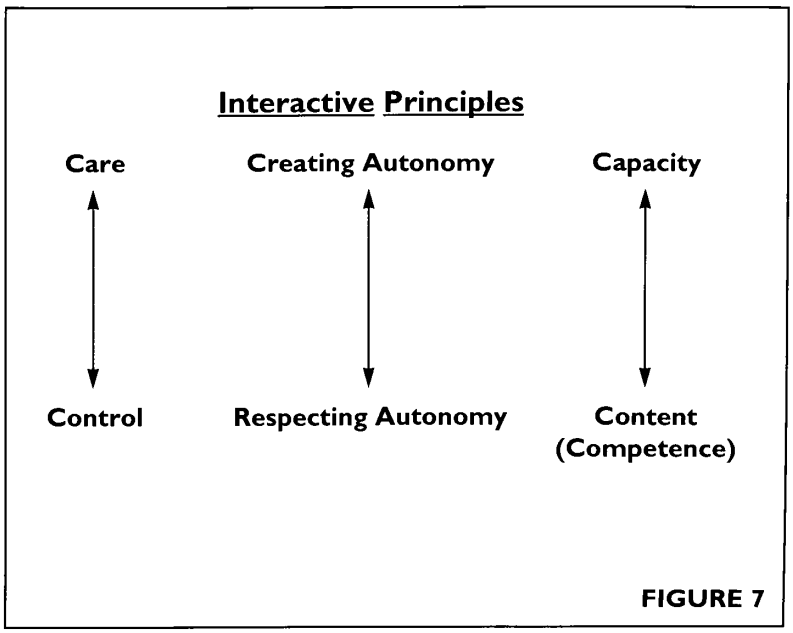


FIGURE 7

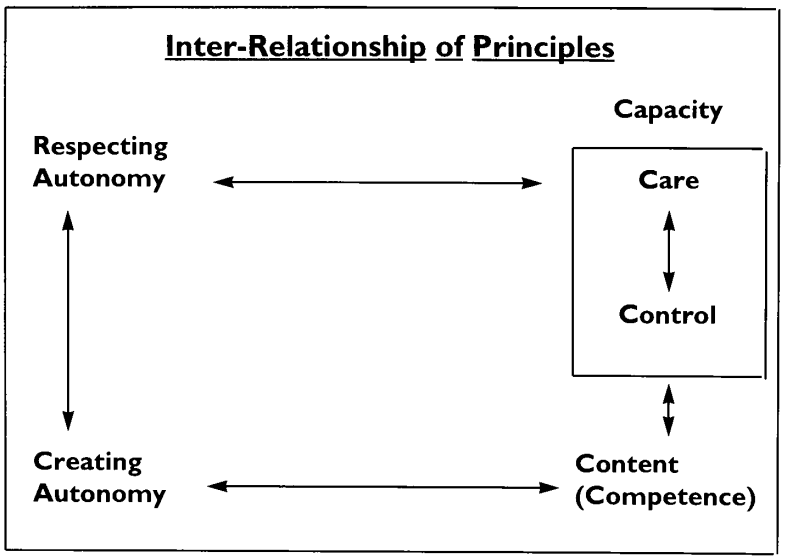


FIGURE 8

Figures 7 and 8 demonstrate that respecting autonomy requires an effective balance of care and control which in turn is rooted in approaches to an individual's capacity; creating autonomy requires the generation of competence on the basis of some capacity and thus affects the content of the decisions made by both staff and users. This will be true of any form of long term or community care service which deals with people who have more or less impaired capacity at some time — people with mental illnesses, people with learning disabilities and elderly people particularly those with mental health problems in old age. It is thus essential that the values underpinning the use of ENQUIRE, if it is genuinely to respect the consumer, will attempt to achieve a balance between the three pairs shown in Figures 7 and 8.

In order to aid further consideration using the matrix these values are shown super-imposed onto the quality matrix Figure 9.

Quality Matrix

PRINCIPLES UNDERLYING DESIRED PERSONAL OUTCOMES FOR USERS

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

FIGURE 9 **(SEEDHOUSE)** **(BRANDON)**

2.2 A Comprehensive Model of Need and Service Delivery

ENQUIRE is intended to encompass different models of meeting need. Figure 10 suggests four approaches: medical, psychological, environmental and social. The medical is rooted in biological approaches to illness or disease; the psychological in psychodynmaic interventions; the environmental (or cultural) considers issues such as housing, urban stress, the effects of racism, and other cultural denominators in the etiology of disorder; and the social considers personal and familial interactions within the community.

Various agencies take differing approaches to these models. Social Services departments often use a social model of intervention considering the interrelationships of an individual within his/her family social networks to be most important. Medicine on the other hand will generally take a more biological approach seeing the disorder as determined by genetic or physical factors over which the individual may have little direct control. The health service tends to take a medical/psychological model; social services departments tend to take an environmental or social model. This is not to say, of course, that there is no overlap between these approaches, or that psychosocial models are somehow unimportant. Rather it is to demonstrate that the interplay between the two key agencies involved in providing services for long term care (in particular social services departments of local authorities and NHS provider units) may be based on broadly different approaches.

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

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

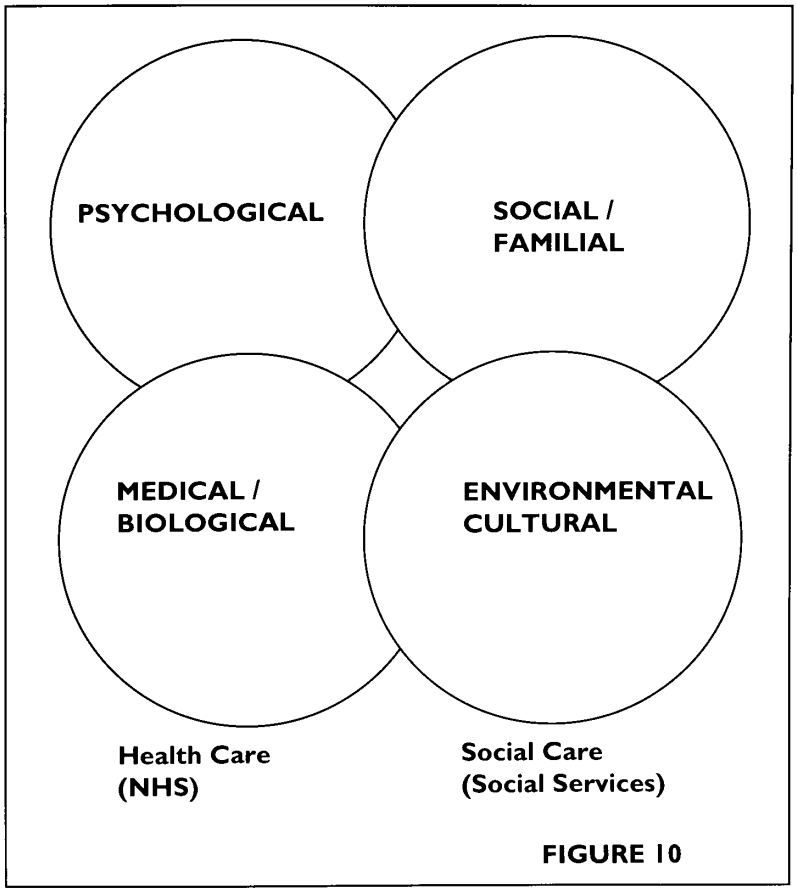


FIGURE 10

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

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

3. The Tools of Quality Assurance

3.1 Building a Matrix (Structure Process & Outcomes)

Donabedian defined three dimensions of human service delivery; structure, process and outcome.

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

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

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

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

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

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

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

3.2 Dimensions of health and social services

Services operate in a cultural, socio-economic and environmental context. Local communities in which the agency functions will have certain characteristics and a particular unit may be accountable to a parent organisation. Central to quality assurance is the users life and the impact that the service makes upon him or her and the social relations that that person has in the local community. How are these diverse factors brought into a systematic relationship with the concepts of structure, process and outcome?

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

If the "individual/users life in a community" is of central value then these various aspects of health and social services can be expressed vertically:

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

These seven dimensions can be applied to three basic concepts of structure, process and outcome and in doing so create a matrix of 21 cells. (Figure 11, overleaf).

Quality Matrix

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

FIGURE 11

3.3 The Quality matrix

Defining the cells as a training exercise

Figure 12 locates concerns and practices within cells of the matrix.
This can be undertaken as an exercise between any or all participants implied in the vertical axis of the matrix by asking respondents to give a description of their services. In order to assist this, examples have been located in the various cells, after extensive use of the matrix with service professionals, managers and users. These are abstract concepts and should not be confused with recorded observations.

Quality Matrix

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

FIGURE 12

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

Having established the Q# and suggested a group exercise to familiarise the QA team it is possible to explore some of its characteristics in practice.

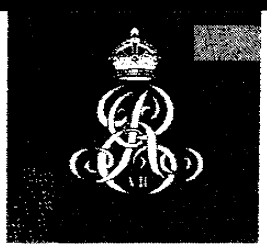
3.4 Q# Plotting, tracking, sourcing and scoring

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

The QA team should make strenuous efforts to make these observations at the critical point of the service where transactions between 'front-line' staff and users occur: the 'hot spot' of the service. If observations from that area are excessively 'structural' there may be concern either about the emphasis or about the focus of the QA team's enquiry, or both; but it would not be sensible solely on the basis of the Q# to draw final conclusions. The reported concerns that will appear on the Q# describe many things over and above the substantive content of the observation.

By 'plotting' within the Q# it is possible to assess what features of the service are attracting energy and resources, and where the emphasis is being placed by managers and staff.

In order to assess the balance in a service between structural, process and



outcome matters, the QA Team must take an observational approach which is itself balanced and not excessively skewed towards certain features. For example, many inspectorates and appraisal systems are overly concerned with buildings, fire regulations, and measurable "**quantitative**" aspects.

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

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

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

3.5 Simplified Q#

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

	STRUCTURE	PROCESS	OUTCOME
USERS/ CONSUMERS			
STAFF/ CLINICIAN			
MANAGERS			

FIGURE 13

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

The inter-relationships between users, staff and managers on issues arising in the Q# are best left until the next instrument, the Quality Star (Q*) has been completed because this provides an understanding of different perspectives, with the actual proposals for change which will have to be negotiated between the QA team and the staff and managers of the service.

3.6 Principles into practice on the Q#

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

'principle' in a service relate to actual outcomes. This is illustrated by the way in which such general abstract statements of principle are in many respects 'process' focused. Whilst helpful and legitimate in that form, they clearly benefit from being expressed as outcomes in a more practical way.

The Q# can be used in training to assist staff to undertake this exercise and then to specify service processes and outcomes which exemplify both an abstract principle and the operationalised principle in the outcome column. For example, when do 'best interests' decisions get made and what is the process and the outcome for the user? These matters can be plotted on the Q# and should specify the actual decisions which are taken for the user, in terms of their structural, process, and outcome characteristics.

3.7 Creating operational objectives using the Q#

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

It will be clear that the Q# can enable the QA Team to have a clear idea of the principles and objectives of the service from materials available at the briefing stage. The 'outcomes' which the QA Team find on a site visit can be compared with the stated principles and objectives of the service. This is of considerable value at the feedback point in the Quality Cycle.

3.8 THE QUALITY STAR (Q*)

The Q# is essentially descriptive but capable of analytical use. The same observations which have been plotted on the Q# and can be analysed further. Firstly there is the extent to which a QA Team report or observation expresses "positive" or "negative" aspects of the service. Diagrammatically this can be expressed as a vertical dimension. Then there is the extent to which the report/observation is a 'description' of the service and whether it contains any 'prescriptive' features. This can be expressed as a horizontal dimension.

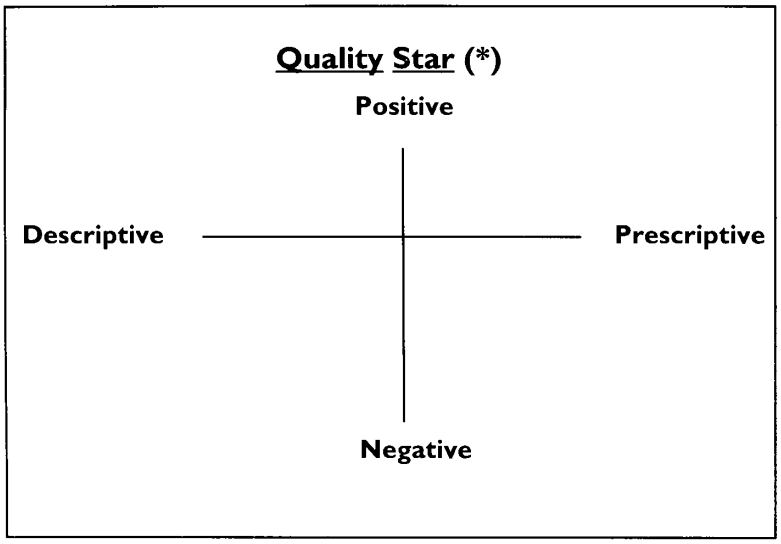


FIGURE 14

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

The Q* makes use of the distinctions between 'descriptions' (attained features) and 'prescriptions' (desirable or undesirable features) precisely, and notes their 'positive' or 'negative' nature. (Figure 14).

The next stage is to 'plot' the same observations/reports used on the Q# within the quadrants of the Q*. This is undertaken by the QA Team in discussion and will be described below in the Quality Cycle.
Observations and reports which are straightforward positive descriptions of the service belong in the top left hand quadrant and these will express **benefits** and **advantages** to the users of the service. This is the quality of service the unit or agency is capable of achieving and is expressed in terms of future action by the QA Team as 'quality maintenance'.

Observations and reports with a negative description of the service are plotted in the bottom left quadrant. These will express actual or potential **defi-**

ciencies — **disadvantages** and **diswelfares** for the user/client. These are matters which the service may seek to improve and to consider framing as future objectives. The QA team will express these items as methods for improvement in quality performance and needing to be framed as future objectives' in order to become operationally viable.

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

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

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

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

The QA Team will consider the extent to which the positive prescriptions, if implemented, would do just that, and emphasise them, rather than simply 'blow indignant moral whistles' and direct the agency into immediate fire-fighting activity. This quadrant can be important if the QA Team is, or is linked to, some formal inspectorate function.

Registration of units, accreditation, disciplinary or even legal action may derive from these items. The QA Team must face these matters at the outset

in the brief; it cannot seek to exclude such matters but it may set limits on what the QA Team is expected to do about them.

The QA Team may agree that such matters are brought to the attention of the managers of the service alongside all other reports and further action will rest with them. This must be stated explicitly to the services and staff taking part in the programme. In summary the Q* now looks like this (Figure 15).

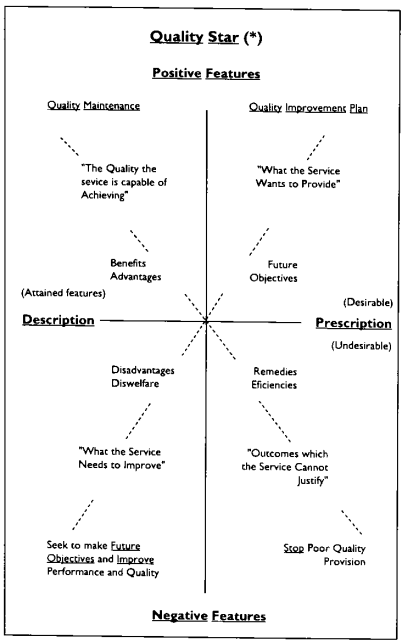


FIGURE 15

It should be stressed that the Q# and Q* are not information gathering tools, but are analytical tools for dealing with observations which have been processed to stand as qualitative data.

3.9 Levels of Application of theQ# AND Q* (Personal/Unit/Area)

The tools in their various forms operate as analytical tools within a quality assurance programme, for QA Teams observations and as teaching tools for

training the QA Team in the first instance. These applications will allow for 'peer review' by the services themselves after having experienced and learned from the external programme (particularly from feedback to units and agencies by the QA Team).

i. In teaching, the Q# can be used in a personal biographical approach and is referred to as "a day in the life of..". This Q# application invites the potential user of the instrument to make observations about his or her own daily life with a focus on a particular area such as "work", "recreation" or "social supports". The Q* can then be applied to the same observations. Such personal use can be used in conjunction with other self-appraisal methods for staff themselves, in particular "domainal mapping". It leads us to the application of the Q# and Q* in **assessment** and **case management**.

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

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

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

iii. The Q# and Q* can be applied to a set of functional services, for example: community mental health services for a particular geographical area or population. This provides a programme for individual agencies and pro jects serving an area and allows for appropriate comparisons between similar types of services over time and by "peer-review exchange". The latter approach trains a small QA Team in each agency — perhaps 2 or 3 people — to use the tools and then to apply them to a neighbouring agency and thus create a longitudinal QA cycle.

Such simple units or agencies can be hostels, day centres, hospices, community nursing services or wards of hospitals, or several components of a service with the same objectives, for example, an elderly care scheme which has residential and domiciliary components.

Area Programmes

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

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

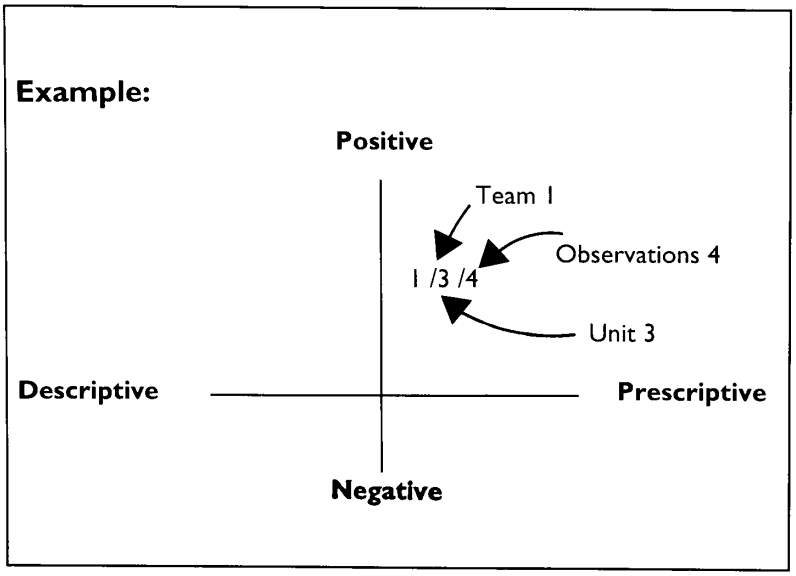


FIGURE 16

In making area appraisals using both the Q# and the Q* it will be clear that every observation/report made by a A Team can be coded by it's characteristics or variables. Area appraisal of service quality can include many projects or units. These characteristics of the observations can be brought into play

with one another by superimposing the Q# on observations falling in each quadrant of the Q*, a qualitative "cross-tabulation".

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

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

The example here shows an observation which has been plotted and can now be described in terms of all the possible variables of the ENQUIRE system as follows:

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

Since every observation can now have a code with between eight and eleven symbols (the non-exclusive 'source' code making the difference in numbers) codes can be used in creating an area appraisal rather than using full written observations. From the patterns of these plotted codes it is possible to refer back to the content of the observations. The code is therefore 1/2/10/C/T/ at the pre-Q# and Q* stage and 1/2/10/C/T/O/U/Po/D after data analysis.

If such coding is used it makes dealing with up to 1000 observations fairly straightforward. The ENQUIRE computer programme will enable further analysis of data by any variable by producing the required lists eg all outcomes, or all negative descriptive processes, or all consumer statements with reference to remedial outcomes.

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

1. Ensure that observers code observations (up to a 5 symbol code initially).

2. Complete the Q# and Q* for each agency.

3. Complete the code for each observation (up to the final set of 8 to 11 symbols).

4. Create a diagram of the Q* with a Q# in each quadrant.

5. The observations which have already been plotted once and the aggregated data replotted on this area Q# and Q* will show all the code variables associated with that data processing visually, so only the first 5 code symbols need to be typed into the figure.

6. Plot all observations of the final figure from computer generated or manually created lists.

The Enquire Quality #*

Positive

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

Attained Descriptions

Amend

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

Desirable Prescriptions Undesirable

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

Negative Defuciencies

FIGURE 17

3.10 THE MATRIX-STAR

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

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

By linking together the Q# and Q* into a matrix-star Q#*, if used correctly in terms of focus (eg functional aspects of a service like day services) and level (all units providing a particular service for a population or community) it is possible to create a powerful form of aggregate qualitative appraisal. There is still much interpretive work to be undertaken once patterns emerge, but key strengths, weaknesses, tensions and problems in an area service show up readily.

For example if the clusters of observations in the positive prescriptive quadrant of the Q* cluster around "agency processes", then since these observations suggest future planning objectives the pattern can be compared to the service as it is in the quality maintenance quadrant of the Q* (top left). Do the future objectives of the area service diverge significantly from the patterns which the service has already established? Furthermore, do these potential future actions address the remedial patterns in the bottom left quadrant.

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

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

3.11 Inspections using ENQUIRE

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

3.12 Action plans, setting standards, abd objectives using Q# and Q*

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

The recorded, plotted and analysed observational data will show what the service can or should do to maintain or enhance quality of service or to minimise or expel deficiencies. These are real objectives and action plans and may contrast somewhat with the more abstract statements of principles and objectives to which the service previously said it was committed. The Q# and Q* therefore encourage participants to be realistic about change and improvement. Sections 5 and 6 provide examples of action planning and standards setting.

4. The Quality Assurance Cycle

ENQUIRE is a systematic approach to quality assurance through qualitative observation, validation and action planning. The complete ENQUIRE quality assurance cycle is set out in Figure . A brief look at the outset will give a sense of the overall picture. Here we provide a short commentary on each of the 15 stages.

4.1. Selecting and Training a QA Team

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

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

One model which has been adopted successfully is to set up a Quality Assurance Team (QAT) which has access to senior management structures and includes on it all sub-unit 'stakeholders' in the QA process. Such 'stakeholders', whose sections, units or departments will take part in the programme, also create Quality Review Teams (QRT) at their department level or across a set of similar services. External trainers are needed to train a panel of potential QAT members and they have the responsibility to see that the cycle is completed. External trainers work alongside the panelists in training the QRTs.

The initial part of the cycle to stage 13 is then undertaken by a Quality Assurance Team made up of QAT and the QRT. The balance between external and internal QA is thereby made. The external trainers enable the internal QA Team to undertake the programme. The first part of the cycle can still involve external trainers since QA is best understood and applied in practice. At stage 14 QA visits between units become possible. In time QA Teams can be put together for specific activities but continuity of membership between initial observations (6) and later observations should be borne in mind.

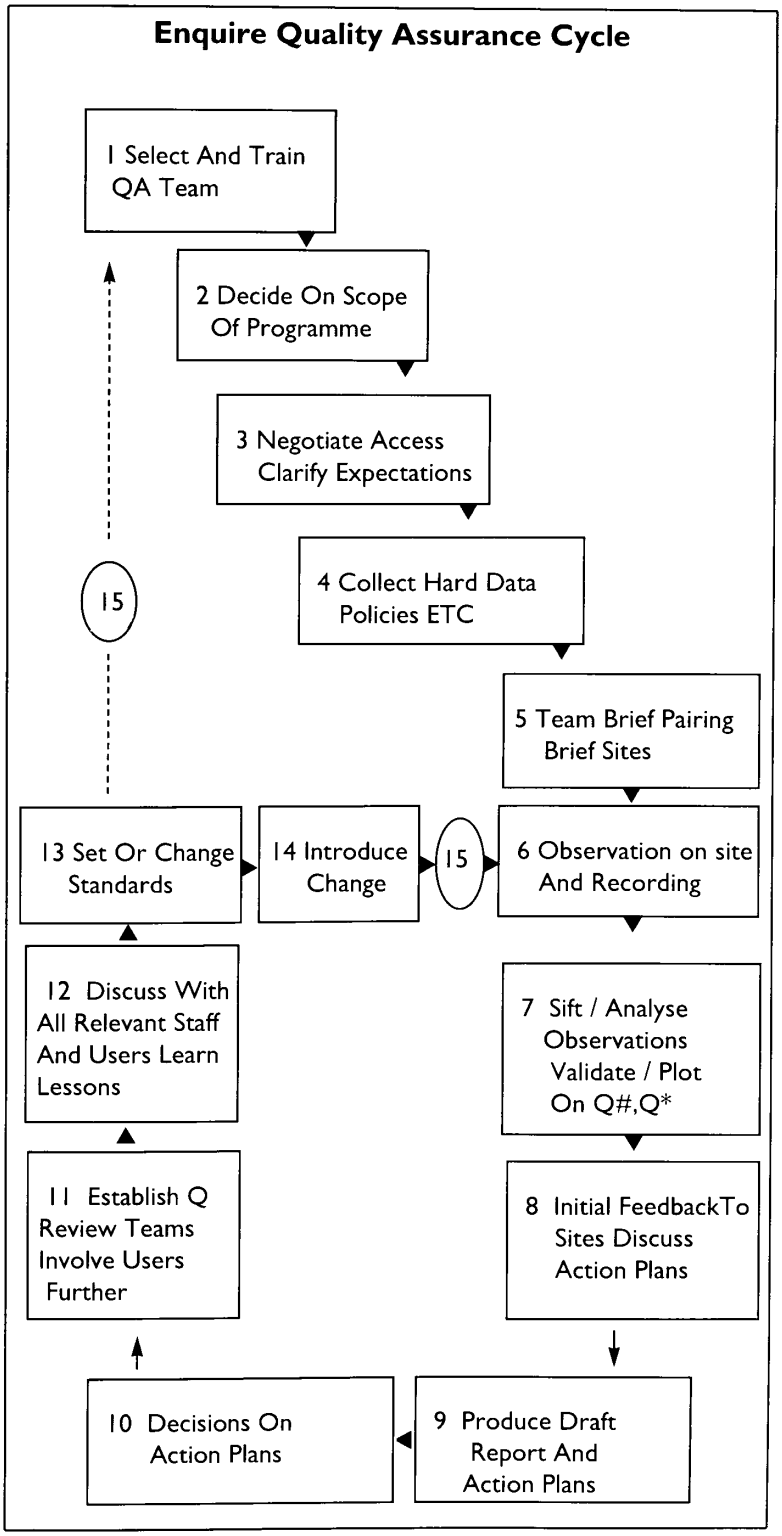

Enquire Quality Assurance Cycle
1 Select And Train QA Team
2 Decide On Scope Of Programme
3 Negotiate Access Clarify Expectations
4 Collect Hard Data Policies ETC
5 Team Brief Pairing Brief Sites
6 Observation on site And Recording
7 Sift / Analyse Observations Validate / Plot On Q#,Q*
8 Initial FeedbackTo Sites Discuss Action Plans
9 Produce Draft Report And Action Plans
10 Decisions On Action Plans
11 Establish Q Review Teams Involve Users Further
12 Discuss With All Relevant Staff And Users Learn Lessons
13 Set Or Change Standards
14 Introduce Change
15
15

FIGURE 18

4.2. Scope of QA Programme

The programme will outline the time scale for the stages 2 — 12/13 and specify dates by which each stage must be completed. Sufficient time must be allowed at stage 10 for analysis and for feedback to the participating units to allow for discussion and agreement on the Action Plans (11) and the changes which are to be introduced (14). This time-scale section of the brief will enable the QA Team to be clear about their time commitment and that QA does not begin and end at the stage of site observation (6). The programme will also include items 4 and 5 below.

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

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

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

An example of this difficulty is the creation of a quality assurance programme

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

4.3. Negotiate access and clarify agency expectations

If a QA programme is to be successful in the first part of the cycle between stages 6 and 11 then the reasons for the visit must be clear to the agencies and units which are participating.

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

Unfortunately such site visits often begin by meetings with management and tail off into an assisted and accompanied walk around the plant with occasional contact with service users. Much energy in these kinds of site observations is taken up in hearing the views of middle managers about their services, do not always involve junior staff in the unit and are likely to become concerned with hopes and aspirations for the service.

It is therefore at this stage in the cycle that these matters are dealt with as well as the items shown at stage 4 — hard data and service objectives, standards and contract specification are collected. The members of the QA Team who undertake the writing of the brief and negotiation of — access have a vitally important task to complete. They will determine the extent to which the programme on-site brings the QA Team into direct contact with users of

the service and front line staff in a sensitive and productive way. It will determine the structure of the day so as to provide a balance between observation and recording for the QA Team.

The first contact between the QA team and the agency is therefore of considerable importance. The opportunity to take part in an initial feedback meeting with other agencies visited should be outlined, the further opportunity at stage 8 — being able to correct any obvious factual inaccuracies in the observations made by the QA Team — should be made explicit. Front line staff and users will also want to know of the material that will go through to the detailed final report at stage 10 and form the basis of action plans at stage 11.

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

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

However, the context in which such qualitative measures are taken in one in which there are clearly important quantitative aspects of the way in which services operate. The on-site observation by the QA Team will be diverted into the gathering of facts and information if that data has not been collected some considerable time before the visit to the service, and provided for them as briefing. Most units of management and social service departments have research information units which will provide much of the hard information ranging from census data, materials derived from the general household survey, more local indices of need and deprivation, the application of norms and other such materials.

Information of population, composition, density, the rural and urban nature of the area to be visited, housing stock, ownership, income levels, family size, age structure of the population are all matters which need to be provided for the QA Team as preparation for the visit. The QA Team will therefore already be aware of a good number of the structural/input 'givens' of a service. A second level type of material which the quality assurance team requires is access to policy statements and planning statements that have been made in respect of the area and the services which are being quality assured.

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

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

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

It is important that the QA team should not have their focus and level of application in stage 2 of the cycle thrown off course by being trapped in considering only what is explicit as statements of standards, conditions of registration or contract specification. However, these matters can be included within the activity of the QA Team and can be sought and identified in terms of structure, process and outcomes in the Q# and Q* analysis and which will result from the use of these instruments.

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

At stage 4 the quality assurance team should be encouraged to learn as much about the area and service before going on-site as possible. A knowledge of the names of managers and staff, the functions of the units, and the area covered all contribute to a sense of concern and value expressed by the QA Team to those who are taking part at the service level.

There are occasions on which it may be helpful to suggest to the QA Team

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

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

One of the central aspects of qualitative analysis is to attempt to appreciate by describing and understanding outcomes in terms **quality of services to users** rather than to specify the volume and level of **outputs** from the service. Some hard data provided for QA Teams will include materials which can give rise to the application of targets in volume of outputs of the service rather than any matters of quality, quality being concerned with outcomes for users from the use of existing resources.

4.5. Team Briefing

As was noted earlier in paragraph 1 the initial team may well be drawn from a quality assurance panel who operate as a form of an external quality assurance team in order to build future internal teams made up of some of their members; that is people recruited from service level quality review teams plus others who may at stage 12 be considered for a 'peer review' quality review team. However, at this stage there are various roles to be performed within any quality assurance team whatever its composition.

a. Leadership

Leadership of the team is something that requires careful discussion with management and the leader should, to be most effective, concern him or herself with the content of the visit and avoid activities surrounding the structure and process of the visit. This associates leadership of the team with the substantive content that will result from action plans and locates the content of the outcome of the visit with a senior position within the quality assurance team. This ensures a greater likelihood that the findings will result in new

action plans and new objectives agreed at all levels and particularly supported by management at point 13 and 14 in the cycle.

b. Briefing

We have already referred within the cycle to a range of activities which are of a preparatory briefing nature and concerned with the process of the quality assurance cycle. This can be an administrative task but will involve visiting the agencies at stage 3 and is therefore best completed by someone who has a sound grasp of the configuration of services for the particular client group. They will need to work closely with the team leader and ensure that the team are well briefed in matters of focus, time scale, transportation and all other aspects of the cycle, especially communications. These team members may not themselves go on-site at point 6 except in a central, coordinating, administrative capacity and may not need to be closely associated with the content of action plans that arise at point 11. A successful quality assurance team will have a close bond between the leader and the person (s) undertaking the preparatory work and the briefing.

c. Facilitation

The team also requires somebody who will facilitate the discussions which occur at stages 7 to 9. In the first part of the cycle the external trainers would be best used as facilitators to enable people to sift observations and to validate and plot them on the instruments. Stage 8 is coordinated by the team leader and 9, 10 and 11 are coordinated by the person who has undertaken the briefing. The facilitator's job is therefore linked to the use of the particular instruments, but also to enable the QA Team to negotiate amongst themselves about which observations are deemed valid or otherwise. This person is likely to be a member of the quality assurance panel and have experience of being a full member of a QA Team, but who may not have been an active on-site observing participant in this particular QA programme.

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

d. Pairing

The pairing of team members with each other is a sensitive and important

issue which is related directly to the leadership of the team as a whole. Considerable thought and discussion will have taken place between the person undertaking the briefing and general administrative tasks for the QAP and the leader of the team as to how the team members should be paired. A range of criteria come into play at this point; a skill mix is important, male and female divisions may be important, background and professional discipline of the persons concerned may be of significance and even friendship or long term knowledge of each other can work towards less creative differences of view than would otherwise be the case.

Pairs should be invited to work together by the leader and this is best set up before the team briefing meeting so that there is no doubt about what the pairings are and who is working with whom. Therefore the team briefing also has a team building aspect in terms of consolidating the pairs by asking them to undertake small preparatory exercises together and building those pairs into an effective QA Team.

4.6. On-site observation and recording

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

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

There is a tendency, once introduced to the analytical tools such as the Q# and Q*, to allow them to structure and determine the way that information is observed, collected and recorded. This should be avoided. The analytical function of the tools should be stressed at the team briefing and they should not therefore be taken on-site and 'filled in' at that point. Rich and meaningful on-site observations emerge from pairs who can work together, one recording and one entering into dialogue and observation with those directly concerned with the service, without 'reading on' too many presuppositions and assumptions or "known answers" to the issues or problems in the services which are being observed.

There is a relationship between a quality assurance system being "value dri-

ven" (in the sense that it gives considerable emphasis to the principles which underline a service) and an awareness of these principles and objectives at the point of analysis in order to assess the degree to which the service exhibits and embodies those principles. The QA Team therefore is not going on-site to solve problems in some 'trouble shooting' way and should hold back from didactic activity even when a particular problem or situation has a very obvious solution which is know to them.

It is a short step from didactic discussion and prescription to making management decisions about the way in which a service should be conducted and that clearly diverts the quality assurance process into executive decision-making rather than into appropriate feedback for those who in the long term are responsible for making such decisions. In short it is undermining of both front line staff and managers. The ENQUIRE System suggests to those members of the QA Team who are going on-site that they consider operating in the following five ways:

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

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

c. That the pair work closely together, observing and recording in turns and that they regard themselves as two separate points of observations rather than one single point of observation. They must decide as a par on whether to source the observations as they record them or not. This dynamic between the pair who are undertaking the on-site work becomes increasingly important when they process their observations from a particular service.

   Processing observations is inevitably a matter of negotiation and an attempt to find agreement on what should be finally recorded. The observations are not just what has been recorded by the person who happened to be recording during the visit. There are 'fieldnotes' and 'headnotes' which contribute to the final observation. This is related to the point made above that **the pair** are **separate sources of observation** whilst

working as a pair. The recording and observing functions do not prevent this from happening. It allows for corroboration or otherwise between the pair about what they have observed. They can then discuss the matter as a potential observation to be expressed in final recorded form.

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

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

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

If this commentary on site observation appears to be full of 'thou shall nots' then it is because it is an attempt to free up the QA team members to be open to a dialogue, to try and create understanding about the operational outcomes of the services' objectives and principles and to record these faithfully and accurately in order that the material is a sound as possible for later analysis.

We will come, in stage 7 when observations are sifted, to look at matters of significance and reliability, but at this stage it is important to create a sense

of openness, exploration and dialogue. It is important not to allow QA Team members to go for a form of 'closure' in their observations by linking them either with 'checklist' ideas which have emerged from the hard briefing material or by using the analytical tools in order to gather the data in the first place, or by "reading on" their own preconceptions on to a service.

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

There will be critics within any organisation of quality assurance programmes. Some of the criticism may be well informed and helpful,some may be from people who resist the introduction of quality assurance for a variety of reasons. Some of the arguments that are used against evaluative techniques and qualitative methods will be familiar to readers of this workbook. They often include an over-reliance on apparently factual material, a paradigm which refers to experimental design and natural science methodologies in order to cast qualitative data as being in some sense arbitrary, less reliable and therefore less true. There is sometimes a 'flight from content' — a desire not to hear unpleasant truths, and this reaction is justified on the ground of 'scientific numerical methodologies'.

The limitations of a qualitative analytic approach must be fully understood by the QA team. The systematic approach outlined within ENQUIRE enables the process to be controlled and managed in such a way that the system does not claim for itself and, QA Teams do not find themselves recording and by implication, supporting, unsupportable proposals or action plans which have no basis in the accurate reflection of the activities of the services they have visited. It is expected and required that a QA Team will comprise people with appropriate training, professional skills and sapiential authority in fields or health and social welfare. The QA Team will have been clear about its focus, scope and level of its activity and it may be aware of some pre-determined evaluative criteria in the sense outlined in section 4, for example contract specifications. But the QA team will not allow itself to be lead entirely by these criteria.

The QA team members will be aware of the importance of seeing principles and values in action and with reference to the previous section on interactive

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

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

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

The need has been stressed to make qualitative observations at the point of the service transaction where front line staff exercise their skills and feel valued and introducing hard data in this process of observation and dialogue can sometimes have a negative and disabling affect on staff and users.

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

If however the staff and managers of the local service do have very significant concerns in the policy and resources areas, then these will show up in reported observations and find their way into structural and process areas of

the matrix which will reflect that that is where much of the energy locally is going, rather than into direct service provision.

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

Observations are not simply reactions. They are considered and reflected responses which are made overt by the member of the pair in the process of recording. The enterprise is inevitably value driven in tow senses. First of all that the observations contain material which relates to how the service puts principles and values into practice. The decision to pursue a particular line of enquire and record it, is in itself a value judgement. Skilled quality assurance team members in pairs will also quickly be able to avoid becoming a "messaging system" between different parts of a service agency.

4.7. Processing and Analysis

4.7.1 Sifting and Processing Observations

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

In a visit to a project or unit there may be up to 100 basic observations that have been made or noted in some form in shorthand or recalled or remembered by the pair from the morning or afternoon's work. The first stage of reflection is simply to list the basic reported observations and to clarify their syntax, grammar and meaning in the form of a single sentence if possible.

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

This process generally will reduce the number of observations fairly significantly.

For the purpose of this example, imagine that the observations have now been reduced from 40-50 to approximately 20-25 observations the pairs next task is to agree which of these are the 15 or so most significant. This introduces a clear evaluative element into the recording process for the first time in an explicit way.

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

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

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

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

*4.7.2 Validation and analysis of observations and plotting on the Q# and Q**

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

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

Considerable discipline, (in terms of time management) is required to get through the amount of material. For example a QA Team of eight people in four pairs who have seen four or five units in an area will have 15 x 4 or 5 observations. The QA Team have a very significant work load to get through if all of them are going to be appropriately validated.

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

It is important to note at this point that the observations will be in the form of sentences and that these will be brief — at most a short paragraph of perhaps 4 lines. Behind these stated observations will be considerable detail which the pair who have made the observation will know about.

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

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

The first task for the facilitator where it is felt necessary is to invite the pairs to read out their 15 key, most significant, observations and open them for questioning to the whole group. The whole QA Team can therefore seek

clarification of these observations and these are therefore rendered meaningful as a result. Questions can be asked of the pair, and cross referring between the pair and other people with other sources can take place to clarify the observation. Reference can be made here to other related observations, to the source of those, and to the briefing materials and to data of a quantitative nature. This process is not primarily concerned with whether the observations are 'true' or 'false' but with their meaning and clarity.

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

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

These steps are effective methods of controlling the large amount of material which will be flowing through stage 7 and assists in validating and analysing observations. It gives the leader of the QA team a very important "overview" whilst freeing the facilitator to work with the group as a whole in pairs to take forward the analysis of their observations.

It should be clear therefore that stage 7 and 8 has a number of levels. The validation of observations is linked to the further analysis by pairs and plotting on the Q#, but the overview of the themes emerging from all pairs is simultaneously being taken forward by the QA team leader. Time management for both the leader and facilitator may be undertaken by the briefing

personnel who are primarily concerned with the actual process of a quality assurance cycle.

Further analytical activity can take place at the same meeting, or can be undertaken by the pairs on their own, at a more leisurely pace. If the latter option is taken it is essential that the pairs return their materials to the briefing coordinator of the quality assurance cycle soon as possible. On either basis the tasks that are undertaken here are broadly analytical. The pair will take the 15 or so agreed observations and will plot them in the Q# cells. This is a technique which can be learned through training with ENQUIRE and is a negotiated procedure between the pair who have made the observations. Reference here can be made to the previous section which outlined the operation of the Q#.

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

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

The pair will be concerned to note the extent to which these observations show that the service is primarily focused on outcomes for users lives in the community. The pair will also refer to the techniques of scoring the matrix and providing a source for the observations and consider in relation to the latter whether any further patterns emerge as to whether sources observations from managers, staff or users show markedly different concerns within the matrix.

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

These reflections on the matrix itself should not be plotted on the actual instrument, but rather kept as an extrapolation from the observations which

can be used for discussion at the feedback session to the particular units in stage 11 of the quality assurance cycle. This once again promotes dialogue with the agency by the pair and also stresses the need to focus on the outcomes of the service. At this point the pair will move on from the matrix to the Q* and using the significant 15 observations will then place them in the appropriate quadrant on the star.

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

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

4.8. Feedback and Action Planning

4.8.1 Initial thematic feedback to agencies and action planning

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

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

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

resented at the meeting.

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

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

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

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

Clearly, sensitivity and skill is required by the pair from the QA Team is feeding back the findings of the quality assurance exercise to the staff and first line management of the individual unit. Critical observations, negative prescriptions and descriptions from the quality star may be difficult for the unit and its staff to accept and own. The committed and systematic nature of the quality assurance programme should be sufficiently explicit to enable the unit staff to hear the content of these observations however critical because they respect the methods and the skills that will have been used in their compilation and analysis.

> However, the objective of feedback is not only to let the unit know of the findings but also to enable the pair to check on matters of fact and any major corrections which the unit would want to make to their observations. It still remains a matter for the pair to decide finally on any corrections they make.

Early feedback to units visited is essential. ENQUIRE has the capacity to interface with other quality assurance measures that have been used within services and these will have been picked up at stage 4 in the collection of

hard date available to the team. At the point of feedback the consistency of results from these alternative systems can be viewed alongside these specific instruments within ENQUIRE.

ENQUIRE is capable of a parallel action in training as well as quality assuring. Stage 11 within the quality assurance cycle enables the pair from the quality assurance team to explain the methodology of the ENQUIRE System as well as dealing the actual substantive results. It therefore will assist in the recruitment of staff from units to any future 'peer review' quality assurance team in the future. A critical "spin-off" from the further analysis stage in the cycle is that the unit can begin to consider what will emerge and be endorsed by their managers at stage in the cycle. It should be emphasised that analysis and feedback at stage to the agencies is not intended to provide them with an opportunity to preempt the action plans that will be agreed by management, but simply to prepare the ground for discussion and agreement about what changes may be possible and be introduced at stages and in the cycle.

4.9. Report and Executive Summary

At stages 7 and 8 the leader of the QA Team is responsible for providing an Executive Summary, and the briefing administrator for the QA Team is responsible for compiling the Final Report. The Final Report will require further analytical work in terms of aggregated unit finding and observations up to completed Q*s for either a set and series of functional units or for diverse units which serve a particular geographical area. The Executive Summary will avoid detailed material, but on the basis of the items put forward at stage 10 in the initial thematic feedback will use the Q* materials aggregated and coded in the way described in the previous section to produce items for inclusion in action plans on an agency basis, a client group basis or an area basis or all three.

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

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

4.10. Discussion and decision on proposed Action Plans

The final report and Executive Summary having now been shown to participants in the programme, stage 10 requires that the leader of the QA Team return to the quality assurance panel and to senior management and contribute to discussion on possible action plans which have emerged from the quality assurance exercise.

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

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

4.11. Consider internal quality review teams and 'peer review'

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

The final report has gone to senior management, action plans have been considered and decisions are therefore being taken about specific items within those plans which can contribute to a review of objectives, the introduction of changes and definition of standards at stages 12 and 14 of the cycle. However, whatever the Action Plans produce in terms of changes, whether they are small or much more significant shifts in policy and practice within units or even within areas, the future quality assurance cycle should be considered at stage 14. It may well be that up to this point there have been external trainers involved with the quality assurance team and external input into the facilitating at stage 9 in particular. However, from this point onwards the ENQUIRE System envisages that the quality assurance process becomes part of the culture of the organisation and becomes built in.

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

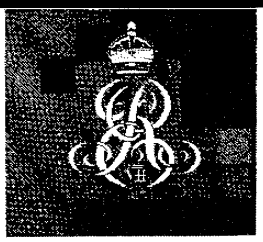
The first wheel of the cycle will have contributed to their skills and knowledge, and to the deployment of tasks amongst members particularly those of the quality review teams. The internal and external balance therefore in the quality assurance team will have been established by stage fourteen of the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

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

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

4.12, 4.13 and 4.14 Reviewing objectives, changing standards and introducing change

These activities are included in the figure of the quality cycle. It is these matters which are going to be quality assured in the second on-site observations. They are matters for the managers of the service and not for the quality assurance team and the leader of the quality assurance team needs to be clear, particularly with the members of the team, that they are not undertak-



ing managerial or executive functions in pursuing changes as a quality assurance team. They have facilitated a discussion and completed the cycle to stage 14. They must then allow the line management and day to day managerial and executive functions to pursue their activities in the way they think best.

4.15. Internal QA activity

Stage 15 must include the core items of stages 1 to 5 over again for the team to repeat the first cycle. However, it should be noted that where action plans have been proposed and where changes have been introduced that these become the focus of the QA activity by the team. Consistency in team membership is of a considerable value in assessing the impact of change.

Repetition of observations: Second and subsequent cycles

Much of this original work will have been done and action plans will have been drawn up and change introduced. Consistency in pairs may be of value and the on-site observation in the second cycle will have a dual focus in that it will enable a relook at the matters which showed up on the Q# and Q* in the first cycle, and assess the degree of change and movement in those items, as well as undertaking the broader descriptive activity described at stage 6 in the cycle. the quality review teams in conjunction with the quality assurance panel have to be clear about the timing of further activity in order to allow change within the organisation to be fully worked through. This is a matter for discussion within the quality assurance panel who will be coordinating quality assurance programmes within the organisation as a whole. Second and subsequent cycles may take place after six months, say, but should be repeated with two years at most so as retain momentum. More frequent cycles can be used if staff is available.

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

5. Action Plans

5.1 Action Plans

Action Plans are a central part of a QA (Quality Assurance) system. They are the vehicles for making the changes and improvements desired. They contribute directly to task of setting and improving longer term standards but in the short term they will, when implemented, show the extent to which the service is able to respond to new challenges.

If they are to be successfully implemented, Action Plans must have certain key features. These can be listed as follows:

- they must derive from sound processed observations, ie be an explanation of **WHY** the action is needed.
- they must be **MANAGEABLE** in number and in scope.
- they must be agreed and **ENDORSED** by management, and if possible, costed.
- they must state WHAT is to be achieved, ie an **OUTCOME**.
- they must state HOW and by WHOM the action will be taken ie the **PROCESS** of implementation.
- they must specify a **TIME SCALE** for implementation.
- they must be realistic and **NEGOTIABLE** with the person and organisation concerned.
- the other possible EFFECTS of taking this particular action must be considered.

The simple method for writing Action Plans is by using the Quality Matrix . It is assumed that an observation or a group of observations have been agreed as requiring action. For example, an observation in a short-term rehabilitation hostel recorded that "residents did not have keys to their own rooms and they reported that this affected both their security and privacy." The reasons for taking action are clear; to increase security and privacy. This is a structural feature (door locks) of the hostel with a known outcome, that is, an effect on the daily lives of the residents.

It is now possible to write into the matrix the intended outcome. Before

doing this however it is essential to consider in what dimension of the service action is located, in outcome terms. Is it expected that the action of providing door locks to affect the treatment and care in a specific sense, or to change the function of the unit itself? It is clear that privacy is a personal matter for users and that the action is intended to define more closely the exclusive use of rooms by residents, ie their "personal space". Therefore the vertical dimension of the matrix is "users life".

STEP ONE: Write on intended outcome in the appropriate cell of the matrix.

Action Planning : Quality Matrix

	STRUCTURE	PROCESS	OUTCOME
Community			
User Life			The privacy and security of residents will be increased by fitting door locks to each personal room and providing residents with a key.
Treatment / Care			
Service Case Management			
Project / Unit			
Agency Organisation			
Culture Environment			

FIGURE 19

The statement is simple and by linking it directly to an outcome for the residents, states what is to be achieved.

The reason for working back from intended outcomes to processes and structures is to avoid agreeing and taking action on matters which have a vague or indirect relationship to the direct service given to the users. For example improving record keeping may be a legitimate goal in an Action Plan. However because its relation to the direct service to users is distant, specifying the outcome of the action forces requires a statement as to whether the result of better record keeping will be better communication with the user, or other agencies; or better defined care plans; or other direct benefits for the clients.

5.2 The next stage considers HOW and by WHOM the action will be taken forward. This is achieved by:

STEP TWO: Write in the PROCESS column of the matrix the persons who will undertake the tasks, over what period of time, with whom they may have to negotiate, and the methods they may employ.

Just as in step one it is important to decide in which vertical dimension of the matrix this action will be located. Is it a task which can be taken forward by the users themselves? If so, write the process part of the action plan in that cell.

Action Planning : Quality Matrix

	STRUCTURE	PROCESS	OUTCOME
Community			
User Life			The privacy and security of residents will be increased by fitting door locks to each personal room and providing residents with a key.
Treatment / Care			
Service Case Management		Staff member "A" will draw up a budget for fitting locks; negotiate with managers on any financial or policy consequences such as tendering; costs of lost keys; changes in insurence or fire regulations. Staff group will write a policy on access to and use of a "master" key; cleaning access and concider the increased security in relation to drug and alcohol policies. A progress report to staff and users within two months.	
Project / Unit			
Agency Organisation			
Culture Environment			

FIGURE 20

The structural aspects of a service are concerned with inputs both financial and physical, and the unit's agreed policies and functions. There may be a number of consequences. For example the referral system and agency prospectus or contract with a purchaser will now need to contain reference to the requirement that residents using the service must be able to take responsibility for maintaining the security of their room. The hostel may have in the past adopted a communal living policy which was consistent with a high level of trust on security matters and a therapeutic rationale for staff access to residents' rooms because of the risks of self-harm. Other consequences may relate to principles of "normalisation". Is the provision of locks moving away from an attempt to create a domestic household atmosphere towards a "hotel" concept?

These aspects, some of which may be unintended outcomes of the action to be taken, must be thought through, with both managers and professional advisers as part of the action planning before implementation.

5.3 A staff member, perhaps supported by an action team has a number of tasks to perform at the level of the service and in negotiation with the parent agency or organisation.

STEP THREE Write into the project/unit and agency cells the structural matters which have to support the outcome and specify costs if these can be obtained.

A formulation may look like this:

Action Planning : Quality Matrix

	STRUCTURE	PROCESS	OUTCOME
Community			
User Life			The privacy and security of residents will be increased by fitting door locks to each personal room and providing residents with a key.
Treatment / Care			
Service Case Management		Staff member "A" will draw up a budget for fitting locks; negotiate with managers on any financial or policy consequences such as tendering; costs of lost keys; changes in insurence or fire regulations. Staff group will write a policy on access to and use of a "master" key; cleaning access and concider the increased security in relation to drug and alcohol policies. A progress report to staff and users within two months.	
Project / Unit	New aspects of security and privacy communicated to referring agencies. Any operational policy aspects on drugs, alcohol, entertaining and on domestic or hotel functioning of the unit to be separated and monitored. Policy in other units to be received when results of this action assessed. Cost to be agreed.		
Agency Organisation			
Culture Environment			

FIGURE 21

It is now possible to see all the elements of the proposed Action Plan. If it obtains the support of management the plan can become a "public" document and displayed in an appropriate place in the unit. It will naturally become an agenda item in both staff meetings, users meetings and in joint discussions.

It will be clear that even for such a simple change considerable activity in process and structural terms is necessary. It is also important to focus on the security and privacy **outcomes** rather than allow the action plan to be driven by the fitting of locks.

In time, monitoring may show that some residents leave their rooms unlocked, or that theft of residents' possessions is or is not reduced. The monitoring of the intended outcome is of course a task for the observers in the next part of the Quality Assurance cycle.

5.4 Why is this change wanted?

The initial observation made a direct link between the need for privacy and security as expressed by residents and the method for achieving this by door locks. There may be other ways of increasing security and privacy, but the observation should provide a sufficient explanation of why security and privacy are less than is reasonable or desirable.

5.5 How difficult are these changes to implement and how many is realistic at one time?

The illustration here is of just one Action Plan, and shows the activity which must take place to achieve a particular outcome. A service can implement only a limited number of plans at one time. Case material using ENQUIRE suggests that 2 or 3 plans for a hostel, ward, or day centre are sufficient for controlled improvement to take place between the first and second periods of observation (6 months). Furthermore, starting with simple manageable and achievable change achieves both the outcome itself and the confident use of change management skills.

However, this leaves the action plan open to the criticism that its proposed change is "trivial" or that "we knew that this needed to be changed". To these criticisms the answers are clear. First, there may be small improvements which have a very significant effect on the lives of users; and second knowing about a need for improvement has clearly not resulted in action having been taken previously.

A method for controlling the implementation of action plans and ensuring a balance of simple and complex activity is to select approximately from three types of action.

TYPE 1 Changes which can be made speedily and are within the managerial control, budget and skills of the existing staff of the service and for which no major policy changes are required. Such changes can also have a short-term and responsive monitoring mechanism, that it can be refined and better focused relatively easily. They may also by service user led.

TYPE 2 Changes which require managerial endorsement for the flexible deployment of staff or other resources, which can be initiated by obtaining permission and support by consultation and negotiation.

TYPE 3 Changes which represent a significant shift in policy and operational practice and for which new resources are required. There may be a need for capital expenditure, a change in contracts, or a concern for physical location of a service.

By selecting one of each of these types a balance can be achieved in the complexity, time scale and control of the desired changes.

5.6 Does management endorse the changes proposed?

The example has shown that there are consequences for managers in even the most straightforward changes. They will have to agree in principle, but also consider the implications of this change for other similar units, the cost of such changes, and some technical aspects such as legal liability, tenure of residents and the operational policies of the units. Proposed changes which are generated from the "bottom" upwards as in the ENQUIRE approach place a responsibility on the "front-line" staff delivering the service not only to implement the change but to consult and negotiate with managers to enable the action plan to be taken forward.

The managers will have endorsed the Quality Assurance programme in principle and will now be involved in enabling the resulting changes for service improvement to take place. They will want to be confident that staff proposing such changes will carry them out. The ENQUIRE process empowers staff but also requires them to take responsibility, in partnership with managers, for implementation.

5.7 Is the outcome clearly stated?

One way of approaching this criteria is to specify what evidence would count towards the conclusion that the outcome of the action plan has been achieved. This means breaking down the single outcome into parts. When dealing with 'feelings' of security and privacy in a user group, where the outcomes are rather abstract, it may be difficult to express an outcome in a tangible and recordable form. As noted above, the second phase of observational visits should look specifically for the effect of changes from action plans. In this case, direct consultation with residents on the benefits or otherwise of door locks will provide the required information. Do residents report feeling greater privacy or security? Do they furnish their rooms with more personal or valuable possessions? Do they invite visitors? Do they express and increased sense of ownership of their rooms and how do they express this? Do they invite other residents to them for specific activities?

To obtain an impression of the outcome for residents such detailed awareness is required. Therefore returning to this criteria, the test of a clearly stated outcome is the ability to identify what that evidence will be for its direct effect in 'practice'.

5.8 How is the action plan implemented and by whom?

In the matrix completion, a single member of staff, if necessary supported by a task group or Quality Review Team must take responsibility for progress. This requires communication with the beneficiaries, ie the service users, and negotiation with managers. The person who occupies the 'centre of the matrix' is the facilitator and progress chaser. He or she must agree to do this task. Many of his/her activities will be indirect, in relation to the outcome. He/she will have a key part in writing the action plan itself, ensuring ownership, considering its public display and seeing it through.

The remaining criteria of TIMESCALE, NEGOTIATION, have been considered in completing the three steps in filling out the matrix.

A final reference must be made to the last criteria, that of unintended effects of introducing change. Sometimes change creates anxiety and a climate of specific, controlled and "owned" improvement is more constructive than changes that seem arbitrary. There are however, usually consequences of even single changes which may not have been foreseen at the time of the action plan. The observers must re-visit the unit to identify whether there

has been a beneficial effect.

The example given here of increased privacy may have an effect on how self-contained residents are; whether they need or want to maintain, decorate or clean their own rooms; whether they invite outsiders to their rooms more often and increase their social networks; whether they can cope better with re-admission to hospital knowing to what they will return and having a greater investment in their residential circumstances; or conversely do residents abuse drugs and alcohol more frequently in private circumstances, or become more isolated or cause themselves self-harm. Also the changes in the unit may have policy consequences in other similar units.

In summary, Action Plans are the essential bond between sound observation of services and intended improvements. Without their implementation the Quality Assurance cycle ceases to have impetus. The three steps taken in completing the Matrix using the eight criteria set out here provides a practical method for creating, implementing and monitoring action and change.

6. Standard Setting

There are two key aspects to standards in services. Firstly there must be a method for setting appropriate standards; and secondly a method for measuring or at least documenting service performance against the standard. Some commentators refer to the second feature as "conformity" to standards but a more dynamic formulation using concepts of attainment and emerging standards is preferable.

When and how are standards set? Standards are closely related to the prospectus of a service — "this is what is offered", and also to issues of quality in contracting. They may also be generated in the process of writing a "mission statement" for the organisation.

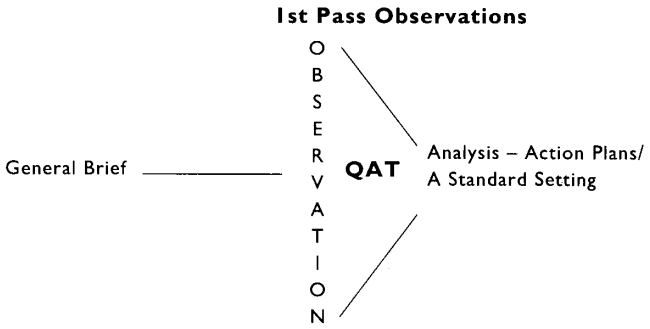
There are some risks associated with setting standards prior to a close appraisal of what the service actually offers and an identification of where there is room for improvement. Unfortunately many sets of standards are hopes and aspirations rather than documented regular attainments.

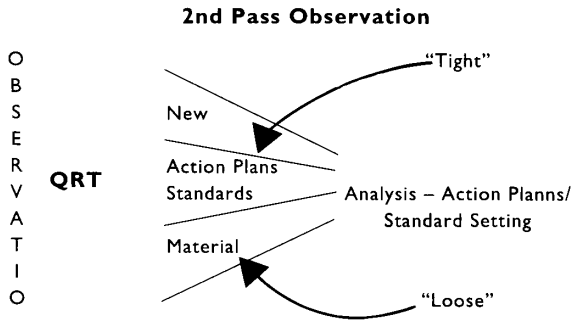
A three way method for setting standards is used in ENQUIRE. Firstly the contract, remit, mission statement, legal and professional standards are used as a basis, if they exist; secondly the observations from the ENQUIRE process are classified and used; and thirdly reference is made to an index of standards generated for an area service, and thus also assists with gaps, wording and linkages between standards (Rosen, Miller and Parker).

For documenting actual performance against these standards, reference should be made to the preparation for the second and subsequent observational visits within the Quality Assurance cycle where 3 sources of material drive the observational process:

a) the first time observations
b) the action plans
c) the standards set.

The key place of standards in funding appraisal by observation can be set out as follows.

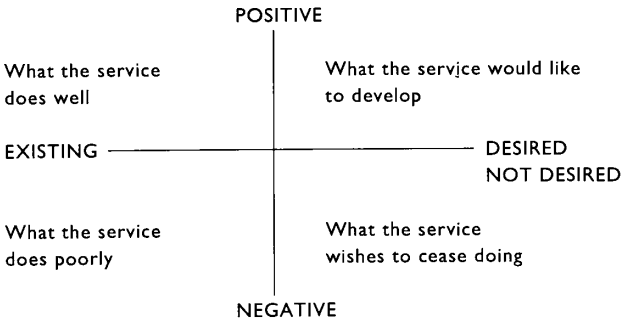




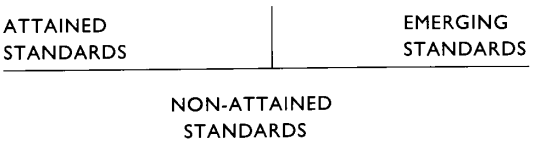
Observations in general provide material for both action plans and standards and the appraisal of them.

Setting standards is achieved by taking the observation from a visit which have been plotted on the Quality Star. The observations are then further analysed by considering them on the following formulation:

Observation plotted on the Star



They are further analysed by considering all observations that are negative (below the line) as a group, but maintaining the distinction above the line between desired features of the service and existing positive aspects:

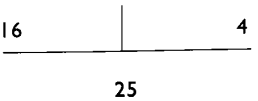


Standards can be formulated from existing deficiencies which fall below the line. Not all observations recorded will contribute to this exercise but all observations must be scanned to select those that provide material for standards.

The three key concepts of structure, process and outcome should always be borne in mind in relation to standard themselves. Many standards have to be expressed in structural and process terms but the challenge will always exist to explore the outcomes which relate to standards expressed in such a way.

Example

Twenty observations were plotted (as the basis for attained and emergent standards) for a rehabilitation Hostel. Deficiencies considered as non-attained standards totalled 25 as follows:



When the twenty 'above the line' observations were scanned, standards were written which were based on what the service currently achieves.

The service provides care to the following standards:

1. An open referral system and access through all appropriate professional groups.

2. A pleasant physical environment of domestic size which is secure and safe and where night cover is rigorously monitored.

3. An active social skills programme with external links to classes; shopping, cooking, cleaning, laundry and crafts.
4. Facility for special needs in a self-contained flat e.g. for mother and baby.

5. A Keyworker system by agreement with residents, who work with staff on a partnership basis and whose wishes are respected.

6. Individual programmes and care plans, which are regularly reviewed.

7. A weekly communal meeting and resident only meetings.

8. An active outreach and support service which establishes and maintains clients independence in the community — possibly on a long-term basis.

9. Negotiated retention of residents' place on re-admission to hospital.

This method and formulation achieves two goals — it sets realistic standards based on known achievement, and gives both staff and managers confidence in their current performance.

The next step is to compare this current performance expressed as standards with the hostel existing permit, with the observation plotted on negative aspects of the service, and with an index of standards. In this case the standards were consistent with the remit of the hostel and against the index standards items 1, 5, 8 and 9 were consistent with the case-management standard.

> "the service will formally assign a case manager to each service user to ensure that all aspects of the users needs are met. The service recognises the case-managers primary responsibility for work-

ing 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."

When the nine standards were considered alongside the 25 deficiencies (considered as 'non-attained standards') a further set of standards were formulated which were expressed as follows:

1. A clear and detailed prospectus of the hostel's services should be prepared and made available to referring agencies and prospective residents.

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.
3. Physical facilities for the maximum participation by residents in programmes should be reviewed.

4. A self-medication programme should be considered, with advice from prescribing medical practitioners, for appropriate residents.

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.

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.

7. Access by residents to personal rooms should be flexible and guided by an agreed policy between staff and residents.

8. Policies on smoking, consumption of alcohol, use of transport, and private entertaining in rooms should be reviewed and a policy agreed.

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.

Here it is possible to see some overlap with the attained standards particularly in item 2 — individual case plans and in relation to item 6 from the first list. This is a warning that there can be events which fulfill one set of stan-

dards but fall below the standards achieved elsewhere in the unit, with the constant challenge being to bring the latter up to the former.

There are therefore 18 items evenly distributed between attained standards and non-attained standards. It is here that the connections with action plans and with future monitoring of the progress on maintaining standards can be made.

The Action Plan approach which is set out in the previous section provides the vehicle for improving 'existing' standards and rectifying deficient standards. In choosing 3 aspects of the service on which to write action plans, it is possible to take one, which may usefully be an achieved standard which might be improved further, and the remaining 2 action plans may address deficient standards and be more difficult to achieve.

The formulation of a set of standards for a service is therefore best achieved at the level of a hostel, group home, day centre or jointly across working teams such as Community Mental Health Teams or community psychiatric nursing services. They can be usefully added to a users charter and assist in contract specification.

Summary

- Use the observations from the first phase of QA visits.
- Divide these observations already plotted on the Star into 3 sets — attained, emerging, non-attained standards.
- Scan the sets separately and formulate achieved standards and non-attained standards.
- Check the formulations against existing service specification, remit and contract requirements.
- Refer to index of standards for assistance in working and gaps in standards.
- Ensure that deficient standards are the subject of action planning.
- Add achieved standards to the service prospectus and communicate to users and potential users in a charter or other form, so that users have a right to the standard.

7. Concluding Remarks

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

The ENQUIRE System is based on a number of important principles:

- that quality assurance incorporates quality measurement and a stated intention to use that measurement to improve and enhance the quality of the service. It requires managerial sanction.

- that no two services are identical and thus individually tailored processes are required.

- that effective QA required an involvement of staff and service users and is geared primarily to service outcomes and their eventual impact on the quality of life.

- that a good QA system will be based on rigorous validated observation aimed at discovering key concerns about a service.

- that off-the-peg solutions are not always helpful or desirable but can be useful once key issues in a service have been targetted, and

- that checklists and standards must be developed locally and applied carefully.

The ENQUIRE System is encompassing in that it:-

- focuses staff and users on the most important area of the service for further consideration, and

- enables a range of specific tools to be deployed appropriately.

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

support from management and staff.

ENQUIRE is proving a valuable approach to all who are tackling the difficult but rewarding area of improving the quality of the services, care and treatment and, above all, the lives of vulnerable or disadvantaged people.

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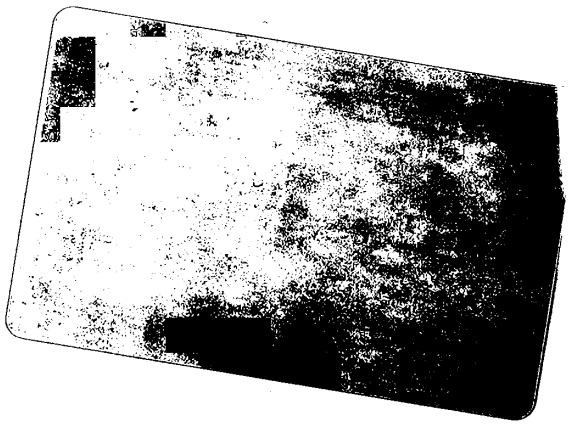

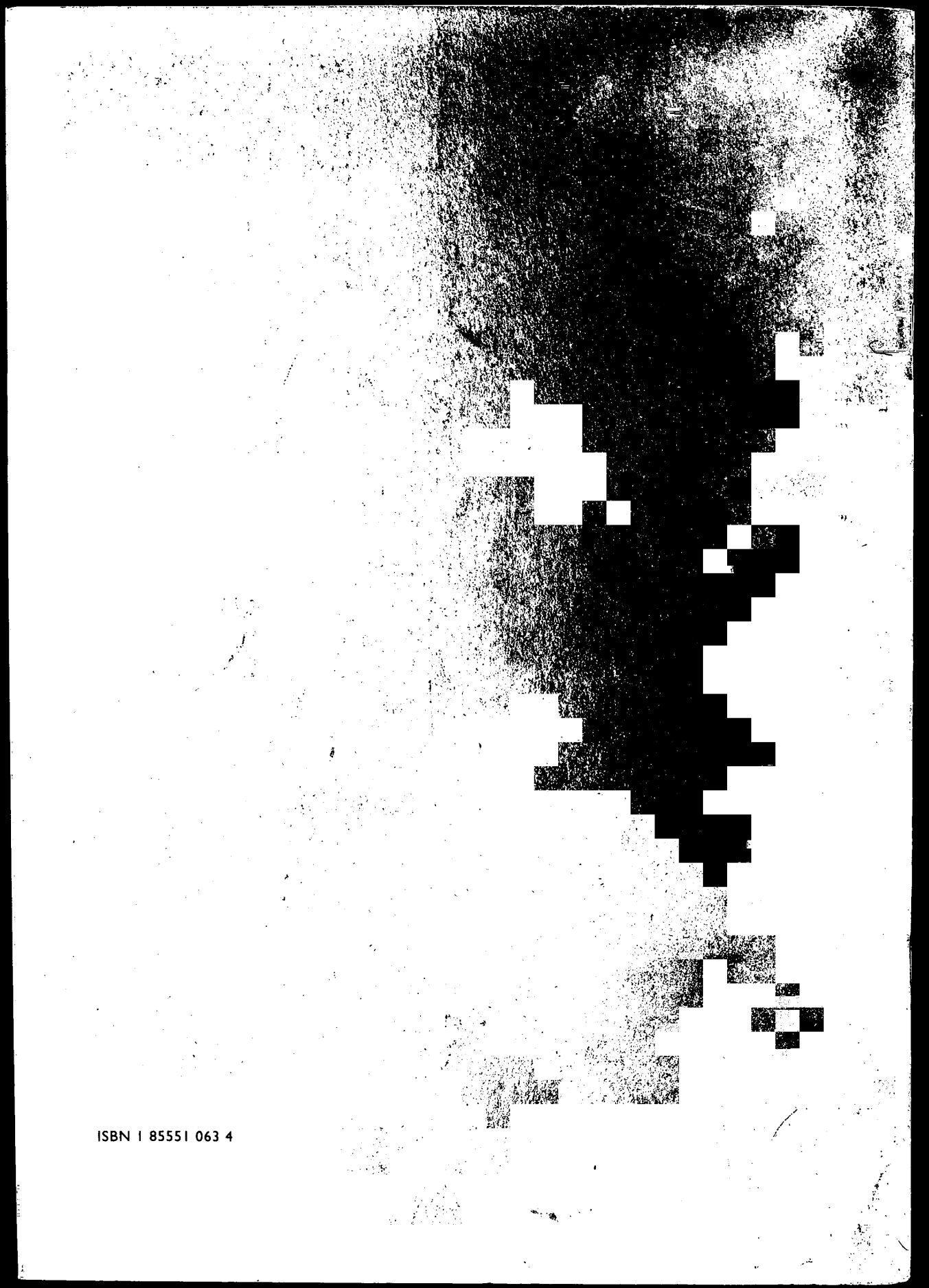

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