

MOVING INTO THE COMMUNITY
VIEWS FROM THE STAFF INVOLVED ON THE
CAUSES AND EFFECTS OF DELAYS IN ONE MOVE
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In recent years the emphasis on moving mentally handicapped people out of large and even medium-sized institutions has been increasing. Administratively, such moves involve assessing the needs of individual residents, identifying cohesive groups, finding appropriate accommodation within the community, renovating such accommodation as required, appointing and training staff, involving resident's relatives where possible, complying with budgeting limits and Health Authority and/or central government guidelines and regulations. This is not an exhaustive list, nor does it reflect any order of precedence in fulfilling these tasks, but it does illustrate the immense demands for a well thought-out plan of action if everything is to run smoothly and efficiently. What it also illustrates is the potential for significant delay at any and all stages in the proceedings.

Plans to establish staffed ordinary housing in the community for two groups of four children living on the children's villas at Meanwood Park Hospital were first put forward in 1982. The two groups chosen were all ambulant and severely mentally handicapped. One group of four, who were aged between 10 and 16 years, had been resident on the villa for an average of five years. The second group were older, age range 16 to 21 years, and had been resident for a correspondingly longer period of time (ten years). One of the minor side effects of the delays in implementing plans for these young people was that the term "children" which could have been applied to the younger group in 1982 became inappropriate for either group by the time the houses were opened. Whilst these eight young people will be referred to as teenagers in the text, planning machinery, being unresponsive to this sort of development, referred to them throughout as children.

The movement of these eight teenagers into two houses in the community was to be implemented through the closure of one of the children's villas which in turn involved finding alternative short-term accommodation for a further six. One of the groups was resident on the villa to be closed and the other group was then living in a different children's villa. Difficulties in obtaining suitable and acceptable housing and confusion over short-term care arrangements occupied the following year. Once a suitable house had been obtained further delays were experienced as necessary repairs and alterations had to proceed through the Health Authority Works Department and tendering procedures. (See Appendix 1 for further details of the process.)

By November 1984 there was a certain amount of concern and disquiet being expressed by those involved in the planning about the length of time the entire process was taking. There was a general feeling amongst the staff that their experiences were not unique and the many valuable lessons being learned might be useful for both future planning within the hospital and for other institutions engaged in the same sort of organisational changes. This study was therefore precipitated by events rather than by any research plan.

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INTERVIEWS

Twelve people who were intimately involved in the project were asked to participate in a tape-recorded structured interview. All agreed. The twelve people interviewed covered the range of professions:

- two hospital administrators, i.e. Unit Administrator and Deputy.
- two nursing administrators, the Director of Nursing Services and the Senior Nurse responsible for the two children's villas.
- five primary care staff, a Sister and Staff Nurse appointed to the first staffed house, a Sister remaining in charge of the villa where those four residents presently resided and who currently shared that position with the Sister appointed to the staffed house, and, finally, a Sister and Staff Nurse from the villa with residents going into the second staffed house. No staff had been appointed for that staffed house.
- Hospital Social Worker responsible for the eight residents whilst in the hospital.
- the Head of the Psychology Department and the Consultant Psychiatrist within the hospital who were involved at planning level, and also, in the case of the Psychologist, with staff training.

Each person was interviewed individually by the first author. The format of the flexible module interview can be found in Appendix 2. The first part comprised obtaining people's views on the extent of the delay, if any, what they felt the causes to be and any remedies that could be taken immediately or in the future. The second part of the interview considered the effects of the delays on the staff themselves, their work, on the people they worked with, on others involved in the project, on the residents and on their families. Finally, they were asked to discuss how they coped with the delay, both personally and in their work and what they thought the lessons were from this experience.

Interviews lasted from 15 to 30 minutes. The recordings were subsequently transcribed by the Departmental Secretary. Participants were then sent a copy of their own interview and requested to correct any mistranslations or omissions.

RESULTS

Analysis of the contents of the type-written transcripts was carried out by the first author. The views expressed by the interviewees are reported by question or question group, with particular professions being picked out where their replies differed from the more usual response, for example, if they were more detailed, dealt with a different area or were contradictory.

1. Extent of Delay

In all but one instance the opinions expressed on this question were the same; there had been a considerable delay. Talking only of the time elapsed since the date proposed initially for the opening of the first Health Authority house, the delay was felt to be in the region of seven to nine months. Those more intimately involved in the planning of the first house, i.e. Director of Nursing Services, Psychologist, Home Leader, all spoke of much longer delays. Here delays were considered to be more in the region of three years incorporating the period since the idea was mooted after the assessment of needs of two of the residents in June 1982. The only disagreement came from the Psychiatrist who felt that the time lag involved was

similar to that experienced by most schemes of this nature and, as such, did not constitute a delay. Indeed, there seems to be a great deal of variation around the countryside in the length of time it takes from identification of a group of people better suited to community life to their moving into the community. The length of time discussed here although not typical, is not unusual.

2. Causes of Delay

There was general consensus on this question of the main causes of delay. Initially, there was the problem of being offered houses by the council which were substandard and in areas of the city which were neglected, run down and generally "undesirable". The main single cause of the delay was seen to be "administration", "bureaucracy", "red-tape". Interestingly, however, no-one blamed the hospital administrators. Problems were seen to stem from management procedures, rules and regulations, which were outside the control of the hospital and its administrators. For example, the use of procedures which had to involve tendering and the Health Authority Works Department. Yet again, however, there was understanding of the need for accountability within a nationalised industry and for such procedural safeguards. On the other hand, there was also the feeling that in this particular situation the operational policy governing the move from institution to community was far in advance of the procedures used to achieve it. This contradiction between ends and means was poignantly conveyed by the Home Leader for the first house: ". . . the idea of us moving out is right, but we are still applying all the 'institutionalised' and 'handicapped' rules towards getting people out."

The administrators themselves, gave the most detailed replies concerning the causes of the delay. Basically, their points were similar to those already mentioned. Firstly, the brief for the repairs to the house had to be sent to the District Works Department where, in terms of budget, it was only a very small project. Moreover it was a small project which had to be fitted into an already organised and full programme of works. Secondly, they had to comply with District Building Office regulations which classified the house as Category II (Group Home) rather than Category I (Single Family Dwelling) with all that that entailed. Thirdly, and related to both of the above points, the whole procedure was new to everyone concerned. This led to people being worried about accepting responsibility for anything which was open to interpretation within the rules. The classification of the house is a good example of this where, although the house was to belong to the four young people for their life-time, and subsequently was a family home, such classification meant that fire regulations need not be imposed. Should the fire officer be asked to make this decision, or should the decision have been made explicitly from above? After all, the District Management Team had accepted the principles of normalisation implicitly and explicitly in the operational policy, but this and its implications was not made clear to the Works or Supplies Departments who had the everyday task of interpreting and applying Health Service regulations. In these circumstances it was natural that people fell back on the institutional rule-book. Finally, everyone involved in the planning and implementation of the move had other calls on their time and so work on the project had to be fitted around their routine duties.

3. Lessons for Next Time

Once again the administrators gave more detailed replies which reflected the general response obtained from the other professionals. These can be listed as follows:

- (i) Build up links with housing associations and the Local Authority Housing Department¹ so that the hospital's plans are almost part of their programme.
- (ii) Anticipate problem areas beforehand and set up systems to cope with them, perhaps getting formal authority from DMT to circumvent some regulations.
- (iii) Construct a timetable around the Works Department's projected date of completion, fitting staff appointments, ordering of supplies and so forth, around this completion date.

From the points raised by the other interviewees, these suggestions would be fully endorsed. There were various arguments over the setting up of a completely separate system or set of procedures to govern moves from institution to community. The most feasible suggestion envisaged a separate funding system with administrative responsibility to deal with moves into the community within its own set of "accountability" procedures.

The Director of Nursing Services further prioritised the appointment of a Resettlement Officer who could take responsibility for implementing and co-ordinating the moves.

4. Effects of the Delay

The views of those interviewed are divided into sections in this part, according to where or on whom the delay was seen to have effect.

- (i) **EFFECT ON RESIDENTS** – Those staff who had greater daily contact with residents were the most sensitive to the detrimental effects of delays upon them. The direct care staff themselves were very aware of the needs of each of the groups of residents with whom they worked – long term care, those moving out and short term care. With regard to the long-term residents there was disruption caused by new faces appearing on the villa. These new faces were those of the new staff appointed to the first house who would subsequently be leaving. In the meantime, although these staff were only supposed to be working with the four residents preparing to move, they were also forming relationships with other young people on the villa, relationships which would be broken suddenly, and, probably to the teenagers, inexplicably. For these young people moving out, the effects most noted by nursing staff were insecurity and loss of faith in the villa staff who were breaking promises by not providing this new home that they kept talking about. The staff of the second villa, who were most directly concerned with children coming in for short term care, suggested that effects on these children resulted from the confusion over where this was to be provided. Neither parents nor staff could prepare them for a change since neither knew exactly if and when this would occur. The psychologist additionally feared an increase in behaviour problems caused by less certain handling on the part of staff who were pretty confused and uncertain themselves about what was happening. A similar view was expressed by the social worker who felt that this effect was worse in the residents who were staying as staff were more sensitive to such problems in those preparing to move and were more protective towards them.
- (ii) **EFFECTS ON FAMILIES** – Once again, the main effects stemmed from confusion over when all the moves would actually happen. Parents of the teenagers who were moving into the two staffed houses were uncertain that

1 (Local government department responsible for housing).

it would ever take place. According to the social worker who visited these families, many were becoming anxious about the implications of the move: a feeling that if there were problems now, there would be more after the move. Moreover, parents who had been at all concerned that moving into the community was really the right decision for their son or daughter were now even more concerned. Parents of the children receiving short-term care were also confused about where their child would be placed, when this would happen, the security of this new placement and their child's adaptation to the change. All of these factors did not encourage parental confidence in staff or administration.

- (iii) EFFECTS ON DIRECT CARE STAFF – Most of the professions were aware of the anxiety, frustration, demoralisation and uncertainty experienced by the direct care staff. The direct care staff themselves felt that they had lost a lot of their initial enthusiasm for the project, had even lost belief that it would ever happen. They felt unable to plan the preparation of the young people for moving out since they had no target date in mind. In fact, a number of these people had already reached their limit within the hospital setting and could go no further. The staff also resented the fact that they were now seen as breaking promises by the teenagers whom they regarded as friends, and they were aware of the implications of this for that friendship.

As each villa was at a different stage towards moving out, different effects were being felt by the staff. In the villa whose house was at least relatively imminent, staff had been appointed for the house. For these staff the delay created two jobs for them and a conflict of roles. On the one hand they had to organise and co-ordinate any administrative duties to do with the house (e.g. choosing furnishings, attending planning meetings), be primarily responsible for the training of the residents moving and continue the normal routine of the villa. Additional problems were faced by the staff newly recruited to post, who were initially supposed to be appointed directly to the house. Due to delays they were asked to take up their contract within the hospital where they could at least get to know the residents concerned. This led to one new staff leaving, but was felt to be useful by the other two staff. However, they did feel torn between their work with the four young people moving out and the other residents on the villa. In the end, they came to be treated as villa staff, including being "rotated" accordingly. Both Sisters were concerned that the new staff were becoming trained in "institutional" practices which they would have to unlearn once in the community, and that they were seeing the young people in the worst set of circumstances where both the level of their behaviour and the expectations of them were self-fulfillingly low. For both Sisters there was the additional difficulty of trying to organise and plan for two different sets of residents and different staff whilst at the same time trying to do so in a way which would not cause conflict or tension either between the residents or between the staff. For the staff moving out there was the continuous dilemma of being separate from yet part of the normal villa routine and similarly for the staff remaining there was the dilemma of continuing routine yet allowing the other staff to make their own preparations. This might have been alleviated by additional staff being appointed to the villa but the shortage of staff in the hospital generally meant that for most of the time the "house" staff were counted within the complement of "villa" staff. One consequence of this was that some staff appointed

to the house were required to continue to work or to relieve on other villas. This meant that liaison was difficult when administrative decisions had to be made and staff were even unable to work with the residents for whom they were now responsible.

For the staff on the second villa where the house was still far in the future, the "house" staff had not been appointed. This caused particular problems for the Sister who had to help to make preparatory decisions concerning the works to be done to the house whilst in no way certain that she would actually be appointed to the house. There was a greater feeling of confusion and uncertainty amongst the staff on this villa and less information reaching them on future plans, all of which tended to undermine the cohesiveness of the unit. Both staff interviewed noted a growing undercurrent of tension and even resentment amongst the nursing assistants who were not being offered the opportunity of working in the house even if they wished to because of the cut in hours it entailed. This, combined with the general uncertainty over the potential closure of the villa; the future placement of the children receiving short-term care; parental anxieties and the lack of progress towards the second house was causing extremely low morale within the villa.

The indirect effects upon the residents arising from the difficulties experienced by all staff cannot be underestimated.

- (iv) EFFECTS ON THE HOSPITAL SERVICE – The most often cited effect of the delay on the service provided by the hospital was in the area of future planning. Future plans were being held up and there was a loss of interest in both implementing them and considering new proposals. The direct care staff saw this problem as it affected what they did with the long-term residents. One Sister remarked when asked about future plans “. . . they are all in abeyance. Everything . . . shelved. In the NHS (National Health Service) shelving is a coping strategy. I shudder to think it might even be a managerial strategy.” The second villa and the social worker were equally concerned with the effects on families requiring short-term care. From the social worker's point of view in particular, it resulted in a difficulty in co-ordinating and administering her work, especially in knowing when to counsel families about the implications of the changes on them and their son or daughter. She felt that most of her work with them involved postponing things and giving explanations of postponements. The results of the delay in the services provided by each villa have been covered already in earlier discussions with regard to role conflicts, staff shortages and villa policy conflicts.

Administration were particularly concerned with the hold up of other projects within the hospital which were not dependent on the move to the community for these groups, but were dependent on the administrators having time free to consider, organise and implement them. Once again, time to actually discuss innovative policies was now a luxury seldom enjoyed. In many ways the administrators were under a great deal of stress for although no-one blamed them personally, explanations for the delays and strategies to circumvent the delays were expected from them by other professions.

The nursing administration also felt this stress: “. . . I think the staff have given a reasonable service under the circumstances but obviously it hasn't been the comfortable sort of relationship there has been in the past because of the confusion and difficulty in communication.”

Both the Director of Nursing Services and the psychiatrist mentioned the dilemma of admissions given a resource (the hospital) that was now under-utilised. However, each approached the dilemmas from a different perspective. The former stressed the problem of making people understand that even though the hospital was there and not full, organising services so that the person could stay in the community might be a better alternative strategy to hospital admittance. The latter spoke of the problem of getting admission for people who might require hospitalisation when the whole impetus for policy was moving people into the community.

COPING WITH DELAY

One of the most common strategies suggested for coping with the delay was a period of in-service training. In fact a programme of in-service training was already in operation for the staff of the first staffed house. It was organised jointly by the psychologist (second author) and the Home Leader, to cover issues relevant to living in the community, such as house policy, social integration, developing and evaluating individual programme plans, and staff support systems. From the responses obtained in the interviews it is apparent that staff found the training very useful both in getting to know each other and keeping up morale and in the discussion of the particular strengths and weaknesses of the residents with whom they would soon be living.

The social worker further suggested that a similar support in the form of staff support groups and better inter-professional communication should be given to the staff of the second villa. However, probably because staff had not been appointed to the second house, this was not done and the second villa was left with only the most informal support from their Senior Nurse and passing professionals.

Staff from the second villa coped with the delay by attempting to carry on with programmes for the residents, even though they expressed anxiety over whether the programmes would continue if and when the residents moved. The Sister would have liked to have provided a smaller unit within the villa for the four residents about to move which would have had a homely atmosphere and training could go on without the disruptions caused by the short-term care children coming and going. However, this was not feasible.

Creating smaller units or finding temporary homes in the community were suggested as possible interim solutions by the Senior Nurse and Psychiatrist respectively. However, both felt that the disadvantages of a temporary upheaval probably outweighed any advantages gained in being one step nearer the desired permanent community goal.

Another coping strategy, that of arranging for the newly appointed staff to take up their posts within the hospital has already been discussed. The net effect of this strategy is difficult to ascertain as the staff themselves felt they had learnt a lot by it but were unable to judge at what cost.¹

Finally, it was suggested that the residents should be encouraged to become *involved in choosing furniture and furnishings for their new home*. However, from previous points made regarding Health Authority regulations, tendering procedures

(1. informal discussions with the first author).

and even staff shortages, the impossibility of this strategy is apparent. Although this actual strategy would have been useful in resident training as well as maintaining staff motivation, it is incompatible with normal hospital procedures as they applied in this instance.

DISCUSSION

The present study demonstrates that delay should not be accepted as inevitable. Although all participants felt frustration and anger the full extent of the effects of the delay on residents, parents and staff, was only elucidated as a result of the study. Delay, particularly where a new and possibly risky venture such as the re-settlement into the community of young people with severe mental handicaps is involved, raises anxieties and doubts which increase correspondingly with the length of the delay. Where staff are actively involved in changing the principles which underpin services, as in this case, much of the motivation lies in the belief of the staff that the new course of action is right and that the quality of life can and will be improved: the evidence for this belief coming from examples in other parts of the country. Delays inevitably erode this belief and the lack of good local examples of this alternative form of care means that little practical reassurance is possible. The study does indicate that the system of communication within the hospital from management and planners to direct care staff was relatively good. Staff did not blame colleagues for delays that they accepted as being beyond the control of the hospital management. However, the system enabling communication from direct care staff to management and planners was much poorer. The effects on resident's quality of life were more likely to be overlooked the further away from direct care the staff were. The needs of residents and staff on the villa which was to be closed were overshadowed by the administrative need to sort out alternative short-term care arrangements at policy level and by the delays and frustrations involved in acquiring and altering the first house.

The extent of the lack of effective communication from direct care staff to planners is apparent only with hindsight. Attempts were made to use the timelag positively, but these efforts were concentrated on staff already appointed to the first house: very little in fact was undertaken to help the staff whose villa was to be closed, cope with the effects of the delay. Inevitably, in an atmosphere of uncertainty, rumour, doubt and helplessness are likely to flourish.

The complexity of the task facing the hospital in the development of new forms of care was under-estimated even by the most cautious. The easiest part of the process, although one which is absolutely essential, is writing the document detailing the proposal. The acceptance of such proposals did not present a very significant problem in this case since the philosophy of future care — local community services based on the principles inherent in normalisation (O'Brien, 1981) — had previously been accepted by both the Health and Local Authorities. A joint forum for planning and discussion existed. Yet, even with these advantages, the first real commitment of significant resources stimulated questions and discussions about the interpretation of the philosophy and extended negotiations between the two main Authorities. Although planning principles had been agreed upon, the details of implementation demonstrated that these principles were little understood other than by those who were working or planning actively in mental handicap. The effect of a change on policy are much more widespread. For example, Finance, Works and Supplies Departments operate within regulations and policies which

have a profound effect on the extent to which ideals can be implemented. The hospital, understandably and rightly, concentrated its efforts on the education of its own staff but without the simultaneous involvement of and discussion with other departments outside the hospital whose co-operation was needed, the enthusiasm excited in residents, staff and parents by workshops and seminars to some extent is squandered.

The present study concentrated on the effects on residents, parents and staff who were already directly involved. The effects of these delays on other residents and staff who were waiting on the sidelines for resettlement into the community may also be significant. These houses were the first attempt to resettle children and young people who, because of their age and individual needs, required a high staffing level, i.e. two staff on duty for the majority of waking hours and a member of staff sleeping in. Three or four houses for small groups (two to four) of ex-hospital residents had already, in fact, been developed in the community. However, the tenants of these houses required minimum staff support. Although delays were also experienced with these houses, the extent was not so great, the tasks involved were much simpler and they did not have such major resource implications. It may well be that one of the long-term side effects of the delays experienced in the present study, is to decrease optimism about helping people who are more severely handicapped to live in the community. It may even encourage the development of a pragmatic policy of concentrating resettlement efforts on the more able residents.

There is also the ripple effect of delay in one area of planning spreading out to affect other areas. Plans, whose aim was to improve the quality of life of those people who would continue to live within the hospital for the time being, were delayed through the failure to close the children's villa. One unacceptable consequence of this was that some people were required to move residence twice within a short period of time in order for refurbishments to take place.

Finally, the uncertainty of funding sources such as Care in the Community and Joint Funding (DHSS 1983) and the constraints placed upon administrators by "the end of the financial year" phenomenon, meant that planning was not in practice the smooth, well thought out process originally envisaged in the initial proposal. The loss of money from the Care in the Community initiative encapsulates the difficulties. This money, £80,000, was made available unexpectedly in February but because of a builder withdrawing from the sale of the house, it was lost again by April 1st of the same year, despite attempts to retain it beyond the financial year.

Despite these experiences, there is still a strong commitment from staff within the hospital and within the Health Authority to establish locally based comprehensive services. The first house in the present study was in fact opened in April, 1985 and the other by August, 1985. The first hand local experience gained with their "conception" will undoubtedly be helpful in the next phase of planning. However, if living and being cared for in valued settings within the community is to become a practical reality for severely handicapped people, then some reappraisal of policies at a National, Regional, and Local level is required. Otherwise, we will run the risk of being left with a few "museum pieces"; a few staffed houses dotted up and down the country which are not an integral part of any Authority's service.

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APPENDIX 1 SEQUENCE OF EVENTS – ESTABLISHING STAFFED HOUSES FOR CHILDREN

June 16th 1982	JCPT Sub-Group set up working party on children's services.
November 30th 1982	Final draft document on "Long-term Residential Care" for mentally handicapped children in Leeds produced. This outlined basic principles and the implementation of Phase 1. Phase 1 was to involve the closure of a villa using the resources released to establish two staffed houses, one for two children who required intensive care and another for four children. Alternative accommodation for children receiving short-term care would be provided by Social Services children's hostel and by an increase in the Family Placement Scheme.
January 1983	In addition, Social Services put forward proposals to establish a small house in the community for children.
February/March 1983	Acceptance of the document by the JCPT Sub-Group and the JCC.
April 1983	Acceptance of the scheme by the DMT and by the Leeds Eastern Health Authority.
April 1983	Money identified for Family Placement Scheme to provide places for children currently receiving short-term care in hospital.
May 9th 1983	Working party convened to enable proposals to become practical realities – tasks identified.
June 14th 1983	Proposals changed with changing circumstances to two houses for eight children. Idea of house for two children abandoned in the light of progress made.
June 26th 1983	Leeds Eastern Health Authority, Leeds Western Health Authority and Leeds Social Services Department draft operational policy for houses put forward and proposed staffing levels agreed. Proposals accepted after amendment September 1983.
July 12th 1983	Open meeting for parents at hospital on future services for mentally handicapped children.

July 1983	Three week orientation course for staff agreed.
August 13th 1983	Regional Research Grant applied for.
September 9th 1983	DMT and UMG agree on no more admissions to villa.
September to December 1983	Meetings of the working party suspended pending Social Services Committee approval of the Social Services House and the use of the resulting vacant beds in the hostel for short-term care for people who currently receive it in the villa.
December 9th 1983	Reconvened working party. Research project agreed to commence 1.4.84 for two years. Arrangements made to inform staff and parents. Arrangements made for recruitment. Induction course fixed for 5.3.84 to 24.3.84. The hunt for houses is on!
January 1984	Projected short-term care arrangements discussed with villa. No progress made on recruitment. In-service course cancelled.
February 1984	£80,000 available from Care in the Community [HC (83)21] money to be spent before April 1st.. Agreed to purchase and equip a new bungalow. Staff recruitment awaiting provision of houses. Joint assessment of short-term care children agreed.
March 1984	Bungalow sale falls through. Attempts to retain the £80,000 fail. Staff Orientation Course reconsidered – reduced to one week in view of organisational difficulties. Fixed for June. Joint assessment of short-term care children completed. Decision of Social Services awaited.
May 1st 1984	Tenancy of house accepted for one group of hospital children. Research worker appointed. Confirm short-term care arrangements in hostel. All short-term care parents seen.
May 22nd 1984	NHS advert for staff issued. Orientation dates changed again to July. Short-term care in hostel still awaiting confirmation. Matter taken to JCPT.
June 1984	Home leader appointed and two full-time staff for first Health Service house. No progress made on second house. Agreement on short-term care at hostel.
July 1984	Staff Orientation Course for Health and Social Services staff. Furnishings requisitioned for first house. No progress on alterations – no explanation.

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| | All full-time staff appointed.
No progress on second house – referred to JCPT Sub-Group. |
| September 1984 | Alterations to first house agreed.
Tenders invited.
Remaining posts agreed.
Possibility of second house. |
| October/November 1984 | Tending period for first house nearing its end.
Predicted date for completion and renovation is January 7th.
All staff appointed.
Social Service house opening date now 1st December.
Second house – final approval awaited.
Working party disbanded in its present form. |

APPENDIX 2
DELAY AND IT'S REPERCUSSIONS
Interview Format

CAUSES OF DELAY

1. To what extent do you think there has been a delay in getting the houses off the ground? If there has been a delay what have been the main causes?
2. Do you think the delay is significant or not? Very generally, what have been the most significant effects of the delay?
3. What might be done to put an end to the delay as soon as possible?
4. What do you think the lessons are for next time? What would you avoid doing and what would you definitely do to prevent such a delay in future?

EFFECTS OF DELAY

5. What has been the effect of the delay on:
 - (i) you personally, and
 - (ii) the service you are giving?
6. What has been the effect on (other) primary care staff:
 - (i) on them personally
 - (ii) their dealings with you, and
 - (iii) the service they are giving?
7. Have you any comments about the effects of the delay on the service generally?
8. How have the residents and their families been affected by these delays?
9. What have you done in order to cope with the delays:
 - (i) personally
 - (ii) within the service?
10. What do you think the lessons are for next time?