MAKING QUALITY CENTRAL TO THE DEVELOPMENT OF COMMUNITY CARE

Report from a Workshop on Quality
Assurance in Community Care,
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Services for people with long term disabilities (arising from mental handicap, mental illness, physical disability or the frailties associated with old age) are currently undergoing major changes - dominated by a shift towards more community-based patterns of provision ie to 'community care'. Associated with these changes has been growing concern with how the quality of these new patterns of services can be assessed and maintained. This concern has also been fuelled by the greater emphasis on quality assurance in N.H.S. management agendas (1), encouraged by implementation of the Griffiths proposals on general management. A great deal of development work is required however to turn the concern with quality into practical strategies of use to N.H.S. and Local Authority staff.

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1. INTRODUCTION

Services for people with long term disabilities (arising from mental handicap, mental illness, physical disability or the frailties associated with old age) are currently undergoing major changes - dominated by a shift towards more community-based patterns of provision ie to 'community care'. Associated with these changes has been growing concern with how the quality of these new patterns of services can be assessed and maintained. This concern has also been fuelled by the greater emphasis on quality assurance in N.H.S. management agendas (1), encouraged by implementation of the Griffiths proposals on general management. A great deal of development work is required however to turn the concern with quality into practical strategies of use to N.H.S. and Local Authority staff.

Our own work at the King's Fund College has demonstrated that there is a network of good people, both researchers and practitioners, involved in serious work on assessing and enhancing quality in community-based mental handicap services (2,3,4). We have also identified others engaged in similar work on the quality of long term support services for elderly people, people with physical disabilities and people with mental illness.

It was clear however that much of this work has been undertaken within 'client group' boundaries and that there is rather limited cross-fertilisation between these different areas of work.

The College, with support from the N.H.S. Training Authority decided therefore to mount a modest initiative designed to explore the scope for mutual learning among workers focusing on different 'client groups' about promising approaches to quality assurance in community care. A Workshop was arranged in February 1987 to bring together invited participants - both applied researchers and innovative practitioners - at the leading edge of developing quality assurance strategies for services to these four client groups. The Workshop looked across client groups to examine three main issues:

* the definition of quality in community care

* the development of methods and tools for operationalising these definitions, including ways of involving consumers

* the utilisation of these methods in self evaluation and quality assurance

The Workshop aimed:

(i) To examine commonalities and differences in current approaches to quality assurance developed in relation to different client groups.

(ii) To pool ideas on promising ways forward for practical implementation of quality assurance in community care;

(iii) To identify the scope and means for further collaborative work.

The programme for the Workshop and a list of those who participated are included as Appendixes to this report. The report itself sets out to distil some of the main themes from the two days discussion and to describe in more detail the practical steps already being taken in some local services to make quality central to the development of community care. I am grateful to my colleague, Ritchard Brazil, for writing up the notes from the workshop and to Val Bracken and Mark Burton for their willingness to contribute papers based on their own experience as managers of developing community-based services.

As these examples suggest, explicit attention to quality issues is perhaps furthest developed in the field of mental handicap although the Workshop showed the wider relevance of this work and the merits of sharing ideas and experience across all forms of community care. The most important lessons from this initial sharing process were two-fold. First, quality assurance needs to become intrinsic to the development of community services - from the design of services and definition of their objectives, through implementation and management, to ongoing review - it is not something to be `latched on' afterwards to a variety of processes which have not made the focus on quality central. Second, this concern with quality must start from the experiences of the users and potential users of services and, wherever possible, involve them directly in shaping improved forms of provision.

This two-day Workshop was only a starting point for further work in promoting quality in community-based services. In parallel, the King's Fund has established a Quality Assurance Information Service (at the King's Fund Centre, 126 Albert Street, London NW1 7NF Tel: 01-267-6111) and in subsequent work the College has already established a peer group of managers interested in developing local approaches to quality in mental illness services and further initiatives in the field of mental handicap.

In 1988 this work is being further extended to incorporate aspects of primary health care. No doubt related work is underway elsewhere and we hope that this Workshop Report will be one stimulus to further sharing of the experience gained from widespread British efforts to achieve and maintain quality in practise.

David Towell

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2. NOTES FROM THE WORKSHOP DISCCUSSION

Ritchard Brazil

A framework for quality

Understanding and recognizing the need to debate quality assurance is a growing strength of the newly emerging community care services. However, there is a perceived gap between the development of services and a real appreciation of how they are influencing the lives of the people that they serve. In broad terms, energy is still directed very largely towards a process of de-institutionalisation together with design of replacement services. Strong models exist which are based around the promotion of individual development and choice, leading hopefully to services which enhance the social roles and expectations of service users. These are powerful principles - well represented by An Ordinary Life and subsequent King's Fund publications (1,2,3). In particular, as the IDC's document Pursuing Quality (4) shows, we have been able to translate our general aspirations for high quality services for people with a mental handicap into operational guidance for practitioners.

For other client groups, we have been less good to date at developing explicit methods for assessing how well we are meeting our objectives. Quality is a key element in our prescription but does not yet occupy centre stage in our practice. Very often quality assurance is still seen as something carried out, usually internally, to supplement or replace external evaluation. A comprehensive approach to quality assurance requires us to share an understanding of what is meant by quality, take action to operationalise quality in service settings, map progress in existing services and take further action on the knowledge gained.

It is useful to set out this approach in three distinct segments of activity;

* Creation and acceptance of value driven principles defining what services should be trying to achieve - Quality guidelines

* Development of methods for introducing ongoing and active consideration of the impact of services on the lives of consumers - Quality management

* Implementing necessary action to redress the perceived imbalance between aspirations and reality - Quality action

This outline demonstrates that quality assurance is a process which ought to penetrate everything to do with service development and delivery. It should not be a tacked on replacement evaluation tool.

Quality guidelines

Good services are value driven. They exhibit a shared understanding at all levels in an organisation of principles which are manifested in the views and actions of planners, managers, direct support staff and others that support them. Good services are based around identification and provision for individuals' needs. Good quality community services also try to be available to all that require them (coverage) and are measured by how well the objectives that are set are truly reflected in the experiences of consumers - (effectiveness).

In services for people with a mental handicap, good quality services have been expressed within a value base which emphasises five key accomplishments - presence and participation in the community, the exercise of choice, growing competence and self respect (5).

The substance of these five accomplishments requires services to take on specific commitments around;

* the importance of consumer involvement: and

* the need to link values and principles to organisational change,

We may not always be sure if these values fully permeate our service systems. However we can be sure that if we do not explicitly state them and operate within them, then we have no firm basis for measuring whether our services are of high quality or not.

Quality management

Once there exists an agreed value base from which community services can operate, it is necessary to establish processes for interpreting the impact of services on the lives of consumers. Quality management should be inherent in the development of any service. Services which are based around innovation and change

away from outmoded practice models are by their nature dynamic, although too often quality management in community services applies only to these new services. It is still important to involve existing services, and to integrate quality activities which sustain progress where it is found with corrective steps in the areas where it is not.

A quality management process helps to ensure the permeation of explicit values and objectives throughout the management hierarchy. Identified criteria for success - like the five accomplishments - can then be clearly formulated and shared throughout the service, with the result that we strive towards achieving effectiveness (impact on the consumer) rather than merely seeking to achieve minimum standards.

The organisation that has adopted an agreed value base and developed the capacity to share this throughout the system is going to be better geared to remedy deficiencies wherever they occur.

Quality action

The implication of a clear quality management process is that where action is then set in train to deal with particular identified problems, such action can also evolve to take on wider significance. Remedying defects where they are found leads to questions about more general lessons that may be learned throughout the organisation. This in turn should lead to continual review of service aims and objectives.

Finally, any commitment to involve consumers in decisions about their service will not represent quality assurance if the product of such involvement does not feed back into the system, and demonstrate responsiveness to consumer views.

For the future

Quality assurance strategies which are built around positive values will allow us to emphasise the depth of our aspirations for community services and the people that they serve.

Using phrases like choice and normalisation, dignity and personal self-esteem, enabling and self determination reflects a desire to fundamentally remould the nature of community care. It should be remembered that these concepts have been developed by professionals for and on behalf of consumers. If these are not to be hollow words in practice, services must strive to ensure that power and control are genuinely shared with consumers.

Service reviews which are built upon comprehensive quality assurance strategies are important safeguards for checking that we are continuing to do the right things. However, it is still a major challenge for community care to ensure that current and future services flow in practice in the same direction as our wider aspirations. This is especially vital as the genuine change we are seeking seems to have few if any precedents in past efforts to move towards consumer control and empowerment in the public sector.

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(3) TAKING STEPS TOWARDS QUALITY ASSURANCE

Val Bracken

This paper sets out some of the steps that we have taken in Rochdale towards building Quality Assurance into our services for people with mental handicaps. In particular, three essential areas in the development of high quality services are emphasised;

* Goal Setting

* Training

* Action Evaluation

(A) Establishing Goals

Our specialist Joint Care Planning Team Mental Handicap came into being in 1982. It was then and is now composed of the following representatives:

3 from the Social Services Department
3 parents from Parent Bodies
3 from the Health Authority
2 from the Education Department
1 from the CHC

We still do not have a service user on the team.

We established that our major initial task was to agree upon a value statement. We stated that all our services would be built on the principles of normalisation. We then listed what we believed all people in our society were entitled to expect. This was written up on a life continuum basis and indicated points at which we believed the different services should prepare to be involved when required. We ended this document by saying that the Health Authority and Local Authority should agree to:

* The resettlement of 20 mentally handicapped persons per year from mental handicap hospitals - this figure to be reviewed annually in the light of experience.

* A review of the role of existing Health Authority and Local Authority hostels.

* A review of the role and function of Social Education Centres.

* The establishment of three additional Community Mental Handicap Teams.

* The development of further education and leisure services.

* A review of the needs and resources required for those mentally handicapped persons with special needs.

* An exploration of the possibility of developing a "Pathway Employment Scheme", in Rochdale, either separate from or in conjunction with sheltered industrial groups.

* Development of fostering schemes for short term respite care and for long term permanent care for mentally handicapped children.

* Development of lodging schemes for mentally handicapped adults.

* Development of joint training programmes for staff of both the Health and Local Authority.

* An extension of playschemes for mentally handicapped children.

* A review of the role of supported housing in the community jointly between Housing, Social Services, Health and Voluntary Agencies.

* A review of the provision of employment for mentally handicapped people jointly with Disablement Resettlement Officers, in both the Local and Health Authorities, and in private industry, including the use of Sheltered Industrial Groups (SIGS).

* The early establishment of a comprehensive register of mentally handicapped people.

* A review of the special needs and services required for elderly mentally handicapped persons.

The JCPT struggled over every word of this list until it was agreed. A true feeling of joint ownership and personal commitment had been created together with an agenda for the future. We then formed each of the points into an action check list and appointed key workers for each task. We update this list annually and it is the task of the key worker to report progress to the team on a six monthly basis. The list has been an invaluable guide for us and the fact that we are able to review the specific tasks has stopped us from becoming too entrenched and inflexible, we have indeed changed our aims as we have learned and become more experienced in the provision of comprehensive services.

(B) Training

One of our immediate priorities was to develop joint in-service training. We initially used joint finance and decided that this would be best spent trying to ensure that everyone working in our service understood what was meant by the principles of normalization - the values on which our services would be based.

We established a series of `Ordinary Life Workshops' and over 250 people have participated in these during the past 4 years (including direct care workers and managers from our statutory agencies), teachers, health visitors, parents, staff from our finance departments and central purchasing, people from our housing department and home helps. We find now that across agencies, departments and families, many of us at least speak the same language.

This was an essential step to take on the road to changing attitudes and elevating peoples' expectations for themselves as well as service users and their families.

(C) Evaluation

It has also been crucial to ensure continuous evaluation both of our services and of the general progress that we have made towards the goals that have been set by the JCPT.

At the service level we have tried to ensure that work carried out on behalf of all our service users is recorded using Guidelines for Individual Programme Planning (initially produced by the Mental Handicap in Wales Applied Research Unit). We have regular if infrequent inspection from our Regional Advisory Group on mental handicap services, the Social Services Inspectorate and have invited the National Development Team.

To supplement these initiatives we established an intra district cross agency evaluation system. The system is designed to examine an individual service provided by one unit, (hostel, home support team, social education centre). Each evaluation team usually consists of;

1 Parent
1 Service User
1 Voluntary Body Representative
1 Health Authority 1st Line Manager
1 Social Services 1st Line Manager
1 Education Manager (Head Teacher)
1 Co-ordinator,

all from within Rochdale. Each evaluation brings together a different team, with the co-ordinator remaining constant.

It is the task of the co-ordinator to ensure that the team understand their task and the evaluation material we use. One day pre-evaluation is needed for the team to learn and plan. The evaluation takes place over a 24 hour period. We measure our service aims, objectives and observable delivery against some guidelines which require subjective feedback and some check lists, the answers to which are more objective. The recommendations of the evaluation process in general form go to the Joint Care Planning Team, and specific feedback goes to the service.

Currently the main impacts of this process include the introduction of effective feedback on services together with positive and worthwhile involvement in evaluation, policy making and decision taking by service users, parents and the voluntary bodies.

As a result, obvious benefits that have derived from this system include; clients frequently involved in recruitment and selection of staff; clients always being involved in deciding where they wish to live; clients deciding what it is they wish to do during the day; clients deciding how they wish to spend their money; and parents' being represented on all our service planning working groups.

These only represent first steps towards our objectives. What is important however it that there must be continuous active evaluation of our current services. Only by investing in an ongoing training programme and constructing a process to enable us to regularly assess our progress, have we been able to ensure that our services reflect both our own aspirations and those of the individuals for whom they are provided.

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(4) QUALITY ASSURANCE IN A COMMUNITY TEAM

Mark Burton

Introduction

There are several reasons for wanting to illustrate quality assurance as it operates in a community team:

1) The function of such teams is not altogether clear, at least as evidenced by the literature that is available. A number of functions have been suggested: provision of a direct service, the co-ordination of services, the planning and development of services, advocacy, training and advice for parents, among others. While there has been guidance from, for example the National Development Group (in its second pamphlet) and in various reports from the National Development Team, this has lacked a clear understanding of what quality for consumers would be, and has therefore inevitably lacked sensitivity to the wide variation in local conditions.

2) Community teams tend to have relatively transient contact with service users. Unlike services based upon a building, community teams organise much of their work around visits into other environments, settings where they may have relatively little power in influencing what happens to service users. Indeed, the community team is not likely to be the major focus for those who rely on services: the ATC, the hostel (for short or long stays) as well as other experiences particularly those in the family, are likely to dominate. It can therefore be somewhat puzzling to define what quality might mean for such a service.

3) However, community teams are generally in a good position to take an overview of a service system. Their members are likely to serve a representative cross-section of the population of potential service users in the catchment area. They are likely to have contact with most of the services in the area, as well as some outside it. They are in a favourable position to review the impact of the existing system of services on service users, and therefore to at least have an understanding of what quality might look like. Such an ability cannot be assumed, but some of the preconditions are likely to be present.

4) In comparison to those in "hard services" (those based around a building, or in prolonged contact with users) community team members are likely to have a considerable degree of autonomy in their day to day work. Such autonomy could prove wasteful but it could also lead to a maximisation of impact if used intelligently.

5) My other reason for wanting to discuss quality issues in community teams is that my own experience for the last 5 years has been in such a service. From the start (and I was there then) our own service has taken the principle of normalisation seriously and tried throughout to maintain a commitment to quality. Before trying to present our own idea of what quality means in such a service, I should provide some information on context.

The Context

In 1982, when the NHS was reorganised the new North Manchester Health Authority inherited a commitment to setting up a small team of NHS professionals to serve adults with a mental handicap. Up until this point the NHS in Manchester had not provided a local service to this client group; services were being provided on an outreach basis from Calderstones, the mental handicap `hospital' some 30 miles to the North. The main service provider in Manchester was in fact the Social Services Department, which in 1982 operated with a tradition of high spending on welfare, but with generally bureaucratic and paternalistic forms of such provision. Their resources comprised a number of 24 place (or more) hostels, a relatively high level of social work provision (an increasing amount of which was organised in specialist teams), a number of "minimum support teams" (the language is revealing of some of the assumptions behind the model of service provision) - ie. flats or houses with one or more people living with intermittent support from social workers or (at that time) home helps. Finally there were two large (200+ places), traditional and `problematic' Adult Training Centres. It was to `support' the work of one of these that the new NHS team was established. However, before anyone was appointed it was already clear that the problems of a large day institution would not be solved by injecting some external expertise, and the early experience of team members confirmed this. Furthermore it took little imagination or knowledge to recognise that not everyone attended the ATC, and that those who did also spent time in other settings! Accordingly the remit

of the team was soon changed to cover anyone with a mental handicap living in or returning to North Manchester.

In addition some further resources were acquired from the RHA so the team was expanded. Such changes in the composition and remit of the team did not occur without debate and opposition from a number of quarters. What was particularly important was the availability of support and protection from within the Health Authority, particularly from Community Medicine in the early stages (1).

A strategy for quality

Over the 5 years of its existence, the team has evolved a strategy for quality, within which a self evaluation strategy is embedded (although this is still in its relatively early development). The two preceding papers have stressed that quality assurance is not a `bolt on' activity, and we have tried to integrate the pursuit of quality with the day to day running of our service. In fact, in the early years we were not particularly aware of the term `quality assurance' and if we had been we might have been less able to integrate this function with our work, instead, perhaps seeing it as a separate function. This may still be a problem with the evaluative part of the strategy; while recognising the need for evaluation to be participative rather than alienating it can be difficult to overcome the habits of thinking within an empiricist or natural science based framework.

Our strategy can perhaps be best illustrated by means of a diagram:-

Quality Assurance in a Community Team

Defining the Service

Definition of population

Definition of needs

Definition of remit

Description of function of service

Negotiate working - *internal*
relationships - *external*

Developing strategies

Operating Environment

Review - *a collective process*

Consumer Experience

Developing Evaluation Strategy

Defining questions to assess quality

Developing info/eval system
eg. * *casenotes*
* *project documentation*
* *'peer review' in field*

Decide which questions to answer first

Develop ways of answering questions

Answering the questions

The box `Defining the service' is crucial and yet this is often missing from services, particularly where (as with many Community Mental Handicap Teams) a service model is taken `off the shelf' or where a service developed in one local context is imitated in another one. As the diagram indicates, these steps are not carried out mechanistically in isolation from real people, but in a dynamic relationship with real users of services. This is to say, throughout, and particularly where consumer needs and strategies for meeting them are concerned, it is essential to stay close to users and their experiences. In so doing we have to explore, invent or discover new ways of relating to users, so that we get beyond a service - based mystification of their experiences, characteristics, situation, and interests. For example, Julie does not `attend the ATC', but rather `spends weekdays in a room with 28 other people with various mental handicaps and one staff member. When she isn't sitting doing nothing she is either doing copy-writing or assembling paper hats. While she enjoys some of the work she tells us through speech and through her behaviour that she gets bored by the monotony and the general lack of activity, and she resents and is embarrassed by being grouped with some of the others in her section'. We have found experience with PASS (2), and some of its derivatives such as `Getting to Know You' (3), particularly helpful in our attempts to gain a better understanding of the interests or needs of the people with mental handicaps to whom we provide a service.

Our understanding of the needs or interests of service users that stems from this kind of a relationship directly informs our understanding of the brief or remit of our service. We see the real segregation experienced by people with mental disabilities, whether they are nominally in the community or not, as our starting point - our premise for action. Our primary function is therefore one of developing the means for enabling people with a mental handicap to live a valued life, participating fully in the activity of the community. A key element in our strategy has been the recognition that in order to make progress in responding to the interests of people with mental handicaps, two different modes of work are necessary.

a) Working with individual people who have a mental handicap, directly or indirectly, assisting them to participate more fully.

b) Working to develop services and other resources so that work with individuals is not limited to the containment of individual problems, but truly acts to address the interests and meet the needs of the person with a handicap.

We therefore differ from both the NDT model which emphasises individual work, and the Nottingham model (4) - which emphasises development work, in emphasising the need for both modes. Indeed we believe that for either to occur in isolation will lead to its irrelevance, with individual work that fails to build up opportunities being doomed to a mere 'patching up' operation, and with development work that takes place without reference to the situation of real service users likely to become paternalistic or irrelevant in its dispensation of developments.

Other elements of our strategy include ideas such as

* Working with the 'healthy parts of the system' - in order to maximise our effectiveness, given our limited resources. This has often meant working with fairly marginal bits eg. a voluntary sector resource rather than a statutory one in order to build some 'visions of possibility'. These are of course intermediate strategies since eventually it is essential to work with the major service providers.

- Building alliances with providers who have made a commitment to better futures for people with handicaps. Much of this involves organisation around a shared ideology that might be based upon a shared experience or experiences. Much of the work of building better futures means constructing a new `common sense' to challenge the `common sense' that persistently threatens the experiences of those who rely on our service.

- Looking for opportunities. We distinguish between mere opportunism and `principled opportunism', ie. the use of opportunities on the basis of some clear principles about desired outcomes. We also distinguish between mere compromise and `progressive compromise' - a compromise that might become less of one because of the opportunities it allows for learning about effective ways of moving towards a better future.

The box `Review' is in a way the core of the process, and it can be difficult to organise. Throughout we have used team meetings and regular review sessions (half or full day) for this purpose. At present we are trying to improve the way this is carried out in our own work as individuals too. There are some implicit ground rules for the collective review process: for one thing it is collective, and all team members including attached students and clerical staff makes valuable contributions to it. We are not naive enough to think that this makes it an entirely equal process or to believe that there is no leadership of it (although this is both explicitly and implicitly shared among several people).

In relation to existing frameworks for quality assurance, the review process probably does correspond to that of the `Quality Action Group' described by Roger Blunden (5) and the IDC (6). That work has helped us to be increasingly clear about specifying the outcomes that we are working towards. We have not been very good at involving other stakeholders in this process, and this may reflect the relative marginality of services like ours in others' realities. However, we do see similar processes developing around us, for example in Social Services led programmes, and we increasingly participate in these (see below for discussion of the changing context or operating environment).

The 'Operating Environment' means the various contexts of our work. Of course these change continually and it is rarely possible to say with complete certainty to what extent our intervention (or presence) has contributed to such changes. What we can say is that changes frequently involve an interaction between our 'ideological' interventions (this should be happening), our 'practical' interventions ('let's try this approach') , the resources available, and of course the changing ideological picture around us. To give a more practical illustration, in 1982 we saw the need for people with handicaps to spend more time in ordinary community locations, with ordinary members of the community, in ways that enhanced their reputation (eg. not in groups of handicapped people). Much of that probably seemed like so much pie in the sky. However, now this need is universally accepted among service providers in North Manchester, and enormous progress has been made (relatively) in making it a reality. The critical features were,

(1) The availability of a new grade of Social Services worker, the specialist 'domiciliary carer' of whom there are now about 30 in the District (District population 145,000). Before the advent of these staff, who are not tied to buildings, and generally work in a 1:1 capacity, it was difficult to see how the accomplishment of sharing places with the rest of us could come about. There is far more to be done, particularly in terms of encouraging contact with people other than paid staff, but the domicilary carers have shown us the beginnings of the way forward.

(2) Work carried out to increase the expectations of parents and others about the capabilities of people with handicaps. This includes work from our team but also the work carried out in the special schools (albeit often out of any meaningful community context), in the adult education and further education sectors, and as things have developed by the carers (often in collaboration with OTs, Community Mental Handicap Nurses, Psychologists etc. from our team).

(3) The availability of outside training from bodies such as CMHERA that has been based around issues of values (especially PASS).

(4) The development of local training that draws and builds upon both that outside training but also on local experiences in developing opportunities for service users. This has led to an increased

understanding locally about the situation of people with mental handicaps and has provided an accessible language for both describing it and thinking of strategies for improvement (we use O'Brien's five accomplishments framework).

(5) Finally, despite setbacks, and while still vulnerable, the ideological situation nationally, regionally, and in the City has changed so that many of the arguments at least seem to have been won about the rightful place of people with a mental handicap.

A further aspect of our operating environment has of course been that of our employing authority, the District Health Authority. It was mentioned above that support, permission, and protection for our work was forthcoming from part of that hierarchy. As the new organisational structure spawned by the 1982 reorganisation settled down it became necessary to seek similar support from the new Unit Management Group, and where appropriate from the District Management Team. We were fortunate in having a UMT that included the very supportive Community Physician who had been our original `patron'. The other members were also prepared to be open to our discussions and explanations of our work, and this must have been quite a challenge since the team could present a fairly intimidating front to the world! The issue of leadership was a difficult one. Team members were keen upon a notion of collective responsibility and this probably was appropriate to the early design and development phases of our history. As the Griffiths reorganistion loomed there was much uncertainty about how the democratic approach could be retained. Ultimately the nurse member of the UMT became the Unit General Manager, and I became sub unit manager with responsibility for the mental handicap service. While not without some difficulties in adjusting to this new structure and its culture, this has allowed us a fairly high degree of continuity. None of the foregoing should suggest that support, permission, and protection came entirely easily. There was impatience at times with our emphasis on thinking about what we are doing. `They're thinking again....,They're using wallpaper', might have summed up some of the impatience and occasional incomprehension about what we were doing, and to be fair this was against a background of increasing accountability for resource management in the NHS and a service system with very little tradition of systematic but `free form' reflection on it purpose and strategies.

understanding locally about the situation of people with mental handicaps and has provided an [illegible] language for both describing it and thinking of strategies for improvement (we use O'Brien's [illegible] accomplishments framework).

(7) Finally, despite setbacks, and while still vulnerable, the ideological situation nationally, regionally, and in the City has changed so that [illegible] of the arguments at least seem to have been [illegible] the rightful place of people with a mental [illegible]

A further aspect of our operating environment [illegible] course been that of our employing authority [illegible] District Health Authority. It was [illegible] that support, permission, and protection [illegible] was forthcoming from part of the [illegible] new organisational structure [illegible] reorganisation settled down it became [illegible] seek similar support from the new [illegible] Group, and where appropriate from the District Management Team. We were fortunate in [illegible] that included the very supportive [illegible] who had been our original 'patron'. [illegible] were also prepared to be won to our [illegible] explanations of our work, and this [illegible] quite a challenge since the team could [illegible] fairly intimidating front to the world! [illegible] leadership was a difficult one. Team [illegible] keen upon a notion of collective responsibility [illegible] this probably was appropriate to the early [illegible] development phases of our history. As the [illegible] reorganisation loomed there was more uncertainty [illegible] how the democratic approach could be [illegible] Ultimately the nurse member of the [illegible] General Manager, and I became [illegible] responsibility for the mental handicap [illegible] not without some difficulties in [illegible] structure and its culture. This has allowed [illegible] fairly high degree of continuity. None of the foregoing should suggest that [illegible] protection came entirely easily. [illegible] at times with our emphasis on thinking [illegible] are doing. 'They're thinking again [illegible] wallpaper', might have summed up some of the impatience and occasional incomprehension [illegible] we were doing, and to be fair this was against a background of increasing accountability for [illegible] management in the NHS and a service system with little tradition of systematic but 'free form' reflection on it purpose and strategies.

If the above activities (Defining the service) and (Review) are important in getting the service orientated in the right direction, and begin to suggest how it might be kept going that way, then the lower box (Developing Evaluation Strategy) in the diagram begins to suggest some of the ways in which it might be able to tell whether it was indeed going that way.

An Evaluation Strategy

As yet we are only up to the second step. This does mean that we have identified 5 key evaluation questions, although they will need translation into more specific 'critical questions' concerning the different aspects of our work. The 5 key questions are:-

- Is the account of need correct?
- Is there a sensible deployment of effort?
- Are the best available methods being used?
- Are positive outcomes attained?
- Is the agency supportive to the work of the service?

It will probably be noted that these questions apply equally to the two different modes of work that we have defined, individual work and resource development work. Furthermore, they correspond to some fairly familiar concerns in service evaluation, the first four correspond roughly to the dimensions of *appropriateness, efficiency,* and *process and outcome evaluation.* The final question seems essential to us since responsibility for our effectiveness depends to a great extent on how supportive our employing authority is. Even if we do not formally evaluate this, it is important to at least keep the issue on the agenda.

We are not yet in a position to formally report on our effectiveness, and realistically we may only ever be able to do this for selected parts of our work. However, I discussed above how it has become more realistic to propose work on presence and participation in the community, and this illustrates some of our success, which has perhaps had as much to do with a continual emphasis on critical reflection on practice and looking beyond surface appearances, than with the practical work that we have done (which is not to devalue the latter). An interesting index of our influence on the service system is that the supports for our work now look very different in 1987 than they did in 1982/3. In 1982/3 most of our support came from the Health Authority while now most of it probably comes from Local Authority colleagues, especially some key individuals in the Social Services Department. The process of building these supports (which seen from another angle are coalitions) has of course influenced us too, but again it is quite difficult to disentangle this from our collective and individual maturation, and the changing operational context, as well as our learning from service users.

Barriers to developing the evaluation strategy

There are of course barriers to the development of the evaluation strategy. Among others, the following have troubled us:- 1) <u>Other requirements for information, imposed from above</u>. The current implementation of the Korner information requirements, for example, illustrates the emphasis on activity measurement rather than concern with the outcomes thereby produced. Our solution here will be to try and integrate such information with our own system, using it to answer our own questions, often in conjunction with supplementary information which may be qualitative rather than numerical. We would not have chosen the Korner approach ourselves, but as it is going to be implemented our attitude is to make the most of it while understanding its limitations.

2) <u>Time.</u> It takes time to develop processes for evaluation, hence our failure to have got further than the second step. Having designed processes it takes time to implement, use, review and adjust them. Against this must be set the opportunity cost of not evaluating the work of the service: this could lead to spending a long time up blind alleys!

3) The inaccessibility of much work on evaluation. Much of the available literature on evaluation is inaccessible to those providing services, locked up in University libraries or written in long texts that seem to have their own private language. It has been helpful having a background in research to access such materials as well as to `cut through the crud'. The most useful texts have been those of Michael Patton (8) which combine an orientation to practicality with an accessible and entertaining style.

4) Organisational issues again. Again it has been important to have the permission and support to pursue this work. By and large there have been forthcoming, but we may have inadvertently replicated the above problem of inaccessibility. Is support based upon a real understanding of what we are trying to do, and would that be a realistic goal anyway?

Conclusion

The above account describes some of the issues in pursuing quality in a community team for people with a mental handicap. Many of the features of our setting are idiosyncratic, even unique, but I hope some lessons can be drawn from our experience. The lessons include the following:-

* The importance of grounding a strategy for quality in an attempt to understand what faces the people who use the service.

* The importance of integrating the strategy for quality with the everyday work of the service.

* The importance of continuous review and reflection on the purpose of the service and its progress towards that purpose. More formal evaluative approaches only make sense when linked to that central activity. They have the potential to increase its effectiveness, but there are probably plenty of blind alleys on the way to that happy situation.

* The possilility of combining the two modes of work, individual - orientated and system - orientated, and the absolute necessity for there to be a dynamic relationship between them and the experiences of service users.

Notes

1. The support of our late colleague and friend, Judith Gray, was particularly important in the early stages of the team's development. She not only had a great understanding of what we are trying to achieve for people with a mental handicap, but also had sympathy for the way in which we were trying to do it. I was particularly fortunate in having a colleague who could draw upon much the same stock of metaphors in thinking through how changes can be brought about in large welfare bureaucracies. Judith is greatly missed in North Manchester although we are fortunate in the continued interest and support of others in the Department of Community Medicine.

2. Wolfensberger, W. and Glenn, L. Program Analysis of Service Systems. (PASS) 3rd Edition, Toronto: National Institute on Mental Retardation, 1975. Training in the use of PASS to clarify issues surrounding dependant disadvantaged people and their services is available from CMHERA, 9a Maddox St., London W1A 9PL.

3. Brost, M.M. and Johnson, T.Z. Getting to Know You. Madison, Wisconsin: Wisconsin Coalition for Advocacy and New Concepts for the Handicapped Foundation, 1980.

4. Wistow, G. and Wray, K. (1986), Service delivery and service development: the Nottinghamshire approach. In G, Grant, S. Humphries and M. McGrath (Eds) Community Mental Handicap Teams: Theory and Practice Kidderminster: British Institute of Mental Handicap.

5. Blunden, R. (1988), 'Safequarding Quality'. In Towell, D. (ed.) An Ordinary Life In Practice London, King Edward's Hospital Fund for London.

6. IDC (1986) Pursuing Quality: How good are your local services for people with mental handicap? London.

7. O'Brien, J. (1987). A guide to personal futures planning In Bellamy, G. and Willcox, B (eds). A comprehensive guide to the activities catalog: an alternative curriculum for youth and adults with severe disabilities Baltimore, Maryland: Paul H. Brookes.

8. Patton, M Q. Qualitatitive Evaluation Methods 1980 Creative Evaluation 1981 Practical Evaluation 1982 Utilization-Focussed Evaluation 2nd Edition 1986.

- all Beverley Hills: Sage.

Appendix 1

QUALITY ASSURANCE IN COMMUNITY CARE WORKSHOP 23-24 FEB '87

PROGRAMME

MONDAY, 23 FEBRUARY 1987

10.30 am - 11.00 am	Registration and Coffee	
11.00 am	Introductions	David Towell
	The state of the quality assurance art in community based services for people with mental handicap, metal illness, physical disability or frailty in old age. (Group-work and report back)	
1.00 pm	Break for Lunch at 1.15 pm	
2.15 pm - 3.45 pm	Involving services users (Opening statements and plenary discussion)	Derek Thomas Helen Smith
3.45 pm - 4.15 pm	Tea	
4.15 pm	Defining quality in community-based services and identifying relevant indices. (Opening statements and plenary discussion)	Paul Williams Simon Whitehead Su Kingsley
6.15 pm	Break for Dinner at 7.00 pm	
8.00 pm	Issue clusters and networking (Small groups organised around common interests)	

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TUESDAY, 24 FEBRUARY 1987

9.15 am - 10.45 am	Brief stocktaking	
	Quality assurance in practice (Opening statements and plenary discussion)	Roger Blunden Mark Burton
10.45 am - 11.15 am	Coffee	
11.15 am	Quality assurance: making it stick and making it influential (Opening statements and plenary discussion)	Valerie Bracken Alan [illegible]
12.45 pm	Break for lunch at 1.15 pm	
2.45 pm - 4.00 pm	Ways forward for quality assurance in community care and proposals for further collaboration. (Small groups and plenary discussion)	

Appendix II

QUALITY ASSURANCE IN COMMUNITY CARE WORKSHOP 23-34 FEB '87

Dr. Ann Antonelli	Training Consultant, NHSTA
Ms. Virginia Beardshaw	Health Policy Analyst King's Fund Institute
Mr. Steven Beyer	Research Officer, Mental Handicap in Wales - Applied Research Unit
Mr. Roger Blunden	Director, Mental Handicap in Wales Applied Research Unit
Mr. Ritchard Brazil	Fellow in Mental Handicap Strategies King's Fund College
Mr. John Bond	Health Care Research Unit Newcastle University
Ms. Valerie Bracken	Handicap Services Manager Rochdale Health Authority
Mr. Don Braisby	Liaison Officer (Mental Health) Camden Social Services Department
Mr. Mark Burton	Sub-Unit Manager Mental Handicap Services North Manchester HA
Dr. Nan Carle	Director, Services for People with Mental Handicap Lewisham & North Southwark HA
Ms. June Clarke	Director of Nursing Services (Community) West Lambeth HA
Dr. Tom Craig	Director National Unit for Psychiatric Research & Development
Mr. Stuart Etherington	Director Good Practices in Mental Health
Ms. Barrie Fiedler	Project Co-Ordinator Living Opinions Working Party
Ms. Su Kingsley	Associate (Psychiatric Services Development) King's Fund College

Mr. James Matthews	Principal Planning Officer Derbyshire Social Services Department
Dr. Norma Raynes	Senior Research Fellow Department of Social Administration University of Manchester
Dr. Judith Renshaw	Research Fellow Personal Social Services Research Unit University of Kent
Mr. Derek Thomas	Director Designate National Development Team for People with Mental Handicap
Mr. David Towell	Fellow in Health Policy and Development King's Fund College
Mr. Simon Whitehead	Assistant Director (Development) Suffolk Social Services
Mr. Paul Williams	Associate Director, Community and Mental Handicap Educational and Research Association