

**QUALITY: A MULTI-METHOD EXPLORATION OF THE SOCIAL
CONSTRUCTION OF A CONTESTED CONCEPT IN THE
NATIONAL HEALTH SERVICE.**

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Abstract

This thesis explores the application and development of the contested concept of quality in four National Health Service acute hospital Trusts: Marketown, Fishtown, Castletown and Shiptown. It shows how quality can be conceptualised along two theoretical planes: the colloquial (or common-sense) and the technical; the focus for this thesis is on this second, technical, level in which quality can be observed as a distinct set of activities – quality has been operationalised. Quality is shown to be explicitly linked to a process of managerialization which has impacted upon public services extensively in the past fifteen years. As part of this process, quality is associated with attempts to recast power relations between groups with a stake in the provision of services and consequently the operationalisation of quality. These groups include professionals, managers and consumers. The thesis represents a snapshot of these attempts to shift power using the language and techniques of quality, and the reactions to these attempts from ‘stakeholders’. It presents stakeholder groups as ‘constituencies of interest’ bound by, amongst other things, organisational culture. These ties are explored using multiple sources of data (Q-method, interviews, observations and documents), within a case-study methodological framework.

The thesis concludes that, whilst the conventional organisational cultures of managerialism, professionalism and consumerism provide useful analytical levers, they are far from the only influence in forming constituencies of interest. Categories such as hierarchical position, market role and insider-outsider status and the power and interests associated with these categories are just as influential. Consequently, policy makers are asked to recognise the complex impact of factors such as power, interest and culture, on the operationalisation of quality in services, and to recognise the multi-dimensional nature of the conflicts promoted by this complexity.

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CHAPTER ONE: QUALITY AND THE NHS - AN INTRODUCTION

The concept, and associated language, of quality has become a major preoccupation with policy makers and service providers alike in the National Health Service (NHS) over the past fifteen years. At a macro level, the use of the term quality has become a pervasive feature of almost every significant NHS policy development in the last seven years. It is now firmly established in the rhetorical toolkit of politicians wishing to comment on the NHS and the services it provides.

In the micro policy arena of service provision, quality is now a substantive component of the work of every NHS Trust. Almost all Trusts are engaged in various forms of *quality* assurance; *quality* initiatives; and *quality* management. Many staff are employed in ‘*quality* directorates’ professional groups have been linked to the concept through ‘directorates of *nursing* and *quality*’ in Trusts. *Quality* has also entered the core financial business of transactions between Trusts and their purchasers in the form of *quality* specifications attached to contracts.

Despite the incursions the concept has made into the work of the NHS, quality itself remains an elusive and slippery concept. It is often ill-defined, if it is defined at all; and its meteoric rise in the NHS is something which deserves further critical scrutiny. As Pollitt pointed out in 1990:

‘Everyone is in favour of quality. To seasoned political observers this alone is enough to make it an object of suspicion. Like performance and efficiency, quality is a danger of meaning all things to all men (and women). Like performance and efficiency, it is a term open to subtle abuse.’¹

This thesis takes as its starting point the need to address the suspicions of observers such as Pollitt and to look at the ‘subtle abuses’ which quality endures in NHS provider Trusts. In order to look at these abuses one must first take a conceptual ‘fix’ on the subject under investigation. Taking such a fix is not easy because quality can often mean ‘all things to all men (and women)’. It is necessary then to be clear exactly

what is referred to in the thesis to when it uses the term of quality. This introductory chapter seeks to fulfil this task and in doing so to outline the scope of the thesis by highlighting some of the salient questions which arise from an examination of the literature on the conceptual nature of quality.

Towards A Taxonomy Of Quality In The NHS

The notion that quality can have a variety of meanings is a factor acknowledged by both theoreticians and policy makers. The National Health Service Executive (NHSE) itself acknowledges that, ‘The term quality is obviously open to interpretation’.²

The Colloquial Sense of Quality

One option for the analyst seeking to explain how ‘quality’ has become so potent a force in NHS rhetoric and policy is to postulate that when quality is referred to in the NHS and when quality is spoken about in our day to day lives, we are talking about two separate (yet intertwined) entities. Having put forward a typology of quality revolving around the diverse formal definitions in use in public services James³ asserts that quality occupies two distinct linguistic and conceptual arenas: the ‘everyday’ and the ‘expert’. These two terms can be recast as the colloquial and the technical in order to better represent the views of other theorists who make a similar distinction, such as Pfeffer and Coote⁴, who refer to the everyday sense of quality as the ‘traditional’ meaning.

James argues that the everyday or colloquial use and meaning of quality has a number of defining features:

- ‘Quality’ can be used to refer to mean ‘high quality’. For example, when talking of quality clothing or quality fittings. Pfeffer and Coote⁵ make a similar point when they argue that the label of quality when used in this sense conveys prestige or positional advantage.

- Quality is understood as both a relative and subjective term. In other words, quality can, quite naturally, mean different things to different people but all meanings can be acceptable.
- People seem to employ, naturally, a number of criteria in individual definitions of what counts as quality. James uses the example of people asked to classify roses according to level of quality. They used criteria such as stem length, fragrance and colour to reach a judgement of quality.
- That when using quality in an everyday sense people have no problem in pulling together these three strands in order to make a judgement.

For James, the judgement of quality is not based solely on subjective-objective criteria such as fragrance or length of stem, but with reference to ‘softer’ variables such as who sent the roses in the first instance and their implied significance to the recipient. She suggests that this is lost when quality enters the organisational [management] domain. Quality is often reduced to a simplistic reductionist argument of subjectivity versus objectivity. Or in her words, ‘either quality seems to be about everything or it is about checklists, when in reality it is about both’⁶.

Quality in this sense is inherently subjective and simply implies a ‘degree of excellence’⁷ in the object it is applied to. Quality is something that can be a characteristic of people or products, but when used at this level is vague and open to interpretation. Nevertheless, the term carries enough weight to imply a value judgement. When something is said to possess ‘quality’ this always has the impact of portraying the object or person in a positive light. When a product is sold to you on the basis of its ‘quality’ it is appealing to something subjective which you hold in high regard.

Pfeffer and Coote call this meaning of quality the ‘traditional’ approach; their analysis derives not from the characteristics of activities labelled under the umbrella term of quality, but from a functional analysis of what quality is used for. As stated earlier, for Pfeffer and Coote, quality is used to ‘convey prestige and positional advantage’. Quality in this sense has some definite advantages for anyone using the term. It is readily understood by people, and almost everyone will assume that the service or

product labelled with the tag of quality will be superior in some way to others. In a public sector context this characteristic can prove problematic. Within free markets the consumption of quality products confers status on the consumer (witness the marketing strategies of Rolex watches). In the NHS however, consumption of the NHS product is not commonly seen as a status enhancing process. Indeed as Pfeffer and Coote⁸ point out it may be positively stigmatising and disabling. In the NHS the status is conferred on the provider as opposed to the consumer. Because of this they argue that the idea of traditional quality has no relevance to welfare.

Pfeffer and Coote's contention of quality's irrelevance to the production of NHS services can be countered, however, by a recognition that the colloquial use and meaning of quality can have a profound influence on services. Like mud, 'quality' (or rather the status it implies) sticks. So significant changes to services such as organisational de-structuring, skill mix, and the questioning of the effectiveness of clinical practice, can all be justified under the banner of quality. Often in a more precise, technical, guise such as Total Quality Management. The organisations involved can remain secure in the knowledge that the more easily appreciable colloquial meaning will remain as a reference point for the public and workforce to fall back on. As Pfeffer and Coote point out:

*'activities which take place in the name of quality may indeed improve matters for the public. But even when they don't the quality message remains.'*⁹

In relation to other areas of public service, in the 1989 research review of universities by the University Grants Committee quality was not explicitly defined 'because it was assumed that the panels would recognise quality when they saw it'¹⁰. The colloquial meaning of the term quality has also found favour within the NHS. One of the case sites in this study had as its organisational logo, '*Partners in Quality Care*'. They had also instituted a district-wide training programme which had been used extensively in the marketing of their services called '*Foundations for Quality*'. One might argue that in these cases quality was simply a rhetorical device used to confer status upon the Trust. There was no need to demonstrate the substance behind these phrases as each served to imply that their Trust was of a higher calibre than their competitors.

The views of Pirsig¹¹ relate to quality in this sense when he states, albeit from a more abstract perspective, that, ‘even though quality cannot be defined, you know what it is’. In later works he refines his arguments somewhat to talk of the relative nature of quality judgements. A judgement of quality, for Pirsig, is made with reference to static and dynamic values. Static values are those values which individuals know and are comfortable with (like James’ rose stem-length and fragrance, or politeness and safe environments in NHS Trusts). Dynamic values on the other hand are those which are new, challenging, and desirable to the individual (for example, the idea of external monitoring of clinical practice to managers in NHS Trusts). Quality is seen as a function of these complementary and cyclical values. Dynamic values arise as an evolutionary response to frequency of contact with static values - people get used to them. The idea of quality is then constantly changing as people get used to the status quo and seek changes.

This view of an evolutionary, common-sense, relative and yet indefinable concept raises interesting questions in relation to the NHS. If quality cannot be defined, and yet is recognisable, how will all stakeholders in public services know it exists? If all groups will recognise it, then will they do so to different degrees in response to their different desires from services? How will services demonstrate it in an era of managed competition between providers? How can something that is indefinable act as the basis for organisational behaviour and change? The colloquial meaning of quality can never do anything other than appeal to each individual’s internalised sense of what quality means to them. Because of this, it poses a severe problem to the manager or policy maker seeking to institute change towards a goal of ‘quality’ in groups of people involved in the delivery of care. The answer to these dilemmas can be found in the technical mode of usage and meaning of quality. For quality to form the basis for organisational action it has to be made *meaningful* to lots of people, it has to be *operationalised* - this is the domain of technical quality.

The Technical Sense of Quality

Whilst the colloquial sense of quality has been shown to have its uses in NHS services and policy, it is not quality in this sense which forms the basis of corporate action.

Quality when used as the basis for strategy, initiatives, planning, action and monitoring occupies a different conceptual sphere. Quality begins to take on a more technocratic feel in the language used to describe it and the means taken to achieve it. Quality in this technical sense has to overcome the inability of common-sense (colloquial) ideas of quality to be anything other than internalised and subjective.

It is at this level that most of the definitions emerge from the operational literature attached to quality. Perhaps unsurprisingly there are very few pieces of work dealing with the conceptual nature of quality in the colloquial sense but hundreds of texts promising to help organisations achieve technical quality. The definition of which is usually dealt with in a cursory paragraph or two at the beginning of the book. Quality in this sense is, somewhat paradoxically, easier to capture and to categorise.

There are three main ways of piecing together the multifarious strands of the quality manuals and technical approaches to its actualisation. One approach is to eschew a definition at all and simply list those activities which are done under the label of quality and let the reader make up their own mind. This is a tactic which the NHSE have used to promote the implementation of quality in the NHS. This approach has the obvious advantage for policy makers that they are not aligning themselves with too narrow a definition which might prove contestable. The approach can be seen quite clearly in this example.

'the term quality is obviously open to interpretation. By way of clarification the work encompassed by organisations [appearing on the Quality Register]...includes:

- *Accreditation*
- *Audit*
- *Benchmarking*
- *Complaints Systems*
- *Consumers Surveys*

- *Inspectorates and Auditing Bodies*
- *Guidelines and Standards*
- *Patient Focused Development*
- *Quality of Life Indicators*
- *Quality Management*
- *Risk Management*¹²:

A second approach, adopted by Pfeffer and Coote and others, is to ask, what use is quality put to in the public service arena and what can be inferred from this about its meaning? This begins to recognise that quality is both contested and can have different meanings according to the uses to which it is put.

A third, and potentially more useful analytical device, is to look at the organisational groups allied with particular operational forms of quality. From the patterns that emerge one can infer something about the links between quality definition and the broader sets of values held by those groups (remember quality as a judgement of static and dynamic values). Proponents of this last approach have included Pollitt¹³, Pollitt and Harrison¹⁴, Gaster¹⁵, and Alazewski and Manthorpe¹⁶.

The second and third approaches have the advantage of ‘grounding’ their analysis in the real world context of the NHS. With all the politics, interest group dynamics, contested meanings, and ‘subtle abuses’ that this context offers.

Taking Pfeffer and Coote’s functional analysis first they classify quality as having five uses and meanings:

Traditional quality: used to confer status and positional advantage. This is discussed in the colloquial sense in the previous section

Scientific or expert quality: to conform to standards determined by experts

Managerial or excellence approach: to measure customer satisfaction in pursuit of market advantage

The consumerist approach: used to empower the customer

The democratic approach: this isn't strictly an approach to quality observed in British welfare services. It is a normative recommendation of the way they would like to see the concept of quality shaped in public services in the future. Because of this normative characteristic I shall not be including it in this taxonomy.

Scientific Quality

Within this approach quality is the logical end product of conforming to standards which are deemed acceptable within boundaries established by expert opinion. Either within organisations or within the knowledge bases of organisational groups (for example, professional opinion as typified by the Royal Colleges). Quality is based on progress towards achieving pre-specified standards representing that which is deemed desirable in service or group activity by the services or groups themselves.

Within the technical sub-domain of 'scientific' quality there are two further distinctions which can be made: the universal and the relativist.

Universal Scientific Quality

Quality along these lines is reached when standards are met which are seen as necessary for *all* producers or service providers. An example here is the development of public sector league tables based on standards contained in the various Citizens Charter derivatives such as the Patients Charter. The Conservative government of 1995 made it clear that:

*'[The Patients] Charter has had an enormous impact on improving the quality of [NHS] services. Of course things sometimes go wrong and the Charter makes clear the standards that ought to be reached.'*¹⁷

Within the universal approach services are deemed to have achieved quality on the basis of their progress towards fulfilling finite standards-based criteria. Once achieved they are heralded as examples of 'high quality' services for others. This process often involves using language such as 'best practice'. An example of this type of approach

can be seen in the NHSE's use of service exemplars based on progress towards Charter standards in a guide to quality in the NHS¹⁸.

Relativist Scientific Quality

An alternative to the universal approach which is based on standards applicable to all services regardless of context or purpose is to adopt a relative stance and base the standards to be achieved on specific functional goals. Relative scientific quality differs from the universal approach in that, instead of seeking to develop standards based on universally accepted criteria it aims to base standards on the task the product or service is designed to perform¹⁹. The tasks of services alter over time and according to need, hence the term 'relativist'. This approach is sanctioned by organisations such as the British Standards Institute (BSI) who view quality as the:

*'Totality of features and characteristics of a product or service that bears on its ability to satisfy a given need.'*²⁰

The BSI summarise this approach as 'fitness for purpose'²¹. A relativist approach acknowledges that it is sometimes difficult to separate the service product from the service provider, and therefore a judgement of 'quality' is made on the basis of the objectives which a particular service is designed to achieve. In this approach, therefore, each service provider makes its goals explicit, possibly in the form of a 'mission' statement and associated criteria. Performance is judged against whether or not these goals are reached. This relativist strand to the standards approach has been termed by other commentators the 'managerialist' approach²². Although as shall be demonstrated by Chapter Five this term fails to capture the other forms of operationalised quality which have found a place within the ideological confines of Managerialism.

An extension to this view, rather than a separate branch of the quality debate is to argue that quality is a composite or function of standards achieved at different points in the production of health care. This is the approach adopted by Donabedian²³ who suggests that quality is a function of standards achieved in the input, process and outcome components of health care delivery. Donabedian's views have been particularly

influential in shaping many of the discussions on quality assurance among groups in the NHS. All of the case sites used in this thesis referred to his ideas in the structuring of their quality strategies.

It is easy to imagine services finding quality as ‘conformity to standards’ an attractive option; particularly if they set the standards themselves. Part of the problem with the ‘scientific’ approach to quality is that it encourages unilateralism, or a focus on the inputs into services rather than the outputs as users experience them. They often call upon traditions and techniques that are professional and paternalistic. They have relied heavily (if not exclusively) on a single perspective’²⁴. A definition of quality as conformity to standards can act to reinforce the dissonance between public and provider perceptions of quality hypothesised by James²⁵. As Pfeffer and Coote highlight, ‘...bed occupancy rates...are of no interest to a patient worried about how s/he will cope on returning home from hospital’²⁶.

The Excellence Approach

The implication of the criticisms of scientific quality is that definitions need to be realigned in order to encompass a consumer perspective. This consumer perspective is addressed through the *excellence* approach to defining quality. Quality in this approach is a measure of customer satisfaction. The theoretical development of the ‘excellence’ approach took place after World War II as a reaction to some of the failings of the old scientific quality approaches associated with commercial management techniques advocated by Taylor, Ford and the idea of Scientific Management.

The initial defining features of the excellence approach were characterised and shaped by ‘quality gurus’ such as Deming²⁷, Juran²⁸ and Feigenbaum²⁹ in the 1950s. Their message was a basic one. Quality is the ‘delighting’ of the customer by producing products with, ‘a predictable degree of uniformity and dependability, at low cost and suited to the market’³⁰. Each of these ‘gurus’ sought to combine a new customer focus with detailed ‘scientific’ techniques using statistical methods to counteract variation in the products produced. Moreover, they advocated the extension of quality

techniques to all sections of the organisation not just manufacturing departments. Their global message was that quality is a product of top-down commitment to customer satisfaction in organisations.

The Japanese from the late 1950s - 1970s introduced the notion that statistics-based improvement can only go so far in satisfying consumers within cost boundaries and that there should be more immediate links between statistical techniques and the production process. Shingo³¹ highlights the essential message by asserting that the best way for organisations to meet customer expectations is:

*'to stop the process whenever a defect occurs, define the cause and prevent the recurring source of the defect.'*³²

This raises obvious questions in relation to the NHS as the 'process' of health care delivery is hardly amenable to constant stop-start production. The ethics of this are challenging to say the least and to attribute cause and effect requires in-depth knowledge of the aetiology behind health care interventions and effects. This is knowledge which is, at best patchy, and in relation to some branches of health care almost non-existent.

Neither of these two groups of theorists could be said to have exerted a massive influence on the characteristics of the current emphasis on quality in the NHS. The next wave of 'new western' commentators, however, have made more significant contributions. Crosby's ideas of quality as '*conformance to the requirements which the company itself has established for its products based directly on its customers' needs*'³³ have influenced many in the NHS. Not least, one case site (Marketown), who adopted the Crosby approach as its underlying theoretical framework for achieving quality. Other contributors such as Peters³⁴ implicitly stress the idea of quality as the end result of a *culture* of customer responsiveness within the organisation. The picture had moved from a top-down managerially imposed vision of quality in organisations in the 1950s, to a shared vision of quality shaped by corporate culture, and led (but not dictated) by management in the 1980s.

Pursuing quality as customer satisfaction to further the organisation's share of the market or profits is, in welfare state terms, a relatively new idea. The advent of the quasi-market in the NHS has meant that, theoretically at least, consumer judgements of quality and alterations in market share for providers can co-exist. The excellence approach, however, does not view consumers as an active entity. Within the excellence approach their views are countenanced and acted upon if the *organisation* decides it will be in its interests to do so.

Consumerist Quality

Whilst the excellence approach sees quality 'as the end result of providers' desires to satisfy customers, the consumerist approach sees quality as the desire of customers to be satisfied'³⁵. This has been an influential approach to quality over the past seven years. The difference between excellence and a consumerist approaches to quality is that it is *always* in the best interests of the provider to satisfy the demands of the consumer. The consumerist approach, as Pfeffer and Coote point out:

*'casts the consumer in an active role and seeks to increase their power to the point where they - as 'sovereign consumers' - hold sway over the decision-making of the providers.'*³⁶

McGrath³⁷ suggests that quality along such lines has, at its core, ideas of a public service orientation: doing *for* rather than *to* the public; characterised by choice, relevance, sensitivity to complaints, easily accessible 'user friendly' information, advocacy, and closeness to the customer through decentralised structures.

Many of the constituent parts of consumerist quality mirror the characteristics of the excellence³⁷ approach. They differ, however, in the means taken to promote the ends of customer satisfaction and in the end points associated with each definition of quality. Customer satisfaction for market gain is the defining feature of the excellence approach; whilst customer satisfaction within consumerist quality is seen as a moral good in its own right.

Values, Means And Ends: Inferring About Quality From Organisational Groupings And Alliances

Thus far the chapter has outlined two domains of quality: the colloquial and the technical. These have been derived from a functional analysis of the term centering around the question, what are the uses and meanings attached to quality? It has used headings generated by Pfeffer and Coote as the basis for the derivation of three sub-headings: scientific (standards-based) quality; excellence-based quality; and consumerist quality. This functional approach, and Pfeffer and Coote's work in particular, has influenced a number of writers on NHS quality³⁸.

Pfeffer and Coote's important work, however, fails to go beyond anything other than a general recognition of the pluralistic context in which 'quality' operates in the NHS. Without a real appreciation of the ways in which quality is defined and perceived by different groups of stakeholders then arguments constructed along these lines will always be limited in their application to the NHS.

The problem with outlining technical quality in a way that doesn't take into account the influential role of group agency in deciding quality, is that it ignores the social context within which quality must operate within services. The functional approach offered by Pfeffer and Coote only alludes to the role of individuals and groups in deciding what quality is; as in this example, where they highlight the role of quality in political conflict but not what that conflict looks like:

*'Quality continues to be used as though it were something we all unquestioningly favour, rather as we all condemn sin. In truth, no such consensus exists; nor is quality something that floats above politics. Once it is applied to the provision of welfare services, it becomes inextricably bound up with the political battles that are being fought on that terrain.'*³⁹

What is required then from a study led by research questions essentially concerned with the dynamics of operationalising quality in the NHS is an empirically derived

outline of what the 'political battles' being fought on NHS terrain might look like where 'quality' is concerned.

Other commentators take the contested notion of quality further and suggest an active influencing role by social groups in the definition of the concept. James recognises that:

*'it is no longer possible to separate the social construction of quality from the political agenda of the market in public welfare.'*⁴⁰

Likewise Alazewski and Manthorpe suggest that the relativist approach to scientific quality also has a pluralistic component to it. They suggest that services have attempted to define quality (and operationalise it in the form of standards) with reference to the multiple interests that exist within organisations:

*'...any welfare service has a variety of stakeholders and these stakeholders will have different aims and objectives, will use different standards to evaluate the service, and will therefore have different definitions of quality. In this approach any definition of quality must start with the aims of different participants and the ways in which the productive process satisfies these different aims.'*⁴¹

Pollitt takes this argument further by recognising, not just that NHS stakeholders and quality are linked, but that quality in the NHS has separated into three distinct strands. Quality for Pollitt has been:

'...quickly divided up along 'tribal' lines...thus it would not be an exaggeration to say that, in terms of the dominant players actually involved, there are actually three possible species of quality abroad in the NHS in the early 1990s.'^{42 43}

He terms these three separate strands medical quality, service quality and user's experienced quality. The importance of Pollitt's model is that, perhaps for the first time in relation to the NHS, the definition of quality is seen to have formal and

informal links to broader sets of values, occupational boundaries and group politics within services. Moreover, Pollitt hypothesises about the ways in which those links are operationalised:

- *Medical quality*: the definition of medical quality ‘remains a professional and highly technical exercise conducted exclusively by doctors’⁴⁴. Evidence for this dimension for Pollitt comes in the form of the Conservative government’s concession of ‘the principle that the quality of medical work can only be reviewed by a doctor’s peers’⁴⁵. Specifically that only doctors should conduct audit; its main purpose should be educational and developmental, not regulatory or judgmental, and standards should be set locally by participating doctors.
- *Service quality*: these are those ‘aspects of providing health care services which remain once ‘doctors’ business has been artificially extracted’. Within the NHS discussions of service quality tend to be dominated by the providers themselves, and especially by nurses and managers.
- *User’s experienced quality*: is the type of quality of which currently least is known. These are the aspects of the hospital experience that patients feel are important and classify as within the remit of quality.

There are some gaps in Pollitt (and later Pollitt and Harrison’s) analysis however. Both neglect the role as stakeholders of ‘professional consumers’. These groups include advocacy and quasi-advocacy groups within services. Examples here include Community Health Councils (CHCs) and Service User Groups who often form a central component in Trusts’ user representation and quality activity (as they did in three of this study’s case sites). Their three-fold taxonomy of quality based on stakeholder involvement in operationalising quality falls short by not including these key groups.

Moreover, their analysis paints a picture of distinct, delimited, links (based on involvement) between stakeholder groups and the types of quality in services. Specifically, medical quality and doctors; service quality and nurses and managers; user’s experienced quality and patients. However, in reality there is some evidence to suggest that such boundaries are more flexible, or at least have shifted since the late

1980s and Pollitt's original analysis. For example, Pollitt feels that much of the activity that nurses carry out in the name of quality such as nursing audits (an operationalised form of scientific quality) are best placed under the banner of service quality; largely due to the involvement of management in the process of determining quality. However, when evidence derived from Nursing's own professional body is examined then it is clear that the approach to defining quality they recommend has clear similarities with a 'medical' approach to defining quality. This example from the Royal College of Nursing's Dynamic Standard Setting System⁴⁶ (DySSSy) illustrates:

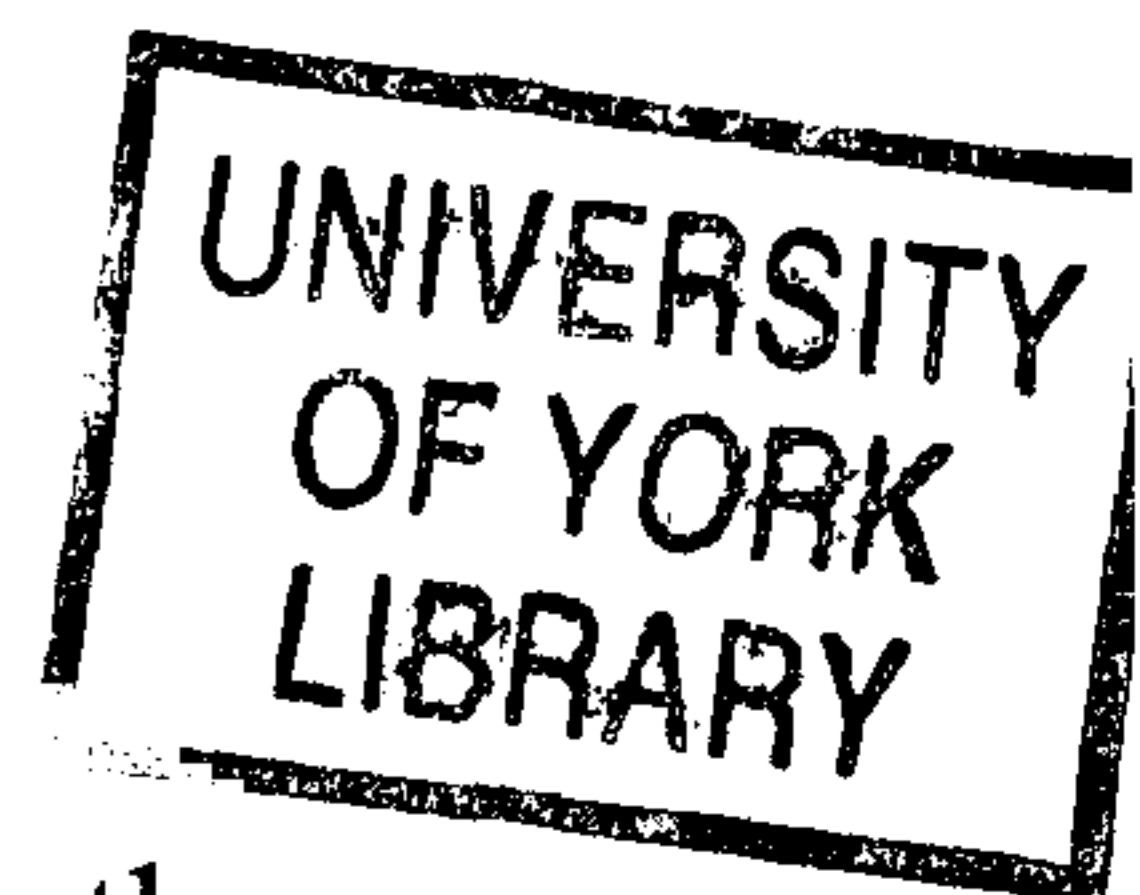
*'DySSSy, however, addresses specifically problems that are identified by practitioners, who are, after all, in the best position to know about the quality of their care. This is where the strength of DySSSy lies.'*⁴⁷

This quote from an RCN training manual says something about the values underpinning the development group's view of quality. It implies that nurses have the only really legitimate claims to judge quality in care and that this recognition is a strength of the system for assuring quality that they are advocating. It also gives a fair degree of control to nurses over the limitations of this examination by restricting quality improvement to those areas which nurses themselves identify. This idea of control is developed within the document as a justification for why nurses should be interested in quality:

*'Why bother with quality?...political reasons. If you do not think about the quality of your service and the standard you want to work to, someone else will!'*⁴⁸

*'there are a number of good reasons (for adopting DySSSy)...the standards are owned and controlled by the practitioners who set them.'*⁴⁹

In relation to medicine the links between the values underpinning the various definitions of quality and the ways in which groups scrutinise quality messages for correlation with their own ideologies can be found in this quote from one physician:



*'I certainly agree that there is a greater need for commitment in the search for quality from administrative groups but I would argue that clinicians are constantly striving, admittedly with varying degrees of success, for continuous improvement. Of the fourteen points outlined by W.Edwards Deming who revolutionised industrial output in post-war Japan, some already exist within a clinician's philosophy and some are not particularly appropriate.'*⁵⁰

The link between quality and stakeholder-group values represents one possible framework from which to add empirical weight to claims of 'subtle abuse' which Pollitt identifies in relation to quality in the NHS. Moreover, it offers a useful starting point in identifying the role of quality in some of the 'political battles' on NHS terrain which Pfeffer and Coote speak of. The possible links may also go some way towards illuminating the social construction process behind the definition of quality in its real world NHS context which Alazewski, Manthorpe and James highlight.

The link between quality and political values is no more evident than in the professional literature. This quote from the British Medical Journal shows how ideas of technical quality can be used to further a professional group's authority on NHS 'turf' and fend off attacks from those not suitably qualified to judge their role in healthcare (i.e. those not part of the group):

*'If clinicians can accept quality management concepts as central to their professional ethos and regulatory structures this could help them to maintain their professional authority and protect them and their patients from imposed decisions based on inadequate understanding of health care costs and benefits'*⁵¹

Perhaps Gaster's analysis of the links between quality and organisational values and the stakeholders who promote those values is the most lucid:

'The question of values covers not only how quality is defined in an organisation, but how it is interpreted and, most important of all, how it is implemented. This is demonstrated through, for example, how staff and consumers are consulted, who gets

*listened to, the style of leadership and other cultural factors. Values are the starting point for the whole quality debate.*⁵²

The Scope Of The Thesis

Firstly the analysis presented thus far has shown that:

- Quality is a contested term and concept. At the level of expert and everyday language (i.e. quality within the NHS and quality in everyday life) the term is somehow used differently. This split is not restricted to internal-external NHS boundaries as quality is also a contested concept within the NHS itself.
- One can hypothesise that quality operates in two conceptual and linguistic arenas the colloquial and the technical. This would account for the apparent dissonance between everyday and expert ideas of quality. Moreover, the two arenas share subtle links. For example, quality can be used in one sense to reinforce the other; an example being we have a quality management programme in place ergo we can justify the logo '*Partners in Quality Care*' (Castletown's logo).
- Quality does not operate in some value-free vacuum. In the NHS various stakeholder groups exist, each with different goals and objectives. Each of these groups appears to align themselves with particular approaches to quality.
- One means of exploring this alignment is to hypothesise that quality has the potential to be used as a means of furthering group goals and objectives. For example, professional autonomy or the influence of management over professional-clinical work.

What the analyses presented thus far lack is any real empirical grounding. Almost all of the literature exploring the conceptual nature of quality is largely hypothetical. It is based on theoretical ideas derived from global overviews of the NHS quality scene. These rarely draw on data derived from sound methodological exploration of the concept's role in the real world context of services themselves. There are some notable exceptions, such as Kogan and Joss's evaluation of the implementation of Total Quality Management in the NHS⁵³, but these are something of a rarity. This presents a considerable challenge for the researcher seeking to explore the role and development of quality in the NHS.

Because of the lack of empirically derived work to draw on the overall approach upon which this thesis is based is primarily an exploratory one; and one in which original empirical data plays a large part. It seeks to consider some of the arguments and hypotheses derived from the literature on quality in the light of data derived from service settings.

This consideration is guided by a series of questions which relate to this discussion of the conceptual characteristics of NHS quality. These present themselves as footholds from which to begin the exploration of quality in the NHS :

- How well does an explanation of colloquial and technical quality ‘fit’ with the real world picture of NHS services, what alternative explanations can be derived from an exploration of this ‘fit’?
- How is the concept of quality operationalised in the NHS?
- What role, if any, is there for the argument that stakeholder groups align themselves with particular approaches to quality?
- Are groups defined simply on the basis of their role or occupational allegiance in services e.g. nurses, doctors, managers or consumer representatives or are there more subtle ways of being a ‘stakeholder’ in quality?
- What form, if any, does the link between quality, its operationalisation, and stakeholder group values take in NHS services?

The boundaries (scope) of this thesis then are set by the propositions that arise during the exploration of the questions presented above. The scope of the thesis is definitely *not* concerned with which approach to quality is ‘best’. Or even whether some new and singular definition can be arrived at by a dedicated and ‘objective’ researcher. It *is* about how a uniformly positive term such as quality has been interpreted and used in the NHS and the organisational processes and motivations behind that interpretation.

The Structure Of The Thesis

The thesis is structured around the exploratory questions outlined above. Chapter Two charts the development and operationalisation of quality as an idea within NHS policy within the last twenty years. It demonstrates how quality has gained an increasing foothold within policy and service structures as a new form of NHS industry employing people in diverse and distinctive roles. Moreover, it outlines some of the alliances that have been formed on the national stage between groups and some of the apparent allegiances that exist between groups and nationally sponsored means of promoting technical quality.

Chapter Three discusses the methodological problematic related to the exploration of quality within the scope of the thesis. It outlines a stakeholder-analytical multiple case site methodology as an ‘appropriate’ means of exploring the central questions. It suggests a method of gaining a conceptual purchase on the shared subjectivities of stakeholders with regard to the operationalised ‘face’ of quality in services (known as Q-methodology). Moreover, it argues for the need to cross reference (triangulate) this technique with, contextually sensitive, qualitative, methods of data collection and analysis.

Chapter Four provides contextual information on the case sites and the ‘officially’ sanctioned structures and processes relating to the concept of quality in each of them. This chapter is intended to give the reader enough depth and contextual information to allow them to relate the findings presented in the thesis to their own settings and interests. The chapter also enables the reader to cross reference the findings of Chapters Six and Seven to the settings from which they were derived.

The idea that the operationalisation of quality in services has strong ideological connections is developed further in Chapter Five when a taxonomy of technical quality, based on the hypothetical links between interventions based on technical quality (such as clinical audit and Total Quality Management) and broader sets of values of professionalism, managerialism and consumerism is presented. This chapter

argues that quality can be seen to be linked to the political battles between groups in services on the basis of its role in impacting on the structural interests of such groups.

Chapter Six explores the results of the Q findings in the four sites in relation to the taxonomy of technical quality previously developed and attempts to explain some of the patterns and ‘anomalies’ that emerged from the exercise.

Chapter Seven proposes a matrix for understanding and explaining the conflict that surrounds the actualisation of quality at service level. In doing so the key areas of value differentiation of values between groups are presented. The matrix is firmly anchored in empirical data, and derives from a cross-case analysis of the qualitative data collected in the four sites.

Chapter Eight presents the conclusion and in doing so revisits some of the propositions presented in earlier chapters in the light of the empirical data and attempts to tease out some of the relevant policy implications. In particular, the attempt by the new Labour government to build professional-managerial co-operation into service structures through the concept of ‘clinical governance’ is related to recommendations regarding the operationalisation of quality at service level.

Conclusion

This chapter has attempted to clarify exactly what the thesis means when it refers to quality. It is no easy task as the debate is still relatively ill-defined in the literature with no ‘gold standard’ or accepted reference points with which to structure the discussion. Because the concept is so disputed and the debate marked by severe cleavages, not just of arguments about what quality is, but also how best to make sense of the huge numbers of initiatives or activities carried out in the name of quality, the thesis aligns itself with a view of quality as a derivative of the activities and agency of individuals and groups.

From this discussion of the conceptual nature of quality it is clear that an examination of the operationalisation of quality must take on board not just the issues of explicit

definitions used but also the implicit definitions which underpin activity carried out under the banner of quality as Pollitt points out:

*'Operational indicators of quality frequently offer strong pointers to the particular definitions of quality which underlie them.'*⁵⁴

Expressed alternatively this phrase might read, 'quality has a face'; namely, its operationalised characteristics and the values which are promoted by these. However, just as meaningful are the groupings of individuals around particular quality activities. This thesis explores both of these features of the quality issue in British health services and attempts to explain the roles and uses to which quality is subjected. Essentially the scope of the thesis can be represented as a model: (see fig1)

fig1: *The Conceptual Arena of Quality in Services: the scope of the thesis*

Legend

<i>TYPE OF TECHNICAL QUALITY</i>	<i>quality defined as....</i>
SC	Scientific quality - quality based on conformity to standards
EX	Excellence approach - quality as customer satisfaction
CO	Consumerist - quality as user empowerment

<i>DIMENSION OF QUALITY</i>	<i>APPLIES TO</i>	<i>GROUPS INVOLVED</i>
P	Professional quality - clinical work of doctors, nurses and therapists - quality as professionally determined criteria	Doctors
S	service quality – those elements left once medical work removed	nurses and managers
UE	users experienced quality - those elements of the health care 'experience' that users most value	service users

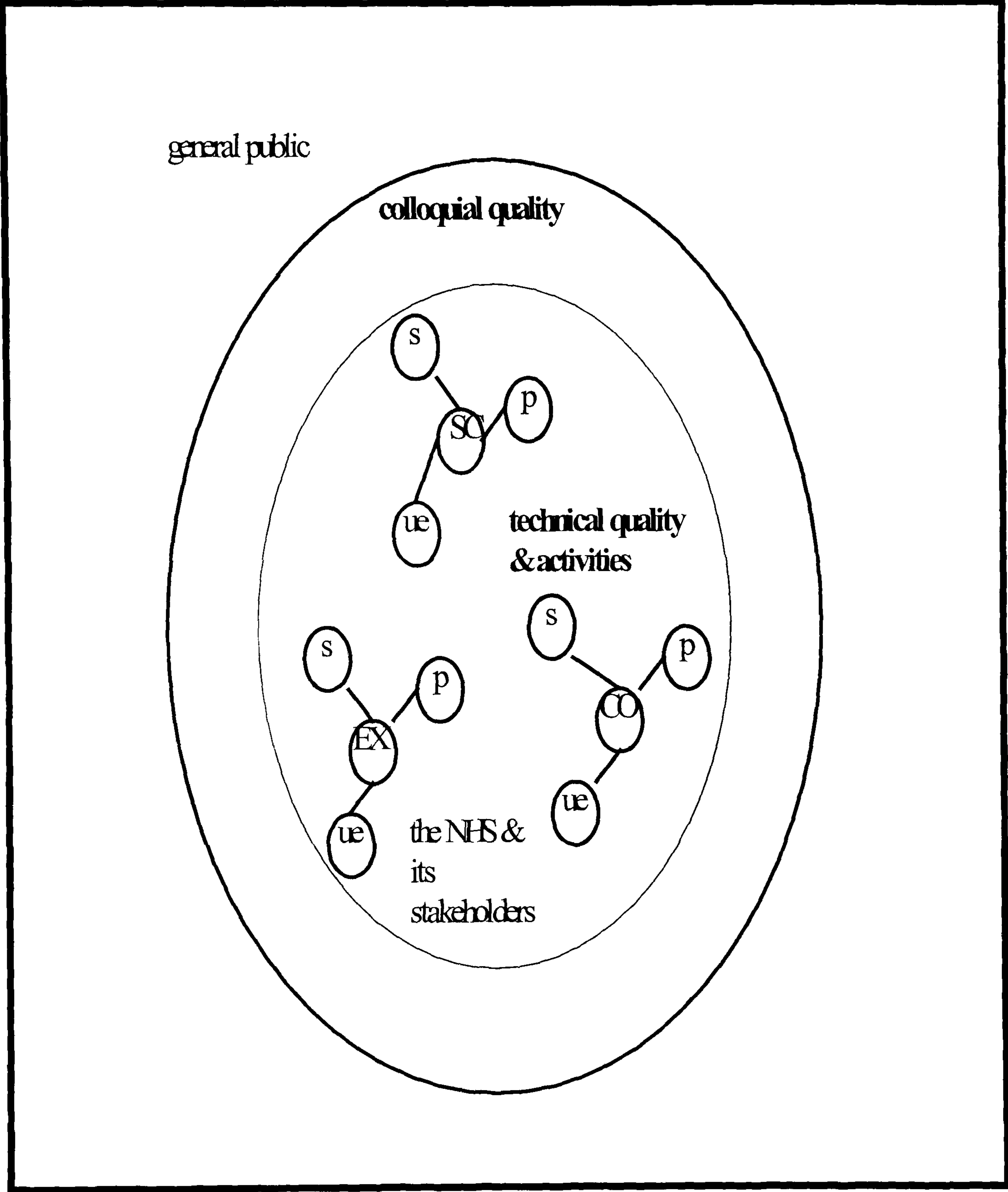


fig1: *The Conceptual Arena of Quality in Services: the scope of the thesis*

CHAPTER TWO: QUALITY - THE POLICY CONTEXT

The introductory chapter highlighted the twin linguistic and conceptual levels which the term quality occupies. The first of these, the colloquial, represents quality's role as a rhetorical device for use in policy development and implementation. For example:

*'Our ambition is for a high-quality, integrated health service which is organised and run around the health needs of individual patients, rather than the convenience of the system or institution. An NHS which, where appropriate, brings services to people, balancing, for each individual, the desire to provide care at home or in the local community with the need to provide care which is safe, high quality and cost effective.'*¹

The second, technical, level constitutes the conceptual and operational foundation for taking quality beyond the vague rhetoric and inherent subjectivity of the colloquial usage. It invariably involves some form of critical scrutiny and possibly change to the processes and structures of service delivery. An example of the use of quality in this technical sense can be seen in the previously quoted White Paper:

*'Whatever the setting of care...quality in this wider sense can only be achieved through systematic setting of standards, careful scrutiny of performance, and effective management including action to make improvements if standards are not met.'*²

This chapter presents an overview of the development of quality in its colloquial and technical senses in the NHS. In doing so the chapter seeks to place the findings of the empirical investigation of quality within NHS organisations detailed later in a broader policy context. The chapter argues that quality has to be seen as part of a broader series of trends occurring in welfare provision since the early 1980s. Moreover, in developing this argument it is contended that these trends have a common thread which binds them together in the form of the ideas and occupational grouping of 'management'. As part of this linkage the contention is put forward that quality constitutes a component in a meta-policy narrative of managerialization. This meta-narrative is outlined explicitly by Clark *et al*³ and features strongly in much of the social policy literature on quality's role in welfare provision since 1979.

Quality And The Managerialization Of Welfare

Quite clearly the welfare state is not the same entity it was 19 years ago; the processes and structures of the post-war consensus-based welfare state have changed significantly. The key characteristics of this change at the level of the welfare state include:

- The growing influence of ‘the market’ as a model for service delivery. The NHS has seen its structural components divided up into a quasi-market of ‘providers’ and ‘purchasers’ and with the development of the quasi-market has come the paraphernalia that accompanies commercial markets: contracts, competitive tendering and the recasting of service users as ‘consumers’. These trends have been accompanied by a market-based tendency to exploit the language and techniques of quality.
- As part of this quasi-market, NHS services have been able to take advantage of the pluralistic nature of the ‘mixed’ economy of service provision and purchasing that the centre has promoted. Consequently, the boundaries between agencies involved in delivering healthcare have become more flexible. These flexible boundaries are often justified with reference to the positive impact they will have on quality (of both service and ‘quality of life’).
- The creation of devolved, decentralised and flatter decision making structures aimed at more responsive and efficient services; these in turn will impact positively on ‘quality’.
- Attempts to forge a more flexible and mobile labour force through which to deliver the new ‘responsive’ services via complex processes of de-skilling and re-skilling. The assumption being the same level of quality at less cost.
- The replacement of traditional forms of accountability (such as political and bureau-professional) with transparent, easily visible, performance indicators, service standards, renewable contracts and systems of incentives or sanctions such as performance related pay. Such systems often include quality standards and assurance techniques.

Whilst not always capturing the link between quality and any specific theoretical framework, the analyses of the concept of quality which form the basis of this review when viewed *en masse* reinforce the message that quality and the above broader developments in the changing face of welfare are linked.

The thread which provides this linkage is *managerialism*, and its adherents - the *new public managers*:

- Managers charged with pursuing value for money in services - quality representing the value component in this equation
- Management at the forefront of the transition to the new customer responsiveness in services and a recognition of user's rights as citizens. Quality as the vehicle for this transition in the form of the Patients Charter and more recently the growth in Patient Representatives.
- Management as the preachers of the 'New Public Management' gospel; with its emphasis on measurement, accountability, budgetary control and 'excellence'.
- Management as a politically-sanctioned challenge to professional dominance in services.

The thesis shall show how responsibility for the majority of NHS activity purporting to promote and maintain quality falls squarely at the managerial door in organisations. And even where areas of the organisation are *de facto* exempted from managerial interference, as was the case with medical audit, then still the language and imagery of *managerialism* are present in the centrally-backed policy messages. In the case of audit, for example, these included the message that practice should adhere to standards, be measurable, and more transparent (even if only to the professional groups concerned).

Management, both as a cultural force in organisations, and as a distinct organisational group, constitute both the policy *message* (witness Griffiths' assertion that better quality management equals better quality services), and the *medium* through which the changes outlined above have been implemented. Though the importance of this thread is much more significant than just using management as the vehicle for introducing a new NHS version of quality. As Clarke et al argue:

'It is not just the appointment of managers or the adoption of private sector management discourses and techniques. What is taking place...is a deeper ideological process of managerialization which is transforming relationships of power, culture, control and accountability..[managerialization] constitutes the means through which the structure and culture of public services are being recast. In doing so it seeks to introduce new orientations,

*remodels existing relations of power and affect how and where social policy choices are made.*⁴

The language and techniques of quality play a central role in managerialization and as such are implicated in the struggles which accompany the process. As Newman and Clarke highlight:

*'The 'hollow' language of Managerialism [of which quality is a part] is open to contestation by different interests. Statements about making services more effective or improving their quality open up spaces for different groups or alliances to give such words particular inflections...professional definitions of quality or effectiveness will rarely be the same as political ones. Neither is likely to be the same as those of service recipients, although both professionals and managers may wish to 'speak' for users...it has also created a field of conflict in which new routes to legitimate claims have been opened up.'*⁵

The ideas and language of quality are quite clearly not restricted solely to the field of health care. Quality has become a prominent term in both public and commercial sectors as well as the service and manufacturing industries. Within the public sector alone, the parlance and techniques of quality have permeated education, social services and the police. As Cameron-Jones suggests:

*'The lexicon and style of educational discussion seem to have entered a new oratorical phase in which everywhere, the key terms are 'excellence', 'better', 'quality', 'reform' and 'competence.'*⁶

Given these factors it makes little sense to approach the analysis of themes relating to quality in the NHS without drawing on some of the arguments derived from the examination of quality's role in welfare change more generally. In examining the evidence of policy documents and the analytic commentaries of other researchers it is clear that there are four main linkages between quality and the changing face of welfare provision generally. These can be summarised as:

- *The economic catalyst:* quality has played a key role in the attempted economic 'reigning back' of welfare expenditure sought by successive governments. Quality is also a vital

means of justifying policies which have at their core cost-containment and simultaneously reassuring the electorate as to their impact. It also constitutes one ‘process’ by which the end goal of cost-containment is sought.

- *The rise of the consumer*: quality has been a prominent vehicle for the development of ideas of consumerism in public services.
- *The coming of management*: quality is a core component in the managerial toolkit of control and has been a central strand of the introduction of ideas and processes of ‘management’ more generally.
- *the quasi-market as the setting for delivering services*: Quality is linked to the development of contracts between purchasers and providers and is supposed to be a priority in the commissioning process itself.
- *the professional response*: quality has played a key role in professional reactions to the rise of management (and managers). Quality also constitutes a powerful tool for professionals to deploy as a strategy for combating the challenges to power and autonomy that consumerism and economic scrutiny represent.

The Economic Imperative

Many commentators^{7 8} argue that a concern with quality emerged as a result of the economic realisation that the high growth rates of input moneys and manpower that had characterised the NHS in the early 1970s could not, or would not, be maintained by a Conservative Government during the 1980s. The modest financial growth rates of the early 1980s were not enough to maintain existing levels of service, particularly given the rates of technological and demographic change. It was within this context that issues of quality soon arose.

Quality (or rather the interplay between its colloquial and technical senses) represents both the means to structural and process-based change to the NHS; but crucially it is also the mechanism for reassuring the public about these changes. In the face of economic decisions which threaten to challenge people’s experiences of services it offers policy makers an attractive option. One which can simultaneously help control the constituent components of services (who spend money) and at the same time reassure the electorate as to the stability of NHS ‘quality’ (in its colloquial, always positive, sense).

As early as 1982 quality and cost-containment were beginning to enjoy something of a symbiotic relationship in official policy documentation. In relation to the development and linking of (costly) information systems in the NHS, Korner used the linkage as a powerful rationale:

[IT would help] ‘...ensure quality, contain costs and secure access to those who need it. Or to put it more simply to provide a good service for as many people as need it at least cost.’⁹

The introduction of General Management in 1983 also reinforced the bond between the twin tenets of cost and quality in the form of ‘value for money’. Certainly, in attempting to negate some of the differences between management in the commercial and public sectors Griffiths himself linked quality and cost containment explicitly through the vehicle of management:

‘They [general managers] are concerned with levels of service, quality of product, meeting budgets, cost improvement, productivity, motivating and rewarding staff, research and development, and the long term viability of the undertaking.’¹⁰

This theme was continued through to the blueprint for the current NHS. In *Working for Patients* (WFP) government placed the issues of quality and value for money side-by-side as one of its key proposals:

‘To ensure that all concerned with delivering services to the patient make the best use of the resources available to them quality of service and value for money will be more rigorously audited.’¹¹

The only explicit tool for promoting quality in the technical sense in *Working for Patients* was Medical Audit. A process defined as the:

‘...systematic critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome for the patient.’¹²

The term medical audit itself represents something of an etymological linkage between NHS quality and the world of financial control; the term audit being more commonly associated

with the role of accountancy. The thesis examines the idea of auditing professional work in more detail in Chapter Five; for now, however, the point is that medical audit (as the predominant mode of assuring 'quality' in a clinician's work) was firmly linked by government to the need to balance professional activity and value for money. Or as they expressed it:

*'the professional responsibilities and rewards of the individual consultant; and the responsibility of managers to ensure that the money available for hospitals buys the best possible service for patients.'*¹³

The majority of the proposals in *WFP* were concerned with the establishment of a 'quasi-market' in health care where funding arrangements would be based-on contractual relationships between providers and purchasers. Within this quasi-market purchasers could, theoretically at least, 'shop around' for those services which best met their requirements. However, this led to concerns that it would be the cheapest services which were awarded contracts in the climate of cost containment prevalent at the time. The government sought to use quality as one device to reassure concerned political and service stakeholders as to the rationale behind the new arrangements and to dissuade purchasers from simply purchasing the cheapest service options:

*'the funding arrangements outlined...will steer resources towards those consultants best able to provide a good quality service and treat more patients.'*¹⁴

and that contracts, as the means by which the market was to operate:

*'...will need to spell out clearly what is required of each hospital in terms of the price, quality and nature of service to be provided.'*¹⁵

As the NHS entered the 1990s the Department of Health actively began to promote specific techniques to reinforce the continuing rhetorical use of quality and to try and get beyond the 'limited' techniques of audit. Quality needed to be more transparent and corporate in scope if it was to have any use as a means of control. To this end a series of Total Quality Management pilot sites were funded in NHS hospitals across the country (two of which were case sites in this study: Fishtown and Marketown). It is not entirely clear why Total Quality

Management should have been the adopted model but the idea of TQM seems to fit nicely with the meta-narrative of welfare reform that was emerging in the NHS. The linking of quality to the issue of value for money, however, was still paramount. Joss and Kogan point out the similarities

NHS changes

strengthening top management at each unit and involving doctors in management of services

value for money

*greater patient focus, including more information, more choice and more involvement*¹⁶

TQM Principles

Corporate approaches to planning, especially planning for quality - working towards common understandings and definitions

continuous improvement through systematic measurement

putting the customer at the centre of process improvement

By the time the Conservative government published its final White Paper on the acute sector in November 1996 the language of quality had moved from a vaguely reassuring rhetorical device to something altogether more substantive. However, the link between this new, definitive, version of quality and value for money was still firmly at the forefront of Departmental thinking:

- *'the term quality is used in the widest sense, embracing the values of equity, efficiency and responsiveness...it encompasses: the effectiveness of treatment in terms of outcome for the patient*
- *the skill, care and continuity with which the service is delivered*
- *the accessibility of the service, in terms of distance, time, physical access, language and understanding*
- *the delivery of the service, covering the environments of care, and the courtesy and efficiency of the administrative arrangements.*

*Underpinning this definition of quality is a commitment to using resources to best effect and getting it right first time.*¹⁷

Using quality as the rhetorical device through which Government could pursue the more contentious philosophies of cost-containment and efficiency was only one strand of the relationship between quality and NHS policy. Another source of ideas was the emerging pressure to acknowledge the primacy of the service recipient in relation to the delivery of public services; linguistically this meant recasting patients as consumers.

The Rise of the 'Consumer': Quality as the Vehicle for Macro-level Consumerism

The recasting of patients into 'consumers' is part of a reaction to perceived rising expectations and assertiveness in individuals and groups in relation to health care¹⁹. Or as Shaw expresses it:

*'Consumerism: public pressure, endorsed by government policy, for involving the users in making choices about their own care but also services in general.'*¹⁸

Just as the etymological links between quality and economics outlined previously have developed at macro-policy level so the discourses of consumerism and quality in policy have become intertwined. The official picture is one suggesting that 'quality' has been used as a form of rhetorical end-point for consumerist strategies of involvement or choice. However, just as convincing, is an alternative scenario suggesting that the language of consumerism has been adopted as a tactic by interest groups in the NHS for gaining the moral high ground in some of the power struggles that have accompanied the reforms: including the debate on quality.

Almost all occupational group cultures have at their core a belief in the virtue of representing the user's voice in services. Professionalism has as its *raison d'être* the idea of the altruistic public service ethic and the placing of the patients interests before their own. Managerialism (or more specifically 'new' managerialism) has at its centre the belief in meeting *customer* requirements. Those in services whose statutory role is to represent the user's voice in the system such as CHCs, or who represent independent advocates, rely on the legitimacy of their claims to be able to speak for the users for their existence. If one adopts the language of

advocacy and representation then it makes claims of legitimacy and credibility that much easier to justify. As Williamson puts it:

*'Every group of dominant interest holders tries to persuade other people that their interests are synergistic with its own; that is a crucial way it seeks to sustain its power'*¹⁹.

Each stakeholder group, including the developers of macro-level policy, have a vested interest in being seen to be synergistic with the consumer population's wants and needs, at least if it wishes to retain its stake in services. Again this theme is explored in more detail in Chapter Five but for now the aim is to demonstrate how the language and rhetoric of consumerism has become entwined with the language and policy documentation of quality in the NHS.

Quality and the 'New Public Service Orientation'

In many ways Griffiths represents the starting point for the imperative to operationalise technical quality. But just as importantly, Griffiths heralded the introduction of a new 'customer focus' in the NHS with the recommendation that services should:

*'ascertain how well the service is being delivered at local level by obtaining the experiences and perceptions of patients and the community. These can be obtained by the Community Health Councils and by other methods, including market research, the experience of General Practice and the Community Health Services.'*²⁰

Moreover, the same services should:

- *'respond directly to this information*
- *act on it in formulating policy*
- *monitor performance against it*
- *promote realistic public and professional perceptions of what the NHS can and should provide as the best possible service within the resources available.'*²¹

Harrison's²² research in the late 1980s into the impact of General Management suggests that the political context in which it was introduced, 'militated against an imaginative and

purposeful consumer orientation emerging in the NHS'. However, perhaps of more interest to this discussion is the fact that, even at this early stage in the introduction of the general management role, issues of quality and consumerism were being pulled together at the micro policy level. As Harrison points out:

*'Our own study revealed 'quality' and consumerism to be concepts pigeon-holed with a particular post in the organisation (usually held by a senior nurse) rather than something which had entered the mainstream of organisational culture.'*²³

Strong and Robinson²⁴ also concluded, along similarly pessimistic lines, that the new consumer orientation, and in particular the emphasis on quality promoted as part of the general management agenda, was no more than a political gesture with little real meaning.

Despite the marginal nature of the relationship at the micro-level, quality and the links with consumerist ideas and rhetoric continued through to *Working for Patients*. The White Paper was replete with consumerist images. Quality and consumerism were linguistically interconnected in many sections. For example, in relation to NHS Trusts:

*'The Government believes that self-government for hospitals will encourage a stronger sense of local ownership and pride, building on the enormous fund of goodwill that exists in local communities...it will encourage local initiative and greater competition. All this in turn will ensure a better deal for the public, improving the choice and quality of the services offered and the efficiency with which those services are delivered.'*²⁵

Notwithstanding the undoubtedly 'consumerist' images conjured up by *Working for Patients*, the emphasis was on the extension of 'choice' and information, rather than 'voice' in the system. Harrison labels this particular trait 'Conservative consumerism' and in the immediate aftermath of *Working for Patients* questioned the level of consumer empowerment attached to the reforms:

'Closer scrutiny of the proposals raises doubts about the extent to which patients can expect to benefit in terms of choice and quality from the major shifts proposed in relationships between consumers, purchasers and providers. The White Paper's approach to consumerism

*emphasises providing information to consumers rather than obtaining it from them. As such the approach is firmly paternalistic.*²⁶

Quality-Right?

There was little emphasis on that brand of consumerism which stresses the legally enforceable rights of consumers by virtue of their rights as citizens. By 1992 however, the rhetorical boundaries of policy in relation to consumers and quality had been broadened to encompass some of these criticisms. As part of John Major's Governmental term the NHS saw the imposition of a series of rights and expectations for consumers in the form of the 'Patients Charter'. The Charter was seen as:

*'The cornerstone of our attempts to provide a quality service to patients. It is a compulsory subject for all purchasers and represents the minimum level of measurable quality performance demanded of all providers.'*²⁷

The Charter is claimed to be helping the NHS to:

- *listen to and act on people's views and needs*
- *set clear standards of service*
- *provide services which meet those standards.*²⁸

However, even with the series of sixteen 'rights' contained within the Charter the amount of sway which consumers as individuals can reasonably exercise is still severely restricted. The area of influence for consumers is overwhelmingly non-clinical and even where clinical areas are involved then the *right* is still dependent on professional opinion. For example, you have the right to:

'be referred to a consultant acceptable to you, when your GP thinks it is necessary, and to be referred for a second opinion if you and your GP agree this is desirable.'

*'receive advice in an emergency, and treatment if your dentist considers it necessary.'*²⁹

Such 'rights' are a far cry from the wholesale shift of power away from the providers of services that the rhetoric would seem to imply. The legal status of the Patients Charter rights

are still unclear so as a mechanism for empowerment of the general population its role appears limited. However, the Charter was not the only means through which government were pursuing the goal of user input into the NHS; the newly formed service commissioning function seemed to offer an ideal chance to involve users and their representatives in the purchasing of services.

Quality and The Electoral Voice

During 1993 the National Health Service Management Executive (NHSME) launched its *local voices*³⁰ initiative with the intention of building user representation into the purchasing process. User involvement was seen as 'an essential tool in creating good quality and cost-effective services'³¹. This was an interesting development; not least as the NHS has had a well established means of gaining the user perspective on services in place for some years in the form of Community Health Councils. However, CHCs have been criticised on a number of fronts.

First, representing the views of groups of consumers is a notoriously fickle process. As Levitt and Wall point out:

*'questions of management and health are of relatively little interest to the general public when compared to issues relating to illness and personal experiences'*³².

Often interest and understanding of complex healthcare issues depends heavily upon input from media sources; this in turn is very often inadequate. Therefore, before CHCs can begin to represent user's views they must firstly provide information in order to educate and raise the awareness of the public; an onerous task for CHCs who may only possess two full time members of staff.

Second, CHCs possess little in the way of power within health services. Their ability to secure outcomes in services is limited and they are almost wholly dependent upon the agency of others. Initially CHCs had the right to ask for and receive information; to attend DHA meetings; to visit NHS premises; to be consulted about development plans, hospital closures or changes of use; give evidence to official committees; and utilise the support of M.P's and the press to put forward their views³³. Taken as a whole, these rights amount to quite considerable

input into health service planning and evaluation procedures but they are not the same as having a measure of managerial authority or responsibility and therefore cannot be taken as indicative of real power in services.

Post-1990 a limited role for CHCs was assured but their influence has become more focused. Their automatic right to consultation has been removed in relation to substantial changes to services or buildings. They do however retain a right of access to self-governing Trusts³⁴. As user representatives and/or service evaluators their future role would appear to be anything but secure; an assertion borne out by Rigge³⁵ who highlights the use of market research techniques and local radio by District Health Authorities as a means of soliciting user views. Both these mechanisms could be viewed as a means of bypassing the traditional consultative role of the Community Health Council.

One of the reasons for the failure of this community participation model in general, and CHCs specifically, is the perceived inability of representatives to bypass the views of organised pressure groups with their own interest-based agendas. Consequently, there is a difficulty in putting forward, alternative, truly representative, views grounded in the community perspective as a whole. The apparent rationality attached to decision making in the NHS, the inability of groups to offer viable service alternatives for local policy makers to decide upon, and their reliance upon 'trickle-fed' information passed to them from providers and purchasers all amount to serious obstacles for any representative group to overcome. Perhaps because of these perceived failings, policy has promoted managers as the conduit through which the user voice flows into NHS services.

The Coming of Management

This role as consumer champion in services is linked to the development of a new management culture and workforce. A transition promoted by policy and drawing on management science and the commercial sector for many of its ideas and practices. Part of this new management culture, variously described as 'Post-Fordist'^{36 37} or 'New Public Management'³⁸, and operationalised in health policy through the General Management function, is a central concern with ideas of quality and customer consciousness. The thesis talks more of the central concerns, values and ideology attached to management Chapter Five but for now it is necessary to show

how quality, this new staff cadre, and its influence on the workings of the NHS and its multifarious occupational groups, are linked at the level of official policy.

The Griffiths report of 1983 made explicit the theme that the new breed of General Manager should assume responsibility for quality in services. Indeed one of the main themes of its implementation was the formation and growth of a whole new breed of managers with specific (or at the very least, combined) responsibility for nothing else but activity labouring under the banner of quality. This change occurred at every level in provider organisations; through the creation of executive level Directors of Nursing and Quality down to Quality Managers, Quality Advisors, and more recently, Patient Representatives. This latter initiative again reinforcing the link between quality and consumerism. In effect, at all levels of the NHS policy structure, a whole new group of people (mainly managers) with a firm stakehold in the concept of quality has been created. Brooks argues that the first generation of these managers were largely unsuccessful in getting ‘the quality movement’s’ messages in to local NHS services:

‘The early history of QA managers, who were often misguidedly expected to shoulder responsibility for managing quality issues was largely one of frustration and powerlessness as they struggled without the necessary skills or support.’³⁹

The linking of quality and the General management function was further strengthened through *Working for Patients* and assured through three mechanisms:

- *Contracting*: the contract was the primary means by which quality would be assured in the new internal market. As has been shown, contracts were expected to spell out clearly the price quality and nature of services to be provided. The skills and functions of contract negotiation and drafting were clearly managerial, at least in the early days of the new quasi-market.
- *Managerial Financial Incentives*: *‘performance related contracts of employment will [similarly] provide strong incentives for hospital managers to improve the quantity and quality of the services on offer.’⁴⁰*

Consequently managers now had a direct financial interest in seeing that quality was pursued in their services.

- *Medical Audit* : at first glance it may appear strange including medical audit as one means of reinforcing the link between management and quality. Particularly as some authors have pointed out that audit essentially constitutes a professional tool for control over what they themselves class as quality. Yet others point to the policy assumption on the part of the Department of Health (DoH) that audit constituted a means of increasing medical accountability. However, it was management who were given the responsibility for ensuring audit frameworks were in place and achieving results. Specifically, four ‘fundamental principles’ the government subscribed to relate to the issue of managerial responsibility:
 - *the overall form of audit should be agreed locally between the profession and management , which itself needs to know that an effective system of medical audit is in place and that the work of each medical team is reviewed at regular and frequent intervals to be agreed locally.*
 - *the results of medical audit in respect of individual patients and doctors must remain confidential at all times. However, the general results need to be made available to local management so that they may be able to satisfy themselves that appropriate remedial action is taken where audit results may reveal problems.*
 - *where necessary management must be able to initiate an independent audit. This may take the form of external peer review or a joint professional and managerial appraisal of a particular service.*
 - *while the practice of medical audit is essentially a professional matter, management too has significant responsibility for seeing that resources are used in the most effective way, and will therefore need to ensure that an effective system of medical audit is in place.*^{41:}

So despite limitations on their role in the processes of quality across the whole of the new corporate providers the responsibility for ensuring it was there at all rested firmly with the new managerial cadre.

Developing 'Corporate' Approaches to Quality

During 1989/90 the Department [of Health] took its stance on technical quality up another notch by sponsoring 17 Total Quality Management demonstration sites. This was a direct attempt to reinforce the NHSME's exhortation that District Health Authorities (DHAs) develop systematic and continuing quality review experience, including provisions to monitor all aspects of quality of patient care including outcomes⁴². Some of these were specific projects concerned with unilateral 'quality improvement or assurance' but a number were funded on the basis of their attempts to introduce Total Quality Management. Chapter Five explores the links between managerial thought and TQM but for now it is sufficient to outline some of the key characteristics of the programmes and how they 'dovetailed' with existing themes within NHS policy. It has already been seen how Joss and Kogan⁴³ isolate the similarities between TQM and NHS policy in relation to 'Value for Money' but there were two other vital points of contact between quality, NHS policy generally, and management. Namely, the development of the manager as corporate lead and the incorporation of *all* groups in the development and implementation of corporate strategy in services.

The Manager as Corporate Lead

The prime characteristic of TQM approaches to operationalising quality is that they are managerially-led. Almost every text dealing with the normative principles of Total Quality Management suggests at some point that the key to its successful implementation is the development of a *management* organisational culture⁴⁴. The idea of organisational culture is unpacked more fully in Chapter Five, but essentially TQM has at its core a belief in the virtues of management; both as a distinct set of ideas and values and as an organisational grouping.

This belief in management as the natural leaders within the NHS's corporate bodies is one of the strongest themes to emerge from policy relating to the NHS during the 1980s and 1990s; and one which has enormous implications for the operationalisation of quality at the level of the organisation. Specifically, the development of managers within the service represents an attempt to redefine power relations away from the bureau-professional dominance of the past. Quality, as part of this shift, may well be viewed (particularly by those who stand to lose power) as just another device through which power can be wrestled away from specific groups of dominant interest holders. Consequently, as in any form of negotiation which involves

potential winners and losers, the skills of pragmatism and concession are pushed to the fore. Certainly, in seeking to promote the idea of medical audit for clinicians the early language used to introduce it to the clinical professions was carefully chosen so as to avoid highlighting the hidden concept of external accountability.

Permeation through Incorporation.

However, positioning managers at the helm in services is obviously not a sufficient intervention in itself to encourage a management culture. Other non-managers have to be exposed to, and subscribe to, managerial values and ideas. Pursuant to this end the governments have successively sought to involve clinicians in management. TQM represents another strand of this theme. A vital characteristic of Total Quality Management is that it should permeate all levels of the organisation and include all staff groups and functions in the organisation⁴⁵. There is an important distinction to be made here however. This relates to the difference between managers (as a distinct occupational group in the NHS) and *management* as the ideas associated with this group but which have also influenced and made in-roads into other staff groups and their work. This is an important distinction as it will be argued in Chapter Five that quality's role in *management* (as part of the managerialization of welfare) has been of potentially more influence on the work of organisations as a whole than the simple association of quality techniques with the work of managers. Indeed, the link between quality and managers may actually be detrimental to the efforts of policy makers at both macro and micro levels to encourage changes in the power relations within NHS Trusts. The association between technical quality and managers was certainly a feature of the interviews carried out with professionals and consumer representatives in the case sites, and if government remains committed to promoting the use of quality techniques and language then the link which some groups make between quality, managers, and loss of status, freedom and ultimately power is something which must be addressed.

As already alluded to, simply giving managers responsibility for 'quality' was not the only strategy pursued in the drive to link the concepts of cost-containment and accountability. Government had already sought to develop ideas of *management* (and the emphasis on technical quality that this implies) in the work of other NHS staff groups (primarily professionals) through other strategies; most notably the development of cost centre-based

systems relating to the costs of clinical resources through the Resource Management Initiative and the extension of this principle to the formation of Clinical Directorates and Clinical Director positions for doctors. One of the earliest pilots of the Clinical Directorate structure and Clinical Director role was at Guys Hospital where the aim was to:

*'reconcile clinical freedom with management authority and accountability...the consultants agreed to accept a system that sought to equate power with responsibility. In return for the freedom to manage their own affairs, they had to accept responsibility for the financial consequences.'*⁴⁶

Harrison and Pollitt⁴⁷ suggest that the *raison d'être* of clinical directorates is managerial control over both doctors and other health professionals. The vehicle for this control being the incorporation of professionals into new managerial roles which have managerial parameters such as limited budgets. These act to constrain action and shape values towards a more 'managerial' agenda, including a concern for technical quality.

Walby and Greenwell⁴⁸ suggest that such a strategy was an attempt to shape the discourse of clinical decision making. As they point out, clinicians have always controlled the distribution of resources in the NHS. But they have done it from within a framework of decision making which articulated choices in a medical terminology of need and clinical science. The vision of this policy of incorporation via budgetary control and a sense of freedom from bureaucratic interference was an increasing salience of financial matters in clinical decision making. Consequently priorities and decisions would be articulated in a language which managers could readily understand and challenge. By implication, this shift also includes greater transparency (and ergo accountability) in relation to clinical work.

Harrison and Pollitt go on to suggest that the developing prominence of 'quality' in the NHS is itself part of the broader strategy of incorporation:

*'if incorporation is a strategy for involving professional producer groups in sharing managerial responsibilities with the state then the most profound level of such a strategy is the creation of shared meanings ... the new prominence (and new meanings) given to quality can be regarded as part of a highly political process. It is therefore pertinent to enquire who is pressing for increased attention to quality and how that quality is defined.'*⁴⁹

Certainly the TQM message is one of incorporation and involvement of *all* groups in services:

*'TQM is an approach to improving the effectiveness and flexibility of a business as a whole. It is essentially a way of organising and involving the whole organisation, every department, every activity, every single person at every level. For an organisation to be truly effective, every part of it must work properly together, recognising that every person and every activity affects, and is in turn affected by, others.'*⁵⁰

Moreover, the link between TQM and control, especially managerial control, is also explicit in the writings of TQM gurus such as Crosby:

*'Quality management is a systematic way of guaranteeing that organised activities happen the way they are planned. It is a management discipline concerned with preventing problems from occurring by creating the attitudes and controls that make prevention possible.'*⁵¹

The message of incorporation of all groups through quality is one which was clearly present in guidance issued by the NHSME in 1993. Whilst not explicitly dealing with Total Quality Management (preferring instead to couch the message in terms of an 'organisational-wide approach to quality') the main themes of TQM were still present and the language strongly 'managerial' in tone. The Guidance suggested that a Trust quality strategy may be best promoted through:

- *commitment to quality and leadership from the chief executive*
- *quality forming an integral part of both corporate objectives and individual staff objectives, and both reflecting the organisation's business*
- *the presence of an organisation-wide quality management programme incorporating training in the use of quality tools and techniques*
- *all staff having access to training to enable them to develop and make best use of their skills as part of an effective human resource strategy*
- *high quality care achieved through teamwork and partnership with integrated working involving every member of the organisation*

- *effective communications both within the organisation and between it and other bodies*⁵²

By 1996 and the publication of the White Paper, *A Service With Ambition* the association between quality and incorporation of clinicians into a managerial agenda of measurement, consumer voice and clinical decisions was firmly established and backed up by high level clinical involvement at the Department of Health in the form of the Chief Nursing and Medical Officers. The message was clear, quality is something that involves clinicians *and* managers and the politicised process of establishing shared meanings should be a priority for services:

*'Quality...should be the driving consideration in clinical decision making and in priority setting, and the basis on which the NHS manages and measures its performance. It is a matter which lies at the heart of the management process in every health authority, NHS Trust and family practice. It needs to be addressed by clinicians and managers, working together to establish a common language and shared objectives.'*⁵³

The document drove quality firmly into the domain of clinical work and attempted to pull together issues which until now had been on the margins of policy documentation and implicit rather than explicit; these included the links between outcome, treatment and commissioning. More importantly, it also opened the door for managers to question the usefulness of professionally-dominated areas of national strategy. For example, whether clinical effectiveness data (of which audit is a component) was useful to them or not:

'Further work to ensure that quality is always central to the management and performance of the NHS needs to address:

- *how the measurement of quality and outcome across a range of clinical treatments and methods of service provision can be improved*
- *how to use patients' experiences to monitor and improve the quality of care, particularly in relation to accessibility, continuity and co-ordination*
- *whether current work on clinical effectiveness data to improve clinical practice meets the needs of clinicians, managers and patients*

- *how greater emphasis can be given to considerations of quality and outcome in decisions taken on priorities and the commissioning of care*
- *how measures of health outcome can become central to assessing the performance of health authorities and NHS Trusts*⁵⁴

These messages reinforcing the link between managerial responsibility, incorporation of professionals into management, and the issue of quality-led change were also promoted by those not directly involved in the hierarchical management of the NHS. An example being the Audit Commission, a body with no line-managerial power over the bulk of managers in the NHS but who represent the managerial expression of evaluation in relation to NHS services and as such are tremendously influential in shaping service agendas at a local level.

‘Chief executives and senior managers are clearly responsible; and should be held accountable, for the day-to-day running of their trust: But they must also create a climate in which change can occur, so that the trust can adapt to changes in its operating environment and bring about improvements in quality and efficiency. In order to establish such a climate, managers should set a limited agenda of key areas where they need to ensure success. This will probably include:

- *devolution of decision making and control of resources (to business units i.e. clinical directorates)*
- *involving professionals in management, and*
- *ensuring that quality and audit programmes result in action to improve processes and outcomes*⁵⁵

The Professional Response

If the macro-policy themes presented thus far were accepted by all groups in the NHS as the only source of priorities for service action then the transition to a managerial culture would have been much easier. However, for professional groups the ‘official line’ of DoH-sponsored policy represents only one part of the clinical practice equation. Doctors and nurses work within the codes of ethics and norms which bind them as a professional group, as well as within the framework of policy passed down the managerial hierarchy and derived from the DOH. Moreover, at the macro-level, the changes heralded by the trends of

consumerism and economic scrutiny represent a considerable challenge to professional power bases in the NHS as a whole. The respective Royal Colleges^{56 57} were not slow to recognise this and swiftly sought to establish a voice in the quality debate. As early as the mid 1980s the professions were beginning to make use of the rhetoric and techniques of quality at a national level. Moreover, the medical, nursing and therapy professions, have been quick to involve themselves in designing and adapting tools for assuring quality in their respective professions.⁵⁸

Pollitt argues that the growth in management (as a group) was a factor in the development of quality; a theme picked up by many authors. However his argument goes further in that he recognises that it was not simply the growth in managers *per sé* that led to the rise in prominence of quality. Rather, it was the ‘struggle for the medical domain’ which the growth in managers and the general management role represented which prompted efforts to operationalise the term by the professions⁵⁹. As part of this struggle Pollitt suggests that professions have taken it upon themselves to develop their own initiatives marketed under the banner of quality. The reasons behind this sudden concern with quality by the professions are summarised as:

‘A genuine, altruistic desire for self-improvement is undoubtedly one [motive]. Another is to protect the integrity of existing services against financial economies, actual or anticipated. Yet another is as a pre-emptive move, to ward off quality audits of any kind from outsiders.’⁶⁰

Shaw also picks up on this ‘defensive’ trait on the part of the professions. Some of the key forces driving quality for him are the:

‘clinical professions determination to retain the initiative in the evaluation of clinical practice and training, and to demonstrate effective self-regulation in the face of growing management demands for accountability.’⁶¹

In later works Pollitt outlines what this struggle might look like:

*'One way of understanding the current to-ings and fro-ings over quality is to view them as a struggle for control, very much including control of the meanings of the terms and labels used to describe and define quality.'*⁶²

Certainly policy has acted, on occasions, to reinforce the message that *professional* quality is a *professional* matter. In *Working for Patients* the message was unambiguous:

*'The Government's approach is based firmly on the principle that the quality of medical work can only be reviewed by a doctor's peers.'*⁶³

In relation to lay involvement in scrutinising the quality of medical work the DOH clearly maintained a professional boundary around the issue of critical examination - at least in the early days of the reforms:

*'the Department has always indicated that, given the sensitivities of the medical profession on the establishment of medical audit committees, there was no immediate prospect of CHCs - or indeed any lay person - being involved in the process'*⁶⁴

The development of medical audit was an example of official policy being 'softened' in order to accommodate powerful interests. The conventional use of audit (in the managerial world) is as a formal tool for control and monitoring of resources by financial mechanisms. As such it is often linked to sanctions and direct intervention by outside parties. This clearly has not been the case in relation to medical audit. It was removed from any formal punitive system of control right at the onset. Moreover, the emphasis in medical audit is that it should be educational as opposed to punitive. External sanctions on practitioners who fall short of quality standards are not expected by participants. Expressed alternatively, audit seems to reinforce the message that the autonomy professionals enjoy relative to other members of organisational groups in the NHS is also extended to the area of quality definition and assurance.

By 1993, having established medical or unidisciplinary audit as the professional mechanism of choice for assuring quality in services, official policy had begun to try and encourage a

greater link between the professions involved and some of the other 'managerially-led' quality initiatives that were going in Trusts. One route to these ends was the reworking of *medical* audit principles into a broader, multidisciplinary, framework of *clinical* audit. DHAs were instructed to concentrate on funding clinical audit which addressed the priorities of all groups including management and users of services⁶⁵. Malby⁶⁶ suggests that the transition to clinical audit from medical audit represents a component of the 'New Public Management' in that it is being heralded under the banner of quality and has a sense of the primacy of the 'consumer' through its emphasis on public accountability. This may well be the case but it is far from certain that the professions' stranglehold on the audit agenda has been relaxed. Even where consumers are allowed into the process of audit it would appear that there are 'limitations' on their role. In discussing the 'role of users in achieving a quality service' Hopkins and colleagues from the Royal College of Physicians suggest that:

*'Users of health services must also be the pre-eminent arbiters of good quality practice in some areas in which they, and only they, can determine good practice...relief of pain...courtesy...communication...personal circumstance and choice... 'hotel' standards...continuity and co-ordinated care.'*⁶⁷

In relation to issues of 'technical competence in clinical practice':

*'It is difficult for users of health services to be competent in judging the quality of the more technical aspects of medical care'*⁶⁸

Certainly in the empirical evidence collected from the case sites in later chapters it is clear that the issue of 'outsider' involvement in audit projects is an emotive one. Moreover, it is possible to hypothesise, given the absence of any recent evaluation of how the shift to clinical audit is performing, that whilst the initial impetus for audit may have been as a part of the 'New Public Management' the reality at service level is of a professionally-dominated technique which happens to slot nicely into the current rhetorical framework of 'quality'. As one Audit facilitator in the Northern Region put it:

'Yes, I think in the early days we just had to let them do the things that interested them as consultants just to get them on board. But now its that much harder trying to get them to do

*projects which come from the Health Authority or the [Trust] board. So I suppose in that sense we did make a rod for our own backs.*⁶⁹

Again, the links between occupational groups, their shared values, and the development of quality in services come under more intense scrutiny in the chapters to follow. For now the aim of this section has been to highlight that policy on quality at the macro level is not some stand alone ‘technical’ process divorced from the political arena. Quality differs according to the power of the NHS group involved. Indeed Harrison and Pollitt argue that the focus of audit (namely a professionally defined and highly technical judgement of quality) actually justifies the label of *medical* quality⁷⁰ (see Chapter One, page 23 for further discussion).

NHS Policy And Quality: Some Concluding Observations?

The introduction of the language and techniques of quality have formed an integral part of a broader process of the managerialization of welfare provision. This process has at its core the ideas associated with managerialism and the consequent recasting of power relations away from dominant bureau-professionals and in favour of the end-users of services. This process casts managers as the ‘champions’ of the service user by virtue of their ideological commitment to the customer, and their logical place as the operators of the new welfare quasi-markets.

The quality debate has reflected the development and progress of the managerialization project itself. The vague calls for services to develop quality using the colloquial sense (which is inherently subjective and open to interpretation) have changed to central exhortations for services to adopt and adapt formal quality techniques. These techniques unlike the simple colloquial usage of quality, and like the process of managerialization itself, involve the creation of winners and losers. Choosing between providers on the basis of technical quality necessarily involves making judgements about that quality. In an era of limited financial resources this means that services and the groups involved in them will be pitted against each other and their interests consequently threatened.

One can see therefore how both the term quality and the activities which represent its operational face in services are attractive targets for manipulation by those parties who stand to gain and lose the most. Perhaps because of this attractiveness the concept of quality has not

been applied unproblematically to services through official policy. It has been shown how the professional response to the threat quality poses to their power base has included the subtle manipulation of the medical audit agenda to allow for all-important characteristics of professional power to continue - autonomy, lack of external regulation and the sanctity of professional knowledge.

At the level of macro-NHS policy the quality debate represents a struggle between competing groups for control of a term which, if utilised effectively, is a powerful source of legitimacy in services and with the electorate. This chapter has outlined some of the characteristics of this struggle when viewed from the level of macro-NHS policies. The focus for the thesis, however, is on the face of these struggles at the micro-policy level of individual Trusts. In outlining the policy development of quality over the last twenty years the chapter has shown how quality goes far beyond the simple technical application of a series of systems with distinct apolitical goals. The Quality debate involves powerful group interests shaping a concept which has become part of the language and 'armouries' of the various cultures in the NHS. It is to the nature of such interests and the links with cultural groups in the NHS that the thesis now turns.

CHAPTER THREE: TOWARDS ADDRESSING THE METHODOLOGICAL PROBLEMATIC.

This chapter outlines an appropriate methodology for the exploration of the theoretical propositions advanced thus far in the thesis. Namely, that:

- Quality is shaped through social action in the form of participation in the design and implementation of ‘quality’ activity. Quality then is socially constructed and a product of the attitudes, values, beliefs and behaviour of the people who play a part in its construction.
- These quality activities are delineated and contested along ‘NHS-tribal’ lines: the professions, management and consumer representatives. The allegiance of these ‘tribes’ to the various strands of quality activity that exist in services is based on a sense of ‘synergy’ between their shared values (as a group) and the values promoted by the activities themselves. For example, professional techniques of audit involve closure, autonomy and formal accountability to one’s peers as well as the organisation: characteristics of professional work generally.
- The contested nature of quality in the NHS, can be seen as symptomatic of quality’s role as a group resource in broader political battles within services. Particularly in areas such as the attempted introduction of new cultural values (as in the case of managerialism), the redistribution of power between groups and the control of working practices. These political battles necessarily create winners and losers whose interests are threatened or enhanced accordingly.

In presenting a methodology to explore some of the questions that arise from these propositions the chapter seeks to strike a balance between four key elements to understanding the social action, upon which quality depends for its actualisation. The balance to be achieved is between explanation versus understanding and holism versus individualism. The chapter represents a strategy for data collection and analysis that concentrates on the four ‘cells’ that necessarily form the focus of organisational research

if the four key elements above are viewed as matrix (see fig 2). The four cells which the strategy focuses on are the areas of systems, choice, culture and subjectivity¹.

The approach adopted as a means of framing research efforts in these four areas is a multiple-site, embedded unit of analysis case study design. Within this methodology stakeholder analysis² constitutes the set of organising principles for the collection and analysis of data.

The chapter first discusses the essential methodological problematic I faced as a researcher in this study; namely, the question of analysing social action in people with a stake or interest in quality in acute NHS trusts. It then outlines the proposed case study design and structure, before going on to address the central theoretical postulates behind stakeholder analysis and the reasons why it is an appropriate organising principle for this study.

The specifics of data collection in the form of participant observation (with the observer as participant), depth interview, and documentary analysis are presented alongside a discussion of the hermeneutic spiral approach used to analyse this qualitative data. The design of the case studies used mixed quantitative and qualitative methods of data collection and the holistic logic behind this is discussed. The structure and form of stakeholder perceptions is further complemented by the use of Q-methodology (see page 82 for an outline) and its central aim of mapping shared subjectivities using statistical techniques. The principles and techniques of Q-methodology are outlined before a discussion of some of the ethical challenges arising from the study.

On Analysing Social Action

Quality, is dependent on social action on the part of individuals within organisations if it is to be realised and made tangible in services. How one best approaches the analysis of this social action that constitutes the actualisation of quality constitutes the essential problematic in this thesis. Hollis proposes a four fold-matrix to analysing social action (see fig 2). None of the individual cells constitute the singular solution to the problematic,

but when taken together offer a framework for both explaining and understanding social action. For Holliss any approach to understanding social action has to address the analytic priorities of holism/structure Vs individualism, and explanation Vs understanding³. The matrix which emerges from these priorities has in its cells the emphasis which different theories place on different elements of the matrix (see fig 2)

	Explanation	Understanding
Holism	Systems	Cultures
Individualism	Rational choices	Subjective Meanings

Fig 2: *A Matrix for Analysing Social Action*⁴

If it is accepted that each cell in the matrix has something to offer, then it is clear that simply concentrating on organisational culture at the expense of the individual meanings which people attach to quality activity would be inadequate. Similarly simply examining the choices people make in their actions at the expense of the structures and systems within which they operate would constitute an incomplete approach. In short any research strategy adopted must generate data fit for the purposes of generating theory relating to each of these elements if it is to understand adequately and explain the social action which underpins the actualisation of quality. With this proviso in mind the strategy adopted for the research is a case study design, or more specifically a multi-site, multi-method stakeholder design.

The Case Study Design

A case study can be defined as:

‘an empirical enquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident.’⁵

The thesis has already argued that quality activity cannot be divorced from the contextual factors that impact upon it (see Chapters One and Two). Furthermore, it will show that theory pertaining to organisations is characterised by ‘conceptual anarchy’ (see Chapter Five). But what unites all theory is the idea that individuals have an interest or ‘stake’ in any organisational phenomenon. Particularly when that phenomenon is tied to the concepts of power, resource and work - as quality is. Stakeholder actualisation of quality, as part of a social policy of encouraging ‘quality’ in NHS Trusts, is dependent on social action by individuals with a ‘stake’ in those Trusts. Social action in turn is dependent on individual perceptions of social reality, and the power dynamic within which individuals are located. As Atkin and colleagues express it:

‘Different stakeholder perceptions may conflict and evaluation must recognise different interests and their perceptions of social reality. Furthermore, because interpretations of social reality occur within a power dynamic, some accounts have greater authority than others. Put more simply, this approach is a reminder that policy is not simply a reflection of the activities of health professionals, but represents the context in which their activities are interpreted and acted upon.’⁶

There are several reasons why alternative approaches to examining social action are not appropriate for this study. A quasi-experimental approach which proceeded from the basis of simply testing the theoretical delineation of the professional-managerial-consumerist typology outlined thus far would be inappropriate. Experiments, by necessity, seek to divorce the phenomenon from its operational context in order that the researcher be able to better ‘control’ the variables involved. Obviously, the researcher in this case has no control whatsoever over the operations of a large acute NHS trust and the groups involved in its services. Attempting such a design, therefore, would be somewhat foolhardy.

Although the rationale for the multiple-site design can be seen as analogous to the ‘replication’ logic involved in experimentation, it does not depend as heavily on formal,

pre specified hypothesis or statements of the relationship between elements of the phenomenon⁷. Any formal hypotheses developed would require a sound empirically derived knowledge base if they were to have any form of validity attached: this knowledge base is lacking. Pollitt's⁸ initial typology of medical-service and user's experienced is only developed from general observations of the NHS quality 'scene' rather than a detailed piece of research, or an examination of others' work conducted in the setting to which it applies. Much of what passes for theory in relation to quality has 'been invented in the abstract by conceptual specialists'⁹. This characteristic of the quality debate not only makes practical application of theory difficult but also negates the use of a hypothetico-deductive approach to theory generation as encouraged by quasi-experimentation.

One question that may be posed is 'if the study is concerned with people's values and attitudes around the issue of quality activity why not just do an attitudinal survey?' But again the requirements for adequacy in survey research design are not met in the case of this study. Part of the rationale for rejecting the survey is the same as that of the quasi-experimental reasons outlined above. Namely, that the knowledge base associated with the phenomenon does not support the generation of valid instruments (hypotheses in experiments). The typology of quality activities outlined thus far is at the 'tentative' end of a theoretical continuum. Simply developing a series of scales of 'managerial' 'professional' and 'consumerist' approaches and then surveying individuals' associations with these perspectives simply risks introducing even greater chances for error in any conclusions drawn. Given the lack of empirical 'weight' behind the theory any emergent relationships might just as easily be due to serendipity or chance rather than actual association or difference. Moreover, a survey, whilst managing to grasp some of the impact of context is too limiting in the breadth of its analysis. Given the lack of quality-specific empirical material to draw on the research would need a hugely extensive questionnaire, observational or interview schedule if the study was to capture all the possible factors impacting on the actualisation of quality in the workplace and the views which people hold regarding the phenomenon. This would be wholly inappropriate and would probably have generated a very poor (and therefore unusable) sample of responses.

Given the social nature then of the construction of quality in NHS services, the phenomenon of quality activity and the service context in which it occurs cannot be separated. For this reason the case study design has several advantages; it:

- *Copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result*
- *Relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, or diverge for theoretically explainable reasons, and as another result*
- *Benefits from the prior development of theoretical propositions to guide data collection and analysis*¹⁰

Case study constitutes a distinctive research strategy and promotes specific approaches to data collection and analysis; a feature that all such strategic methods share. What the case study method offers is opportunities for what Lincoln and Guba¹¹ term 'naturalistic inquiry'. This approach to research has at its core a number of characteristics which equate with the conceptualisation of the case study deployed in this study. For Lincoln and Guba the primary characteristics of this naturalistic approach centre on issues such as sensitivity and flexibility in reporting, design and analysis; a preference for methods which reflect these values (usually qualitative though not exclusively so); inductive approaches to analysis; and a desire to ground this analysis in the data as well as generalisation through a linkage with the readers own tacit knowledge of similar situations¹².

Such a detailed, sensitive and multi-faceted approach lends itself to the study of the actualisation of quality. For quality, according to Patten:

'...has to do with detail, with the subtle and unique things that make a difference beyond the points on a standardised scale. Quality descriptions provide the detail to explain what the lives of two different peoples are like, one of whom responded that he or she had a

*'highly' satisfactory experience, the other of whom responded that he or she had an 'extremely' satisfying experience. This is not a question of interval versus ordinal scaling, but one of meanings. What do programs mean to participants? What is the quality of their experience? Answers to such questions require detailed, in-depth, and holistic descriptions that represent people in their own terms and that get close enough to the situation being studied to understand firsthand the nuances of quality.'*¹³

Selecting The Cases

The theoretical importance of a case comes when its results are set against knowledge of its background¹⁴. This background information is presented in Chapter Four. Cases were selected on the basis of a screening pro-forma sent to all acute NHS Trusts in Northern and Yorkshire Region. The pro-forma asked Trusts to detail their quality strategies, the techniques in place, how long they have been in place and details of the groups involved and the nature of their involvement. Cases were then selected based on differences in the groups identified as involved in quality activity; the length of time that defined, coordinated, quality activity had been a feature of Trust corporate activity; the nature of group involvement and in two cases due to their geographical similarity and the fact that they shared the same corporate purchaser. These two sites (Fishtown and Shiptown) offered special theoretical interest due to their similarities of context in service provision. The aim of the case-sampling procedure was to expose theoretical propositions to the widest possible set of conditions and the Trusts selected represented these conditions. However, whilst providing the necessary breadth for robust theory development they were in no way atypical from the overall picture painted by the pro-formas received. Three of the four sites were either actively committed to a formal Total Quality Management (excellence/cultural¹⁵) approach to quality (Marketown and Fishtown), or had developed their own 'TQM-like' model based on past experiences with the 'excellence' approach to quality (Castletown). Shiptown was committed to a standards-based 'scientific'¹⁶ emphasis in its quality strategy and for this reason was picked as it offered a theoretically different context with which to aid theory contrasting and development. Each of the sites had varying degrees of 'external' involvement from

CHCs, user groups or local voluntary organisations in the activities and planning and evaluation of its quality strategy.

A Strategy For Data Collection: Case Study And Stakeholder Analysis

Whilst case study methodology constitutes a form of organising strategy for research, and one in which the virtues of flexibility, depth and richness are associated with the analytic process, it is necessary to get beyond this level and address questions of data collection and analysis if an adequate balance is to be struck between holism, individualism, explanation and understanding. Specifically, at an early stage in the development of strategy it was necessary to ask ‘what will count as data?’ ‘Where should it come from?’ and ‘how should it be used?’

The study’s theoretical base has at its core (see Chapter Five) the notion of stakeholding - that people have an interest, or stake, in the way quality is actualised in services. Chapter Five argues that the actualisation of quality is linked to issues of power, resource, structure and the organisation of work. For these reasons it is a concept which people wish to influence in order to help secure their interests in these areas.

In order to explore this argument one of the study’s primary tasks in each of the case sites was to identify who these stakeholders were as a first step in identifying their relationship to the manifestation of quality in their Trusts. This was not always an easy task as much of the manipulation and shaping of the quality-agenda took place away from officially sanctioned fora such as quality committees or user-consultation groups, making identification difficult. In order to both recognise the importance of individuals, allow for the possibility of alliances between individuals not based simply on occupational role, and as a means of remaining systematic in the data collection and analysis stages, the framework adopted was Stakeholder Analysis¹⁷.

This approach to the identification and elucidation of theory specific to stakeholders aligns itself to a number of key philosophical propositions:

- *That reality is to some extent subjective - different stakeholders experience the nominally 'same' phenomenon differently, and this is not perversity. Investigations themselves have stakeholders and social contexts, and are not neutral or value-free in the problems they address, the ways they frame them, the data and interpretations they select.*
- *Situations are not necessarily manifestations of single purposes and plans, but may be created by the interaction of multiple purposes and multiple agendas for achieving them.*
- *The post-structuralist rather than structuralist view of the generation of behaviour. That is, that much/all of behaviour is the manifestation of cultural software that actors have internalised, rather than hardware of a basic structure of human personality as a fixed reality across people and over time¹⁸.*

Stakeholder analysis is simply a broad organising principle for research which does not have a particularly coherent base in any specific epistemological or ontological world view, but it is sympathetic to the theoretical stance on quality adopted in this thesis. Namely that as it manifests itself in services, the concept is bound to a constructionist (rather than realist) and pluralist (rather than unitary) reality¹⁹.

Stakeholder analysis has five stages in its framework:

- The identification of the phenomenon of interest, the research questions, and the general research approach (inductive, deductive, comparative). The phenomenon (quality) has already been outlined and the broad research questions already expressed in the introductory chapter. The general research approach adopted was inductive in character:
- The deduction of a likely set of initial stakeholders, the collection of initial data and the identification of other stakeholders.

- Collection of fuller data and the construction of a multidimensional database and the filling in of this until complete enough for analysis.
- Analysis of data in order to address the research question.
- Writing up and presentation of conclusions addressing questions of stakeholder audience and how and why to reach them.

The initial stakeholders in each of the sites are outlined by Chapter Four and the multidimensional analytical database forms the basis for Chapter Seven and the discussion of the qualitative findings across the sites.

Access Arrangements

In all of the sites access was surprisingly easy, with active support and encouragement offered from senior management. However, each of the Trusts wished to be kept informed of which senior clinical staff were to be interviewed. In Marketown access to senior medical staff was arranged through the ‘Matron’ of the Trust as she felt that this would be more a more successful approach. As a tactic for securing interviews and access, however, it was not that successful with most of the medical staff refusing to be interviewed. Having interviewed the medical director of the Trust his help was sought in securing interviews with colleagues with markedly better results. Only one of the consultants approached after the Medical Director’s intervention would not be interviewed. Subsequently, senior medical staff were used to ‘introduce’ the researcher to colleagues as a strategy for securing interviews. It was not clear whether the initial reluctance of medical staff was due to a cultural strategy of non-compliance due to an ‘outsider’ (a senior nurse) making the introductions. It was, however, undoubtedly easier to get interviews when an ‘insider’ made the initial approach on the researcher’s behalf.

Each of the Trusts made it a proviso of the research that the results of the study were fed back to the participants. It was made clear to them that the study was exploratory, concerned with organisational politics, and not of the comparative ‘which approach is

best' type. It was also made clear that the results would be anonymised and no case sites or individuals would be identifiable. This anonymity was vital as many of the respondents made it clear that they feared repercussions if they could be identified from either their Q-sorts (the ways in which they sorted the theoretical statements presented as part of Q-methodology (see pages 83-88 for details) or interview quotes. Although, interestingly, this concern appeared less common amongst senior medical staff who on more than one occasion stated that they had few qualms about the issue of anonymity. In one case stating that:

'nobody gives a toss about the quality people in this place so why should they worry if I express an opinion?' (General Surgeon: Fishtown)

It was made clear to the sites at the outset that the local purchasers and CHCs would be approached for interview. Only in Marketown did this present a problem; the Trust were not keen to involve the CHC as the two organisations had what one manager called a 'history of bad blood' between senior managers and the Chief Officer. Eventually in Marketown a compromise was reached with only the Q-sorting component of the Trust's report being sent to the CHC. A situation which the CHC accepted as necessary if the research was to be completed.

On Multiple Methods Of Data Collection

The primary units of analysis in the case sites were the organisations as a whole but analysis also occurred at the level of meetings, small groups, and individuals. This 'embedded'²⁰ design entailed multiple strategies for data collection. These included in-depth qualitative interviewing, observation, documentary analysis and Q-methodological investigation. These multiple strategies were intended to examine the perceptions and actions associated with the actualisation of quality from different perspectives; thereby promoting an expanded data set and deeper understanding of the phenomenon under investigation²¹. Each of the elements of the strategy was designed to examine particular,

but different, aspects of the same reality²². Advocates of multiple methods of gathering data on the same phenomenon (between method triangulation) suggest a number of reasons why triangulation is of benefit to the researcher, but most centre on the benefits to a study's validity of such an approach. As Brewer and Hunter point out:

*'Triangulated measurement tries to pinpoint the values of a phenomenon more accurately by sighting on it from different methodological viewpoints. To be useful, a measuring instrument must both give consistent results and measure the phenomenon that it purports to measure. When two reliable instruments yield conflicting results, then the validity of each is cast into doubt. When the findings of different methods agree, we are more confident.'*²³

However, such 'testing' of the validity of each method was not the primary aim of this research. Analysing the processes and attitudes associated with quality from multiple sources of data in this study is more akin to the deeper levels of knowledge and exploration alluded to by Walker:

*'Triangulation can add qualification to research that would otherwise be accepted uncritically...and (methods) can also complement each other when the survey provides a context for the qualitative work which in turn permits commentary on the survey findings.'*²⁴

In this study each method of data collection is intended to add to, and complement, each other along the lines of what Robson terms the 'complementary purposes model'²⁵. At the level of design this means that each method is designed to address a different research question. So for example, Q-methodological exploration addresses the question:

'What form if any do shared subjectivity's take in relation to perceptions of quality activity amongst stakeholders in NHS services?'

Another example can be found in the way that participant-observation (with the researcher as participant-observer) at meetings and in quality fora addresses the questions:

'What is the relationship between people's expressions of views on quality activity in interviews, and their actions in key settings to do with quality activity?'

'how do the structural elements of a Trust's quality strategy act to shape the concept's actualisation in services?'

At the level of analysis this means that the Q-methodological exploration of shared subjectivity's provides a context for the elucidation of theory derived from the interview data. This in turn informs the observational material. Such 'compounding' of sources of data to arrive at a fuller, more holistic, level of understanding is not without its dilemmas however. As Hammersly and Atkinson point out:

*'The aggregation of data from different sources will [not] unproblematically add up to produce a more complete picture.'*²⁶

It is symptomatic of the complementary purposes model that divergence is almost always a feature of research carried out this way²⁷. However, whilst posing a problem, the characteristic remains useful. If the data appears to throw up contradictory accounts and these contradictions can be accounted for theoretically, then not only can the theory be considered more robust, but an agenda for further empirical exploration is also established. This logic is analogous to the replication logic of the multiple case site design itself. The aim of such design is theoretical explanation of any convergence or divergence between cases. Where cases do not 'fit' the theory developed then the theory must be modified and further testing carried out²⁸. Certainly in this study there were contradictory results and divergence between and within case sites, these have been highlighted and addressed in Chapter Seven.

Data Collection: The Specifics

Both case site methodology and stakeholder analysis constitute broad, yet complementary, organising strategies for data collection. They both favour a 'naturalistic' research design but neither is particularly prescriptive about how data is to be collected within this set of principles. This flexibility, whilst an advantage, means that careful questions of suitability for specific data collection techniques must be addressed. The adoption of an inductive approach to theory construction means the data collection and theory development processes occur concurrently. Consequently, the data collection strategies must be broad enough to yield rich and varied data, yet also practical enough to enable the theory to develop and move on within the permitted time scale. They must also enable me to 'revisit' stakeholders and the data generated as many times as necessary in order to refine the theory. With these requirements in mind several strategies to data collection were employed.

Organisational Literature And Documentation

Organisational literature can give valuable clues and insight into the definition of quality purportedly employed by units, the values attached to the organisation's view on quality, and the weighting attached to the various groups involved around the concept. The reasons why it is such a useful source of data are explained by Forster:

*'...documentary records constitute a rich source of insights into different employee and group interpretations of organizational life, because they are one of the principal by-products of the interactions and communication of individuals and groups, at all levels, in organizations.'*²⁹

Moreover, it acts as a source for comparison with other data sources. Documents are a useful way of cross-referencing the interviews of people with their written accounts.; and can also assist in the interpretation of informants' rewriting of history in later verbal accounts of events around quality activity development³⁰. In this study there were no hard

and fast rules as to what would count as documentary data in each of the sites as it was not possible to develop ideas of the forms of documentation relating to quality in each of the sites prior to immersion. The starting point for most of the sites were copies of the quality strategy (where they existed); however, by the end of the fieldwork documentation in the form of committee meetings, training manuals, private memos, working papers and internal and external reports had all been scrutinised.

Participant Observation

Jorgenson argues that this is a suitable strategy for data collection in research problems where, 'there are important differences between the views of insiders as opposed to outsiders'³¹. The tentative theoretical typology deployed thus far can be seen to have an insider-outsider dimension. Within the delineated picture of quality professional and managerial approaches are associated with the status of organisational 'insider' whereas consumerist approaches are accessible to those 'outside' the organisation's managerial and professional stakeholders. Indeed, to attain consumerist quality, the views of 'outsiders' are actively encouraged as a criteria for successful implementation.

Participant observation can also be seen as an appropriate data collection tactic where 'the phenomenon is somehow obscured from the view of outsiders'³². Again the literature suggests that quality activities, particularly in the sphere of 'professional' activity, is often obscured from lay scrutiny. This is a criticism that has been labelled at medical audit strategies in particular. A point which relates to Jorgenson's criteria that the method is suitable where 'the phenomenon is hidden from the public view'³³. He also goes on to suggest that participant observation as a strategy is most appropriate where certain minimal conditions are present:

- *the research problem is concerned with human meanings and interactions viewed from the insider's perspective;*

- *the phenomenon of investigation is observable within an everyday life situation or setting;*
- *the researcher is able to gain access to an appropriate setting;*
- *the phenomenon is sufficiently limited in size and location to be studied as a case study*
- *questions are appropriate for case study*
- *the research problem can be addressed by qualitative data gathered by direct observation and other means pertinent to the field setting.*³⁴

Quality, as has been argued, is dependent for its actualisation on the meanings and interpretations that ‘insiders’ attach to the concept and the techniques used to promote it. If one takes the stance, as this study did, that quality activities represent the observable ‘face’ of the concept, then participant observation is an eminently appropriate strategy for collecting data on the fora and meetings which form the backbone of such activities.

The style of participant observation adopted in this study is of the *participant as observer* model described by Robson³⁵. The researcher’s status as an observer was made clear to members of the groups at the onset. This had the advantage that, as an observer, I could legitimately probe areas of the meeting that were not understood or followed and also revisit aspects of the meetings in interviews with key stakeholders. However, it also meant that it was extremely likely that the research presence had an impact on the behaviour of the meetings themselves. This behavioural effect was minimised by attending more than one of the same fora. So, for example, whilst nine Quality Improvement Team meetings in Marketown were attended, they were from only three specialities. This meant that the research presence became a fairly familiar faces at the meetings and the trust of the participants increased. In the meetings which involved users or their representatives, it was more difficult as the researcher was neither one of the ‘insiders’ from the Trust, or one of the ‘outside’ lay group. The research presence as an ‘objective’ researcher was still made clear to the groups (such as the community fora in Marketown and the Quality fora in Castletown) but it was clear that at least some of the members saw the researcher as part of the Trust’s staff.

The role of outsider (which the researcher represented) carried several advantages and disadvantages. The advantages included the ability to overview a scene, noting major and distinctive features, relationships, patterns, processes and events. It also provided access to the phenomena of interest; considerable freedom to concentrate on the research; was readily assumed and took little adjustment to the researcher's self image. Furthermore because access and presence was negotiated with the organisation itself it raised relatively few ethical dilemmas.

The flip-side of these advantages was that the research role was hardly ever 'natural', and in this sense constituted an obtrusion and in some cases was accompanied by a sense of imposition on the setting; with the potential effects on observed behaviour that this intrusion implies. The two techniques used to minimise these effects were, as stated previously, time and rapport. Repeated presence at the same fora over an extended time-scale was used; thus making it more likely that the people observed perceived the research role as non-threatening and existence at fora for granted. Rapport was promoted through the judicious use of conversation and the maximisation of the opportunities afforded by casual interaction away from the phenomena being observed. Every opportunity to mix with participants 'off duty' was taken up. These included lunch with medical staff, coffee bar conversation and even attendance at one Director of Nursing's barbecue party! This not only served to add a more human face to the research presence but also generated useful data on contexts such as local politics and personalities which would not have been raised in the formal settings of quality fora and committees. The question of researcher impact is discussed more generally later in the chapter (see page 92).

Depth interviewing

The aim of using depth interviewing as a means of gathering data was to generate material that could be used to give a picture of respondent's perceptions and also as a source for comparison with the data generated by participant observation, documentary and Q analysis.

By using a hermeneutic approach (see page 78) to analysing the qualitative data patterns, encounters and reactions were both grounded and presented in the respondent's terms, using *their* language, *their* frames of reference and *their* constructs. This comparison between observed events and respondent's perceptions serves to add to the richness of the data available and therefore to the validity of the theory developed. There was however a degree of structure to the interviews. This was inevitable for as Walker points out:

*'There is no such thing as presuppositionless research. In preparing for interviews researchers will have, and should have, some broad questions in mind'*³⁶

These 'broad questions' are evident in this study and consequently constituted a loose framework or structure for the interviews. A level of structure was necessary to maintain the study's focus on issues of quality activity in services and the relationship with the respondent's broader experiences, values and perceptions. Atkin and Lunt, in their study of nurse, GP and managerial perceptions of the role of practice nurses found that maintaining a focus on practice nursing when interviewing the different groups involved was difficult:

*'...a study concerned with the role of practice nurses required that the 'depth' of the interview should be about practice nursing. This, however, was rarely where the 'depth' in either the general practitioner's or manager's account occurred....there was, therefore, a constant tension in the interview as we attempted to lead the respondents back to the areas relevant to the aims of the research'*³⁷

Preliminary interviews carried out by myself with nurses, doctors and managers, revealed that, while a relatively unstructured approach was useful in identifying areas of primary concern to the respondents, the picture was occasionally confused. At times the answers to the questions did not seem to relate to experiences or conceptualisations around quality activity. Atkin and Lunt³⁸ suggest that such difficulties can, in some cases, be attributed to the separate frames of reference used by researcher and respondent. Based on these examples one of the justifications for adopting a loose framework based around the research

questions was to promote sufficient specificity and focus in the answers to questions, but at the same time not to exclude respondents' own perspectives and constructs.

With this in mind topic guides were used as guides for questioning and modified as a response to observation-based data and the initial interviews. One of the key findings from the preliminary interviews carried out was as each respondent's answers were provisionally analysed and incorporated into the questions used in the interviews that followed, the data became richer and the interviews more fruitful. Although the extent to which this was to do with improved question construction or simply better technique acquired as part of the researcher's experiential learning curve is debatable. Interviews lasted on average around an hour. They were usually conducted in settings in which the interviewee was comfortable (usually an office or side ward) but occasionally took place in an individual's home when they did not wish the Trust to know they had been interviewed.

Analysing The Qualitative Data: The Hermeneutic Approach

Analysis of documentary, observational and interview data all followed a similar pattern; one that was sympathetic to the notion of interests and social action deployed thus far in the thesis. At the core of this approach was hermeneutic interpretation^{39 40}. Hermeneutics takes as its starting point the contention that all human interaction is based on meaning-laden, negotiated interaction involving self presentation, secrecy, 'front', and political gamesmanship⁴¹. This behaviour is conditioned by the awareness individuals have of the situations in which they participate. So, the meanings which people attribute to these situations, rather than casual variables', become the basic units of research⁴². The basic process revolves around a *hermeneutic spiral* process of understanding and involved seven stages aimed at fostering an 'emic' (from within) style of understanding of the themes and meanings associated with stakeholder participation in quality activity.

The first stage was understanding the meanings of individual documents, meetings or interviews. This stage focused on gleaming the 'taken for granted' assumptions and view points (frameworks of meaning) of respondents or document authors from the data source.

So in this study common frameworks of meaning included, amongst others, issues of power relationships and communication. As typified by these sources of evidence:

*'A medical audit project will normally be led by a senior consultant in the team involved'*⁴³

*'The Quality Improvement Team is responsible for disseminating information on quality back to the clinical departments.'*⁴⁴

From these general issues, themes and sub-themes (or 'clusters of meaning') emerged. For example, in Castletown (as in all the sites) there was a distinction between the power relationships in medical as opposed to clinical audit. Clinical audit was not necessarily led by a clinician whereas medical audit always was.

When these themes were triangulated with data from the other methods clusters of themes began to emerge. For example the broad issue of power relations, and the theme of leadership as an expression of this, had linkages to the perceived 'power' of the audit projects. Medical staff tended towards seeing clinical audits as less successful change agents, whilst nurses and therapists (the less powerful) group perceived them as more so. What this triangulation achieves is the dovetailing of the individual frame of meaning (power relations) with the wider contexts in which it exists: for example, the quality strategies in place, formal quality structures and inter-group politics.

From this point it was possible to compare these clusters of meaning with the study's research questions. However, it is at this point that questions of reliability and validity of data arose. Specifically, how could the validity of documents, interviews and meetings observed be assured? Alternatively, were they representative of the varieties of meaning around the issue of quality activity in Trusts? The research took as a starting point Glaser and Strauss' notion of theoretical saturation⁴⁵. At the point where documents, interviews and observation ceased to reveal any new frameworks of meaning or insight into the research questions then this was the point at which the data was re-contextualised and the picture

analysed as a whole (the aim of hermeneutic method is seeing and understanding the whole through its constituent parts).

Moreover, employing a stakeholder methodology meant that 'coverage' of stakeholders proceeded in a similar manner. The network of stakeholders within the Trust was mapped by asking interviewees to name other people involved in quality activity in their areas or those in other areas they thought should be interviewed. When no new names were added to the list of stakeholders then the network was assumed to be complete. References to individuals made in fora, or indeed other relevant meetings, were also recorded and followed up.

A further check on the validity of the analysis was through discussing the analytic matrix and findings with key members of the team responsible for the quality strategy. The analysis of interviews and broad themes within them were also fed-back to interviewees wherever possible in order for them to add to, or question, any of the interpretations by the researcher. As new and theoretically significant clusters of meaning emerged then these were discussed with the people who's 'world-views' influenced the shape of quality in the Trusts. Where areas of divergence between the researcher's interpretations of themes within data and theirs occurred these were discussed and explored and interpretations adjusted where necessary. This was not wholly satisfactory, as in some cases it may have been in their interests to reject some elements of the analysis. One solution would have been to have a second researcher as an arbiter. However, the opportunity for immersing another researcher in the data and asking them to confirm or reject the analytical conclusions of the textual, interview or observational material used as representative was not present in such a limited study.

Mixing Qualitative And Quantitative Techniques: Q Methodology As A Sympathetic Paradigm

Strauss and Corbin suggest that quantitative and qualitative techniques can be incorporated as long as the researcher is aware of the limitations in doing so. First, they point out that the researcher must be clear about the uses and purposes to which the quantitative component

will be put. The purpose of the quantitative component in this study was, as has already been stated, to contribute to the richness and depth of the data surrounding the phenomenon of quality in services. Thereby adding to the breadth of theory by feeding-back into the theory construction process itself.

In taking this approach the associated complexities and need for caution were acknowledged. However, the potential quality of the data and resultant theory acted as mitigating factors for the required rigorousness, and possible pit-falls, attached to the proposed strategy. There are also other reasons for combining the two apparently incompatible paradigms.

Tactical Advantages

A qualitative-quantitative mix can facilitate easier access to research sites for case-study⁴⁶. Although equally convincing is the argument that richer qualitative data could prove more interesting to organisations. By mixing the two the study effectively 'hedged its bets' and maximised its chances for successful access. This did not mean that methodological questions of rigour and appropriateness were abandoned in favour of pragmatic questions of access. Merely, that this was a factor taken into consideration in the overall design of the research.

The second tactical advantage attached to mixed methods is that an understanding of the workings, attitudes and 'politics' of an organisation can be enhanced by initial exposure as a qualitative researcher. This in turn enhances the success of the quantitative component⁴⁷. This understanding can be used to ensure that questions are framed in such a way as to maximise response. Judgements can also be made about likely sources of staff resistance and modifications to survey and administration made accordingly: for example, self administered versus structured interview. It is also feasible that as a rapport develops between researcher and key groups as a result of the researcher's role in qualitative data collection then resistance to a quantitative strategy will be potentially reduced. Certainly the ability to contextualise the Q-findings was enhanced by exposure to the case sites during the

qualitative phases of the study. The importance of contextual factors such as the quality structures in place, local politics and cultures were more easily incorporated into the analysis.

Q-Methodology: An Outline

A Q-methodological approach^{48 49 50 51} was used for the quantitative element of theory construction. This was selected for a number of reasons. The primary reason centres, both on the appropriateness of Q methodology and the limitations of conventional quantitative R-based methods⁵². In conventional approaches to the measurement of perceptions and attitudes (for example, through the use of Likert scaling) the element of 'self reference' and subjectivity which the qualitative methodology will have sought to retain is, to a degree, lost. Categories and items for inclusion are constructed deductively based on the interpretation of qualitative results and ultimately reflect some of the biases and value judgements of the researcher. Q methodology combats this tendency by retaining *self reference* and *subjectivity* as the core goals of the approach. The methodology manages to retain the respondents subjectivity as the focus by foregoing the pre-conceived structures of conventional quantitative attitude/survey methods.

The key axiom behind the methodology is that:

*'...only subjective opinions are at issue in Q, and although they are typically unprovable, they can nevertheless be shown to have structure and form... [Q techniques make] this form manifest for the purposes of observation and study.'*⁵³

The primary reason then for adopting Q as a means of complementing the qualitative data is that it enables the 'mapping' of opinions or values in a 'scientific' and rigorous manner (as a conventional scale would also do). But does so in a way which extends the aims of the qualitative approach rather than opposes them: the framework of self-reference remains the focus.

The other reason centres on the issue of practicability. Q involves developing strong statement or issue samples and is designed with small 'person-samples' in mind. As McKeown and Thomas point out:

*Q-method is biased towards small-person samples and single case-studies, a preference in keeping with the behaviourist dictum that it is more informative to study one subject for 1'000 hours than 1'000 subjects for one hour...Q, in fact, is a method of and for the single case.*⁵⁴

Because of the methodology's lack of reliance on large 'n' samples for valid and reliable results it is a more practical route for this study, with its limited budget and time scale. The fact that the method is designed to be utilised in case-studies concerned with issues of subjective opinion or values makes the arguments for its adoption even more compelling. The focus for Q is subjectivity, or as Brown puts it:

*'...subjectivity is always anchored in self-reference, that is, the person's internal frame of reference, but this does not render it inaccessible to rigorous examination. Nor does it serve to reify the self in any metaphysical or phenomenological sense. Self-referent subjectivity of this sort, on the contrary is pure behaviour...it is at issue anytime an individual remarks, it seems to me...or in my opinion. In speaking thus an individual is saying something meaningful about personal experience...what Q-methodology provides is a systematic means to examine and reach understandings about such experience.'*⁵⁵

Q-Method: The Stages

Q involves four main stages:

- 1) *Construction of a 'Q - sample'*: a sampled set of stimuli (commonly statements) which will enable the respondent to model his or her viewpoints on a given topic.
- 2) *Q - sorting*: the modelling stage, involving the systematic sorting of the Q-statements so they portray an accurate 'ranked' picture of the respondent's views.

- 3) *Data analysis:*
- correlation of persons (a key difference from conventional methods)
 - factor analysis of the resultant NxN matrix
 - isolation of components of factors in order to enable interpretation.
- 4) *Interpretation:* 'in terms of consensual and divergent subjectivity, with attention given to the relevance of such patterns to existing or emerging theories and propositions.'

The Q-Sample

For the purposes of this study the Q-sample, or the set of statements used to model opinion, was naturalistic and inductive in design. This means that the statements themselves were drawn directly from the qualitative data. Decisions to include them in the sample or not were made on the basis of the hermeneutic approach to analysing the qualitative data in each site and the research questions.

The framework that emerged from Marketown (the first site) and which was carried through to the other sites (where the themes still remained) is presented in fig 3:

MAIN EFFECTS	LEVELS
A. Direction	a) positive b) negative
B. Focus	d) professional e) managerial f) consumer
C. Themes	g) definition h) evaluation i) activity preference j) structure k) information l) leadership m) markets n) conflict o) control
Q-sample = (main effects)(replications) = ((A)(B)(C))(2) ((A)(B)(C)) (m) = ((2)(3)(9)) (2) = 108 [54 in 3 later sites].	

fig 3: *The Q-sample matrix.*

A set of statements drawn from the qualitative data was constructed which reflected this framework in each site. So a statement such as:

'Professionals (nurses and doctors) know quality when they see it. That's why it should be left to them to define what it is.' (Q-sample Castletown)

would represent an (a,d,g) orientation. A statement such as:

'a lot of what I do, as a professional, is unmeasurable along quality lines. Quality initiatives don't always recognise this and consequently a lot of professionals see them as irrelevant.'

would represent a (b,d,g) orientation.

Each element of the sample frame should ideally have a number of replications, or statements expressed in different ways in order to allow for the possible varieties of expression that could exist. The number of statements required for the sample can then be computed from the formula:

$$Q\text{-sample } (Q) = (\text{main effects}) (\text{replications})$$
$$Q = (A)(B)(C) (m)$$

However, it was clear that the 108 statement Q-sample generated in Marketown using two replications was excessively large. Whilst coverage of the issues around quality activity was excellent it took nearly an hour (and in some cases longer) to complete. A number of respondents commented on this and it was felt that losing the second replication was the only solution if breadth was to continue to be a feature of the sample. Consequently, in Fishtown, Shiptown and Castletown 54 statements were used. The Q-samples for each site are presented in the appendix - tables 2:a-d.

The Q-Sort

This stage involved the systematic, rank-based, sorting of the statements by the respondents in order to represent their views on quality activity. The subjects were presented with a continuum defined by a condition of instruction. The continuum ranged from -5 to +5 and the condition of instruction in this case was:

*'Sort the statements according to those which are **most like** your position (+5) to those which are **most unlike** your position (-5).'*

Each point in the continuum has a limited number of spaces and the subjects were asked to repeat the process until all the statements are placed in the available spaces. In this way a picture of the respondent's views emerged which equates to a normal distribution

For the purposes of data analysis each statement's number is recorded and given a value according to its position in the distribution. So those under -5 would receive a score of 1 those under -4 would receive a score of 2 and so on up till those under +5, who would receive a score of 11. This translates into a data matrix of Q-Sort scores x n (where n = number of people taking part). The Q-sorts for each person can then be correlated and factor analysed in order to discover groupings of opinion among the respondents (the results of this process are enclosed in the appendix - tables 1:a-d).

Once factors are established the difference between Q and conventional R methodology becomes clear. In Q methodology the variables are the people conducting the Q-sorts and not the Q-sample statements (as they would be in conventional R methods). Therefore, by looking at the factor loadings of each subject it is possible to determine a significant association with a given factor. Respondents who are significantly associated with a given factor are assumed to share a common perspective. The factor loading represents the degree of association between the person's Q-sort and the underlying composite set of values reflected in the factor. The key point here is summed up by Mckeown and Thomas:

'the presence of several orthogonal (independent) factors is evidence of different points of view in the person-sample. An individual's positive loading on a factor indicates his or her shared subjectivity with others on that factor; negative loadings on the other hand, are signs of a rejection of the factor's perspective.' ⁵⁶

Factor analysis was of the principle components type and factors extracted were those with an Eigenvalue of greater than 1.0. Statistical advice was provided by the Department of Computer Science at the University of York and analysis carried out using SPSS for Windows v6.0.

The content of factors was initially explored by examining the composition of the groups who defined each factor; although, as Chapter Six shows this was largely inconclusive. They were then explored in greater depth by examining and converting the factor scores for each statement in the Q-samples. A factor score (a weighted Z-score) can be converted into the

original integer format (-5 to +5) through computation thus allowing the picture of statement scores to be examined individually. In this way a picture of factor opinion on each statement can be constructed. The factor scores for each statement and factors extracted are presented in tables 2:a-d in the appendix.

The Weaknesses Of Q Methodology

The first criticism of Q is that inference to populations is unwise given the limited numbers of the person-sample which often accompanies the method⁵⁷. This is undoubtedly true in the positivist sense; however, the case study approach adopted in this study does not require the ability to generalise to large populations.

The second criticism of Q is that the sorting method violates the assumption of independence which is a feature of most statistical testing. The placing of one Q-statement *does* affect the placing of another. The method is after all concerned with ranking statements. However, this need not prove overly problematic for the researcher as long as the central question, as posed by Kerlinger is addressed:

*how serious is the violation of the assumption? Is it serious enough to invalidate the use of correlational and ANOVA [analysis of variance] procedures?*⁵⁸(my parentheses)

Kerlinger⁵⁹ responds to this question with the assertion that the violation can be countered by ensuring there are sufficient items in the Q sample, and when in doubt by raising the level of statistical significance required from p0.05 to p0.01.

Researching Quality Activity And Stakeholding: Ethical Issues

*'knowledge of man is not neutral in its import; it grants power over man as well'*⁶⁰

Friedrichs' comment highlights one of the essential dilemmas facing the researcher attempting to look at issues of quality in organisations: knowledge is not ultimately divorceable from the uses it is put to. As Smith points out.

*'...scientists are not interested in simply describing present reality but wish ultimately to predict future events. Science as a descriptive enterprise implies science as prediction. Prediction may lead to greater control, and control of other humans is not only a scientific decision. Control of other humans is also a moral or ethical decision.'*⁶¹

This assertion concentrates on two elements of control: control over the subjects under examination and control over the usage the research results are put to once in the public domain. These two areas raise a number of ethical dilemmas.

First, it is possible to argue that even though manipulation of humans is not an explicit research strategy (as in experimental designs) this only disguises other ethical problems. Nagel elaborates:

*'...every branch of inquiry aimed at reliable general laws concerning empirical subject matter must employ a procedure that, if it is not strictly controlled experimentation, has the essential logical functions of experimental enquiry'*⁶²

The chosen methodology for this study combats Nagel's claims by deliberately adopting a qualitative approach to theory construction. But even though *experimental* logic does not apply in this case, the *scientific* logic of rigorousness and integrity in inquiry does. The hermeneutic approach calls for rigorous category development, coding, testing and re-testing of data, all of which can be considered 'scientific' in character.

Second, Jorgenson⁶³, in relation to participant observation, suggests that as this form of enquiry is effectively no different from the healthy interest that ordinary people take in other people's interactions, then the researcher has 'no more or less of an ethical obligation to the people encountered in the course of the research'⁶⁴. The obligations the researcher holds are

the same as any other participant in the research subject's life. Jorgenson uses this as a means of excusing the 'obligation to inform people of research intentions, or even to protect them from harmful consequences'. This underestimates the dilemmas attached to the research strategy adopted. These dilemmas centre on four primary areas:

- the question of fully informing the research site
- the issues of reciprocity and use of results
- confidentiality
- the question of researcher impact on case-site

Informing The Case-Study Sites

NHS services are, theoretically at least, supposed to compete in a market situation based on different levels of cost, and more importantly (from the research point of view) quality. Consequently this meant that quality was a sensitive topic for Trust managers and clinicians. Some managers feared that the study, in being concerned with quality in their unit, could have negative effects on their local market position. From personal experience in the NHS it was clear that even one incidence of low-quality in a service can have significant ramifications in terms of negative media coverage and public perception. In response to these potential fears, and the ethical obligation not to wilfully harm the organisations' standing in the local communities, a policy of honesty was deemed the most satisfactory approach. This was based on the argument that, as the primary research interest was in staff and user's perceptions and experiences of quality activity, there was little utility in seeking instances of poor quality. While instances of poor quality emerged, positive experiences and perceptions were just as much a feature in each case-site. The approach, based on this potential 'balance' argument, was a primary feature of attempts to negotiate access based on an 'up-front' explanation of the research interest and questions.

Issues of Reciprocity and Use of Results

Part of the research strategy involved the feeding-back of results to the case sites. This was primarily undertaken as an aid to validity enhancement as part of the methodology but was also undertaken in order that Trust managerial and clinical groups could use the data to add value to their planning, development and training around the issue of quality. I placed no restrictions on the use of the results and, likewise, none was placed on me. However, I did ask that anonymity be retained in the production of training materials and other information likely to be disseminated widely. This was respected by each of the Trusts. The global aim of this tactic was to avoid the phenomenon often exhibited in social research whereby subjects provide data for researchers, with only marginal or no benefits associated with their participation. On the whole the tactic was a useful one and one which was valued by the sites involved.

Confidentiality

This strategy raised problems of confidentiality. Atkin and Lunt point to the difficulties attached to rendering identities anonymous in health care settings:

*'Although pseudonyms offer some protection, individuals can often be identified by their situations, particularly by readers with a knowledge of, and interest in, the locality.'*⁶⁵

With this in mind it would have been unethical to assure people of complete anonymity and confidentiality across the organisational spectrum. Cases involving specific senior posts or medical specialities could easily have been narrowed down by people with insight into the organisation. Therefore, every effort was made to change names, titles and to subsume specific positions and specialities within umbrella categories. The site names were also given pseudonyms in an effort to maximise outside confidentiality.

Researcher Impact On The Research Site

By observing, interviewing and exploring the shared subjectivity's of respondents the potential to affect the ways in which respondents perceived quality activity and, potentially, themselves, was always present. Atkin and Lunt draw attention to the specific problems of interviewing; but their arguments apply equally to other qualitative and quantitative approaches. In their view research is a consciousness raising exercise in which respondents are asked to think and talk about particular subjects which they may not have thought or talked about in such detail before. This can have the effect of making a respondent aware of how little he or she knows about the issue - in this case quality. Similarly, the respondent may become more aware of their relative positions within the dynamics of the organization, with potentially negative effects on the working relationships that existed before the research presence. Atkin and Lunt point to the need to become aware of such possibilities and the fact the ultimate benefit of research is to the researcher as means of diluting such researcher-based effects as a means of minimising such effects.

Such recommendations, however, tell the researcher little about practical tactics that can be deployed. A degree of sensitivity and awareness of the potential effects of researching each research site was, of course, a feature of the strategy. As was the feeding-back of results to the Trusts. This ensured the ultimate research benefit did not rest solely with the researcher. Every effort was made to ensure that respondents were not knowingly made to feel undervalued or ignorant as a result of the methods employed. This was particularly so in the case of interviews, where the potential to 'lead' and influence the respondents was greatest. These values were promoted, in part, by the choice of a qualitative framework and data collection techniques. All of which rely on the skills of listening and observation on the part of the researcher for successful deployment.

Conclusion

The key to understanding social action is achieving a balance between two sets of competing analytic emphases: explanation versus understanding and holism versus

individualism. The focal points for research efforts to gain a purchase on each of these emphases are as was seen in earlier chapters, entirely relevant to the phenomenon of quality in the NHS. Specifically, in order for quality to be actualised in services it must negotiate, and is dependent upon, a complex matrix of systems, rational choices, cultures and subjectivities. It is worth enlarging on this point with an example of the rationale behind it. Quality can be considered as the end point or outcome of the application of systems such as Total Quality Management or Quality Assurance. Alone, however, these are insufficient; for if one chooses (if one is able) to not participate in these systems then the system will fail. One might choose not to participate (or conversely to marshal one's efforts) because the culture of the group, or groups, to which you belong to view such systems as unsynergistic with their own values. Conversely, the subjective feelings you have about the system being proposed, or indeed imposed, will impact on how you approach the social action required to achieve the system-goal of 'quality'.

These arguments then form the basis for the research effort in this study. In order to examine these cells, or keys to analytic understanding, it is necessary for any methodology and its methods to be, in quality parlance, 'fit for the purposes' of analysis. Case study methodology and analysis offers the chance to gather in-depth, rich and contextualised data and to maintain a sense of academic rigour and focus.

The argument (further developed by Chapter Five) has been that organisational ideologies in the form of professionalism, managerialism and consumerism are instrumental in shaping all four of the analytic 'cells' of systems, choice, culture and subjectivity in social action. To this end, stakeholder analysis offers the chance to remain sympathetic to the view of the self. Namely, the individual is cast in an active role within a constructionist and pluralist view of reality. Stakeholder analysis offers the chance to remain flexible in the data collection methods deployed and to gear the methods to the research questions as they emerge from the sites.

The multi-method approach adopted is not without its problems; but with the study's design emphasis on the naturalistic and qualitative paradigms each of the methods used

complements each other. Participant observation provided insight into interpersonal behaviour and motives; interviews provided transcribed evidence of perceptions and the causal inferences made by individuals; and documents proved a rich source of 'official' group attitudes. Q methodology is all about eliciting shared subjectivities in a way which is sympathetic to many of the assumptions of qualitative research. It demonstrates structure and form in what can constitute plausible accounts of shared perceptions of quality activity between individual stakeholders. Although as indicated in Chapter Six these are not always in the forms expected.

The design used is intended to generate theory which is both rich and firmly grounded in the contexts of the sites. In short a move away from theory generated in the abstract by conceptual specialists towards theory which is generated from empirical material and which can be readily interpreted by the stakeholders involved.

CHAPTER FOUR: THE CONTEXTUAL BACKGROUND FOR THE CASE SITES

This chapter portrays the particular contexts of the individual NHS acute hospital Trusts involved in the study. It highlights those variables within particular sites which, while highly influential within specific sites, were not always so in others. Material is presented in the form of a series of four descriptive vignettes. The rationale for including such detailed information on each of the sites is that the Q-method results of Chapter Six and the results of the cross-case analysis presented in Chapter Seven have to be viewed in the individual contexts of each of the sites if readers are to reach informed decisions about the levels of generalisability of the thesis' findings.

Towards Identifying The Stakeholders

Given that stakeholder analysis is the key feature of the case study strategy, it was necessary to identify those individuals in the case sites with an interest or 'stake' in quality. Each of the Trusts used as case sites had a quality strategy in place. These ranged from the 9 page document available to the public (Castletown) to the internal one page document circulated internally in Marketown. In each of the Trusts the strategies tended to evolve incrementally rather than via great 'sea changes' in approach. There were nominal associations made between the quality and business strategies of the Trusts, but as shall be indicated in Chapter Seven the reality was something of a conceptual split between quality and business functions in the sites.

The common feature in all the strategies was that corporate structures and processes had been, and were being, created under the banner of quality. Each strategy had an 'official' quality structure in place which represented the framework for the implementation of quality in services on a corporate-wide level. These ranged from the devolved, relatively autonomous Divisional Quality Teams of Fishtown, to the more centralised 'core' of Shiptown.

Coupled to these structures were specific initiatives such as Total Quality Management; Continuous Quality Improvement; and Consumer Fora. These represented the main mechanisms for promoting quality within specific services or clinical divisions of the Trusts. It is from these two elements of corporate strategy that stakeholders were initially identified. In each Trust initial stakeholders were those with a place in either the quality structures or the quality processes attached to that Trust. This chapter describes those structures and processes.

As well as the stakeholders attached to the structures and processes in each site there were also other factors which affected the way in which quality and quality activity was perceived and operationalised in Trusts. Primarily these were to do with individual personalities; the interface between national/local party politics and local health services; and the localised historical legacies of pre-1990 service provision. Where such factors relate to the development and operationalisation of quality in Trusts then this is made clear.

Quality Strategy, Structure And Process In Marketown

Marketown has a population of approximately 300,000 people located in largely urban and suburban pockets within the Town's boundaries. The Trust serves this population and also smaller numbers of patients who travel from nearby rural areas. Coal mining was the main employer within its boundaries. Given the demise of the industry, poverty and higher than average male unemployment were associated with parts of the Town. There is a small Asian and Afro-Caribbean population within the town but little in the way of specific interventions within the Town's health services to deal with their particular needs.

The Trust was a 'first-wave' modern unit with 750 beds and a smaller 165 bed unit attached which was mainly orthopaedic, 'cold' elective surgery, and elderly-care beds. This smaller unit was perceived by respondents in both sites as being something of a poor relation to the more acute and specialised hospital site. The two sites were about 15 miles apart. The bulk of the data was collected in the main hospital site; primarily as most Trust activity was located there. The Trust had recently added a new privately

funded wing to its portfolio. This was very small (twelve beds) and didn't feature in the Trust's quality strategy.

Access to the Trust was negotiated with the Chief Executive and the Matron in the first instance. After two explanatory visits access was granted with the proviso that no confidential or commercial information would be made available to either the local District Health Authority or Community Health Council. Free reign was given to speak to anyone in the Trust with the exception of senior medical or managerial staff. Interviews with consultants and Trust Board Members were arranged through the Matron. The quality structure of Marketown is shown in fig 4¹:

The Quality Processes: Marketown

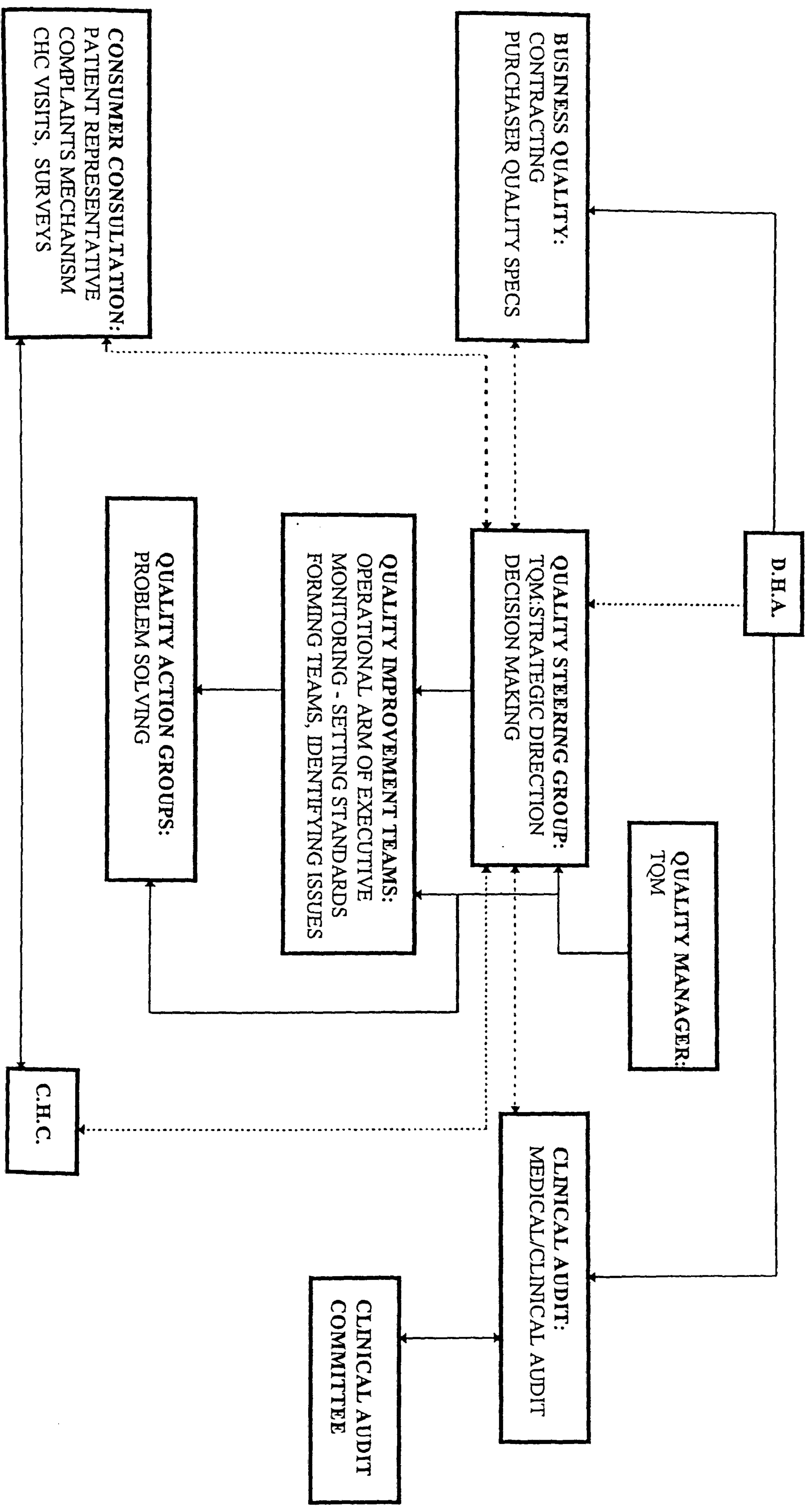
The Strategic Core: Quality Steering Group, Quality Improvement Teams And Quality Action Teams.

The Trust was a pilot site for the Department of Health's Total Quality Management Initiative. This pilot status attracted funding (circa £50k annually) for two years, and half this amount again in the third year to fund the development of TQM in their site. Part of this development had been a year's training input from a firm of Management Consultants who specialised in the quality techniques and messages promoted by Philip Crosby². Consequently, they had a well established TQM structure in place and several core activities which came under the TQM banner. These included:

- an executive-level quality steering group
- divisional quality improvement teams
- intra/inter directorate problem-solving quality action groups

The Quality Steering Group (QSG) comprised all the executive directors of the Trust and had responsibility for setting strategy and operationalising the Trust's mission statement based on the statement: 'Treating People Better'. The five principles they aligned themselves with were:

Figure 4: The Quality Structures And Processes: Marketown



- encouraging evidence based clinical practice
- encouraging partnership between patients and staff
- providing a safe environment for staff and patients
- listening to staff and patients and acting on this intelligence
- maximising available resources to improve the lot of patients and staff³

This strategic group were supported by a full time TQM manager with responsibility for the day-day workings of the initiatives. He acted as the facilitator for projects, giving the benefit of his experience and knowledge on quality and organisational change; as well as ensuring a sense of coherence with the corporate business strategy. This same manager was also a key link between the executive and their operational arms, the Quality Improvement Teams (QITs): these teams were located in clinical divisions and met monthly; ostensibly with the intention of developing and co-ordinating quality activity within the divisions, and problem-solving where necessary. In practice these meetings were primarily problem solving in character with a heavy concentration on general non-clinical issues such as laundry or catering facilities. Indeed, laundry and catering were themes in every QIT meeting attended, regardless of division. QITs were in turn supposed to generate problem solving teams to address the problems identified and feed back progress to the QIT. In practice, however, no evidence was encountered that such teams had been established in recent months other than in relation to laundry services. Even in these limited cases a 'team' generally comprised one or two specific individuals, primarily nurses, singled out to follow up an issue.

Quality improvement teams rarely entered the clinical arena, despite their all encompassing remit. They were intended to be multi-disciplinary in their composition, but of the four monthly meetings attended only one member of the medical profession was present. This doctor was recruited from the 'staff-grade' structure and had a special interest in quality through his ongoing Masters of Business Administration degree.

The QITs did, however, have non-executive members of the Trust Board attached to them as active participants. It was clear from both the meetings attended and interviews with these Board Members that they were far from token placements in the teams. The Board member attached to Women's and Children's services in particular was vocal in expressing her opinion on the service's lack of suitability for a Chartermark application due to the fact that its bereavement services for parents of deceased babies were of a poor standard in relation to the work of other Trusts. Her voice alone on a team of twenty people prevented the application progressing. It was clear then that these 'lay' members, albeit from the relatively powerful ranks of the non-executive Trust Board, had the potential to influence such fora.

Because this core structure and the associated TQM processes were limited in their clinical scope, alternative structures and processes were in place to handle those elements of the Trust's work which TQM missed; namely, quality in clinical work and meeting the quality demands of purchasers (especially the corporate purchasers in the form of Local Health Commissioners).

Clinical Audit

The clinical audit structure encompassed two separate audit processes: medical and clinical. At the time of the field work the Commission was not responsible for managing or funding medical audit. Funds were administered from Region, top-sliced from Health Authority allocations and left to the Trust to distribute. The purchasers therefore, bought the 'promise' of clinical audit rather than audit projects *per se*. However, the Trust was in the process of preparing for DHA-led audit funding and were just beginning to negotiate a likely Trust agenda for audit for the following financial year.

The Chairman (sic.) of the Clinical Audit Committee oversaw the allocation of funds for specific projects within the Trust. The audit agenda was therefore left to the Trust itself to dictate. There was a district-wide Medical Audit Advisory Group (MAAG) and the Health Commission had some say (via the Director of Public Health) in the Trust's audit agenda by virtue of the Chairman's involvement with this group. The

Local District Quality Network (see page 101) also influenced, to a degree, the audit agenda. Audit activity itself tended to be primarily uni-disciplinary (medicine or nursing) with process-led or clinical audit projects in their infancy. The Commission were keen to see more multi-disciplinary clinical audit conducted but conceded that the chairman had, in the past, been 'all things to all people' in order to secure a foothold within the Trust and to combat the initial hostility of some of the consultants. Consequently, the manager with responsibility for quality at the Commission felt that the Trust Audit Committee was now 'set in its ways with no real impetus for change' and that the District MAAG was 'like a medical school reunion' rather than any real mechanism for advice or scrutiny.

The Trust participated in national audits led by the Royal College and backed by the DoH and had a small complement of three audit assistants, responsible for clerical tasks such as 'pulling notes', following up patients, and maximising response rates. Clinical or medical audit projects themselves were carried out by practitioners with no provisos other than to provide a brief, anonymous, report to the Audit Committee. Audit processes were linked into the quality strategy via the membership in the Quality Steering Group of the Audit Chairman (who held an executive position as Director of Clinical Audit).

Business And Quality

The link between quality and business centred on the use of contract quality standards. These standards were developed by the District Quality Network. A consortium of four corporate purchasers in Marketown's locale who set out to:

'develop a consistent methodology for the setting and monitoring of quality standards for all the four purchasers'⁴

The standards were the basis for quality in contracting, although they didn't actually make it into contracts. They were seen as a useful lever by the Health Authority and a 'bureaucratic nightmare' by the Executives with most to do with them in the Trust;

namely, the Matron. The quality standards were heavily influenced by the Patients Charter and required that the Trust:

- *submit an annual position statement to the Health Authority demonstrating 'a clear organisational commitment to quality, led by a designated officer, with plans for improving and monitoring quality including clinical audit and quality assurance plans'.*
- *submit a mid year progress report... 'reporting on progress achieved during the first six months... on certain standards (as specified in this document).'*
- *submit quarterly returns on specified standards (the Patients Charter).⁵*

The standards themselves were organised around the following principles and associated standards:

Meeting People's Needs:

- *Everyone having contact with the health services will be treated with courtesy and respect for their dignity, privacy and cultural and religious needs.*
- *People will receive care and treatment which is appropriate to their individual needs. People will be involved in decisions about the evaluation of their care and treatment.*
- *People will be given the opportunity to express their views on the service and care which they have received and have any complaints investigated.*

Standards of Care and Treatment:

- *The clinical care provided will be proven effectiveness and minimise risks to the patient. It will be in accordance with the best professional practice and be subject to regular audit.*
- *Continuity of care will be ensured through effective liaison with other care agencies.*

Accessibility of services

- *Patients will be able to exercise an informed choice about the services available.*

- *Delivery of services will be organised in such a way as to minimise unnecessary delays and reduce patient anxiety.*
- *Users of the service will be able to make appropriate use of the facilities available.*
- *Facilities used by patients and other visitors must be well maintained, clean, comfortable and safe.*

Meeting Staff Needs

- *Providers will implement sound employment practices which promote staff welfare, education and development.⁶*

Additional standards specific to Marketown⁷ covered areas such as:

- Patients charter standards
- standards of nutrition
- medical audit
- the implementation of Care Programme Approach
- Manpower
- Standards of Nutrition
- Trust Annual Report

Most standards concerned issues of process with no indication of the sanctions to be applied if the standards were not met. Evidence from talking to staff from the Health Authority and the Trust suggests there was little, if any, action taken if the standards were not attained. On the basis of most of the standards and their associated monitoring procedures it is easy to sympathise with those staff who saw the exercise as ‘little more than a paper pushing exercise’ (Divisional Manager). For example, the standard for individualised care planning highlighted below shows both the lack of clarity in the standard, and in the response proffered from the Trust in its Annual Position Statement. The responses from the Trust also demonstrate that, almost without exception, the standards with a clinical focus all refer to nursing and Professions Allied to Medicine (PAM) services. Medical professionals were almost exempt from the control mechanism such standards represent.

Standard: *Care planning will be developed on an interdisciplinary basis* **Reporting**

Requirement: *report on plans developing care planning and its implementation and monitoring.*

Method and Frequency: *Annual position statement and details of any plans for action to improve quality in the year ahead.*

Trust Response:

- *Areas working towards interdisciplinary care plans.*
- *Care plan audits ongoing in all areas*
- *Nursing documentation recently undergone extensive review*
- *Patient held records being encouraged in the community*
- *Care planning with patient/family and Primary Health Care team ongoing*
- *Multi-professional referral meetings are held each week in Elderly Mental Health Directorate.*

A Trust wide initiative to develop collaborative care plans has commenced. For example Critical Care Pathways have been developed. (their emphasis)⁸

Contracting itself involved contract negotiation teams from both the Trust and the Health Authority. The Trust team comprised the Directors of Nursing, Medical Services, Contracting and the appropriate Divisional Manager. There was a universal recognition that money and volume were the key variables in contracts and that quality was separated out into other mechanisms; namely, the quality standards system.

The Internal Business Links: Internal Quality Standards

Contract Quality standards were for Trust activity with external customers (corporate purchasers), but there were also standards for internal customers detailing the levels of quality expected between departments. The standards-manual (on its third edition) did not include either nursing or medical services; and of those departments that were included very few standards went beyond a very cursory level of specification. For example, in relation to pharmacy the only standard proffered was that:

- *The pharmacy will endeavour to ensure that Patient's Take-home medication is delivered to the ward within one working day of receipt of prescription.*⁹

The lack of coverage in the standards was aggravated by the fact that virtually everyone outside the quality management department had neither heard of the document or used it in relations with other departments.

Consumer Consultation

The Trust's 'official' consumer consultation processes revolved around four mechanisms:

- Statutory visits from the CHC
- The local Press
- Complaints - and a patient representative role
- Patient Satisfaction Surveys

The CHC usually visited twice a year. These were to pre-arranged destinations and pre-set agendas and were accompanied and arranged by the Matron. Visits were acknowledged by both the Trust, and surprisingly, the CHC as ineffective. The focus for visits was usually on standards of hygiene, food and some time to talk to patients. The overall consensus, from both parties, was that visits were rushed, over-prepared and hindered by poor specialist knowledge on the part of the CHC.

The links between the CHC and the Trust had been 'somewhat strained' (CHC Chief Officer) since the Trust's formation in 1990. The explanations given by both sides revolved around a combination of party politics and conflicting personalities. The CHC officer made no secret of his staunch Labour sympathies, and did not disguise his dislike for what he saw as the 'desecration of local health services'. Similarly, one Executive at the Trust spoke of the CHC's 'loony left' leanings and the narrow minded nature of the Chief Officer in relation to new developments in the Trust. Some

managers also recognised that the Executive Board were perceived by many as willingly putting into practice a right wing agenda:

'Some people see us as arch Tories.... but if that means agreeing with the ideas in the Reforms and the move to Trust status then I suppose they're right... I'm not ashamed to talk politics when it comes to health.' (Director of Contracting)

There was personal animosity between the CHC Chief Officer and the Chief Executives of both the Trust and the local Health Authority. Several managers below the level of Executive spoke of managing to foster good relations with the CHC on an individual level but of being blocked by the attitudes of those above.

The Trust had been the focus of local press scrutiny following a series of large compensation pay outs arising from medical negligence cases in its maternity services and the consequent birth of children with brain damage. While the Trust recognised the difficulties this posed in terms of public relations and commercial sensitivity, it had led to a far more effective relationship between the Trust and the Press. The matron spoke of reporters having a better understanding of the service and of the workings of the Trust and of using the Press to get messages to the public regarding the achievements of the Trust. Press enquiries were handled via the Chief Executive's office or the Matron. There was an information department within the Trust but this handled internal data such as consumer satisfaction results and Patient's Charter Monitoring Returns.

The Trust's complaints procedures were largely dictated by the Statutory requirements of the Health Service Management Hospital Procedures Act 1985 and the subsequent Health Service Guidance and the Executive Letters from the NHSE. At the local level the Trust's structure was already compatible with the latest guidance from the DoH¹⁰. Specifically, the Trust had appointed a Patients Representative to act as complaints manager and to brief the Chief Executive prior to his written responses. The Patients Representative was previously a senior nurse in the Trust and had had no formal training for the post. It was felt by the Matron that she would be a suitable appointment by virtue of her clinical background and longevity of service in the Trust. The Patient representative role in her own words included:

'Investigating the complaints and writing the responses for the Chief Executive, which he then signs. Its a bit of a rubber stamping exercise but then every other Trust had to do it like that...there just isn't time for any other way'.

The post was also a key point of contact with the CHC and the District Health Authority. Both of these organisations had established local fora to establish consumer's views and to feed these into the health service planning process at a local level. The Patient representative was invited to these fora, but again in her own words:

'They're a waste of time...no one talks about anything clinical, its all transport, bus routes and all those sort of things, which we can't do a lot about as a Trust. Plus its full of the elderly and all the usual complaints they make, visiting times, lifts not working etc. We already know about these things so these meetings don't really help us, though I do make an effort to attend'.

Unfortunately, she did not attend either of the two CHC fora attended and no apologies were given; the CHC research officer could not remember the last one the Patient Representative attended.

The final means of 'communicating' with consumers was through patient satisfaction surveys. These were divisionally focused and information fed back to divisional managers, the TQM manager, and Matron. These were generally developed 'in-house' and consisted of approximately 10-15 questions such as (in relation to nursing):

- *Did the Nursing Staff giving you treatment tell you what her (sic.) name was?*
- *Are you satisfied with the care and information you received?*
- *Did the nurse tell you why your treatment was necessary to you?¹¹*

These mechanisms formed the primary means of assuring quality within the Trust's quality strategy and structure. There were other, smaller, isolated, initiatives in place within the Trust which people classed as 'quality' but these tended to be isolated, one-off, applications, and generally not publicised outside the directorate in which they

were taking place. These included the development of nursing standards and a patient discussion group in gynaecology; and the application of new technologies such as personal pain relief in midwifery.

Fishtown

Fishtown was one of two sites (the other being Shiptown) who shared the same corporate purchaser (District Health Authority). Although, as the chapter shows the two Trusts took very different approaches to the operationalisation of 'quality' in their service provision. The Trust was situated in a large conurbation in the North East of England and served a population of around 250,000 people. The area has pockets of residual and higher than average unemployment, poverty and poor housing. It was mostly urban in character with mainly heavy industry, supply and chemical companies acting as the main employers. There was also an emerging industrial sector based on the production of components for high technology consumer goods. This was as a result of inward foreign investment from a number of Far East and Asian companies.

The Hospital was spread over two main sites: a relatively modern (15 years old) purpose-built unit on the outskirts of the Town, and an older (pre-2nd World War) site in the town centre. Some support and managerial functions were based in a Victorian building in another part of the Town centre. There were logistical problems attached to this arrangement as some clinical divisions were based in more than one site. For example, surgery had clinical areas in both sites and its divisional manager was based in the old workhouse site. The Trust was in the process of relocating to a single site in the new building while the fieldwork was being undertaken.

Fishtown (and Castletown) were demonstration sites for Total Quality Management. Although, unlike Marketown, these were Regional initiatives and therefore attracted smaller levels of funding with no formal evaluations by external consultants. This was in contrast to the national initiatives who had been the subject of an evaluation research project based at Brunel University and funded by the DoH. This was in 1991 and in Fishtown the initial impetus this represented had been carried through and many of the original components were still in place in 1995-6.

The Trust had a healthy relationship with its local CHC although there was little evidence of any involvement on the part of the CHC in Trust quality matters other than through the usual visits, consultation exercises and complaints procedures. In contrast to Marketown, however, both the Chief Executive and the Chief Officer of the CHC said that each had a direct line to each other if they needed to voice opinions and it was clear from their interviews that each thought highly of the other.

The Chief Executive had a particularly strong interest in matters of quality; prior to the establishment of the Trust he had been a district general manager and personally set up initiatives such as patient perception groups and the initial TQM bid to Region. Of all the Chief Executives interviewed his knowledge of quality activity in the Trust and the national picture was the most detailed.

The main structures within which the quality strategy has to operate are represented in figure 5¹².

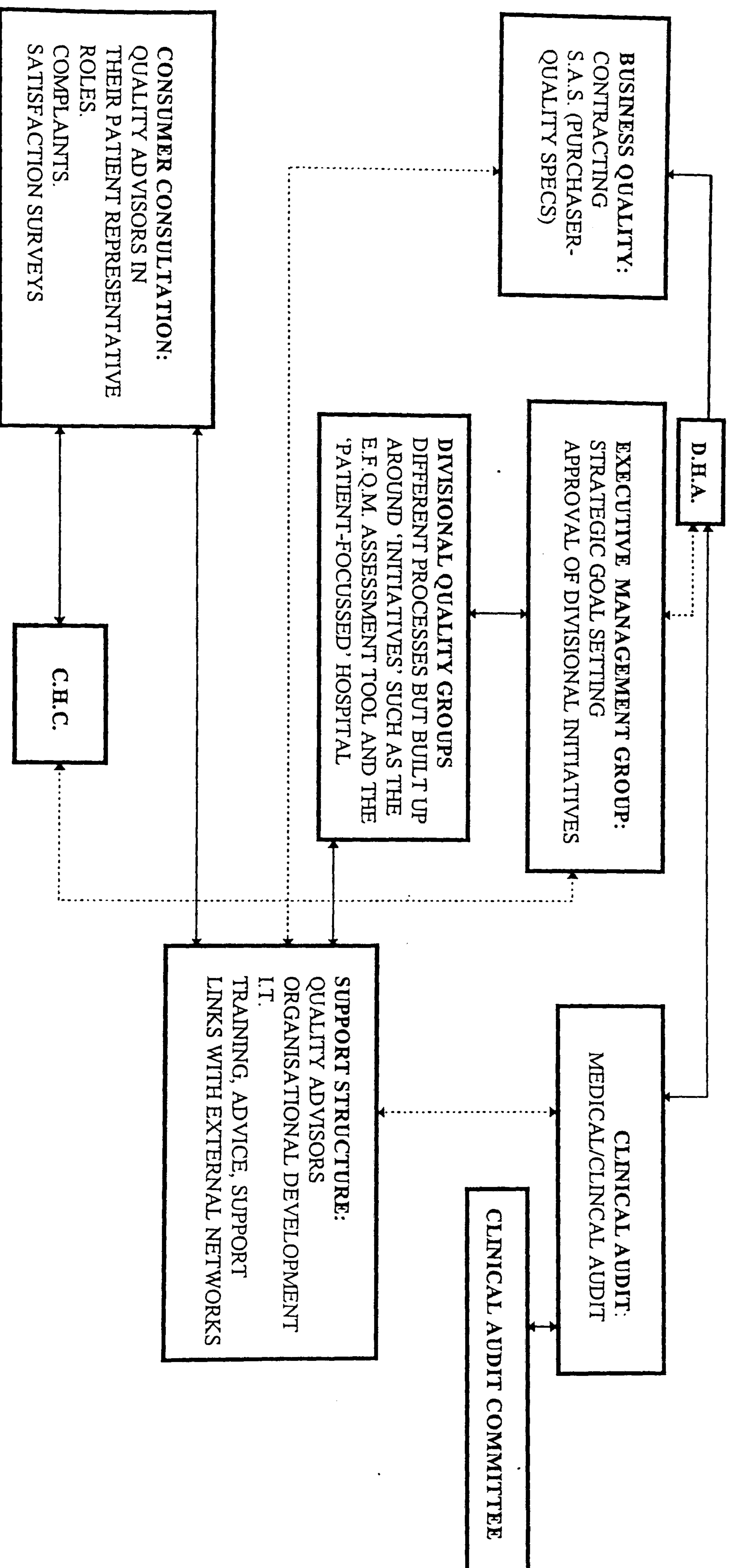
Quality Structure And Process: Fishtown

The Executive Management Group And Divisional Quality Groups: The Core Of The Strategy

At the core of Fishtown's quality strategy were the operations and functions of the Executive Management Group and the Divisional Quality Groups. These two groups were intended to co-ordinate and oversee quality in the Trust and the clinical divisions respectively. Their remit was broad but generally based on working towards Total Quality Management along the lines of the European Foundation for Quality Management Model¹³.

The European Model for Total Quality Management (*EFQM*) is a model for organisational quality based on a self assessment of the organisation based on the principle:

Figure 5: The Quality Structures And Processes: Fishtown



*'Customer satisfaction, people (employee) satisfaction and impact on society are achieved through leadership driving policy and strategy, people management, resources and processes, leading ultimately to excellence in business results.'*¹⁴

The assessment 'scores' success according to criteria developed around the above principle. So for example, successful criteria for 'People Management' include:

'How the involvement of everyone in continuous improvement is promoted and people are empowered to take appropriate action e.g. how:

- *individuals and teams contribute to quality improvement*
- *in-house conferences and ceremonies are used to encourage involvement of people in continuous improvement*
- *people are empowered to take action and how effectiveness is evaluated*
- *awareness and involvement of people in Health and Safety issues is promoted'*¹⁵

The executive's role was as the operational arm of the Trust Board with responsibility for establishing long-term strategic aims on quality. At this level the issue of quality was primarily promoted by the Chief Executive. However, the development of quality activities within the Trust was primarily devolved down to the individual clinical divisions and Divisional Quality Groups. As one Quality Advisor explains:

'We have two approaches: one is a corporate approach whereby the Chief Executive and the executive board and the non-executive board who makes all the long term strategic decisions on quality.... Then below the Board level there is a management group which consists primarily of the directors plus chiefs of service who are clinicians for each of the divisions; and they supposedly make all the corporate decisions about the way forward. But once those corporate decisions are made its really up to the Divisions to take those corporate decisions and translate them into things on a day-to-day level and in with their strategic plans as well. They have to satisfy the Board and the Management Group that their local strategy fits in with the overall philosophyerm some divisions are better than others it has to be said.'

The Divisional quality teams were supported in the implementation of quality initiatives by a team of Quality Advisors. Each of these had responsibility for a separate clinical area and also served as 'Patient Representatives' within the Trust. The Quality Advisors were, as their title suggests, just advisors; they were removed from the line managerial hierarchy and had no corporate power to help in achieving their aims. The Chief Executive felt this was necessary in order to prevent 'getting people's backs up'. As individuals they all came from a nursing background and were in middle managerial, or nurse-management, positions prior to the development of their role within the quality strategy. At the time of the fieldwork serious questions were being raised by members of the Executive Management Group as to the Quality Advisors functions, effectiveness and affordability. As the Director of Personnel and Organisational Development put it:

'they're an expensive luxury we can perhaps do without. My medical colleagues often ask me what they do and sometimes its very difficulty to give them an honest and straightforward reply.'

Clinical Audit

Clinical audit in Fishtown, more than any other of the sites involved, was a separate and distinct element in the Trust's approach to quality. There was a clinical audit department which consisted of a full time clinical audit co-ordinator and a team of about 10 part time assistants. Compared to the role of clinical audit assistants in other Sites such as Shiptown their role was purely clerical as opposed to providing advice on design and analysis. There was little co-ordination, or even communication, in a formal and structured way, between the 'core' quality structure of divisional quality teams and the Management Group and the clinical audit department. However, it was within clinical audit that most medical involvement was secured. There was a clinical audit committee chaired by a senior Consultant and, as in the other sites, negotiations with the main local purchaser regarding audit were conducted between two clinicians: the Trust Audit lead and the Director of Public Health at the Health Authority.

One of the Quality Advisors had responsibility for supporting the development of audit in the Divisions and linking it to the central approach to quality; but she felt generally excluded from the audit process and that the mechanisms for selecting and funding audit projects were separate from 'quality' in the Trust. This view was reinforced by the Clinical Audit Committee Chair who felt that:

'the concept of quality in this Trust is erm...wishy washy and not at all scientific. Audit, means looking at problems scientifically and rigorously. The two are not compatible, no matter what the execs might think'.

The Quality Advisor's role in relation to audit was largely restricted to issues around the Patient's Charter and its monitoring. She led audits related to non-clinical topics such as name badges, privacy and dignity, and waiting times.

Generally the agenda was decided 'in-house' and away from the purchaser-provider relationship and the local Medical Audit Advisory Group (MAAG). This was in contrast to Shiptown where the local MAAG was quite influential in the development of audit within the Trust.

Business Quality

The Trust, with Shiptown, was committed to assuring contract standards through a system of evaluating performance against a series of purchaser-led quality specifications. Known as the Standards Auditing System (SAS) these specifications were distinct from the contractual relationship *per se* but were intended to make comparison between providers easier when it came to re-negotiating contracts in the next business round. To this end, the format's for the two Trust's standards were the same with only the detail altered to reflect the particular contexts of the two settings. These standards concentrated almost entirely on the non-clinical and environmental aspects of services. Specifying requirements such as age appropriate magazines in waiting areas for outpatient clinics; name badges to be worn by staff; curtains in place around bed areas; and satisfaction of patients with food and cleanliness.

The assessments had initially been carried out by the purchaser; then a joint purchaser-provider team was developed; and now the process was devolved down to the provider alone by using SAS teams. Each team comprised one Quality Advisor with staff (usually nurses) drafted in to do the monitoring. Results were then fed back to a liaison manager at the Health Authority with responsibility for quality in the Trust. The Health Authority had the power to visit the Trust to satisfy themselves that standards were being evaluated accurately but no visits of this kind had taken place in the three years that the programme had been in place.

Quality in contracts themselves was defined in terms of patient activity (volume) or cost and was widely acknowledged by managers on both sides of the purchaser-provider equation to be inadequate. Detailed specification were not a feature of the contractual business relationship; as one Trust manager commented:

'Why complicate things with talk of quality when its been difficult enough to get the whole thing moving just concentrating on cost and volume. They [the DHA] aren't in a hurry to move on this one and neither are we...its a kind of mutually agreeable stand-off'.

The Support Structure And Quality Processes

Business, clinical and core structures received support from, as previously stated, a team of four Quality Advisors. This team had recently been incorporated into the Organisational Development wing of the Human Resources division in an attempt to make the link between quality and the business strategy of the Trust more explicit and coherent. The primary processes occurring within this structure were around training. Organisational Development handled training for clinicians on management, audit and contracting, and a Quality Advisor ran a training programme for all Trust staff on 'Total Quality Improvement' (TQI).

The organisational development (OD) co-ordinator (she had eschewed the title of manager deliberately) acknowledged that clinical scepticism was a problem. She felt though that OD had always been seen in a supportive light by the clinical professions

and didn't have the problems of legitimacy that 'quality' had experienced. She put this down to the explicit links made between quality and the Chief Executive over the previous five years and the problems of being associated with something overtly managerial in tone. While broadly welcoming the absorption of the quality team into her remit (she now carried line managerial responsibility for them) she felt that significant changes would have to be made if the team's work was to progress properly; namely, they would have to make more of an effort to be seen as a support to the professions' way of doing things as opposed to a challenge and 'something else to give you a headache on the wards when you're just trying to get on with the job'.

The TQI training programme was based on an activity-centred training day for staff where they were asked to complete an activity pack with questions such as:

- *how would you define TQI?*
- *What is the Trust's definition?*
- *The Trusts mission statement is:*
- *In your current job you supply a service to internal and external customers, select one and identify what they expect from you.¹⁶*

People were then encouraged to reflect on their situations; jobs and expectations and to develop a personal problem solving approach to work. The training was mainly attended by nursing and lower-level managerial staff. The Trainer conceded that while it had been possible to get a few consultants to come in the early days they hadn't managed to secure attendance on anything like the scale of the nursing staff. He attributed this to a combination of time constraints and arrogance on the part of some medical staff but also, and more significantly, to the format of the training pack which didn't reflect the:

'different ways in which you have to approach quality issues with nurses and consultants or the fact that Doctors are higher up the social scale and what might work for a staff nurse isn't always appropriate for a surgeon'. (Quality Advisor and TQI Trainer: Fishtown)

Each clinical directorate, manager, and Quality Advisor had IT support in relation to quality by virtue of the development of a series of computerised cost, volume and quality indicators available on a trust-wide network. However, the quality indicators were acknowledged to be limited in scope (re-admission rates and pressure sores in the surgical division) and, more importantly, were consistently out of date. At the time fieldwork was undertaken (July through September 1995) the indicators in most directorates were from January/February of the same year. Their usefulness was, therefore, questionable, particularly in terms of the responsiveness which installing the system was supposed to encourage.

Consumer Consultation

As in Marketown the primary means of consultation were through a series of well defined procedures:

- the complaints structure and patient representative function
- patient satisfaction surveys
- patient representative functions

These formal procedures were supplemented by informal communications between the CHC Chief Officer and the Chief Executive and the Patient Representatives/Quality Advisors and the CHC Chief Officer .

The complaints procedures were similar in content to Marketown, with four patient representatives instead of one, and a separate complaints manager. Patient Representatives acted as the first point of call for complaints made whilst patients were still in hospital and they passed information to the complaints manager. Patient Representatives also liaised with the CHC Chief Officer in the preparation of complaints made once the patient was discharged or complaints made to the CHC directly. The Chief Officer , whilst less sceptical of the Patient Representative role than his contemporary in Marketown, was still unsure of the ethics of employing paid members of the Trust's staff to act on complainants behalf's:

'no matter how well meaning the people are, at the end of the day they are employees and that has to be explained to people making complaints and that there are alternatives.'

Patient satisfaction surveys came under the remit of a Quality Advisor and were contracted out to a private firm using a survey tool called *'My stay in Hospital'*. This is a questionnaire used across the Region and based on standard questions such as:

- *How satisfied were you with the concern and care shown to you by nursing staff? (Scale 1-5)*
- *How satisfied were you with the doctor's explanation of your treatment? (Scale - 5)¹⁷*

The survey itself was conducted with a sample response rate of only forty seven percent (47%) and some of the analyses were statistically rather dubious given the size of the sample involved. This was something recognised by the Quality Advisor but not highlighted in the feedback to Divisional Managers or the Executive Management Group.

CHC visits were conducted approximately twice a year and, as in Marketown, were pre-arranged and targeted clinical areas on a rolling basis. Again, both sides acknowledged the lack of utility in this arrangement; however, unlike Marketown, the Trust was keen to develop alternative ways of involving the CHC on a corporate level as opposed to individual divisions making their own arrangements. Although at the time this was little more than a statement of intent as no plans to change the visits system were being developed.

Shiptown

Shiptown shared its Health Authority with Fishtown; its population characteristics were very similar as they were located within five miles of each other. They were in direct competition with Fishtown for the contracts to deliver some services (major gynaecological surgery) and there was a recognition that over-provision was a feature

of both Trust's work. Rationalisation of its services and the commercial viability of others were a very real issue within the Trusts and were causing concern amongst staff - particularly nursing staff.

Shiptown was a combined (community and acute) unit also providing mental health care services. It was primarily based in two large blocks on a single site. One block (mental health) was built in the early 70s and had major design faults. One example being a lack of adequate fire exits in some departments causing it to fail an annual Fire Service inspection. The more modern block was a combination of 70s and 80s design and was generally seen as the better serviced and more pleasant environment to work in. Some services, such as maternity, were in the process of moving over to the modern block. Such major changes were, in themselves, seen as aiding quality improvement by virtue of the fact that women wouldn't have to be wheeled between the two sites for investigations such as non-standard ultrasound scans and other radiological investigations. The Trust was formed in 1992 (second wave) and employed around 2,500 people.

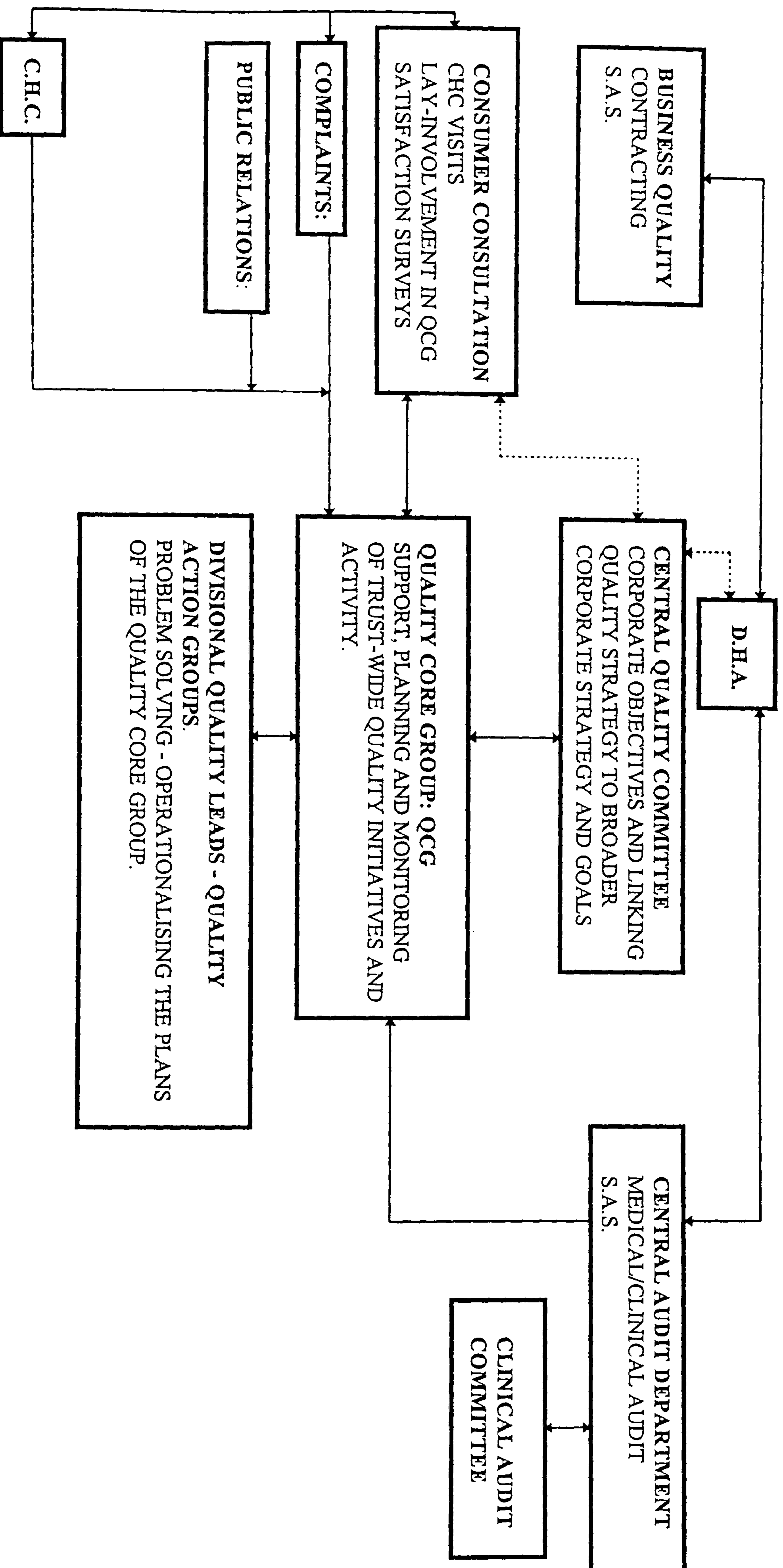
Despite sharing the same purchaser the two Trusts took very different approaches to the operationalisation of quality. Shiptown's emphasis was on a firm, centralised, quality strategy based around the workings of a Quality Core Group which fed into a Central Quality Committee; as opposed to the devolved decision making and objective setting of Fishtown. The overall structure is represented in fig 6¹⁸.

Quality Structure And Process: Shiptown

The Central Quality Structure: Central Quality Committee, Quality Core Group, Divisional Quality Leads And Quality Action Groups.

The quality structure was at the heart of the Trust's quality strategy and incorporated the fora in which objectives were established, progress reviewed and decisions taken in relation to quality. The Central Quality Committee was made up of the Chief Executive, the Director of Nursing and Quality and the clinical audit lead for the

Figure 6: The Quality Structures And Processes: Shiptown



Trust. This clinical audit lead was a doctor who also ran the Central Audit Facility and was chairperson for the Trust Clinical Audit Committee. Their combined role was strategic involving the synchronisation of Trust quality activity and more general corporate quality strategy. However, at the time of the fieldwork the Trust was without a Chief Executive and this group was temporarily disbanded. The Quality Core Group met monthly and was made up of representatives from each of the clinical divisions, the complaints manager (known as the Patient Liaison Manager), the Public Relations Manager and the Director of Audit. The committee was chaired by the Director of Nursing and Quality. As the site was left they were just about to officially appoint the CHC Chief Officer to this committee in an effort to increase the involvement of the CHC in Trust quality matters. The core group's functions were, officially:

*'supporting, co-ordinating and planning quality activity and receiving feedback from within the Trust.'*¹⁹

From analysis of the minutes of these meetings and from the meetings attended it was clear that the bulk of their work was co-ordination of the following:

- monitoring the purchaser quality specification audit process (SAS)
- Patients Charter monitoring
- Kings fund organisational audit (a form of hospital accreditation programme)
- Patient Satisfaction Surveys
- the production of a quality newsletter
- the Chartermark application procedure

The group also had information passed to it on clinical audit (what was going on) and complaints (general trends). Although this was more in the form of feedback as opposed to active involvement in agenda setting.

Action towards objectives set by the Core Group was secured by a series of Quality Action Teams in each division. They were intended to act as problem solving groups but membership was variable and a number of Divisional representatives on the

Quality Core Group felt the groups' turnover of staff was too rapid and that securing action suffered accordingly:

'finishing what we start is difficult, as fast as we recruit people they get tired of trying and leave - we are trying to secure a greater level of commitment from people that volunteer for the group' (Mental Health Divisional Manager).

There was no formal model of Total Quality Management in place in Shiptown (as opposed to Marketown and Fishtown). The strategy was acknowledged as 'home grown'; a conscious decision on the part of the Trust, as they felt that management consultancy attached to Quality and the start up costs of getting initiatives off the ground were not paying dividends in other Trusts. The Director for Nursing and Quality also expressed a desire to secure a greater level of support for the concept of quality by allowing people within the Trust to take the ideas forward themselves as opposed to having outsiders providing the lead.

Shiptown placed a heavy emphasis on techniques involving measurement of their activities. For example, they had invested much time and effort in carrying out the SAS audit system (with a full time SAS officer in post); they had undergone the initial assessment involved in Kinds Fund Organisational Audit and devised action plans for divisions based on this. They had submitted a Chartermark application for their Breast Screening Service and had encouraged a number of non-clinical areas to undergo BS5750/ISO 9000 accreditation. All of these involved some degree of conformity to pre-specified standards. This was a key difference in the approach of Shiptown to any of the other Trusts, who all undertook such activities, but without the degree of importance, or on the scale afforded by, Shiptown.

Central Audit Structure

The central audit structure was very well developed at Shiptown with a complement of four full time staff (three audit facilitators and a secretary); a SAS quality specification officer; and a part time Director who was also a radiologist. They

occupied a suite of offices and two of the facilitators had established a private training and consultancy business.

More than any of the other sites there were large scale clinical audit projects in place and supported centrally. Medical and uni-disciplinary audit was still occurring but was supported by the same team and concerted efforts were being made to procure a multi-disciplinary team approach to auditing practice. Or as one Audit officer put it:

'steering people who come to you with a problem down a multi-disciplinary route. By the time they realise they've done it its too late to change.'

The Department was well funded and had maintained a very high quality database of projects and produced a detailed report on audit which was released into the public domain (as an adjunct to the Main Trust Report - which one had to request).

The overriding message which emerged from interviews with clinicians and managers within the Trust was that the Central Audit Facility was a useful resource and one that had a high level of credibility within the organisation. All the staff were, in the eyes of others, of a high calibre and had high levels of research, audit and communication skills. The Director was aware of the status of the facility within the Trust and felt that:

'while forging closer links with the work of the Quality Core Group has been necessary, I need to ensure that all the work we have accomplished up until now is not undone by getting too close to something which has had its shaky moments with the consultants and senior management.'

Another member of the QCG felt that:

'[Director of Central Audit] comes along [to QCG meetings] but you just know that his heart really isn't in it. He always leaves early, he just does what he needs to do then disappears. You can't blame him though he has carved out a nice wee empire for himself and had to work really hard to do it.'

The central audit facility also collected large scale outcome data as part of the Regional Health Authority's 'Maryland Quality Indicator Project'. These are outcome indicators which enables comparisons with other hospitals. Indicators included:

- **for in-patients:**
- surgical wound infections
- in-patient mortality
- neonatal mortality
- peri-operative mortality
- caesarean section rate
- unplanned readmissions
- unplanned admissions following day case surgery
- unplanned returns to Special Care Unit
- unplanned returns to the operating room
- **for out-patients/A&E**
- unplanned returns to the A&E within 72 hours
- Patients in the A&E dept more than 6 hours
- Cases where discrepancy between initial and final x-ray report required and adjustment in patient management
- patients who leave the A&E prior to completion of treatment
- Cancellation of treatment procedures on the day of procedure

Business Quality

As in Fishtown the purchaser quality specifications were monitored by a devolved audit process involving a specialist officer recruiting professionals (again it was nurses) to scrutinise particular areas of practice and to feed these results into the divisional business planning and contract negotiation processes. Again, like Fishtown, contracts themselves were defined mainly in terms of volume and cost with quality dealt with outside the main contracting process. Unlike its neighbour the Trust's

Quality lead (the Director for Nursing and Quality) generally felt the SAS process was worthwhile as an aid to measuring standards. Although this Trust, as previously mentioned, placed a greater emphasis on measurement generally than any of the others.

The links between the work of the Quality Core Group and the business of the Trust were not great. The Divisional representatives on the QCG were drawn from the ranks of assistant divisional managers, or more commonly, the nurse-managerial hybrid posts such as nurse managers or clinical managers. Consequently there was a feeling from some of the representatives interviewed, that initiatives derived from the QCG were difficult to implement at divisional level because they had failed to gain the support of either senior clinicians, or as was more often the case, senior managers.

Contract negotiations generally involved the people with least involvement in the quality activities of the Trust: the finance division, divisional managers and very occasionally, the Director for Nursing and Quality. There was no single person with overall responsibility for quality at the Health Authority; until November 1994 there had been a specialist quality department but it was felt to be an unnecessary drain on resources and so was now pushed down to individuals in the contracting department.

Consumer Consultation

The Trust's consultation structure in relation to the quality strategy focused on three processes and associated roles:

- The complaints process and patient liaison role
- Public Relations and a public relations manager
- Involvement of the CHC with the QCG and CHC visits.

The complaints structure was, as one would expect, broadly in line with DoH guidance. Where it differed from the other Trusts was in relation to its links with the central quality structure and in the role of the complaints manager, a post termed the Patient Liaison Manager. Complaints trends were routinely fed back to the core

quality structure of the QCG and the complaints manager was a routine part of its meetings. This was not the case in any other Trust. Moreover, the complaints officer role was more than administrative in that the manager's legal qualifications meant he also undertook preliminary work on routine cases involving litigation prior to involving the Trust's solicitors. He also made no secret of his dislike of the term 'patient liaison' and that he perceived his primary role as one of saving the Trust money through what he called 'the judicious application of complaints machinery'. Whereas in other Trusts the role of patient representative/liaison in complaints was generally seen as a quasi-advocacy function, pursuing the patients interests in a sometimes hostile organisational environment. The Shiptown Patient Liaison manager adopted a more business orientated view of the role.

The Trust had a very smooth public relations department in place; an ex-journalist held a PR managers post and handled all press communications, publicity and public-domain output. She also developed an internal quality newsletter which was sent to all staff and available in the reception area of the main hospital site and its departments. She saw herself as an integral part of the quality strategy and that her appointment and its alliance with quality was a key difference from other local providers of health services. Whilst researching the site the PR manager was in the process of organising publicity as part of the Patients Charter initiative at the Department of Health. It was somewhat ironic, however, that on the day the results were published only two of the twelve members of the QCG were aware of the Trusts performance and there was universal acceptance of the Chair's comments that, while publicity would benefit the image of the Trust, the league tables were not seen as terribly important to the purchasers or the public at large and so were not worth dwelling on for too long.

The CHC and the Trust, or more specifically the Director for Nursing and Quality, had a well established relationship and one that each were keen to foster. The CHC Chief Officer had previously been an employee at the main purchaser for the Trust and had been left somewhat disillusioned with the whole process of contracting and purchaser-based bureaucracy. Consequently, he was well informed and sympathetic, to the claims of the Trust regarding the sometimes problematic nature of working with the Health Authority. At the time of leaving the fieldwork site the CHC Chief Officer was about to attend his first QCG meeting having previously been part of a Patient's

Charter Implementation Group within the Trust. This had been disbanded some three months before the research presence and was subsumed by the QCG. He saw his role within the Trust as interpreting and feeding back information received from people attending CHC community fora into the Trust's strategy in a form that would be listened to. Moreover, he wished to portray a realistic picture of Trust activity and efforts on quality to the public. He was keen to move away from what he saw as the traditional, combative, function of the CHC and to develop a model of CHC-Trust relations based on partnership and co-operation. This, he felt, would be more productive in the current service and policy climate.

The CHC Chief Officer, in common with all the Chief Officers interviewed, saw an extremely limited role for CHC visits to wards and departments. These still went on, *'as some of the members like them'*, but he was making a concerted effort to persuade the CHC that they should concentrate their efforts on other strategies for involvement in the work of the Trust.

Castletown

Castletown was a 770 bed acute hospital Trust spread over two sites: Castletown and Sheeptown (its more rural counterpart). This arrangement was due, in part, to the geographical size of the Trust's catchment area but was primarily attributable to the need to demonstrate 'viability' as part of its original application for transfer to Trust status. It provides a full range of the usual District Hospital services to a catchment area of approximately 750,000 people.

The catchment area was very large and as a consequence was more diverse in its composition than in other Trusts. The Trust took patients from rural farming communities, ex-mining communities and a medium-sized University city. Socio-economic differences between the various communities within the catchment area were marked; and some locations were sites for European, national and local monies aimed at combating poverty and long term unemployment. The area had been heavily dependent on mining and steel for employment and many communities were left without significant employment opportunities following these industry's departures.

The large geographical size of the Trust's catchment area and the need to avoid unnecessary excess replication in the provision of services in the two sites meant that issues of access and transportation were a real issue for patients, their families, and service developers within the Trust.

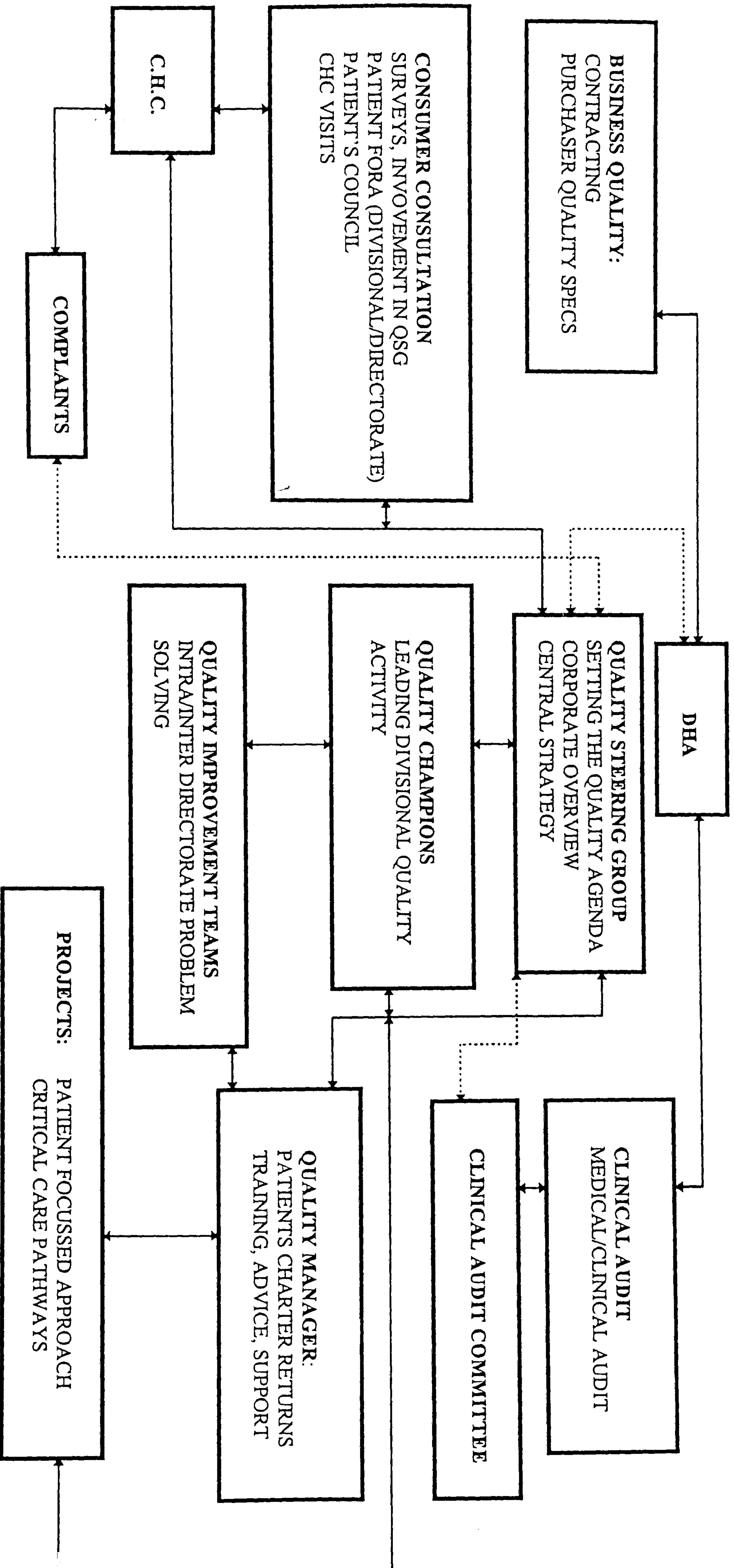
Castletown was built in the Second World War and was the larger of the two sites (428 beds). It provided general clinical services and was also the base for the Trust's management and support services. The Sheeptown site developed 'pragmatically' over a hundred year period with major building in the Second World War, 1970s and 1980s. On top of general medical and surgical services, this site provided burns and plastic surgery units. It was the smaller of the sites (342 beds) and there was a general feeling amongst many staff that this was the 'poorer relation' of the two sites. This perception was compounded by the fact that Trust management posts were mainly based at the Castletown site and that a large scale rationalisation process was in place which was interpreted by many staff as simply a downsizing exercise and a precursor to the closure of Sheeptown as a provider of local health services. The interim rationalisation process was being undertaken prior to the opening of a new District General Hospital which was being funded under the Private Finance Initiative policy (PFI). Sheeptown was to be, in the words of the Chief Executive:

'...reshaped into an active, dynamic local healthcare facility for the 21st century'.

The site had recently lost its accident and emergency facilities a process which many local people resented and which had involved the Community Health Council significantly. The Community Health Council had opposed the rationalisation plan but it was approved by the District and Regional Health Authorities regardless.

The Quality structures in place are presented in fig 7²⁰.

Figure 7: The Quality Structures And Processes: Castletown



Quality Structure And Process: Castletown

The Trust had been another Regional TQM site prior to its transformation to Trust status (like Fishtown). However, the term TQM and some of the initial 'commercial' terms and ideas were abandoned within two years. The Trust had decided to develop its own model of quality; this had at its core the views of service users and a much looser theme of 'Continuous Quality Improvement'. The Trust's strategy revolved around four key areas: communication; quality assurance; privacy and dignity and staff development. Each of the elements of the Trusts quality structure emphasised these themes to varying extents.

The Central Structure: The Quality Steering Group (QSG); Quality Champions And The Quality Improvement Teams

This structure represents the core of the strategy. The quality steering group consisted of the Director of Nursing and Quality (Chair), the Quality Manager, nominated representatives from each division and, just as the site was left, the CHC Chief Officer . The function of this group was to assist in setting the quality agenda for each business year. The group was the top tier of the Trust quality hierarchy and consequently, because of the lack of senior executive involvement (apart from the Director of Nursing and Quality), there was a general acknowledgement amongst the members that quality did not always have the profile it merited at the highest management level.

The strategic decisions of the group were put into practice via a network of 'Quality Champions' all based at ward or departmental level. These nurses and low-level managers were selected for training in theory and practice related to quality and used as the operational arm of the QSG. They were generally perceived as the 'high flyers' within the organisation. Some felt that this targeting was unfair, and to the detriment of those staff who might benefit from training input:

'its all very well targeting the high flyers, but they're already motivated and keen. Its the ones who aren't so aware of issues and maybe who aren't so visible that we need to concentrate on. They're the ones who need the training and involvement with the quality directorate.' (Senior Nurse: Research)

These 'Quality Champions' were also intended to co-ordinate the establishment of problem solving teams as required in their departments. The success of this policy was variable and whilst, in surgery for example, teams were established to look at issues such as infection rates, these rarely involved doctors. As a consequence these Action Groups had a strong nursing flavour and only limited spheres of interest; namely, those they could control such as non-medical work.

This structure was supported by a full-time quality manager (with a learning disability nursing background) who organised training and oversaw the day-day operations of the quality strategy as a whole. He had no direct line-managerial power other than within his own directorate of quality. He therefore relied on the support of divisional colleagues and clinicians for achieving success in initiatives developed by the Quality Steering Group.

The Training strategy, led by the Quality Manager, was based largely on a system termed '*Foundations for Quality*' aimed at all staff and based on five areas:

- *The introduction of 'quality tools' for use in the workplace*
- *An appreciation of the Patient's Charter and the Patient/carer view'*
- *Identification of Hard and Soft issues of quality*
- *An appreciation of internal and external customers*
- *An introduction to the quality approaches of successful commercial organisations.*²¹

Whilst this training was intended to reach all staff it was mainly nurses, managers and ancillary staff who attended. There were no medical consultants in the 45% of staff (n=900) who attended this programme in the year up to June 1995. The Quality

Manager in charge of the programme put this down to the inability of the message being able to apply to everyone equally within the Trust.

Interviewer: *'I notice in the strategy that you plan on holding specific sessions for clinical directors to 'explore and challenge their current contribution'. Is getting the message across problematic then?'*

Quality Manager: *'Yes, I think its a real issue and I hope that in the strategy we've reflected that. Like the Foundation for Quality Programme, in theory, was for every member of staff and I think we managed to get most of the members of staff through that. But most of the other stuff that we do is targeted. Its no good putting a nursing assistant on the same training as a consultant - that isn't going to work in the majority of cases. Because they don't come to training involving others we've had to say 'well do we not bother or do we lay something on specially for them?', and that's the road we've gone down. So we've done some work on management of change with them and we will handle the complaints training like that - its the only option we really have.'*

The Central Quality Structure also co-ordinated the application of a number of other activities relating to 'quality assurance'.

- *BS5750 and the Charter Mark systems:* this was restricted to catering services but there were plans to involve other non-clinical services.
- *PIER:* this was a quality assurance system for individual wards and departments, led by a quality champion. It was based around establishing the principal functions of a ward, isolating the important components of these functions and setting up indicators of performance for them such as customer satisfaction. The results were fed back to the Quality Manager.
- *Maryland Quality Indicators:* as in Shiptown, the Trust had agreed to be part of this Regional initiative.
- *The Patient Focused Approach:* as in Fishtown the trust was re-designing some of its services to 'bring services closer to the patient and to greater meet the expectations of service users.' (Trust Project Officer's Description). The Trust had appointed a Patient Focused Approach Co-ordinator (a nurse seconded from her

clinical area). At the time of fieldwork, however, she had only been in post two weeks.

- *Critical Care Pathways*: These were protocols for the ‘guidance’ of clinical episodes of care for specified patients. For example, those with a ‘routine’ myocardial infarction or recovering from a Total Hip Replacement. They were intended to be based on research evidence and used as the basis for care unless clinical needs made them unsuitable. They relied on all members of a clinical team to ‘sign up’ to the protocol for them to work and this invariably involved members of teams in their development. This project was also led by an ex-nurse.

The Clinical Audit Structure

The Trust had recently established a Clinical Audit Committee which had initially been chaired by a senior consultant and now the Director of Nursing and Quality. It was to:

*‘bring together audit activity, develop multi-disciplinary audit and re-emphasise the benefits of team working.’*²²

The links between quality and audit were through the Director of Nursing and Quality’s place on both the Trust Audit Committee and the Quality Steering Group. Apart from this there were no formal links between the audit department and the central quality structure. There were two Audit Officers in post and a secretary but the team itself were still in their infancy compared to the well established department in Shiptown. As in all the Trusts, this was the component of the Trust’s quality strategy that had secured most medical involvement.

There was a CHC representative on the Trust’s Clinical Audit Committee but the CHC Chief Officer felt the Trust representatives were not comfortable with their presence and each proposal tended to be ‘couched in the particular language used by the group putting the audit bid in’. The Trust also maintained a low-profile within the local district wide audit support group. A number of Audit Managers from other

Trusts mentioned the lack of output from the Castletown site and the self-imposed marginalisation of the audit team from the rest of the Trust:

'they're [the audit department] just a tool for a few powerful consultants to pursue issues they are interested in. That wouldn't be so bad if they [the consultants] actually did the work for themselves but they get their poor registrars to do it and then take all the credit. They really need to start again and be clear about where they stand within the Trust - for everyone or just for the consultants?' (Audit Officer: neighbouring community Trust)

This image of a medically-dominated, occupationally segregated, department was reinforced by the fact that the nurse manager with responsibility for Nursing Audit had no formal link with the mainstream clinical audit department and felt that it was:

'like banging your head against a brick wall sometimes trying to get people to think as a team.'

The audit contract was negotiated with the local Health Authority and took the form of a fairly detailed and extensive set of projects. This was in contrast to the other Trusts who generally negotiated moneys based on a central core of audit topics and a block of money to be spent locally on projects as the Trust saw fit through scrutiny by the Clinical Audit Committee. The projects were 'grouped' under broad headings:

- *Health of the Nation: e.g. smoking and pregnancy; review of sterilisation*
- *Changing Childbirth: e.g. Named Midwife*
- *CEPOD: e.g. DVT prophylaxis*
- *Clinical effectiveness/use of protocols: Paediatric pain management*
- *Outcomes: Long term outcome of total hip replacement*
- *Royal college comparative audits: appropriateness of medical admissions*
- *Patient satisfaction/facilities: e.g. Counselling of Relatives in ITU²³*

Unusually for something paid for as part of a contractual relationship there were no indications as to the methods used to explore particular questions or the expected

outcomes of any scrutiny in the bid. So although the list was quite extensive there was room for interpretation on the part of the Trust. In common with other Trusts there was also no requirement for the results to be fed-back to the Health Authority in anything other than an anonymised format.

Business Quality

As with the other Trusts the main purchasing relationship had a system of quality standards attached. These were District-wide and applied to all providers from whom the local Health Commission purchased services. These were largely based around the standards and themes expressed in the Patient's Charter. They were not, however, afforded the same status (in terms of monitoring) as the Shiptown and Fishtown Trusts. In fact, no form of monitoring was in place, other than the obligatory Patients Charter quarterly returns. There was a feeling within the Trust that these standards were not important to the purchaser and several of them were either wholly unrealisable or so vague as to be 'open to severe interpretation' (Quality Manager: Castletown). For example, in relation to the reporting of 'quality initiatives' the provider was to simply:

'provide details of any initiatives which enhance the quality of service provision'.

In relation to the monitoring of contract quality specifications by the purchaser:

'members and authorised officers of the purchaser shall have the right to visit any part of a Trust for the purpose of monitoring contracts. Areas open to the public may be visited at any time and all other areas at short notice, by arrangement with the provider'²⁴.

This last standard had, as far as anyone at the Trust or the Commission was aware, never been exercised. Monitoring was also hampered by the fact that no one at the Trust could identify who the person with responsibility for quality was at the Health Authority (independent enquiry revealed it to be a manager in the contracting department).

Consumer Consultation

The processes which occurred within this part of the Trust's strategy set Castletown apart from other sites in terms of its approach to quality. While the other sites paid lip service to the idea of listening to consumers through the use of surveys and CHC involvement with a central committee or two, Castletown had a number of explicit and dedicated mechanisms in place to gain the views of users with regard to the services provided:

- *Patient Satisfaction Surveys*: analysed by ward or department and fed-back to the Quality Steering Group. The survey tool used was 'my stay in hospital' as it was in Fishtown and Shiptown.
- *Patient Liaison Group*: this group set up complaints monitoring and handling systems for the Trust and has CHC representation.
- *Patient fora*: these involved groups of service users who have been discharged taking part in a discussion about the service they received. These were organised, by individual departments or wards but could address Trust-wide issues such as provision for disabled users. Service areas examined included:
 - Orthopaedic out patients
 - Audiology
 - The Trusts disability provision
 - A general surgical ward
 - Maternity services
- *The Patients Council*: this was just being established whilst fieldwork was undertaken in the Trust site and consisted of ex-Patient Fora members. This was chaired by the Director of Nursing and Quality and was charged with getting user's views into Trust policy at the highest level. However as will be seen in Chapter Seven this was not necessarily how it operated.

The Trust's Quality Manager or Director of Nursing often acted as facilitator at the fora which nurses, managers and doctors from each of the departments involved were invited to attend. However, of the two fora attended, and the inaugural meeting of the Patients Council, there was no medical presence or apologies given.

The CHC attended at least two of the patient fora that had been organised and both sides were generally approving of the other's approach to involvement. The CHC were keen to move away from the visiting system that was such a feature of the other Trusts and were actively seeking new ways of involving themselves in Trust activity. Because the rationalisation process had pitched both organisations on different sides of an issue, the CHC Chief Officer spoke of:

... 'a healthy respect of the tactics of the Trust...but generally I think they want to do the right things for patients. Even the closure, or rationalisation as they call it, we have to argue a case for the local people because that's what they want, but we all know it makes sense to get a new site and better facilities.'

Conclusion

This chapter has described the case sites and outlined the main features of each Trust's quality strategy. These strategies can be thought of as a series of inter-linked (although sometimes tenuously) structures and processes, each designed with the explicit aim of operationalising 'quality' in services.

Marketown was characterised by a strong commitment to a formal model of TQM based around the ideas of Crosby and 'getting it right first time'. As well as an active central core structure and fairly acrimonious relations with its local CHC.

Fishtown and Shiptown shared a common primary purchaser and yet were very different in their structures and processes. Both had a central structure but Shiptown was more uniform in the shape of the quality activity adopted by divisions. Shiptown it eschewed TQM in favour of a 'home grown' strategy that relied heavily on measurement and a strong (but relatively distinct) clinical audit department.

Fishtown, on the other hand, was another (regional) TQM site and encouraged a more autonomous role for clinical divisions - as long as they met corporate goals. Their clinical audit function was medically dominated and the Trust relied on a heavily

developed 'support' structure of advisors to push the issue of quality to the fore in divisional work. Both Trusts enjoyed good relationships with local CHCs but only Shiptown was making real efforts to bring the CHC into corporate business in any meaningful way.

Castletown, was the most overtly consumer-focused of the four sites. The central strand of its approach to quality was a diverse range of consumer involvement fora; as opposed to the primarily survey-based techniques deployed by the other Trusts. These fora were now beginning to impact on the business of the Trust proper through their role in discussing issues relating to the design and operation of the new District Hospital and in the way the complaints system was designed and operated. They had originally adopted a TQM model but rapidly moved to another in-house design which, whilst using Total Quality ideas, was designed with more user (and professional) friendly terminology and techniques in mind.

These structures and processes form the basis for the identification of stakeholders within each of the Trusts. It is these stakeholders and the common themes of consensus and conflict within and between them that form the basis of the next two chapters.

CHAPTER FIVE: QUALITY - IN WHOSE INTERESTS?

The introductory chapter highlighted the multi-dimensional and complex nature of the concept of quality. It also outlined the 'tribal' delineation at the level of services and the role of values in the social construction of quality. Chapter One showed how the concept of quality has played a significant role in the political battles within NHS services over the past 18 years. Many of these relate directly or indirectly to the process of managerialization and the recasting of power relations between NHS groups.

This chapter seeks to unpack some of these links with reference to key analytical concepts such as power, interest and organisational culture. Taken together, these form a theoretical basis for empirical data collection and analysis. The chapter takes as its starting point the argument that in order to be implemented quality is actively operationalised at a variety of policy levels and in a variety of arenas in the NHS. The driving forces behind this operationalisation are not simply the policy messages from the 'top' of the NHS hierarchy, but also the values and interests of 'stakeholders' in NHS provider units. Quality has occupied a prominent place in the meta-policy agenda of managerialization. Which is itself concerned with redefining power relations and the consequent creation of winners and losers (see Chapter Two). Because of this, quality needs to be understood from within a framework which examines the relative inputs of power, the pursuit of interests and organisational culture as elements in the social action required to make quality 'real' in NHS services.

The aim of this chapter is to provide a theoretical starting point for further, empirically grounded, exploration and refinement. Yin¹ uses Christopher Columbus and his exploration of the 'new world' as an example of the need for such starting points: even when dealing with something of which very little was known Columbus needed to have reasons for the number of ships required; criteria for recognising that which he sought; and a rationale for the direction he would take. In short, even if his initial assumptions proved wrong he still required those initial assumptions. Providing

these initial assumptions regarding the operationalisation of quality at the level of NHS Trusts is the task of this chapter.

The Structure Of The Chapter

The chapter first proposes a model of policy implementation which posits organisations and the social actors within them, in an active role in interpreting and developing social policies. It then goes on to explore a variety of means of conceptualising ‘the organisation’ before outlining the common theme of ‘interests’ which dissect each of these conceptualisations. It shows how the interests of groups are inexorably linked to questions of power and organisational culture. The details of the organisational cultures likely to impact on the development of quality in services are then fleshed out with an outline of what an ideal-typical value stance on quality for professionals, managers and consumer-representatives might theoretically look like.

A Starting Point: The Organisation And The Politics Of Policy Implementation

The starting point for this exploration has to be what is already known about quality. Perhaps the most significant theme of the policy overview presented in Chapter Two is that responsibility for delivering technical quality (in the form of TQM, QA, CQI, quality specifications in contracting) is firmly at the level of individual providers. Delivering quality in the NHS is then an organisational responsibility.

It has already been seen that policy documents have made use of the term quality as a kind of virtuous label with which to justify changes in NHS structure and process. Quality is simultaneously one of the end points of the NHS organisation and also constitutes one of the means by which it will be sought². It is at the level of the provider organisation, however, that most individuals will experience ‘quality’ either as users of the service or as participants in its delivery.

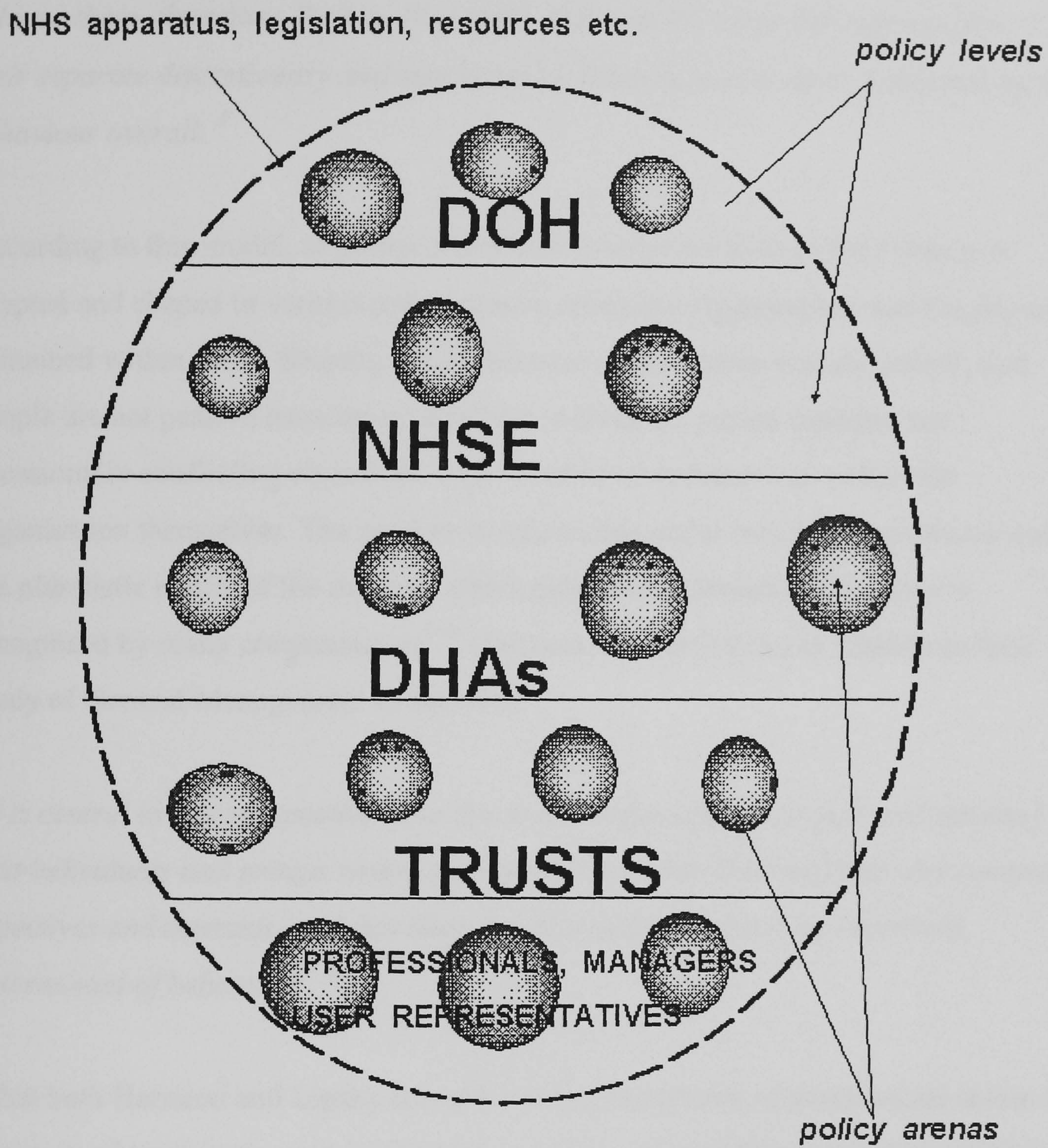
The importance of an understanding of the organisation to policy implementation is highlighted by Elmore:

*'Concern about the implementation of social programs stems from the recognition that policies cannot be understood in isolation from the means of their execution...virtually all public policies are implemented by large public organisations, knowledge of organisations [must] become a critical component of policy analysis. We cannot say with much certainty what a policy is, or why it is not implemented, without knowing a great deal about how organisations function...The translation of an idea into action involves certain crucial simplifications. Organisations are simplifiers...only by understanding how organisations work can we understand how policies are shaped in the process of implementation.'*³

Without organisations policy does not become action. Moreover, it is at the levels of provider organisations that quality is delivered. Quality initiatives are part and parcel of the mechanics of service delivery in the late 1990s. However, simply knowing that organisations play a crucial role in the implementation of social policies does not help the analyst seeking to examine what that role might be.

Fulcher⁴ outlines a policy implementation model which recognises both the role of the organisation in shaping policy but also allows for the complexities that present themselves in trying to make sense of that role(see *fig 8*). She posits the argument that policy implementation is made up of a variety of levels and arenas; levels constitute the stages at which policy is made rather than simply implemented; arenas (for there are multiple ones) constitute the fora in which issues are debated, struggles ensue and decisions made. This recognises the active role of individuals within the policy making process and does so in a way which recognises the plurality of interests present in most organisations and the policies enacted through them. In this way it encompasses some of the criticisms of the top down⁵ approach to framing policy making. It recognises the essential role of those at the periphery of the policy making structure (or the core if you adopt a bottom up approach). Those who Lipsky terms '*street level bureaucrats*'. Their importance is summarised thus:

fig 8: Examples of Policy Levels and Arenas in the NHS⁶



*'...the residual discretion enjoyed by workers who interact with and make decisions about clients results in workers effectively 'making policy'. They effectively 'make policy' not in the sense that they articulate care objectives or develop mechanisms to achieve these objectives. Rather, they make policy in the sense that aggregation of their separate discretionary and unsanctioned behaviour adds up to patterned agency behaviour overall.'*⁷

According to this model, as policy progresses through the levels of the state it is adapted and shaped in various policy arenas; primarily organisations and the sub-units contained within them. Shaping occurs because organisations contain people, and people are not passive translators of policy; individuals pursue multiple and occasionally conflicting objectives. This is reflected in behaviour within the organisation themselves. The need to recognise this active role of organisations and the pluralistic nature of the interests which people may pursue within them is recognised by many commentators^{8 9}. Harrison *et al* spell it out in relation to their study of General Management in the NHS:

*'It is central to this perspective [one that treats organisations as political systems] that individuals and groups within an organisation often have multiple and competing objectives and interests, and that their desire to defend these is an important determinant of behaviour.'*¹⁰

What both Harrison and Lipsky recognise is the importance of group social action in the work of organisations in implementing policy. This applies as much to quality as it would any other organisational process. Quality is frequently discussed in terms of group activity; for example, 'quality improvement teams', 'quality circles', and 'quality committees'. How people interact with quality processes in terms of their participation says something about the meaning they attribute to it. Alternatively, this assertion can be restated as, the researcher can infer meaning from the ways in which individuals participate in quality activity. But how you arrive at that meaning depends on the conceptual lens through which you view the participation and the context in which it occurs; this is where organisational models prove most useful.

Conceptualising The Organisation

Whilst organisations can be considered the ‘simplifiers’¹¹ of policy in that they translate intent into action, this belittles the complicated nature of the entities themselves. This complexity is reflected in the literature concerning itself with conceptualising ‘organisation’. As Elmore puts it ‘the single most important feature of organisational theory is its conceptual anarchy’¹². His approach to reconstituting this anarchy into a format with a degree of analytical utility is to tie together the disparate (but finite) strands of the literature. This is also an approach adopted by Reed¹³ and one which shall be adopted here. The aim in doing so is simply to introduce the models, in order to act as a starting points for the collection of empirical data and the generation of an inductively derived, but politically ‘grounded’, theory regarding patterns of participation in, and allegiances with, types of quality activity by social actors with a stake in NHS services.

What outlining a variety of conceptualisations of the organisation achieves is a highlighting of the concepts which run through each account and which have to be addressed if a fuller understanding of the link between quality and NHS organisational ‘tribes’ is to be appreciated. Words such as power, values, interests, culture and ideology need greater explanation in relation to quality than has been proffered thus far in the thesis; the notion of organisation provides one way of framing such an explanation. For now the aim is to see how these key concepts present themselves in models dealing with the transformation of policy intent into organisational action. The various conceptualisations of organisations¹⁴ are presented as a series of models. The main points are outlined and a ‘thumbnail’ explanation of NHS-tribal delineation around the actualisation of quality offered.

Organisations As Social Systems

1. Organisations are social units directed to the achievement of collective goals or the fulfilment of institutional needs for the wider society or environment of which they are a constituent part.
2. These externally derived goals/needs set the parameters within which the structural forms that organisations exhibit must function; organisational structures must facilitate the realisation of collective goals/needs set by the environment if their longer term survival and viability as 'going concerns' is to be secured.
3. Structural forms appropriate to the goals/needs set by the environment establish a framework of interrelated roles that integrate organisational members into a coherent and relatively stable social unit.
4. This set of roles imposes a pattern of behavioural and attitudinal expectations and norms to which individual members must display a minimum degree of obedience.
5. Organisationally determined demands for compliance are often perceived as constraining, to some extent or in some degree, by individual members and exist in a state of permanent tension with their preferred wants/expectations.
6. The resulting tension between organisational demands and individualised needs is a perennial source of conflict in organised systems and generates endemic instability and disequilibrium within structural designs that have to be coped with or managed in some way or another if organisational survival and effectiveness are to be secured.
7. The coping strategies undertaken by organisational management will, during the course of time, modify the organisations' relationship with the environment and the internal designs through which this relationship is mediated and developed.

The tribal delineation around quality according to this model is a result of the disequilibrium and conflicts felt by individuals who share a sense of tension promoted by the imposition of structural forms which seek to pursue the policy 'goal' of quality. These forms (Quality Manager, Quality Circle Leader, TQM Facilitator) may conflict with the other roles which people pursue as part of the structure of other policy goals in place for organisations (skilled 'expert' clinician, budgetary controller or client advocate).

Organisations As Negotiated Orders

1. Organisations are social units that are created, sustained and transformed through social interaction; they have no separate existence's as entities or structures independent of their grounding in social interaction.
2. As socially constructed and negotiated phenomena, organisations are most appropriately conceptualised as emerging out of the ongoing interaction of participants; they constitute temporary arrangements or patterns arising out of the social interaction undertaken by social actors which are always open to modification, revision and change through their interventions.
3. In so far as they are the products of negotiated interactions then they have *temporal limits in the sense that they will be reviewed, re-evaluated, revised, revoked or renewed over time.*
4. The organisational relationships and order arising out of this negotiating process have to be worked at; the organisational bases and forms produced and reproduced through interaction have to be continually reconstituted.
5. The more formalised and 'permanent' conventions, rules and relationships entailed in established structures set partial limits to, and some direction for, the process of negotiation; they provide the more stable elements of complex organisations as a general background against which foreground day-day negotiations can be set.
6. These, more formalised, organisational elements constitute a relatively fluid structure of power and control which constrains and facilitates political bargaining between organisational coalitions or 'stakeholders' over the allocation, distribution and utilisation of scarce resources, as well as shaping the 'constituencies of interest' which crystallise around these bargaining relationships.

The tribal split in quality according to this perspective would revolve around the role of quality as a new area in services and which is in the process of ongoing negotiation and reconstitution. The pre-existing conventions of roles such as professional, manager or patient representative act to set limits and directions to the quality debate.

They also form the basis for the 'constituencies of interest' around the notion of quality in services.

Organisations As Structures Of Power And Domination

1. Instruments or mechanisms geared to the protection and advancement of dominant economic, political and social interests prevailing within the societies of which they are a part; in this respect, organisations are constituted by the macro-structures of power and control in which they are located.
2. The structural arrangements and managerial practices typical of formal or complex organisations are determined by these wider configurations of domination; the latter also control the extent to which organisations reproduce the ideological and political constraints in which they are embedded.
3. Within the context of institutionalised constraints set by dominant groups, specific organisational actors - such as professionals, managers, technicians...clients and customers - struggle to control the ideas and techniques through which work is co-ordinated.
4. This struggle for control generates endemic conflicts of interests and values within and between organisational actors over the way in which work is to be structured and the benefits derived from productive activity are to be distributed.
5. The conflicts that are embedded in the very social structure and fabric of organisational life produce contradictions and tensions which have to be regulated by administrative technologies and managerial practices of various kinds if co-ordinated productive activity - geared to the interests of dominant groups is to be sustained.
6. These regulative technologies and practices are partially successful but usually give rise to problems of their own in terms of establishing new sources of potential power and control that are fought over by contending groups.
7. This 'dialectic of control' - that is, the continually shifting balance of resources and power reproduced by the uneven struggle between dominant and subordinate groups to exercise some degree of control over the conditions through which organisational existence is secured - is the primary source of structural change within complex organisations; endemic conflict between contending power groups

over the conditions through which the most significant features of organisational life are reproduced is the underlying force that drives transformations - of varying magnitudes and scales - in structures and practices.

Quality from this perspective is a product of interest groups struggling to gain control over an area which threatens to alter the structure and processes of NHS work. The central policy message appears as a means of reinforcing the discourse of managerialism so prominent in political ideology and action. Technical quality techniques such as TQM, or Quality Assurance represent 'regulative technologies' devised by managers to attempt to gain control over the tensions which the conflict generates. These are, in turn, the focus of more conflict as they represent sources of power which could be used against constituencies.

Organisations As Symbolic Constructions

1. Organisations are cultural artefacts that are produced, reproduced and transformed through processes of symbolic construction, mediation and interpretation in which all members are routinely engaged; organisational reality is constructed, internalised sustained and changed through processes of cultural; creation and enactment.
2. Organisational cultures are constituted through the generation of values, ideologies, rituals and ceremonies that express and make sense of participation within a collective enterprise.
3. As shared constructions of collective values and symbols, organisational cultures are shaped by and articulated through modes of thinking and conduct which embody and represent the collective experiences and meanings entailed in organisational membership.
4. Organisational cultures simultaneously socialise individuals into institutional patterns of thinking and acting, and into alternative schemes of interpretation and 'sense making' that diverge from the former.
5. Organisational cultures, and the collective meanings which they frame, transmit and reframe schemes of interpretation; they are never uniform or monolithic in the

messages they communicate and their implications for social action; they consist of multiple rationalities and realities that overlap, interpenetrate and contradict each other.

6. Organisational cultures simultaneously support and question dominant structures of meaning, power and control; they consist of loosely coupled systems of meaning and interpretation that can be accessed and mobilised by various groups for their own purposes within and outside the organisations.
7. The degree of effective control that managers can exert over the impact of symbolic creation, transmission and interpretation is inherently constrained by the complexity of these processes and by the fact that dominant cultures are usually internally contradictory; the 'recipes for action' which the latter convey need to be supplemented by auxiliary systems of meaning and action that dilute and fragment the behavioural injunctions that they entail.

According to this perspective quality is a function of the shared values and experiences of different participants in the cultural arena of the organisation. These values act as the basis for perception of, and action on, quality. Quality, in turn, acts as the basis for the regeneration of the participants' shared values. So a professional will hold 'professional' views on quality, which lead them to design 'professional' ways of operationalising the concept, which in turn reinforce the value of 'professional' activity and status to those within the profession and outside it; the prime example here is medical audit. The profession designs it based on the assumption that only professionals can recognise quality. The results are made available only to other professionals which in turn ensures the continuing and special role of the professional in defining quality in their work. Elements of other cultures can be drawn into these frames of meaning as means of furthering their own structural interests. So the language and techniques of consumerism can be brought into the managerial and professional 'folds' as a strategy for reinforcing their values and cultures. So involving consumers in clinical audit is a logical cultural development but with very specific boundaries on what they can contribute; these boundaries do not normally encompass technical clinical issues¹⁵.

Organisations As Social Practices

1. Organisations are social practices geared to the assembly and integration of other social practices concerned with transforming the conditions - both material and ideal - under which collective action is made possible.
2. As practices geared to the assembly and integration of other practices, organisations are reproduced through the design and deployment of various administrative mechanisms by means of which managers attempt to realise effective regulation of and control over the performance of work.
3. These administrative mechanisms of assembly, integration and control embody structural resources - such as hierarchies, information systems and rules - and require processual facilitators - such as ideologies, coalitions and cultures - for their effective reproduction and implementation so that conditions under which organised action becomes possible are established.
4. Both the structural resources and processual facilitators necessary for organisational assembly and control become focal points for power struggles between contending groups to gain access to the authoritative mechanisms - through which 'organization' is accomplished - and the allocative outcomes that they produce.
5. Power struggles to manage authoritative mechanisms and the allocative outcomes they produce form the underlying dynamic for change and transformation in the social practices through which organisations are created.
6. This conflict dynamic has to be analysed in relation to the strategic choices made by specifiable groups of social actors and the decision making practices through which they are formulated and the action recipes through which they are undertaken.
7. The modes of calculation, techniques for decision making, and means of action available to and utilised by organisational agents as a basis for intervening in the course of events to maintain or change structures in their favour becomes central to an understanding of power struggles and the organisational outcomes they realise.

Quality from the social practice approach is an administrative mechanism used by management who wish to see the structural resources of NHS service delivery allocated in their favour. As an administrative mechanism it embodies pre-existing power relations (in the form of hierarchies and rules) and also the ideologies, coalitions and cultures of the organisation (most of which are based around the roles of professional, manager and consumer representative).

The Ingredients Of Organisational Action: Interests And Stakeholding

What runs through all of these different conceptualisations of the organisation is the notion that individuals have an 'interest' in the organisation, its structures and processes. Consequently they have a 'stake' in these structures and processes, including the operationalisation of quality. Williamson offers a succinct and valuable definition of interests:

*'Interests are to do with advantage and detriment to individuals and to groups. Interests are difficult to define but are something in which a stake is held; a personal or group resource or means to protect or enhance a resource. Everyone has interests in resources like influence, power, time, money, knowledge, the way situations involving themselves are defined, how words are used about them and in a host of other material and immaterial things and in the relationships between them. Everyone has interests in health care, in its accessibility, its quality in general, and its standards of treatment and care.'*¹⁶

People with interests in an organisation represent stakeholders in that organization. Stakeholders are of interest as their needs, wants, desires, perceptions and conceptualisations are frequently different¹⁷. It is the source of these differences which form the starting point for this thesis. Namely, that participation in quality activity and your perceptions of that activity will depend on the broader values which people hold in services these in turn can be held as reference points in pursuit of their interests - and serve to help them achieve the meeting of those interests.

Synergy And Non-Synergy In Stakeholding

Williamson's¹⁸ framework outlines the interplay between interests and people that hold them (stakeholders). The first split is between interests that are synergistic or non-synergistic. That is, interests which are compatible with other peoples or, conversely, are in conflict with others. So for example, the use of quality (at the colloquial level) in Trust marketing and public relations (such as publishing a list of quality improvements) is synergistic with both senior managers' and the local populations' interests. For the managers, quality serves to deflect potential criticism and attract referrals (as long as the purchasers acting on behalf of the local community believe the marketing 'spin'). For the local community audit gives a feeling of reassurance that their local provider is working towards such a virtuous ideal. A non-synergistic scenario would be one in which critical medical audit results for a group of urologists are made public. Whilst the public's interests might be met in terms of information, the medical team's interests in maintaining the flow of referrals, and therefore surgical experience, might be detrimentally affected - the action threatens one groups interests.

Dominance And Repression

At the next level interests can be seen as either dominant or repressed. This refers to situations in which one group's interests regularly prevail over those of another group. For Williamson the example *par excellence* is the dominance of health care professions:

*'The health care professions are long-established, strong and cohesive. In each profession there is a basis of common knowledge and perception and an understanding of the interests that all members share...In their relationships with those recipients [of care] and in their practice, professionals are largely self-regulating. All have exceptional power to define their patients' situation and their interests.'*¹⁹

Once dominance is established then the weaker party can be seen to be repressed. This doesn't mean that their interests however, will always go unmet. In simply providing care of an adequate standard both professional and consumer interests can be synergistic (even though the professionals have more power through the assets of being able to prescribe antibiotics, perform surgery or seek out sources of expertise). Consumers get to return to the previous level of health and the professional claims the social and financial rewards in meeting that need (and in the process meets his/her own interests).

Oppression And Suppression

The final distinction is between oppressed and suppressed interests; and those which are apparent and inapparent. Interests are oppressed when repressed interest holders clearly recognise their interests and are able to articulate them but are prevented from striving for them by dominant interest holders. For Williamson the struggle between midwifery and the breast-feeding lobby of the 1960s and 70s is an example of this type of conflict²⁰. In relation to quality the desire of CHCs to participate in medical audit in the early 90s and the consequent rejection by the Department of Health could also be flagged up²¹.

Suppressed interests occur when issues are managed by dominant interest holders in ways which ensure that individuals are not even aware that their interests are threatened. Secrecy is the best and most obvious example of a situation in which the interests of one party can be considered suppressed. In the context of this study the confidential nature of audit results and the lack of compulsion on teams to deliver anything more than reassurance that it is taking place can act to deny purchasers the opportunity to place contracts with another provider and improve the outcomes of care. Or the 'massaging' of agendas of meetings with consumers or their representatives by managers so that only non-clinical aspects are considered can also be considered along the same lines.

When interest-holders are repressed but the issue is synergistic with their interests Williamson distinguishes between apparent and inapparent interests. Apparent interests being those which repressed interest holders can see are being met. An example being the use of sterile gloves in aseptic areas - as long as the patient is conscious and aware then both parties know that their interests, with regard to avoiding infection are being met. Inapparent interests are those in which the repressed interest holder is unaware that their interests are being met. For example, the nurse who covers up an individual with Alzheimer's disease wandering naked in a hospital ward is meeting both the patients need for dignity and the nurse's interests in being seen to be compassionate. Even though the individual may never be aware of the intervention. This typology is represented diagrammatically in Fig 9.

Williamson's typology was based on the work of Alford who concerned himself with the issue of structural interests which are:

*'those interests which gain or lose from the form of organisation of health services.'*²²

The value of an approach based on a recognition of structural interests is demonstrated by Ham²³ who makes the link between values and social action in arguing that the key issue (in relation to policy issues in the NHS) is:

'...to develop mediating frameworks to connect macro-theory with specific policy issues. One approach to this is through the examination of dominant value systems in particular policy areas and their influence on policy. More specifically, by analysing the operation of professional ideologies in health services it may be possible to establish links between the way issues are defined and resources allocated, the nature of structural interests and the distribution of power...'

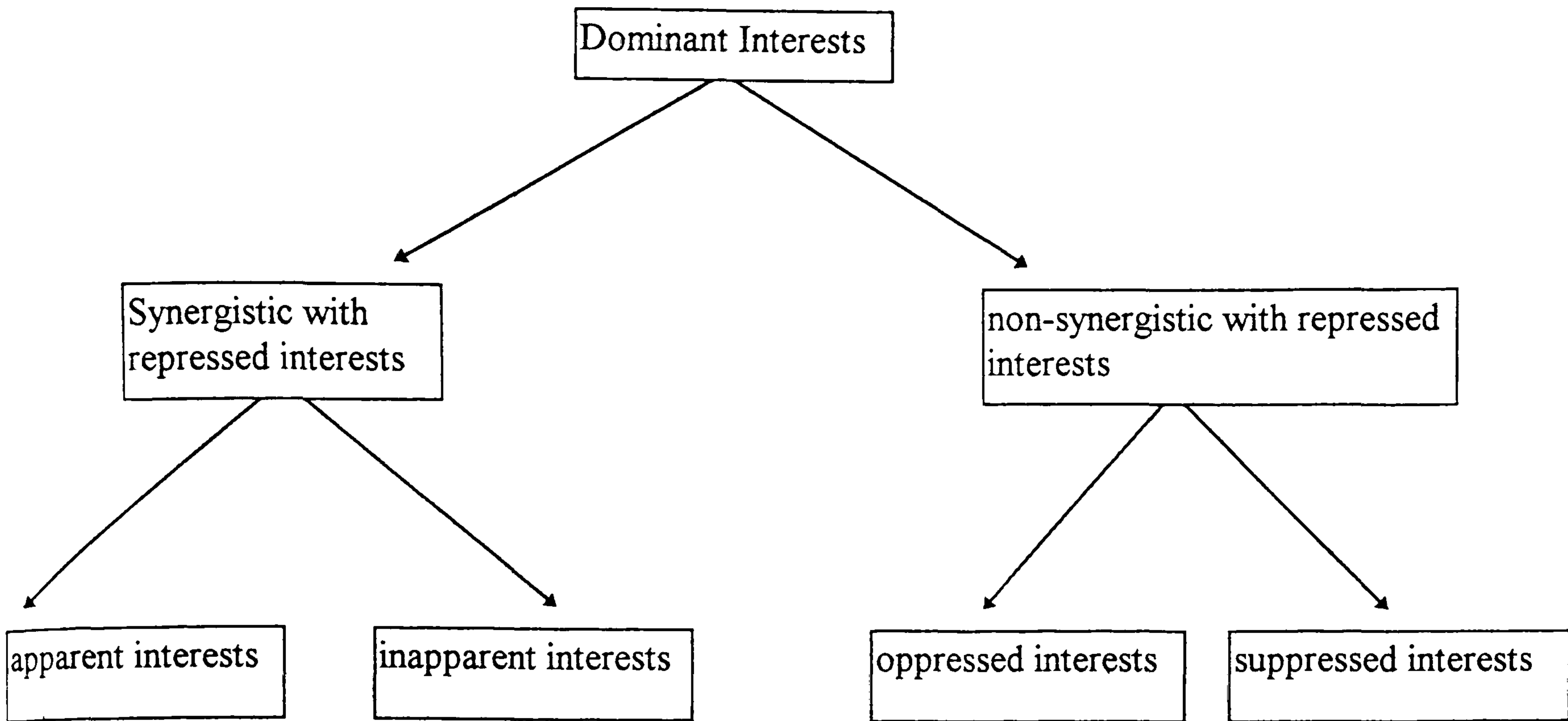


Figure 9: *Williamson's Structural Interest Model*²⁴

An interest-based framework also holds the possibility of illuminating the delineated (and therefore conflicting) picture of quality that emerges from the literature. As Giddens highlights:

*'It is the concept of 'interest', rather than that of power as such, which relates directly to conflict and solidarity. If power and conflict frequently go together, it is not because one logically implies the other, but because power is linked to the pursuance of interests, and men's interests may fail to coincide. All I mean to say by this is that, while power is a feature of every form of human interaction, division of interest is not.'*²⁵

Obviously simply having a stake in quality is not enough to explain the tribal delineation put forward as the predominant feature of quality in the NHS. It is the pursuit of interests and how you utilise your stakehold that is of interest to the researcher seeking to examine the operationalisation of quality in services. Pursuing interests is dependent on two other factors in the emerging framework: power and ideology.

Power

Power acts as *the* organisational resource for people to draw on as part of their behaviour. If you wish to pursue your interests unfettered and in ways which you want to control, then you require power. Power can be defined in various ways and, like quality, is a heavily disputed concept. Essentially however all discussions of power refer to the transformative capability of individuals to alter the course of events²⁶. Although it is the nature of this transformative capacity which distinguishes the views of different commentators on the subject. What is clear, however, is that power plays a significant role in human relations. As Weber's definition of power highlights:

*'[power is] the possibility of imposing one's will upon the behaviour of others.'*²⁷

It is possible to isolate two divisions in the concept of power:

- power as an element of social action
- power as feature of social relationships

The Lukesian View: Power In Action

The first of these perspectives is characterised by the typology offered by Lukes. For him there are three dimensions to power as social action:

1. Situations of observable decision-making, focused on key issues over which there is overt conflict concerning the subjective interests of the individuals or groups involved.
2. Situations of ‘non-decision-making’ in which only some potential issues become explicit, where there is covert as well as overt conflict concerning the subjective interests of individuals or groups;
3. Situations in which the social agenda is established (that is, potential and explicit issues are created) in which there is actual (overt and covert) and also latent conflict over both objective and subjective interests of individuals or groups.²⁸

The three dimensions of Lukes’ typology are perhaps best illustrated with reference to some potential scenarios relating to the operationalisation of quality in NHS services:

scenario one: A Trust’s quality manager asks a consultant to be a part of a Trust-wide quality committee. The consultant refuses saying that his clinical work comes first and that he has little interest in ‘talking shops’ run for management. Such an encounter can be seen to conform to Lukes’ first dimension of overt conflict and emphasises the power of the consultant (and the relative lack of power of the quality manager).

scenario two: The consultant ‘invites’ the directorate manager to attend his firm’s medical audit meetings for the last twenty minutes in order that the manager can help ‘in an administrative capacity’ secure resources for the equipment they need to improve their clinical outcomes. The manager feels compelled to attend as ‘something is better than nothing’ but feels that he should really be insisting on attending the full meeting as he has responsibility for audit as a whole for the directorate; and anyway ‘this is par for the course of manager-medic relations in the Trust’.

From Luke’s second dimension it is clear that the consultant has left the manager little choice and has, through his actions, ensured that only certain issues will be made available to the manager. However, it is Lukes’ third dimension that best addresses the analytical needs of the researcher. From this perspective it is clear that the actions of the consultant have contributed to the establishment of an agenda for future action that will conflict with the objective and subjective interests of the manager. Moreover, it is going to be increasingly difficult for the manager to combat the agenda as the format will remain even as medical staff come and go. Eventually it just becomes accepted by all parties as the status quo.

This third dimension provides for a clearer distinction between coercion, influence and authority as forms of power. It emphasises the social nature of action through the recognition that there is power over others as well as power to (act)²⁹. Expressed in Lukes’ own words:

*‘The bias of the system is not sustained simply by a series of individually chosen acts but also, more importantly, by the socially structured and culturally patterned behaviour of groups, and practices of institutions, which may indeed be manifested by individuals’ inaction*³⁰

Power Through Communication

Lukes’ social action view of power, in which power is exercised through action, is contrasted by the view of critical theorists such as Habermas³¹. For him power is seen

in the structuring of social relations through communication. He shows how communication can be directed towards the achievement of ends which aren't necessarily being communicated directly. Communication when used in this way becomes discourse. Discourse, in turn, shapes the rules and resources which actors can draw upon in their relations with others. Some discourses are more 'powerful' than others; for example, currently the discourse of 'work and contribution' is more dominant than the discourse of 'individual freedom and non-contribution [to society]'. Although of course, at different times in history these positions can alter. Hugman gives the example of how the power of professionals over patients is expressed through discourse based around the three elements of content, relations and roles.

*'Usually the content [of a meeting] is controlled by the professional, and even when the client is able to introduce topics for discussion the professional can avoid these either by ignoring them or by introducing those which he or she considers important...this has a surface appearance such as in the use of particular words, tone of voice, and non-verbal expression, and also a structure in which the expectation of social roles (professional, client) serve to create 'scripts' which, while not totally constraining, establish the dimensions of normal communications.'*³²

Exercising Power In Pursuit Of Quality

Whilst power as *capability* is fascinating and omni-present in all interactions it is the exercising of power in the pursuit of interest that is of interest to this discussion.

Handy distinguishes between power as a resource and power in its verbal form; for Handy the verbal usage of power is termed *influence*³³. Influence in organisations is seen as having a variety of sources:³⁴

1. *Physical power*: the power of superior force. Influence is exerted through physical force. Whilst obviously not a common feature of everyday organisational life (save in prisons or mental hospitals) it does manifest itself in picket lines and mass demonstrations.

2. *Resource power*: influence is exerted through the possession of valued resources which are a) controlled and b) desired by others. Handy uses the example of the monopoly of labour supply and the power to award pay increases or status via symbols, as examples where resources are the basis of influence.
3. *Position power*: This is the power that comes as a result of the role or position in the organization. The occupancy of a role entitles one to all the rights of that role in the organization; power resides in the position rather than the individual. For position power to be able to influence people the position has to be backed by the organisation and also be in possession of desired resources. So the quality manager who 'is out on a limb' and lacks either coercive powers or significant desired resources will have difficulty in influencing people towards his or her vision of desired social action. Importantly, position power gives control over certain invisible assets which assist in the ability to influence. These include:
 - information
 - the right of access to networks and committees (and also information)
 - the right to organise: through organisation of work, environments and the flow of communication, individuals' behaviour can be influenced
4. *Expert power*: this power comes from being acknowledged as a source of expertise in a field. As such, and in contrast to the other types, it is bestowed upon the expert by those over whom it will be exercised. Anyone can claim to be an expert but if those claims are found to be fraudulent then this negates further attempts to claim expertise on the part of the individual. Expert power can be seen to be a particularly influential resources for professionals in services where progression within one's professional group and ones position in the organization (and hence position power) is often bound explicitly to levels of expertise.
5. *Personal power*: is power derived from charisma or popularity.
6. *Negative power*: this is not strictly speaking a conceptual distinction in its own right. It refers to the use of the above resources in ways which fall outside the agreed constituency or contrary to accepted practice: power used *negatively*. It is the power to stop things happening; for example, the personal assistant who wilfully screens out those messages to his/her boss from people in the organization he/she doesn't like.

Quality, as part of the broader process of managerialization is concerned with shifting the balance of power in organisations³⁵. Sometimes explicitly, as in the case of user involvement initiatives and the granting of apparent 'position power' to service users by giving them places on committees. Sometimes implicitly, as in the transition from medical to clinical audit and the diminution of 'expert power' that opening up one's professional actions to others for scrutiny might entail.

This process inevitably involves winners and losers; to lose power, or to grant someone more power, is to reduce part of your ability to pursue your interests. In an organisational context an example can be found in the publication of 'raw' audit results outside the immediate environs of the clinical team. The team's ability to disguise the complexity (or lack of it) of the role they are asked to fulfil, and the outcomes of their attempts to perform one or more parts of those roles has been diminished. This in turn breaks down the mystique of expert power, which in the NHS is linked to position power and the trappings of those positions such as salaries, prestige and organisational status. Quality is clearly then not just about 'quality'; if the development of quality threatens peoples' interests then the application of resources (power) to oppose or resist the concept is likely to be a feature of the process.

This is something which appears to be overlooked by most quality 'gurus' or at least the adapted versions of their theories³⁶. There is an implicit assumption that the simple use (colloquial) of quality backed up by techniques which reinforce corporatism will be enough to influence even the most hardened cynic into a shared vision and meaning which might run counter to the values promoted by their role or broader stake in the organisation. Based on the delineated picture of quality in the NHS, one has to entertain the idea that quality is as much a focus for conflict as it is consensus between groups.

Virtuous Reality: The Role Of Shared Values

The theoretical stance that emerges thus far is that action by individuals and groups is meaningful and linked to the pursuance of interests. However, the ability of individuals to use behaviour to pursue interests, no matter how powerful they are, is also influenced by the values they hold and their links with people who hold similar values. This is essentially the basis of a social action approach to human interaction and behaviour. Degeling and Colebatch outline what such an approach means for the study of organisations and the processes that occur within them:

*'[in social action theory]Actors are... intentional beings who, in casting their own actions and interpreting and evaluating the actions of others, make use of frameworks of meaning which are socially and historically based, are (in part) institutionalised and, in many instances, are perceived by those involved as social facts. To the extent that particular frameworks of meaning are shared by numbers of actors and provide a basis for them to cohere, and people act in terms of these frameworks, their actions contribute to both the re-affirmation of these frameworks and the maintenance of social (and hence organisational) structure.'*³⁷

Frames of meaning can be expressed more clearly as sets of values or normative reference points for behaviour and relations; or as some commentators have classed them, organisational cultures.

Organisational Culture

It is in the notion of organisational culture (or organisational ideology as it is sometimes referred to) that the twin elements of social action, namely value frameworks and power, converge. From this perspective:

*'...the various dimensions of organisational structure and process (and the arrangements and practices which give them form) can only be understood when they are examined from the perceptions that participants hold of them, and how they act accordingly.'*³⁸

Organisational culture or ideology in this context can be simply expressed as a set of beliefs about the way to behave, about standards and values³⁹. Handy prefers the term 'organisational cultures' rather than 'organisational ideologies' but to all intents and purposes the two terms are interchangeable; besides, his work is a direct extension of Roger Harrison's⁴⁰ initial treatment of the latter. For this chapter both terms are used interchangeably. For Handy organisational culture:

*'...turns organisations into cohesive tribes with distinctly clannish feelings. The values and traditions of the tribe are reinforced by its private language, its catch phrases and its tales of past heroes and dramas. The way of life is enshrined in rituals...not all cultures suit all purposes or people. Cultures are founded and built over the years by the dominant groups in an organization. What suits them and the organization at one stage is not necessarily appropriate for ever.'*⁴¹

However, this conceptualisation of organisational culture can be criticised on a number of fronts; the most pertinent being that it is unlikely (as will be seen in the Q-results in Chapter Six) that such homogeneity in a complex organization such as an NHS provider Trust is likely to exist. Moreover, if more than one culture exists then it is logical to suggest that each will constitute a 'cohesive culture with clannish feelings'. From a more anthropological perspective it is possible to conceive that culture is simply an 'ideational system' which therefore allows for the possibility that beliefs and behaviours can diverge and that several different cultures can co-exist in an organization⁴². Like Harrison and colleagues, the thesis shall employ the notion of organisational culture to signify the systems of values, beliefs and ideas held by groups within NHS organisations.

Pollitt uses the definition of organisational ideology proffered by Hartly as the basis for his examination of managerialism in public services:

'The essential characteristics of ideology are, first, that it consists of values and beliefs or ideas about the state of the world and what it should be. Second, these cognitive and

affective elements form a framework. In other words, ideology is not simply a set of attitudes, but consists of some kind of relatively systematic structuring (though the structuring may be psychological rather than logical. Third ideologies concern social groups and social arrangements - in other words, politics in its widest sense being concerned with the distribution and ordering of resources. Fourth, an ideology is developed and maintained by social groups, and thus is a socially derived link between the individual and the group.... Fifth, ideology provides a justification for behaviour.'⁴³

It is clear from such a definition that organisational culture provides a powerful reference point for social actors reflecting on their choices in relation to quality in the NHS.

Identifying The Cultural Components Of Services

It is clear that in order to progress beyond this point the chapter must begin to seek out those organisational cultures or 'frames of meaning' which actors draw on in making their choices to participate in quality activity in the NHS.; it is equally clear is that these frames of meaning must be:

- socially and historically located
- institutionalised
- make up, or contribute to, some of the rules and resources which individuals can draw on as part of their role in social action.

From the multiple typologies of quality put forward by analysts, those that are most useful and have the biggest ring of authenticity about them are those which are most heavily grounded in the political context of NHS services. Of these, it is Pollitt's distinction between *medical*, *service* and *user's experienced* quality which is most detailed and most readily backed up with empirical examples. Whilst taking issue with some of Pollitt's reasons for his distinctions (the notion of nursing as not being 'professional' enough to have their own approach to quality) he does make the essential link between participation in quality initiatives and the broader frames of

meaning that people in services draw upon. Explicitly Pollitt talks of the links to professionalism but also imply linkages to the ideologies of managerialism and consumerism.⁴⁴

Professionalism And Quality

There are a variety of approaches to defining the organisational culture of professionalism. Moreover, it is possible to see how quality could be used to further the values, and therefore interests, of those calling themselves 'professionals'.

Professionalism can be approached from a variety of angles, two of the most prominent: the 'trait' and 'functionalist', will be explored here.

The first trait identified by theorists such as Johnson⁴⁵ is homogeneity of outlook within a particular occupational community. This implied need for homogeneity in outlook could explain the need for the professions' use of consensus-based approaches to intra-professionally defined 'good' practice as a route to quality; an example being the national audit standards being developed in hospital orthodontic specialities. There are some problems, however, in viewing professionals as being entirely homogenous in the values between and within professionals. The distinction between medicine and other professional groups (or groups with claims to be professions⁴⁶) has been well documented⁴⁷. In recent years nursing, in particular, has sought to emphasise its distinctive value-orientation as part of its claims to be a 'profession'⁴⁸. A further criticism can be levelled at the nature of ideology itself. One of the key features of professionalism is that adherents may 'dip' into the shared values or beliefs of the ideology as they see fit but overall homogeneity is difficult to predict. As Pollitt points out:

*'ideologies...may be firmly or weakly adhered to by particular individuals. Some elements may be rejected while the remainder of the 'package' is, however inconsistently, still maintained.'*⁴⁹

The second trait of professionalism concerns the acquisition and development of specialised knowledge. Patrick and Scrambler⁵⁰ suggest that knowledge is an essential component in the process of professional legitimacy. In order to safeguard professional legitimacy professionalisation involves producing, assessing and approving knowledge within the profession itself. This internal process of production, assessment and approval can be seen in the way medical audit has been used to promote 'quality' in the clinical care component of services. Audit's key features are that it should be professionally-led, confidential and conducted on terms which clinicians and professionals feel comfortable with.

The third professional trait involves promoting a monopoly of practice in a particular area of work. This monopoly is primarily achieved by developing control mechanisms (such as professional registers) which are sanctioned by the state and complied with by employers who employ only those people whose names appear on the register. Proponents of medical/professional quality utilise similar tactics as means to promoting their particular brand of quality. The central assumption within medical audit that only professionals can assess the quality of other professional's work can be construed as an attempt to develop a monopoly of opinion regarding what constitutes quality in professional practice. The official sanctioning of professional monopoly of practice is also extended to the mechanisms which promote the idea of medical/professional quality. *Working for Patients* demonstrated that the Government conceded quality (of medical work) can only be reviewed by a doctor's peers and should be professionally led⁵¹. Professionalism is about controlling work practices in specific occupational groups and medical/professional quality is about controlling for 'good' practice in professional work. Friedson⁵² points out that while professions are not always free to control the terms of their work, they are free to control the content of that work. Medical/professional quality represents an extension of this control into the field of defining the constitution of 'quality' in this self-defined work.

Parsons suggests that one of the key values attached to professionalism⁵³ is the altruistic notion of the public service ethic, or the placing of clients' interests before the profession's. Harrison and Pollitt⁵⁴ question whether professionals really do work towards meeting patients' interests out of altruism, or whether autonomy and self

regulation are actually more useful in promoting the professions' interests. Certainly the mechanisms employed to promote 'professional' quality, such as audit and peer review, rely on the extension of principles of autonomy and self regulation in quality assurance. The principles of monoprofessional audit can be seen as a very effective means of professionals legitimating pre-existing practices and perpetuating the mystique attached to professional activities. This role is further enhanced, from the professions' point of view, by virtue of the fact that, outside of employing organisations and the Royal Colleges, the results of audit are generally only released in anonymous and edited formats. Larson shows that self definition of good practice by professions is nothing new and can be considered as one of the traits of professionalism:

'a profession is, in fact, allowed to define the very standards by which its superior confidence is judged' ⁵⁵

Whilst using the 'traits' of professionalism as a framework for analysis is useful there are some problems attached to this approach. First, the trait-based models take as a starting point the assumption that there are 'true' professions which exhibit all the essential elements. These ideal-typical models act as normative benchmarks for what ought to be. In this sense they move away from being models of description to ones of prescription. This prescriptive role is highlighted by Johnson⁵⁶ who points out that the preamble and rhetoric of professional codes of conduct bear remarkable similarities to the core 'traits' of professionalism identified by sociologists.

Second, the ideal-typical approaches, with their emphasis on 'lists' of core elements do not explain adequately how these elements relate to each other; for example, is the growth of a specialised knowledge base related to increased autonomy? Or are there other factors in play?

Finally, Larson⁵⁷ points out that the ideal-typical approach to describing the ideology seldom takes into account the concrete historical and cultural conditions within which professionalism has developed. The development of professionalism in medicine and law, and the extension of the ideology into other groups, are indicative of the condition of modernity; the advance of science, cognitive rationality; and the progressive

differentiation and rationalisation of labour in industrial societies. What is not so clear is how robust the conditions for being counted as a 'profession' will be in the social context of the 'post-modern' world. New types of knowledge and new means of dissemination represent significant challenges to the 'mystique'-based, and opaque nature of professional technical practice and modes of thought⁵⁸.

In order to increase the validity of the central argument that professionalism and professional quality share values and complement each other it is necessary to examine the ways in which the two are linked. Moreover, this needs to be carried out from within a framework which recognises and responds to the criticisms outlined above. One such framework can be termed the functional approach to professionalism. This approach to examining professionalism stresses the perceived utility to society of being at the receiving end of professional activity. Barber⁵⁹ puts forward four attributes of professionalism which at first appear almost identical to the trait approach. However, the functionalist nature of these attributes becomes clear in his analysis of the reasons for the development and maintenance of such facets: namely, the exercise and retention of power.

Knowledge, for Barber, provides a powerful control over society. Because of this it is vital that specialised knowledge be used in the community interest. Barber assumes that professionals will naturally act in this way because of their internalisation of the public service ethic and values. Along these lines, professionals are perceived as the only social group who fully understand the implications of their practice and knowledge: it is, therefore entirely logical that they should be the dominant force in the control of their practice. Because professionals control the application of skills and knowledge based on the promotion of public welfare, society rewards them for what Johnson terms their 'highly valued occupational performance'⁶⁰. This analysis, however, can be criticised on two counts: first, the argument that only professionals understand the implications of their practice devalues the experience of being a consumer of health services. It can be argued that no one understands the implications of professional interventions better than the person actually experiencing those interventions. It is, after all, the patient who lives with the result of medical or nursing activity; whether that activity is good or bad. Second, the assumption that society rewards professionals because of highly valued

occupational performance neglects the role of power as a variable in service delivery and reward. The rewards for professionals, particularly medical professionals, are themselves partially created by the claims of professional groups who possess the power to secure outcomes based upon these claims. Certainly until recently the merit award system of financial and status based reward, while sanctioned by Government, was almost entirely controlled by the profession itself. Similarly pay claims for nurses and medical professionals are often justified with reference to their contribution to the welfare of the nation, and the implications (both politically and in terms of public health) of the withdrawal of their skills and knowledge. This style of argument is a feature of professional quality; a judgement of quality is made with reference to the claims of the group that the judgement applies to, and in the case of audit from *their* data and by *their* peers.

Harrison and Pollitt⁶¹ highlight the issue of trust as a variable in the functional approach to the ideology of professionalism. They suggest that professionalism and the structures that have emerged to support it act as means of preventing abuse of the trust that service users place in professionals, or the doctor-patient relationship. Professionals claim that to safeguard this trust two freedoms are necessary: the professional must be free from external interference when exercising his or her expert knowledge according to the patient's best interests; and the profession must be self regulating. This second freedom is perceived as necessary as only the profession possesses the necessary technical knowledge to prevent patients being exposed to 'charlatans and incompetent practitioners'.

Professional quality and the mechanisms used to promote it act as means to promoting two functionalist ends. First, it safeguards standards of care and contributes to improving patients outcomes in services. This is the justification often held up by the professions as the reason for the format of confidential, non-punitive audit.

Second, the professional view of quality reinforces professional values such as autonomy and self-regulation and contributes to the safeguarding of knowledge and skills; and therefore control, power and status. There is, therefore, a synergy (along Williamson's lines) between the community and profession's interests. Professionalism has also been

seen as one means of evading managerial control and supervision⁶² and promoting a monopoly of specific skills which in turn contribute to high earnings and social status. Certainly the concept of a type of quality which only professionals can recognise and evaluate and which is linked to financial gain or access to resources, reinforces this value. Whichever stance is taken on the ideology of professionalism: traits based on ideal-types, or the functional utility to society of the characteristics of professional groups, the values identified by both analytical routes are reinforced by the professional approach to quality.

Managerialism, Managers And Managerial Quality

In line with the previous section it is first necessary to isolate those values beliefs or norms which collectively might constitute the ideology of Managerialism. In doing so it is useful to acknowledge the 'multi-layered' structure of the ideology. Pollitt suggests that Managerialism has both horizontal and vertical value structures:

- *Macro-values*: the level of ideology, deep assumptions and generalisation
- *Micro-values*: the middle layer where ideology meets specific theories, models and techniques. The ideological component plays a background contextual role here and is replaced by more technical elements of managing people and resources.
- *A final layer*: ideological influences appear minimal and widespread use is given to seemingly value neutral tools and technical artefacts such as performance indicators (for example, bed turnover rates, mortality/morbidity rates). The managerialist element enters in the ways in which these tools are deployed; the ways the data generated by them are used and the tool's position in broader models of management theory.⁶³

At the macro-level, or the level of tenets and generalised beliefs one can isolate several values which Managerialism and managerial quality share and mutually reinforce. First, is the value of management itself; the worth of management, both as a body of workers and as a feature of work is something which is very much a feature of managerialist

thought and concepts of managerial quality. The scientific and excellence approaches to quality have their roots in strands of managerialist thought:

- *Scientific approaches*: Taylorist or Fordist notions of organisational production which emphasise fragmentation of skills and the breaking down of tasks (de-skilling), with consequent separation of knowledge from work, can be seen in the promotion of universal and relative standards which concentrate on systematic assessment of specific service elements (such as BS5750 - 'the kitemark'). Such quality standards view quality in a service as the sum of well delivered constituent parts rather than the whole.
- *Excellence approaches*: TQM, and the patient focused hospital, have at their core Post-Fordist notions of quality through cultural change, consumer orientation and 'subtle' control mechanisms.

Within each of these approaches to quality, management and managers are afforded the lead or principle agent role in promoting the concept of quality.

Second, managerial quality and Managerialism both share a belief in the worth of explicit objectives or goals, a highly motivated workforce who work towards these goals with attention to detail, costs and a desire to reduce bureaucracy and red tape⁶⁴. This picture of a motivated, cost-conscious, objectives-based, workforce is one which quality mechanisms such as TQM promote. TQM central tenets such as 'quality is free', responsibility lies with the individual for securing quality in interactions with internal and external customers; and defining self-objectives based on customer requirements, reinforce such values.

Third, Managerialism espouses the virtues of 'good' management practice. The definition of which is commonly based on models of practice or examples derived from those companies that are successful in the private sector. Service quality models such as those based on Peters and Waterman's oft quoted, but seminal text, *'In Search of Excellence'*⁶⁵ reflects this belief in the worth of private sector achievement and management practice.

Fourth, they both afford a negative valuation to the worth of 'politics' (as discussion, debate and consensus) in securing beneficial processes and outputs in services. Pollitt suggests that Managerialism perceives politics as inefficient, sectional and possibly irrelevant and conflictual⁶⁶. The shift in management style since 1983 then, approved and led by government, can be seen as a move away from allocating resources at organisational level based on consensual agreement and discussion between doctors and managers and towards more rational allocation by managers with greater power to act independently.

Quality and General Management, and by implication apolitical decision making, were linked at a governmental level. In terms of the power of the management tier in services this development represented a significant shift in their favour. As Day and Klein point out:

*'[general management was a]... move from a system that is based on the mobilisation of consent to one based on the management of conflict - from one that has conceded the right of groups to veto change to one that gives managers the right to override objections.'*⁶⁷

The central role that quality occupies in general management means quality has played a part in the overriding of objections, and therefore the exercise of power. This role for quality in the changing power relations of the NHS is a point recognised by Clarke et al in their managerialization thesis⁶⁸. They argue that quality, as a component of managerialization, is explicitly about control. The point here has been to show that quality and consensual or 'political' decision making do not necessarily go hand in hand; even where quality techniques emphasise 'partnership' and 'team-work' there is usually a managerial hand at the helm.

These values or beliefs are those derived from an analysis of management thought generally rather than specific models or frameworks for management action. It is this 'middle-level' which is of most interest to a discussion of value differences between ideologies. This middle level theory involves the use of techniques and normative assumptions about the way the organisational world *should* be which are more specific

in nature. It is at this level that labels such as 'Fordist', 'Taylorist', 'neo-Taylorism' and 'Post-Fordism' enter the discussion. The values attached to these models of management and managerial action are replicated and reinforced in tools and techniques which focus on actualising the concept of service/managerial quality. Prior to exploring the ways in which notions of service/managerial quality fit into the ideological 'starting blocks' of Taylorism and Fordism it is useful to examine what is meant by these terms.

Taylorism & Fordism: Commanding Quality

The terms refer to the ideas and values of Taylor and Ford at the turn of the century in the United States. Their ideas constitute the ideological roots of 'scientific' approaches to achieving service quality - such as performance indicators and quality assurance. Their ideas are of direct relevance as some of the methods initiated by government and used at macro and micro policy levels on the premise that they would improve quality (Performance Indicators, management information systems, Resource Management) through the 1980s and now into the 1990s possessed, and retain, a distinct 'Neo-Taylorist' character⁶⁹.

Taylor's theoretical base was undoubtedly positivist in character. His key assumption was that management could legitimately lay claims to being a science; with all the associated constants and laws that this label implies. It was this assumption which provided the basis for the school of 'scientific management'. The values attached to Taylorism are those of precision, measurement, waste-reduction, systematisation, and monitoring of activity.

The means to achievement of these goals were the scientifically derived new rules of production which would involve specialisation and deskilling, analysis of task, task prescription based on that analysis, financial incentives for workers, and individualised work with responsibility for that work's standards. It is worth expanding on these points to gain a 'flavour' of Taylor's ideas in relation to the management function.

The techniques associated with the promotion of the 'scientific' type of managerial quality clearly align themselves with middle-level Managerialism; of which Taylorism is one strand. Donabedian's⁷⁰ assumption that quality improvement in the processes of health care delivery can improve outcomes can be considered 'scientific' in its logic and 'Taylorist' in its character. The managerialist-ideological heritage of the 'scientific' approach to quality has been well noted by a number of commentators^{71 72} but it is worth extending their observations further in order to provide a fuller examination of the links between the ideology of Managerialism and the concept of managerial quality.

Taylor's original texts placed very little emphasis on the issue of effectiveness in relation to the management function. The quantifiable nature of other variables in his analysis: efficiency, time, cost, method did not extend to product effectiveness; the criteria for which is largely left to managers discretion in the short to medium terms, and the market in the long term. This means that managers' values and perceptions directly influence the processes used; and therefore, using Taylor's own logic, the outcomes produced. Similar criticisms can be levelled at the managerial tools in use in the NHS. Quality assurance, management information and Resource Management all depend on the assumption that 'get the process right and the outcomes will look after themselves'. While these tools all pay great attention to those values associated with Taylorism such as measurement, cost and efficiency, it is only recently that they have begun to be linked to variables concerned with effectiveness in the form of clinical outcomes. Taylorism in its pure form was very much a creature of its historical context and the development of quality has reflected the changes in managerial thought over time. Most notably the transition to 'Post-Fordist' models of management. Before examining the links between quality and Post-Fordism it is necessary to unpack the term Fordism.

Fordism shares with Taylorism the normative stance that management needs to control the workforce by specifying what is to be done, how it is to be done and in what quantity it is to be done. In this sense it, like Taylorism is a 'command' model of management⁷³. Fordism promotes the type of organisational culture which Handy⁷⁴ refers to as a 'role culture' in which power and authority share the same boundaries. Authority in the organisation is linked to hierarchical position. The role and power of experts or professionals is accepted within its allocated and well defined place: 'on tap but not on

top'⁷⁵. This 'role culture' is seen as a result of, and a reinforcement for, the Fordist model's dominant hierarchical and self-contained organisational structure. Fordism places heavy emphasis on conformance to rules and procedures. These are developed within the context of the organisation's mass production aims which are relatively stable given the infrequent nature of any product/service changes and which are designed to reinforce the producer-driven nature of any product or service delivered. The model is associated with prominent 'career' employees, who have learned the necessary rules and procedures. Key management functions in this model are the fixing of effort levels, specification of work methods and ensuring workforce compliance⁷⁶.

The success of Fordism, Taylorism and other derivatives of the 'scientific' school of management lies, in part, in their place in history. Prior to the Second World War manufacturers were able to create new mass markets (as in the Ford Model 'T') and could afford to focus merely on satisfying demand through quantity of supply. Success in such a context could be measured against satisfying demand, control of costs and through economies of scale. Since the Second World War increased competition, international production and trade, coupled with an increasingly sophisticated and wealthy consumer population, have led to markets becoming saturated with goods and the recognition, on the part of manufacturers that simply increasing quantity as a means of satisfying consumers was not enough. Quality or 'excellence' began to figure in manufacturer's plans and strategies for production⁷⁷.

Obviously welfare services have significant differences from the private industrial sector - the lack of assembly lines and the dominant role and numbers of the 'professional', are just two. However, as Alazewski and Manthorpe⁷⁸ point out there were also many similarities between welfare provision before the advent of the new managerial styles and structures and the private industrial sector. These include the primary aim of delivering the maximum quantity of welfare to the maximum quantity of consumers and at the lowest cost; the provider-driven nature of the product; and the use of standard packages of services with little or no choice or adjustment for individual need. These similarities, while vital to understanding why 'Fordist' management was so attractive prior to the mid-1980s do not explain the need to shift to Post-Fordist structures and techniques in welfare services.

It has been seen in the review of the literature that two of the key influences in the rise of 'quality' in NHS policy were the economic crises of the 1970s and 1980s and the linking of ideas of 'managerialism' to the political goals at the centre of policy; particularly the rise of the New Right in Conservative Party politics. A Post-Fordist perspective shows that these are linked and that an emphasis on quality is part of this linkage⁷⁹. These similarities and the shared influences between quality and Post-Fordism reinforce Pfeffer and Coote's assertion that the 'excellence' approach to managerial quality is a feature of the 'Post-Fordist' nature of welfare state restructuring and management⁸⁰.

Post-Fordism And Quality: A Question Of Culture

Post-Fordism can be used to subsume a variety of 'middle-level' managerial approaches. Theories such as New Public Management and Public Service Orientation in welfare can all be viewed from within the loose perspective of Post-Fordism. The common thread which runs through all these is an emphasis on 'quality' as an explicit managerial priority and as a feature, or outcome, of service delivery.

Post-Fordist models of management promote organisational cultures which are seen as hybrids of Handy's role and task-type cultures⁸¹. The task-type organisational culture is a direct contrast to the role culture described earlier as part of the Fordist command model. The task culture acknowledges expertise and thereby negates the 'deskilling' elements of Taylorist/Fordist scientific management. Power in this organisational culture is spread amongst those individuals who are, 'positioned at the intersections of networks of specialist, task orientated groups'⁸². These individuals might be experts or simply good 'fixers'⁸³. An example of such an individual in the NHS might be the clinical director, who does not necessarily occupy the top position in each medical 'firm' (that position is usually reserved for consultants or professors at the top of their professional hierarchies) but nevertheless controls resources, liases with other organisational teams, holds responsibility for resource decisions and generally straddles the arenas of management and medicine. The aim of creating such individuals is to spread power more widely and

facilitate the formation of a 'team culture' in which collective organising is highly valued⁸⁴.

Post-Fordist organisational structures are typically decentralised and consist of specialised and local units bound together by contractual relationships. The workforce are encouraged to achieve results rather than merely conform to process specifications. Innovation, therefore, is not necessarily discouraged. Providers frequently change product or service design and are seen to be, or at least attempting to be, responsive to consumer wishes. Post-Fordist organisations employ a 'core' of professionals or experts to perform specialist functions and rely on short-term contract-based staff to fulfil other organisational tasks. In direct opposition to the scientific or Fordist model of management, managers are there to develop employee commitment, ensure output targets are met, and to develop and maintain close relations with other units and the centre⁸⁵ - to 'empower' rather than merely monitor and plan.

It is clear that the 'excellence' approach to technical quality dovetails well with a Post-Fordist conceptualisation of the management function. This dovetailing has not been lost on commentators such as Pfeffer and Coote⁸⁶ who subtitle their analysis of the excellence approach 'the managerial approach' and make explicit their belief that the excellence approach to quality is a component of Post-Fordist managerial ideology.

Cultural change along Post-Fordist lines invariably involves the reshaping of power relations, or at the very least the perceptions of those relations. Quality appears as one of the means this reshaping has been pursued at the macro level. A point recognised by researchers from Bristol University who see quality as one means of changing the role and dominance of 'the professional' in services⁸⁷. At the organisational and specific (middle-level) managerial theory levels quality often appears as an end in its own right; quality as an organisational and personal goal as opposed to a route to new power structures. Certainly in each of the case sites used in this study quality was often discussed as an end-point in itself. Its links to a broader agenda of challenging existing power relations were not a feature of the material used to promote the concept (although participants frequently recognised it as such).

Clearly quality in its managerialist guises of the scientific, economic and excellence approaches appears remarkably similar to the ideas and specific models of management expressed as Taylorism, Fordism and Post-Fordism. What is unusual is that all three approaches to quality are pursued simultaneously at policy levels with little or no apparent co-ordination. The approach to managerial quality in the NHS represents a reflection of the values of managerialism generally rather than one all-consuming set of managerial ideas along the specific lines of Ford, Taylor, and the Post-Fordist Deming, and Peters and Waterman. The values promoted by techniques such as quality assurance, universal standard setting and statistical process control represent their 'scientific' managerialist ideological heritage; for example, cost, efficiency, compliance with rules and process based standards, and provider-led specification. The 'new wave' of quality techniques based around the excellence approach to quality similarly reflect the Post-Fordist, consumer-centred, ideas of New Public Management and Public Service Orientation; for example, consumer responsiveness, new and more subtle mechanisms of workforce control such as Resource Management and short term contracts, small, decentralised and accountable work units, and organisational goals as the basis for action. It is clear that the values promoted by managerialist ideas of quality are often different to those attached to the professional approaches to quality previously outlined. One example is provided by the explicit and monitored performance criteria involved in managerial quality mechanisms which completely counter the claims for autonomy promoted by professional approaches. Before going on to examine conflicts between these two ideologically influenced approaches to quality it is necessary to highlight the values attached to the final approach to quality in the 'tribal' typology: user's experienced or consumerist quality.

Consumerism And The Notion Of Consumerist Quality

The links and shared values between consumerism and consumerist quality differ from the other types of quality and their respective underlying ideologies in two important respects: first, consumerist quality is in some respects a much more normative ideal-type than either the professional or managerial approaches. Actual micro-level mechanisms for promoting consumerist quality in organisations are (in contrast to the professional

and managerial approaches) often poorly developed. Consequently, the theoretical material put forward by analysts draws on normative, rather than descriptive, data.

Second, the language of consumerism and its values are often taken on board by professional and managerial groups as means of furthering *their* ends as opposed to consumers. This is not to say that consumer representative groups do not occasionally make use of managerial techniques and rhetoric; but their legitimacy in services does not come from doing so. The moral high ground in the NHS is in being seen to be 'doing the right thing' by your customers. From a perspective concerned with interests it is quite feasible for dominant stakeholders to synergistically meet both theirs and consumers needs (if only by repression or oppression of consumers interests). Despite this synergy consumer representatives tend not to be the dominant interest group in services.

The Macro Picture

At its most general level consumerism can be seen as consisting of five primary values⁸⁸:

Access: consumerists see the need for clear and explicit criteria as a feature of access to services. Because only in this way can decisions about access to services be questioned. If a potential customer knows what criteria apply for access to a service, for example, age or condition, then they can challenge decisions and argue for fairer, more equitable, rules. The other value promoted by consumerists in relation to access is the issue of accessibility. The rationale behind this promotion is to break down the perceived impenetrability of large, monolithic, public sector organisations and bureaucracies. It is sometimes confusing to know where to enter the system to gain advice or help other than through the conventional 'gatekeeper' route of General Practitioners.

Choice: basic consumerist arguments value the provision of services in forms which enable the consumer to exercise a degree of choice between the available options. This has been a significant feature of policy rhetoric since the introduction of the quasi-market in health care.

Information: information is a valuable commodity, and as such, its use (and the disparity in availability between providers and consumers) is heavily contested by consumerists. For consumerists, consumers need information to enable them to make the best choices from the available options, to maximise the utility they gain from using them, or to gain a foothold in the running of public services. Information is seen by Potter⁸⁹ as the key to conferring power to consumers. By providing information on factors such as standards attainment, rights, responsibilities, organisational structure, decisions made and the reasons why, she argues that consumers will affect change.

Redress: the value of redress to consumers is perceived as lying in its ability to settle grievances quickly, simply and fairly. Redress procedures are also seen as providing a check on the activities of providers and as a mechanism for controlling quality (albeit retrospectively) by allowing management to identify and rectify problems of policy, system or structure⁹⁰.

Representation: This is the belief that it is worthwhile representing the views of consumers and expressing these to decision makers at the crucial points in the policy and decision making systems. Commonly, at the level of the individual, this means some form of advocacy, either in the shape of a member of a formal advocacy organisation; a Community Health Council representative, or a solicitor. The unorganised nature of, and lack of resources attached to consumers of health services as a collective mean that group or community interests as a whole are represented by institutional bodies such as the Community Health Councils. Although the funding and other limitations attached to these bodies make their presence little more than cosmetic; particularly in the new 'contract culture' of the NHS.

The Links: Quality And Consumerism

The links between consumerism and quality can be explicit. For example, between Potter's⁹¹ five basic principles of consumerism and Mcgrath's general conceptualisation of consumerist quality⁹²:

POTTER'S CONSUMERISM

- *access*
- *choice*
- *information*
- *redress*
- *representation*

MCGRATH'S CONSUMERIST QUALITY

- *access*
- *choice*
- *freedom of information*
- *redress*
- *empowerment*
- *advocacy*

McGrath's last two categories, empowerment and advocacy, roughly equate with Potter's notion of representation; although, obviously they mean much more to the end-user of services. At this most general level of discussion then it is clear that consumerist quality shares values with the broad ideology of consumerism. However, just as with professionalism and managerialism a degree of heterogeneity is present in the concept.

The Middle Layer

There are three sub-divisions to consumerism, each of which attaches slightly different weightings to the core values of information, access, choice, redress and representation. Equally, they all differ in the ways in which these values should be achieved and promoted in the context of services. These three models can be termed:

1. *Market-based consumerism*
2. *User participation consumerism*: which incorporates the sub-categories of:
 - community participation
 - democratic accountability
 - partnership
3. *the radical approach*

The 'Market-Place' Model

This model of consumerism puts forward the opinion that a consumerist product is one which is based upon what consumers want and provided at a price that consumers find

acceptable⁹³. As the title suggests it is dependent upon the structure of the market for its existence and market-based economic assumptions underpin the theory. By being able to choose between alternatives the consumer is seen as an active participant in raising quality and by exercising choice through their purchasing power they can directly influence service providers. Quality in this context is a product of the effects of the market. The dominant value in this approach is consumer choice. Put simply, market place consumerism posits the notion that if consumer choice is increased, in a setting which enables purchasing power, then product or service quality will be enhanced. Quality services within this approach will be those that attract the most customers based on the operations of the market.

However, as Nocon points out, these two elements: choice and purchasing power, are currently a long way from conforming to the free market standard required (leaving the private sector aside)⁹⁴. Patient choice in the NHS is mediated by third party 'gate keepers' such as General Practitioners (GPs), Social Service Departments and Health Authorities. Moreover, even if this structured mediation were not in place, consumers would have to assert themselves in the face of other competing interests, such as budget holders desires to avoid overspends.

Even if it is accepted that consumers possess the faculties and willingness to choose they still require information relating to the effectiveness, quality and costs (opportunity, social and marginal) of each of the alternatives; information that is essentially inadequate within current service provision. The performance indicator system (post-Korner) has been shown to inadequately reflect the concerns of the consumer⁹⁵, and is largely inaccessible to those outside the NHS. As has been seen already in the earlier literature review, clinical audit (a prime measure of effectiveness) is dependent on anonymity and secrecy for its success and professional co-operation. Such structural features of NHS quality do not constitute a recipe for successful information dissemination to consumers or their representatives.

Despite its obvious theoretical flaws, which are largely attributable to the structural effects of the NHS quasi-market, the market-place model is immediately relevant to an examination of quality in services. This type of consumerism is manifest in services via

initiatives based around customer relations, service settings, and the manner in which services are provided: the 'charm school' approach to quality and consumerism⁹⁶. This approach, whilst providing a pleasant service delivery context for the consumer, does not address more weighty issues such as rights to a particular service or standard, or the empowerment of the service user.

The User-Participation Model

This is a broad category for what are, in essence, three separate sub-models:-

- i) The *community participation* model.
- ii) The *democratic accountability* model based on notions of citizenship and caring.
- iii) The *partnership* approach to service planning, management and evaluation.

THE COMMUNITY PARTICIPATION MODEL.

The ideal-type often used as the basis for exploring this model is the development of the Community Health Councils (CHCs). These arose out of governmental concern that the users and representatives of services were exerting too little influence on services – services which were becoming dominated by professionals, via their combined roles of management and evaluation of services and service quality⁹⁷. They were formed principally to put forward local users' views to Health Authorities and act as the missing cog in the planning and evaluation processes of services. However, CHCs have been criticised on a number of fronts. Some of which were outlined in Chapter Two (see page 45) and include their inability to bypass the views of organised pressure groups.

Quality services along the lines of the community participation model are those services that respond to organised 'community' requests and allow effective user inputs into planning and evaluation. Quality is seen as being promoted by organised representation. Consequently, it is collective rather than individual satisfaction with services that dominates as the outcome of a 'quality' service.

THE DEMOCRATIC ACCOUNTABILITY MODEL.

The democratic accountability approach to consumerism and consumerist quality has at its core the notion of the 'empowered' citizen, with commensurate rights to variables such as choice, redress and representation. These rights amount to levers which consumers can use to raise the quality of the services they receive to a level which they think they ought to have. The dominant values in this approach are equity (in access and opportunity) and meaningful representation - consumers actively shape decision making rather than just being heard. The model also values the idea of 'rights' to standards and participation in services. Quality in a service, according to the democratic accountability model is where equality in access and standards is achieved for all its customers; the key negative indicator being the lack of consumer recourse to their 'rights'. It draws heavily on the notion of citizenship, and has been a central strand in governmental policy since the Conservative launch of the Citizens Charter.

Citizenship, Rhodes⁹⁸ argues, has the advantage of providing an ethic for action due to its political heritage and established theoretical base; it is also thought to enhance the standing of an organisation and increase the motivation of its employees. Pollitt suggests that the concept of citizenship involves the promotion of equity, equal opportunities, representation and opportunities for participation⁹⁹. It is by no means clear that inequalities in these variables, which are being addressed as part of the current debate surrounding health service provision and quality, are being adequately remedied. It is hard to see how, given the structure of current provision and policy, the gaps between rhetoric and reality can be bridged in relation to equity, equal access, and the opportunity to participate. As has been shown in Chapter Four, representation (via CHCs) in many Trusts is limited and participation in services still in its infancy.

Citizenship not only relates to the actualisation of these noble concepts in dealings with the state but also with the individual's relations with the organisations of the state. It is with this in mind, and the distancing of providers and purchasers from central government, that the *Citizens' Charter* was applied to health services in the form of the *Patients Charter*. The Charters promote quality, choice, standards and value as their main themes, and also the notion that citizens' rights can be equated with consumer

rights. This conflation can be considered misguided as the concept of active citizenship involves not only rights related to societal contribution via consumption, but also full contribution in the literal sense. In short, the empowerment of consumers to contribute via a framework of 'rights' with the provision for increased accountability which accompanies such a framework. However, any pressure that is applied to services or managers seems to be only done so in an informal manner. The Charter's vision of the citizen is that of a consumer with increased rights and expectations and not fully empowered citizens along classical lines¹⁰⁰.

The concept of citizenship also lacks a recognition of the power asymmetries that can exist even when consumers are involved via representation on, or participation in, National Health Service committees. Hudson suggests that one of the key components of democratic accountability - the election of consumers or their representatives onto committees - could result in a role which is indirect and limited. This is due to the:

'existing power relationships which do not favour consumers or consumer groups and as such [the] considerable difficulties in involving users in systematic planning and management'.¹⁰¹

This involvement can be criticised along the lines that the distorting effects of unequal power relationships mean that such legitimisation cannot truly be seen as acting in consumers best interests. Such legitimisation techniques, with concepts of citizenship at their core, are also being adopted as means of making decisions and judgements regarding the quality of care/service provision; with similar distortion of consequent action in dominant interest holders' favour.

THE PARTNERSHIP APPROACH.

This approach foregoes the political problems inherent to the concept of community participation via organised representatives and the conceptual 'minefield' of citizenship based rights. It emphasises the benefit of informal collaboration between providers and users. It involves the medical profession, para-professions, and managerial sector

relinquishing some independence and users relinquishing some dependence¹⁰². This approach to consumerism suffers similar problems to the democratic accountability model previously outlined; in that it neglects to account for the unwillingness of powerful agent groups to relinquish their respective power bases. Moreover, it fails to recognise the significant differences in knowledge and information between consumers and their professional or managerial counterparts in services.

Consumerism along the lines of those organisations seen to be doing something as a response to consumer wants circumvents these difficulties somewhat. Hudson¹⁰³ argues that much of the consumerist activity in services centres around 'hotel' matters, due not only to a narrow conception of the capabilities of the consumer, but also the unassailable power of the medical profession. This power means it is reluctant to lay itself open to what it considers uninformed and unfair comment. An example of this can be found in the lack of consumer involvement in medical audit and the proviso on the part of the profession that its co-operation will only be given if the process is confidential.

One means of bypassing the resistance present when questioning managerial or professional power is by co-opting consumers into planning or evaluating services based around an intermediary concept - such as health service 'outcomes'. By allowing users or their representatives into outcome measurement and development processes one element of the 'quality' equation can be questioned using a quasi-objective concept. Yet measures can be developed which reflect consumer interests and go some way in re-dressing the inequalities involved. However, the ability to question power in this way arises only when the data is published and made available for comparison by consumers. A situation, which while improving, is still woefully inadequate. The involvement of consumers in the DoH Clinical Outcomes Group and the publication of selected Performance Indicators in 1997, are evidence of greater openness and participation, but there are still no consumers involved in the Clinical Standards Advisory Group, which suggests there is still some way to go.

Winkler¹⁰⁴ suggests that the problems of power disparity, which are still a fundamental block to consumerists' involvement in partnerships with providers, could be eased by

setting up institutional arrangements with the aim of empowering users. These arrangements have six key elements:

- *User information*: on service availability, delivery, accessibility and, above all, quality, compiled independently of NHS management.
- *Patient advocacy*: by using an independent or quasi-independent advocate.
- *Clinical audits*: with results available to user groups.
- *Improved complaints procedures*
- *User participation in decision making*
- *Collective accountability of user representatives*: user representatives need to be accountable to and supported by a community group with research facilities. This would ensure that consumer representatives enter into partnership with management; as opposed to becoming part of that management.¹⁰⁵

The values most heavily promoted by this approach to consumerism and consumerist quality are similar to the community participation and democratic accountability models. However, the partnership approach lacks the formal criteria for user involvement, representation, information or access which accompanies the other two models. This means that it relies on more powerful groups, namely doctors and managers - 'allowing' consumers to play a part in planning and evaluating for quality. In effect, these powerful groups can control both the pace and nature of any changes along consumerist lines. This model is perhaps the least attractive to consumerists attempting to develop quality in services based on consumerist values as the agenda for evaluation remains with powerful groups. Any consumers allowed into the process, at either macro or micro policy levels, will be exposed to the full rigours of NHS power play amongst stakeholders.

The Radical Approach

This approach to consumerism rejects the notion that professionals and managers should lead the way towards consumerist services by 'allowing' the consumer into service planning, management and evaluation. It does this, not by pursuing the goal of consumer rights, but by challenging professionals' right to govern the service relationship by

replacing the old doctor-patient relationship with a model based upon an active, wise and selective consumer who doesn't automatically comply with all service directives or expectations of the patient. The overall aim being the consumerist tenet of greater egalitarianism in services¹⁰⁶. Haug and Lavin¹⁰⁷ put forward four reasons why the radical approach to services has arisen.

Firstly, consumer's education levels have risen over time. The educated consumer is seen as being in a better position to question professional or managerial competence. As Wirt suggests:

'while more education does not make everyone a critic, it does increase the chance that the myth of professional omnipotence will be questioned, particularly if the results are less than anticipated'.¹⁰⁸

By education Haug and Levin do not simply refer to general education, but also the health specific field. The exposure of issues surrounding health and health care in the media, information leaflets, and self help groups, all serve to meet the demands of an educated consumer population.

Secondly, there has been a growth in the number of para-professionals. These are quasi-professional groups who have shattered the mystique of medical practice by taking on (or being allowed to take on) tasks that traditionally were the preserve of physicians or surgeons. Examples in this country include the resurgence of independent midwifery practice, the development of specialist nurses, district nurse prescribing and the expansion of the role of the practice nurse.

Thirdly, they put forward increased public belief in the efficacy of self-care as a precursor to increased consumerism; although the position of this variable is unclear as it could also, conceivably, be a result of greater consumerism in services. Self-care is, as Haug and Lavin point out, the dominant form of healing for the majority of the population but is limited in its applicability - i.e. the person with a broken wrist would be foolish to attempt to heal it themselves. However, in the case of long-term or chronic illness it is often the case that as service users grow used to their condition then so their

ability to self-diagnose change and treat themselves improves as well. In this sense it is possible to view this 'learning' process as similar to the physician's key tools in effective diagnosis, namely knowledge and experience.

Similarly, Haug and Lavin's final point concerned with the new medical ethics which have arisen out of the development of new technologies, is seen as levelling the playing field between doctor and patient; a point recognised by Watkins and colleagues¹⁰⁹. The ethical dilemmas of technology related interventions such as whether to abort a foetus on the basis of amniocentesis, or whether to continue the interventions necessary for life support in someone with irreversible coma, are perceived as being accessible to the public and are often part of general media debate. As a result, some argue that because lay-value judgements are involved (such as the quality of life and the needs of relatives) the lay person is as well equipped as the professional to make decisions. Haug and Lavin do not suggest that lay people *should* be making these decisions but that by their realisation that they perhaps *could*, consumers become aware of the limits of medical authority and therefore question it.

The dominant values in the radical approach to consumerist quality centre on the consumer's right to information, choice, access, redress and changes to services based on changes in the consumer body itself. Quality is seen to exist in those services which recognise those change; for example, they adapt their provision to the level which matches the raised educational levels of the consumer collective. It is also seen as present in those services which are considered 'reflective' in the consumerist sense; i.e. they take time to consider challenges to their competence, methods and treatment of consumers. More importantly, they act on these challenges and alter their service processes accordingly.

Conclusion

Policy messages from 'the centre' concerning quality encourage the view that the concept is vague and open to interpretation¹¹⁰. However, despite this vagueness providers are expected to deliver on the quality front: they are expected to

operationalise the term. Consequently, quality is an organisationally-located phenomenon in terms of the ways in which people encounter it.

Despite the conceptual anarchy associated with conceptualising the organisation, notions of power, values, culture and structure all constitute recurring themes in relation to questions of organisational action on quality. Moreover, there is insufficient empirically derived material in relation to quality in organisations to allow for any grounded statements of the possible explanatory utility of any one model.

Despite this gap in the literature on quality, there are some constants which relate to all organisations and which impact upon quality just as they would upon any other organisational phenomenon. Taking this into account, this chapter has argued that the operationalisation of quality at the level of services must take into account the context in which it is located and the variables likely to impact on its development - namely power, group values (in the form of organisational ideology/culture) and the interests of the people drawing on these sets of shared values.

The thesis has taken the idea that quality is socially constructed (first mooted in Chapter One) and shown that the conceptual split associated with Pollitt's original 'tribal' typology of *medical*, *service* and *user's experienced* quality can be recast along the broader organisational ideological lines of professionalism, managerialism and consumerism. So the typology now has more breadth and becomes - *professional*, *managerial* and *consumerist* quality. Along these lines then, a theoretical starting point for the chapters to come can be represented by the following broad statement:

Quality as it manifests itself in NHS acute provider organisations is a function of the group values found in services. These values are represented in the organisational cultures of professionalism, managerialism and consumerism: organisational cultures which help define and shape the pursuit of group interests. Moreover, because social action in the pursuit of interests is always mediated by power (i.e. your ability to pursue your interests and the ability of others to stop you) then the 'pure' operationalisation of quality along

organisational-cultural lines will be heavily influenced by the composition of stakeholder groups and their consequent position in the power relations of the unit.

The tasks for the coming chapters are now clear. First, to explore the contention that groups do indeed hold 'tribal' perceptions of quality activity. Second, to explore the development of quality in organisations from within a framework which is sensitive to, and can account for, the power dynamics between groups which all organizations (however conceptualised) possess. Finally, to pull together the findings of these two explorations in an attempt to account for any patterns that may emerge.

CHAPTER SIX: VALUE-BASED STAKEHOLDING & QUALITY - THE RESULTS OF A Q-METHODOLOGICAL EXPLORATION.

Chapter Three outlined the unique contribution of Q-methodology in helping to understand the structures and forms of what are referred to as ‘shared subjectivities’ between individuals. This chapter outlines what some of these ‘shared subjectivities’ or points of view look like in relation to quality activity. Specifically, it presents 14 points of view which were defined by the significantly similar ways in which people sorted Q-statements which were all based around the same Q-sample theoretical matrix (see Chapter Three). The bases for the matrix were the theoretical points of conflict within the ‘tribally’ delineated view of quality activity presented thus far.

The chapter shows how points of view emerged from people’s Q-sorts which approximate to the consumerist, managerial and professional categorisations outlined thus far in the thesis. However, the chapter also shows that there are a number of factors (4) which do not easily fit this category. Moreover, the overall demographic composition of the groups defining each factor does not follow any obvious pattern; although there were some important exceptions in relation to ‘managerial’ and ‘professional’ view points (Factor Two in Shiptown and Factor Five in Marketown).

The findings are explained with reference to the concepts of organisational ideology/culture, interests and power outlined in Chapter Five. The argument is presented that as quality is a mechanism for the furthering of organisational-group interests then it is in group’s interests to portray their stances on quality activity in the ways they do (as expressed through their Q-sorts). So the dominance of consumerist values in the Q-sorts of professionals and managers can be explained by the fact that it is in their interests to be seen as the ‘guardians’ of these values.

This interest-based approach does not, however, take into account the disparity of power between and within the different groups in services and the ability of groups to control agendas, definitions and service action and to resist the cultural incursions of others in varying degrees. For these reasons it is argued that some of the ‘anomalies’ in patterns of allegiance can be explained partly by some group’s efforts to shape the

culture of other groups. In particular the culture-management approach of TQM and the general managers who pursue it.

The Theoretical Matrix: The Q-Samples

In order to represent the factorial design of the ‘global’ theoretical matrix described in Chapter Three each site used quotes from stakeholders from within that site. This fulfilled two needs:

- The need to ‘ground’ the Q-sorts of individuals in the language and situations of local services.
- The need to incorporate local contextual factors such as differing structures between sites (some clinical divisions in Fishtown were classed as directorates in Marketown).

Compiling a cross-site, standard, Q-sample would have entailed fundamentally altering the quotes used to represent points on the matrix; something which needed to be avoided if the principles of Q were to be maintained.

Where ‘raw’ quotes from respondents involved expletives or extensive gaps or repetition then a small amount of editing was carried out purely to enhance readability. The Q-sample construction was always sensitive to the need to retain the original sentiment of the person’s verbatim response. The Q-samples from each of the sites are represented in the appendix (tables 2:a-d) along with the factor scores for each statement. These give the weighted average scores on each statement for each point of view expressed in the factor.

What Factors (Shared Subjectivities) Emerged and Who Defined Them?

In all, fourteen factors emerged across the four case sites:

Marketown = five factors

Shiptown = four factors

Castletown = three factors

Fishtown = two factors

Tables 1:a-d in the appendix detail the composition of the groups who defined them and the strength (factor loading) of each person's association with the view expressed in the factor scores for each statement

Towards Interpretation

Factor interpretation can occur in two ways. First reference can be made to the demographic characteristics of the p-samples (the sorters) who define each factor. The demographic characteristic of interest for this part of the study was occupational role or grouping. Clearly, there appears to be strong *prima facie* case for arguing that there is little, if any, evidence of a substantive link between role in services (manager, professional, consumer representative) and the factors which emerged from the case sites. It follows then that one of the theoretical 'mainstays' pursued thus far in the thesis appears somewhat compromised by this finding. The chapter will show later how this picture may not be as indicative of organisational-cultural disharmony as it first appears.

The second means by which factors can be interpreted is with reference to the factor scores associated with each factor. These are presented in the Appendix, Tables 2: a-d. Factor scores represent the emphasis which the groups defining a particular factor place on the various elements of the Q-sample's statements. It allows the researcher to gain a purchase on the shared forms of those perceptions of quality activity which people hold. Moreover, by establishing the standard error of the difference between scores in the emergent factors it can be seen how groups differ in their perceptions. When the factors are examined and the areas of divergence outlined then it becomes clear that people's responses have more than a passing resemblance to the organisational cultural elements of the 'tribal' typology of quality activity and association outlined thus far. Factors which represent that which might be labelled

consumerist, professional or managerial approaches to quality activity all appear to be represented in the ways in which people sorted the Q-sample statements.

The Customer at the Forefront: The Consumerist Factors

Factor one in Marketown, Fishtown, Factor two in Shiptown and Factors one and three in Castletown, all portray quality as something which should positively seek to pursue the consumer interest:

'I think quality works best when words like choice, customer-power and voice in the system, actually mean something. If you want to define quality you've got to start with those three in mind.' (Castletown factor one +4)

People defining this perspective placed a strong emphasis on notions of choice:

'Quality is all about giving patients control and choices while in hospital - real control, not just menus and colour televisions. Obviously there are limits but we could do more than we do at the moment' (Fishtown +5)

'Quality is about promoting access to services and choice for patients in the service itself and even before they get to us so they can choose where best to go.' (Marketown +5)

As well as consumer choice, issues of greater control over the hospital experience for customers were also strongly represented and valued:

'Personally I don't want some stroppy patient with no real knowledge of his or her medical needs controlling what counts as quality in what I do for him.' (Marketown -5)

'Quality and customer control of the health services they receive cannot be separated. Quality is all about giving customers choices and control over those choices in the hospital.' (Castletown factor one +5)

Information was seen by the people defining these factors as a key source of realising this control:

'Information is the key to the whole quality strategy. Surveys, patient fora, and audit results should be the basis of the whole quality thing.' (Castletown factor one +5)

'I can't honestly see how giving patients tons of information is going to help them question what we do...not in the real world anyway.' (Marketown -5)

The corollary of this pro-consumer interest stance was this factor's negatively valuation of the autonomy and power of professional groups in relation to elements of quality activity:

'Its all very well letting and Drs and Nurses decide that their work is excellent or of good quality, but not everyone - patients included - is always happy to take their word for it. We need evidence.' (Fishtown +4)

'The only way to really ensure quality is to let the doctors and nurses on the wards set the quality standards. They are the only ones with the necessary knowledge and skills.' (Castletown factor one -4)

For Castletown the two consumerist factors were differentiated along two distinct axes. The first was a sense of *realism* in relation to the furthering of consumer interests through current 'quasi-market' structures and processes and an associated emphasis on values such as choice:

'All this emphasis on choice [as part of quality] does is raise patient's expectations unnecessarily. Its not always possible to meet those and so quality suffers.' (factor one 0; factor three +5).

The second major split was in relation to the idea of management and quality activity. Those individuals aligning themselves with factor 3 took a decidedly anti-managerial stance within this factor:

'Managers should be involved at every level, but especially in terms of deciding if a service is good enough. It's their necks that are on the line if the customers are let down.' (factor one +1; factor three -4)

'quality is pretty low down on most manager's agendas in the divisions. They have to worry about balancing the books first and foremost and so there is an inevitable conflict between what they want and what they can achieve.' (factor one -3; factor three +4)

The Pro-Professional Stance: Professionalism Valued

The consumerist stance of the above factors was directly countered by those factors which appeared to value and stress the interests of the professionals involved in services. (Factor Five in Marketown, Factor Two in Castletown and Fishtown and Factor two in Shiptown.)

In many ways the factor represents the antithesis of the values expressed in the consumerist factors. The primary valuation was on the worth of professional traits of autonomy and self-regulation in quality activity:

'Quality can be a good thing if, as professionals, its left to us to set the standards we are judged by...after all we're the one's with the specialist knowledge.' (Marketown +5)

'Its important that we allow professional groups to keep control over the issue of quality if it is to benefit services in the long run.' (Fishtown +5)

There was a distinct 'anti-managerialist' tone expressed in the factors in relation to the imposition of standards on professional work:

'Management-set standards have an important role to play in raising hospital-based quality. Obviously professionals should be involved but they shouldn't have the whole say.' (Marketown -5)

Some Trust's factors went further and represented a much broader devaluation of management in relation to quality activity:

'Putting management in charge of quality in the Trust hinders rather than helps. People just see it as a management thing' (Castletown +5)

There was also a rejection of some of the managerially-initiated structures and processes associated with quality:

'Having directorates and divisions means that managers and professionals work together for quality and that has to be good.' (Castletown -5)

'The paperwork that we have to collate as a result of the purchaser interest in quality doesn't achieve anything in terms of the quality of clinical care.' (Castletown +4)

But this anti-managerial stance was not universal; and as a force for the reduction of conflict, quality activity was viewed positively by those subscribing to these factors:

'Quality creates more headaches than it solves. It gets people's backs up and makes them worry unnecessarily about the way they work. It creates more aggravation between doctors, nurses and managers than it cures.' (Shiptown -5)

'Quality has done next to nothing as a means of improving the relationships between the clinical groups and especially management and professionals. Its just a focus for more bickering over money.' (Shiptown -4)

'Quality standards, forums and quality stuff like that are just an excuse for consultant bashing. Quality causes more arguments than it solves.' (Castletown -4)

Despite the factors' emphases on professional autonomy in relation to quality activity there was a pronounced rejection of many of the statements painting 'consumerist' issues of information provision and 'voice' in a negative light. But in each of the factor's there were boundaries to this enthusiasm:

'I don't think there is any benefit to services from asking patients to constantly question what we do to them all the time.' (Castletown -4)

'I think there is a danger in letting non-professional groups take control of quality in services. You need the knowledge and skills that come with being a doctor or a nurse to really understand a service.' (Castletown +4)

'We call it the patient focused approach but its not as if patients actually lead the whole process, I think if we are to really give people what they want then it should be patients or consumers who take the lead.' (Fishtown -4)

'Its important that we allow professional groups to keep control over the issue of quality if it is to benefit services in the long run.' (Fishtown +5)

'If you give patients detailed information on quality in the Trust, first they don't know how to use it and second, you just ask for trouble with more complaints - just look at the Patients Charter and all the hassle you get with that.' (Shiptown -4)

'Quality in professional work is a professional issue. Its up to us to decide what quality in our work is' (Shiptown +4)

The Managerialist Alternative

The notion that professional groups should be largely self regulatory in quality activities is countered directly by Factor Two in Marketown. Of all the factors derived

from the case sites this was the only one which equates with a 'managerial' approach to quality as portrayed in the theoretical typology utilised thus far. The factor's strongest rejection was concerned with the issue of professional autonomy and leadership:

'Quality is about leaving it to the health care professionals on the ground because they know how best the job should be done' (-5)

'Most health care professionals know good quality when they see it. Its part of being a professional that they already provide good quality care.' (-5)

'Quality can be a good thing if, as professionals, its left to us to set the standard we are judged by...after all we are the ones with the specialist knowledge.' (-5)

'Hospitals are about providing care and treatment, and its the professionals that do that isn't it....so it should be professionals that drive the process of quality improvement in a trust.' (-5)

There was a strong positive valuation however for the idea that quality is best served through alliances and partnerships based around attaining a common culture:

'Quality is about having a culture where everyone is linked together with a common aim of doing the right things at the right time by getting the processes right.' (+5)

'Linking managers and professionals together in the Quality Improvement Teams in each directorate has gone a long way in promoting quality standards and attitudes that are sensitive to each directorate's priorities rather than those of the management executive.' (+5)

Given the rejection of professional autonomy and the valuation of shared cultures and Post-Fordist autonomous management units (clinical directorates) and techniques such as TQM-teams, the overall feeling of this factor is one in which an *active* management role in quality is seen as essential. This is reinforced by the weightings

attached to those statements which have, at their core, the degree of managerial intervention:

'Quality is about meeting the customer's requirements through a concentration on actively managing the processes of service delivery.' (+5)

'Management should deal with recalcitrant professionals, one skin nailed to the door in the name of quality would soon get people to play along and take notice.' (+5)

Interestingly, of all the factors that emerged from the case sites this was the only one which could most be seen to be relatively firmly defined along 'tribal' demographic lines. Of the fourteen people's Q-sorts which defined this perspective twelve were either general managers or nurse managers (there was also a nurse and a CHC member). This factor was also significantly ($p < .05$) different to the other factors in relation to the question of complaints. This factor agreed with the statement which suggested that complaints as a feature of evaluation would:

'...encourage more complaints from those difficult patients and their families. Consumers don't always know what they want from services so using them to make judgements about them just gives you a misleading picture.' (+1 factor two, -4 factors one, three, four, five)

The 'Middle Ground'

Factors three and four in Marketown and Shiptown do not sit easily in the organisational-cultural categories used thus far as analytical reference points. Both these factors do not easily 'fit' into a tribal typology of quality. Each, however, differed significantly (± 4 points on the -5 through +5 scale) in a number of key areas and also in the general 'tone' of the factors. Factor three in Marketown and Factor four in Shiptown were generally quite negative in the perceptions of quality activity:

'Part of the reason that there are so few doctors on-board in terms of quality is that the TQM thing and the people that run it just lack credibility...if you're not credible in the NHS and don't know what you're talking about then people won't respect you.'
(Marketown +5)

'Quality has done next to nothing as a means of improving relationships between the clinical groups and especially management and professionals. Its just a focus for more bickering over money.' (Shiptown +4)

The other two 'middle ground' factors in these sites were generally more positive:

'Quality creates more headaches than it solves. It gets peoples' backs up and makes them worry unnecessarily about the way they work. It creates more aggravation between doctors and nurses and managers than it cures.' (Shiptown -4)

'TQM and quality promotion generally has been a good thing in that its got people from different professional groups talking together and reduced all the conflicts that go on in clinical teams.'(Marketown +5)

There is little, if any pattern, to the responses along ideal-typical 'tribal' lines. Each of the factors simultaneously stress apparently conflicting groups of values:

Factor three in Marketown simultaneously stresses the desirability of managerial leadership in quality issues and the normative value of professional self determination of work processes:

'managers shouldn't have to wait for professionals to come on board in relation to quality. I think a stronger managerial hand in the issue would be advantageous all round.' (+5)

'Quality rests on solid measurable outcomes. The process behind those outcomes should be professionally determined; you can't have a good outcome with a crap process...but the quality people don't seem to realise that.' (+5)

So Where Does This Leave 'Tribal' Quality?

Obviously the results do not paint a straightforward picture of tribal delineation in relation to perceptions of quality activity. There appears to be a *prima facie* case for arguing that at least some of the factors have the group members that one would expect in terms of the interests the factor apparently most favours; for example, the 'managerial' factor in Shiptown, with its emphasis on strength for and through 'management' as a positive factor in organisational quality activity. Similarly, the lack of a managerial presence in the anti-managerial, consumerist factor of Castletown. But then again other perspectives appear to be defined by people who, if the factor was a basis for group action, would apparently harm their interests. This is particularly the case for the consumerist factors which all allude to a greater say in, and control over, services for patients as a desirable feature in quality activity. These factors obviously have consumer representatives aligned with them but also nurses and managers. Conversely, the 'professional' perspectives of Fishtown and Shiptown were all defined by the similarities of consumer representative's Q-sorts to their professional and managerial counterparts. The 'tribal' typology advanced thus far has (apparently) broken down at this point. However, closer inspection reveals this may not necessarily be the case.

Going Back To Questions Of Organisational Ideology and Interests

One of the fundamental underlying assumptions of Q-methodology is that people will always advance a point of view from a position of self reference¹. The positions of self reference which informed the Q-samples were the areas of interest-divergence associated with the interface between quality activity and the organisational cultures/ideologies of professionalism, managerialism and consumerism. What the results appear to suggest is that the *de facto* association between being a professional by virtue of your *professional* role as a nurse in the organisation and an ideal-typical professional-tribal stance on quality activity does not exist. Moreover, the results also suggest that you are quite willing to relinquish position and expert power in favour of consumers. However, when the notion of organisational ideology is unpacked it can be seen that ideology is not:

*'some tightly defined package of items, each one of which will be clearly and firmly held...Ideologies are much looser, messier and more contradictory creatures than that. They may be firmly or weakly adhered to by particular individuals. Some elements may be rejected while the remainder of the 'package' is, however inconsistently maintained.'*²

Given these ideological characteristics it is quite reasonable to suggest that what the Q-results portray are the rejection and maintenance (albeit inconsistently) of ideologically influenced stances on quality activity. If it is accepted for a moment that the Q-sorts of groups do represent loose forms of 'tribal' quality stances then this inconsistency actually tells us something about those stances. Beckford³ highlights the issue with the example of the almost infinite possible responses to the question, 'why are those people dancing?' Two possible answers are put forward: the first, in a native American context, is 'to make rain'; and the second in a British ballroom, is 'to win the Come Dancing Golden Sequin Tango Award.' Beckford's point is that these responses are given with reference to the credibility they will be afforded in the society in which they are located. What this means for the analyst is that:

*'...in both cases the accounts may be incorrect. The real motive of the actors in the first case might be to reinforce tribal mores, and in the second case the dancing couple may be trying to engage in surreptitious sexual dalliance. However...there is no question that [the accounts] could only have been given in very different sorts of societies. The sociologist has learned something about the respective societies by discovering that these are what **could** count as an account in these societies.'*⁴

So from this perspective the accounts given by nurses and managers which seemingly portray their stance on quality as a consumerist one (i.e. they positively value 'freedom of information', 'voice in the system for consumers', 'greater control over services' and other 'consumerist' messages) are provided because that is what could count as credible in their organisational cultures. This in turn suggests that some ideas are seen as more credible and appropriate than others.

If the proportion of variance explained by each of the factors is examined it can be seen that the ‘consumerist’ factors (factor one in Marketown and Fishtown; factor two in Shiptown; and factors one and three in Castletown) constitute the significant themes within the Q-sorts for each site:

all figures are %	Consumerist	Professional	Managerialist	‘Middle Ground’
Marketown	35.4	8	15.5	10.1
Castletown	54.2	12		9.7
Fishtown	43.3	21.7		
Shiptown	35.7	11.4		15.8

Table 1: *Proportion of Variance Between Q-Sorts Explained by Factors.*

Perhaps, this is not surprising; the idea of putting the patient’s interests before one’s own is central to the ethical codes of both nursing and medicine. Both nursing’s code of conduct and medicine’s Hippocratic oath - whilst expressed very differently - both have at their core the primacy of the individual:

‘[In broad terms nurses will]...act in such a way as to safeguard the interests of individual patients and clients, serve the interests of society, justify public trust and confidence, and uphold and enhance the good standing of the profession.’⁵

‘I will follow that method of treatment which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous...’⁶

Moving beyond the ethical dimension, there is another argument that can be expressed as part of the rationale for the apparent strength of consumerist-type perspectives on quality activity. Namely, that consumerism represents some form of ‘moral currency’ in the current NHS. As the thesis showed in Chapters Two and Five, policy-makers since 1979 have made increasing recourse to the ideas and language of consumerism in their efforts to restructure the power relations of public services (via its incorporation in the process of managerialization). Success is measured partly by services progress towards consumerist goals of choice, voice, participation and

satisfaction. So from one perspective stakeholders in the NHS have a very simple incentive to be seen to 'be doing the right thing'. That is, apparently aligning themselves to a consumerist vision of services.

Using the conceptual lens of structural interests outlined earlier it is in provider's *interests* to be seen to be aligning themselves to a consumerist vision of services. The question of interests in this regard is implicitly linked to power. However, the pursuit of interest always has the potential to create winners and losers and one must ask, in relation to that activity which labours under the banner of quality, who really gains the most: the providers or the consumers?

The position of trust which the ethical commitment of individual professionals make, and the moral capital which they hold as guardians of the consumer interest, mean provider organisations and the professional groups within them gain much of their power by encouraging a sense of synergy between their interests and the consumer population. From the consumerist's perspective a service which purports to be incorporating within its quality strategy the release of information on services to community groups; choice for individuals, and formal more accessible means of redress, goes some way in meeting his or her value-based needs for these characteristics. However, the service also gains from this sense of synergy. More specifically the cultural groups within the services stand to gain from capturing the 'moral high ground'.

In appearing to further the consumer interest, professional groups are offered the opportunity to reinforce their positions of expert and position power in services. Both these types of power (especially the tag of expert) depend, in part, upon the 'granting' of the status by others - including consumers. The tag of expert is a powerful force in gaining societal status and once attained can assist greatly in the struggle to control the features of daily life in the organisation. As Abbott points out:

'A jurisdictional claim made before the public is generally a claim for the 'legitimate control of a particular kind of work. This control means first and foremost a right to perform the work as a professional sees fit. Along with the right to perform the work as it wishes, a profession normally also claims the right to exclude other workers as deemed

*necessary, to dominate public definitions of the tasks concerned, and indeed to impose professional definitions of the tasks on competing professions. Public jurisdiction, in short, is a claim of both social and cultural authority.'*⁷

However, there is a sense in which if consumers are overly empowered with information and the means to challenge professional groups then the balance of power will swing in their favour and away from professionals. The task then for groups is to control the activities which lead to people having an interest and to suppress those which might challenge professional power.

So the question now can be recast as 'can the apparent dominance of consumerist ideas in the self-referent accounts of people's stances on quality activity be taken as 'real' in the sense that they will be the basis of action? The problem here is that the next chapter will argue (with reference to qualitative interview and observational material) that it cannot. The overriding picture in all of the sites was of structural boundaries to the attainment of consumerist ideals. Exclusion from key meetings; the control of agendas by professional and managerial groups; blocking of information and subtle strategies of confusion and alienation in meetings were all features of the actualisation of quality in the sites studied.

Power To Control The Cultural Incursion

One explanation of the reasons why professionals and managers, who are the more powerful groups vis a vis consumers, in services might portray an alliance to cultural stances which may in the long term threaten their respective power bases is that their existing levels of power allow them to control the implementation of ideas derived from them. The apparent adoption of ideas from other cultures and absorption into one's own is not necessarily a tactic for the imminent demise of the culture; particularly if the cultural group doing the adopting is a powerful one. Pollitt highlights how ideas of managerialism have made incursions into professional work but may not necessarily threaten it:

*'Doctors, teachers and social workers had their own practices, and their own professional cultures. The prospect of 'outsiders' refining their goals, streamlining their professional decision procedures and inspecting their 'feedback' was not an overwhelmingly attractive one. If, however, specific borrowings could be kept under the control of the profession concerned, then that would be a different matter...'*⁸

The argument relates specifically to managerialism, but logic dictates (given that they both constitute ideologies) that the salient features could just as easily relate to the adoption of consumerist ideas into other group's cultures. Certainly there appears to be a degree of 'selectivity' in the factors; the middle-ground factors in particular appear to portray a 'bounded' picture of meeting the consumer interest through quality activity. For example, in Marketown factor four strongly rejects the idea that information on 'quality' given to outside groups constitutes a means for attacking provider groups:

'By giving information on quality to outside groups, like managers and the CHC we are just giving them a stick to beat us with' (-5)

At the same time it equally strongly rejects the idea that audit results should be released to the same community:

'We should release audit results to the community at large as an impetus to improving the quality of our services.' (-5)

Similarly in Shiptown factor one (the 'professional' factor) feels that audit and the confidentiality that accompanies it is the route of choice for promoting 'quality' in professional work:

'I think audit within the profession is the most effective way of promoting quality within our work, people take notice and take part when they know its confidential.' (+5)

Yet at the same time they accept that information on quality should be released to 'customers'. There appears then to be a split between information on quality and

information relating to professional work gleaned from audit:

'Managing information is management - therefore information is quality. I don't have a problem with giving information on the quality of our service to customers or with receiving information that helps us plan for quality changes.'(+4)

Supporting The 'Opposition'

Whilst it is easy to see, in the context of public services, why stakeholder-groups would express preferences for value-stances which portray them as actively promoting the consumer interest (proto-supporters in the parlance of Williamson⁹). What is not so clear is why consumers or managers would align themselves with a 'pro-professional' viewpoint; or why nurses or consumer representatives would adopt pro-managerialist perspectives on quality activity. Obviously it would be difficult to see how aligning oneself to a value stance which appears to favour managerial or professional group-interests constitutes any form of increase in 'moral currency'. From within the current theoretical framework the conventional argument would be to suggest that it is because it is in their interests to do so. But how so? There are three plausible explanations:

- That groups manage to control the degree to which the 'absorption' of messages from other organisational cultures impact upon the interests of their cultural group.
- That the efforts of groups (particularly managerial groups) to change the cultures of other groups are having a degree of impact.
- That cultural groups are not a homogeneous entity in terms of the power they possess; because groups are inherently heterogeneous then this degree of 'cultural contamination' will impact upon different members of the same cultural group in different amounts.

Selective Osmosis?

The idea put forward in the last chapter that groups adopt just those messages they can retain some control over, still holds water in this scenario. Whilst not constituting the 'moral high ground' exposing one's cultural group to certain managerially-derived ideas may not be as big a threat as one might suspect. For example, accepting the need for critical scrutiny through something like 'transparent' measures of outcome which was the focus of one Q-statement, may not actually be as problematic as it sounds. If the measures of outcome themselves are professionally controlled then the potential to distort the process in one's interests is certainly present. There was evidence from some of the interviews conducted that outcome indicators were developed in services whose main criteria for selection was that they were simply eminently achievable. One surgical charge nurse in Castletown expresses the issues well:

'Well its like the complaints thing isn't it. We had to come up with four indicators of quality for the ward. We had to put in things like pressure sores but that was no problem because we don't have any or very few anyway because most of our patients are up and about in two or three days and then we ended up with re-admission rates, satisfaction surveys and complaints. But the surveys and the complaints...well if I'm honest were just a laugh...we always have about 98% satisfied or very satisfied and hardly any complaints against the nurses really. Most people are just glad to get out. So no...I can't say that the quality standards we had to agree to were that threatening for us as a team.'
(Surgical Charge Nurse: Castletown)

A Reflection Of The Impact Of Culture Management?

Some of the managers (and a number of professionals and consumer representatives) in the case sites felt that the techniques of quality which they associated with 'management' such as Total Quality Management had exerted an impact on the cultures of other groups. Commonly, people suggested that progress had been slow but was now beginning to show signs of becoming, as one Business Manager in Fishtown put it, 'part of the mainstream of the clinicians' way of thinking about the Trust.'

Having already established that the recasting of patients into 'consumers' is a central part of the managerialisation of welfare and that messages of customer 'choice', 'closeness' and 'sensitivity' are at the heart of the new 'Post-Fordist' schools of management, it comes as no surprise to recognise that it is seen as part of the management function itself to be seen to 'shape' the values of other cultural groups. As the gurus of the 'excellence' school of quality put it:

*'Even management's job becomes more fun . Instead of brain games in the sterile ivory tower, its shaping values and reinforcing through coaching and evangelism in the field - with the worker and in support of the cherished product.'*¹⁰

If the power of groups (especially professional groups) includes the power to 'absorb' those elements that it can accommodate and use for its own ends, then any notions of managerial 'success' in preaching *their* version of quality can be questioned. However, it is clear that certain managerial 'messages' enjoyed the status of universal consensus within at least some of the sites. For example, was it a coincidence that in each of the factors in all three TQM sites quality activity was seen as needing to be 'corporate' in nature and based around ideas of common goals, aims and language?

Quality is about having a culture where everybody is linked together with a common aim of doing the right thing at the right time by getting the processes right (Marketown +2, +5, +2, +5, +3).

Quality needn't necessarily be a focus for aggravation between nurses, doctors and managers. It can be used as a means of getting everyone talking the same language and moving towards common goals. (Castletown +4, +2, +3)

Trying to manage professionals through quality techniques doesn't work. They don't take it seriously and we [managers] speak a different language (Fishtown -1, -1)

A Question Of Power?

One of the prominent findings of the qualitative interviews and observations conducted in the case sites was that nurses were far more 'managed' than medicine in respect of quality activity. It was nursing activity which was the primary focus of the clinical elements of quality activity rather than medical work, and it was nursing who lacked the ability to reject the imposition of quality ideas and techniques from other groups (especially management). This pattern is not new and a number of authors have recognised that 'quality' activity is far from all encompassing. In particular the word 'total' in Total Quality Management appears to be something of a misnomer given the power of the medical profession to opt out of involvement in the corporate totality of quality management^{11 12}. The idea of medical staff opting out is something experienced in this study. In only two of the case sites could doctors be persuaded to take part in the Q-sorting exercises. This was despite a Chief Executive's letter backing the study and support from the heads of the respective quality hierarchies in each Trust - in three of them a Director of Nursing.

Speaking of nursing and medicine as a homogenous entity - that of the profession - is perhaps misleading as there are a number of factors which make them very different; social status, salary and autonomy controlling work practices are just three. But it is the relative power to defend themselves from the involvement of managers in their 'professional' spheres of activity that most distinguishes them. For medicine, clinical freedom and professional autonomy are necessary for the execution of treatment itself and well established. For nurses, these values constitute the goal or end point of the 'professionalisation' project they are currently embarked upon^{13 14}. This does not mean that doctors are not 'managed'; but refers instead to the differences in the models of management that nurses and doctors work within. Both senior nurses and doctors organise, monitor, and regulate the work of junior members of their respective professions; and they each organise patients. Finally, both groups organise and monitor the workings of each other. This is done formally in the ways in which medical staff organise admissions and treatment (which in turn impacts on care) and informally, in the ways in which nurses 'steer' doctors towards decisions they might not have made otherwise¹⁵. Medical management, however, is still predominantly a

medical matter. Nursing, meanwhile, is characterised by closer involvement in clinical work from general managers and a more defined managerial hierarchy within the profession itself with the presence of nurse managers and a more prescriptive code of conduct laid down by the profession's governing body.

The differences then can be seen to relate, not just to the impact of *management*, but to the impact of general *managers* on the shape of the professional working day. Nowhere is this more evident than in relation to quality and specifically the question of professional models of audit. For medical audit the principles of peer review, confidentiality and educational purpose are paramount. But for nurses the idea of mono-professional audits have been characterised by factors which amount to a greater degree of linkage between management and the profession. As Harrison and Pollitt point out [within nursing audit systems...]:

- *'There has been less concentration (though still some) on issues of membership of committees, rules of confidentiality, etc. and more on the exact, step-by-step procedures to be followed in carrying out the audit.'*
- *The detailed products of nursing audit have frequently been made available to management.*
- *...much nurse quality assurance has been introduced and run by nurse managers rather than (as in the case of medical audit) by nominal 'peers'.*
- *Some (not all) of the methods used make specific references to the need to consult patients and take heed of their views and preferences.'*¹⁶

So in relation to the area of defining and evaluating 'quality' in professional work - which is the focus of audit - significant differences in the role of management between the two professional groups exist. Specifically, it would appear that nursing's power to resist managerial involvement in shaping the tone, design and uses of quality activities and the data they generate is lower than that of medicine.

However, differences between the professions also extend to the degree of homogeneity within the professions themselves. The professionalisation project of nursing has led to a situation in which the profession is being split into those who are

seen as more 'professional' than their peers. Current plans for specialist nurses to have their status as specialists recorded on the professional register are of concern to some commentators¹⁷. The introduction of Project 2000 has led to a sense within the profession that a highly trained 'elite' cadre of Registered Nurses is being created at the expense of those less well qualified¹⁸. It is not clear what extent the management of this new 'elite' nurse will take and whether nursing as a whole will manage to 'colonise' and consolidate its own new management strategies; or even extend them into the medical sphere through Clinical Director positions. But it is clear that to speak of the profession of nursing as a closely knit band of workers all united in similar values, ideology and levels of power is a little simplistic.

It follows then that the apparent lack of uniformity in nurses shared subjectivities around quality activity may well be due to the lack of uniformity in the profession itself. Following this line of argument one would expect nurses to deliver different accounts, they are not wrong, or correct, or ideal-typical, 'professional' responses but they count as credible accounts in the context of a pluralistic view of the notion of the profession.

Conclusion

Q-method is undoubtedly a powerful technique for mapping the structure and form of shared subjectivities between individuals and within groups. However, what this chapter demonstrates is that *a priori* links between occupational role, organisational-ideology and stances on quality activity are not as clear cut as one might suppose, especially when derived from the literature alone.

The factors (or self-referent stances) that emerged certainly have a 'flavour' of the viewpoints expected from social actors along the lines of the 'professional', 'managerial' and 'consumerist' typology deployed thus far. However, the demographics of those groups who define these viewpoints mean that in one respect at least - the occupational composition - the thesis falls flat.

To reject the typology at this stage would be premature however; as indicated in previous chapters, the language, ideas and techniques of competing organisational ideologies are eminently capable of being used (and abused) by groups not immediately associated with the values they promote. A useful example here includes the incursion of managerial language and techniques into professional life: medical *audit* being the exemplar used previously. But managerial-professional is not the only cross-boundary flow in place; consumerist language is part and parcel of both managerial and professional life. Moreover, even the language and claims associated with professional groups (such as greater autonomy) have emerged as a rallying call for the 'new wave' managers of the 1990s, in the form of claims for a 'right to be free to manage'.¹⁹

It should come as no surprise then that degrees of cultural 'cross-pollination' exist in the accounts that people present through their Q-sorts. This chapter has argued that groups present accounts that count as credible within their cultural groups. This credibility is borne of groups' abilities to absorb and shape ideas and techniques which, whilst ostensibly a threat to their interests, can be used to further them. The example *par excellence* here is the idea of auditing one's professional practice; which whilst derived from the world of management, manages to retain the professional virtues of self-regulation and confidentiality.

In as far as the messages seem to be 'getting through', then the claims of groups to be influencing the cultures of other groups are sustainable. However, this ability to influence groups is dependent in part on the power of the groups one is seeking to affect. The relative variability of nurses in respect of the factors may, according to this logic, represent their relative lack of power to prevent the ideas of other groups (particularly management) from influencing them. Moreover, nursing as a cultural group highlight the diversity attached to questions of cultural influence. Nursing in particular has a series of separate roles and sub-divisions; nursing can encompass the managerial role of nurse-management, yet at the same time the label includes nurse specialists: those at the forefront of nursing's professionalisation project and attempts to legitimate nursing's perception of its skills and knowledge as special and unique.

When viewed solely from a Q-statistical perspective the links between occupational groups, organisational culture and self referent stances on quality appear tenuous. With little in the way of conclusive evidence to steer the researcher towards rejecting or accepting any of the theoretical propositions developed thus far. It is at this point, however, that the strength of adopting a multi-method approach to data collection and analysis becomes clear. The qualitative data derived from Trust documentation, interview and observation all paint a far more delineated picture and one that is more firmly 'tribal' in its composition. This is the focus of the next chapter.

CHAPTER SEVEN: STAKEHOLDING AND QUALITY - THE RESULTS OF A CROSS-CASE ANALYSIS

This chapter argues that occupational grouping alone is an inadequate framework for understanding the apparent differences in the perceptions and social action of groups around the issue of quality in services. It proposes an analytical framework based around four contingent types of 'stake' in quality; each seen as influential in shaping a person's approach to actualising quality in the case sites examined:

- *occupational based group*: i.e. nurses, doctors, managers and consumer representatives.
- the individual's *position in Trust managerial, clinical and quality hierarchies*.
- the individual's *personal stake* in an element of the Trusts' *quality strategy*.
- the individuals *position in the local internal market*: i.e. whether they were involved in the provision or purchasing of services or represented the users of those services.

The chapter paints an overall picture of the issues associated with actualising quality: a picture characterised by variable degrees of conflict. The groups of stakeholders above comprise the participants in that conflict, but the primary research interest is the structure and composition of that conflict. The chapter shows how conflict between these groups was focused on eight key areas:

- preferences for actualisation
- defining quality
- evaluating quality
- information: its use and abuse
- the market and quality
- the structures of quality
- leading the process

Finally, the chapter shows that the structures and processes associated with quality in each Trust constitute both the settings for the conflict and one of the key outcomes of the processes of negotiation, control, conflict and concession associated with the concept in services.

On Stakeholding And Differentiation

*'Organizations are not machines...they are communities of people and therefore behave just like other communities. They compete amongst themselves for power and resources, there are differences of opinion and of values, conflicts of priorities and goals. There are those who want to change things and those who would willingly settle for a quiet life. There are pressure groups and lobbies, cliques and cabals, rivalries and contests, clashes of personality and bonds of allegiances.'*¹

The terms stakeholder and differentiation are not used lightly. By using the term stakeholder the chapter acknowledges that NHS Trusts, like all complex organisations, have organisational groups present in them who have a stake, or vested interest, in organisational issues, technologies and techniques. These interests include the concept and application of quality in public services. The potential for competing interests in services (for example, between those of managers and professionals) means that the goals of such groups have the potential to be divergent. This internal goal diversity has been termed differentiation²; recognising and pulling together this differentiation is seen as one of the key functions of organisations³. The examination of this differentiation is crucial to understanding the ability of quality, as the concept behind a distinct set of organisational techniques, to impact upon the work of the constituent parts of an NHS Trust's workforce.

On The Structuring Of Stakeholders In Relation To Quality

The study initially sought to explore the proposition that an individual's perception of quality activity would be heavily influenced by membership of one of the broad occupational groups in services. Consequently, initial sampling was on the basis of the occupational grouping of informants. However, it quickly became obvious that such a simplistic framework would

prove inadequate given the multidimensional nature of the struggles which individuals within the sites were describing. This does not mean that people made no reference to membership of an occupational group in describing conflicts and patterns of reaction to quality activity. Commonly, participants in these struggles made implicit or explicit reference to membership of a group as an influential factor in their reactions and views. This was an especially prominent feature of the transcripts proffered by professional stakeholders. For example, one senior nurse in Fishtown told how she and her colleagues in a surgical division had struggled to come to terms with managerial involvement in something which they felt had previously been a part of their clinical practice:

*'its not like we didn't care about quality before [the introduction of TQM principles into the Division]. Quality has always been an important part of being a nurse, you know doing the best for the patients and being accountable, but it did take us, as a group of Sisters, a long time to get our heads around the idea and what we had to do... Involving [the Quality Advisor] was our Divisional Manager's idea and one which we didn't fancy at first... you know exposing all our faults to someone who wasn't a nurse and everything. But it was obvious pretty quickly that we didn't know what we were doing, so we didn't have a lot of choice. It wasn't easy though, there was a lot of worrying about it.'*⁴ (Ward Sister: Fishtown)

Initial analysis and coding of interview transcripts, reflective notes and *aide memoirs* taken from each site quickly established that organisational differences of opinion were characterised by a variety of groups:

First, occupational stakeholder group. There was evidence to suggest that how one perceived and acted regarding the concept of quality was affected by the occupational group to which you belonged. This was as expected from the literature and the theoretical assumptions made prior to beginning the fieldwork. Groups such as doctors were heavily concentrated in the work of audit departments and had developed and maintained *their* medical audit structures which were separate from the clinical audit structures dominated by nurses and therapists. Similarly, there was a central band of quality activity which was heavily orientated towards ideas of quality assurance and quality management. This was sponsored by the central managerial structure of the Trusts and had little medical involvement.

Second, the position an individual occupied in the managerial and quality hierarchies within the Trust. Disputes around quality and quality activity also centred on the views and actions of groups of people located in the senior, middle and lower levels of the professional and managerial hierarchies. Accounts from the higher levels of the organisation (such as Directors of Quality and Chief Executives) tended to stress the organisational benefits of quality techniques and initiatives in terms of cultural change and improved organisational and user outcomes such as cost and user satisfaction. Whilst accounts of experiences of quality activity derived from the lower end of the organisational hierarchy saw quality as something which often was imposed from above and which exerted a negative effect on organisational outcomes such as staff morale and the sense of stability necessary to run a service.

Third, within both of these groups there was a further split between those who had a direct stake in the success of elements of a Trust's quality strategy and those who experienced it simply as participants. The key example here is with regard to the struggles that the two Clinical Audit Directors (both doctors) in Marketown and Shiptown described in trying to persuade their medical colleagues to play a greater part in an organisational stance on clinical audit as opposed to a purely unitary strategy of medical audit. Commonly, the greater the individual's stake and level of contact with the strategy then generally the greater the levels of enthusiasm for the mechanisms in place.

Finally, the local purchaser-provider split provided a powerful force in shaping people's perceptions and actions around quality. Some of the activity occurring in local markets did not fit comfortably with the ideas of competition, raised quality and efficiency encompassed in the spirit of the reforms. For example, one Purchaser had recently 'moth balled' its quality department; and all three purchasers expressed the view that while quality was important they were not in particularly strong positions to influence the concept at the provider end, despite a wish to do so.

Essentially these groupings provided the participants in the organisational conflicts that surrounded quality and its actualisation in services. Conflict has been described by Coser as:

*'A struggle over values or claims to status, power and scarce resources, in which the aims of the conflicting parties are not only to gain the desired values but also to neutralise, injure or eliminate their rivals'*⁵

As the chapter progresses it will be seen that quality constitutes a domain *par excellence* for observing just such a struggle between groups. Moreover, that they sought to utilise claims to status, power, or scarce resources as part of this struggle was a dominant thread within the analysis. The idea of neutralising, injuring or eliminating rivals is something which might concern the reader at first glance; however, in the context of the modern organisation, it can be argued that such terms are not as misplaced as they might first appear. The tactics may be more subtle and less overt than the language might suggest, but the end results, in an organisational context were analogous to these ends.

What the chapter, indeed the thesis as a whole, represents, is a study in a disputed concept's application and the conflict-based nature of the social action that accompanies and defines it in the NHS. In order to develop this argument it is necessary to explore the boundaries of the struggles observed in the case sites and more specifically the conceptual areas they dispute.

Preferences And Operationalising Quality

The immediate impression that strikes the researcher examining the make up of the different elements of each Trust's quality strategy is the grouping of people from similar occupations and with similar interests around particular techniques aimed at promoting quality. This was to prove a key finding as it was the political decisions made by groups in choosing or participating in techniques to promote quality which were to prove the key to defining the areas of greatest conflict between the groups of stakeholders in the Trusts.

Of all the groups interviewed the one that had the firmest ideas of which approach was right for them (indeed there were no negative cases) were the medical consultants. They expressed clear preferences for existing methods of peer review and either mono-professional audit or clinical audit with clear boundaries on what should be examined:

The reasons why centred on:

- *'The need to retain confidentiality'* (Surgeon: Fishtown)
- *'why not? Its clinical work it should be clinicians who review it?'* (Obstetrician: Fishtown)
- *'It works well so why change it?'* (Surgeon: Castletown)
- *'It was developed by the profession so it works for the profession, other approaches don't do the job as well.'* (Obstetrician: Shiptown)

The initial theoretical typology suggested that members of occupational groups would express a preference for those techniques which best 'fitted' the organisational cultures with which they were associated; this was not the case, the interview data revealed a mixed picture of preferences regarding the best way to operationalise quality:

Nurses who strongly favoured TQM because:

'The way it is structured within the Trust means that divisions and directorates get more say over what gets done and how. Also because the doctors tend not to get involved there's more of a focus on nursing issues rather than them just taking over...don't get me wrong I'd rather see them working with us, but it is nice for a change.' (Staff Nurse: Marketown)

'EFQM is good for nurses because, as a framework, it recognises our contribution to patient care. You can't run a ward without nurses so its good to have a tool in place which notices us. We have our own ways of doing things and our own views, we're not mini doctors, we are separate and I think the EFQM sees that...so on the whole I think its good.' (Staff Nurse: Fishtown)

CHC Chairs and Chief Officers who favoured clinical audit:

'Because no matter what we do they're never going to let us in on everything so its better to stick with something that actually has some impact on clinical care than go with this constant tinkering around on the margins.' (CHC Chief Officer: Shiptown)

Perhaps most surprisingly, managers who favoured clinical audit for similar reasons:

'I've tried for the last five years to get them (the consultants) to take quality seriously but its like banging your head against a brick wall. So I've reached the conclusion that I'm better off trying to encourage them to do audit and build up trust that way. Eventually I think they may allow me in to every meeting and to get at the findings...in fact its already happening to an extent. But whichever way you look at it if they don't want to know they don't want to know and as it stands there's not a great deal I can do about it.' (Divisional Manager: Marketown)

From these accounts it is clear that the notion of interests has a role to play in understanding the informant's viewpoints. What each of these accounts shares is a recognition that in order to pursue one's interests sometimes it is necessary to accept techniques that may 'go against the grain' of the cultures to which they are associated. So for the nurse used as an example above, the idea that TQM assists in enhancing nursing's contribution to services and nursing's ability to control its work is a positive influence on her expressed preference. Not because the type of quality promoted by TQM (excellence) fits with her world view, but that TQM becomes the means to more important ends.

However, interview was only part of the social action through which preference is expressed. Action relating to preference was best observed through the composition of key committees, working parties, and other fora relating to elements of the Trust's quality strategies. At this level the picture was far more easily discerned, and once again it was the notion of interests rather than because it fitted with the broader cultural group to which you belonged played a part which proved influential.

A useful way of conceptualising the key arenas in each of the Trusts' quality strategies is by placing them at a number of levels and examining the composition of groups at each of these levels.

Observed Delineation In Participation

The Level Of Quality Strategy Formation

At the highest level of strategy formation, usually made up of Executive Directors (such as the Executive Management Group in Fishtown and the Central Quality Committee in Shiptown), then it was clear that all the major occupational stakeholder groups (from within the Trust) were represented - nurses, management and medicine. Purchaser and Consumer representation at this level was absent; the emphasis was on promoting the interests of the organisation as a whole and a common theme that emerged was that these could only be pursued by restricting the group to 'insiders':

'the Central Quality Committee is where the real business is done. Its where we try and tie quality to the business plans and goals of the Trust its more about business than the nitty gritty of quality. We don't include [the purchaser] or the CHC because its where myself and the chief exec air our cock-ups and it can be sensitive stuff...so it wouldn't do to let them in at that level.' (Director of Nursing and Quality: Shiptown)

The Overseers

At the level of deciding which techniques were actually used to pursue broad Trust quality strategy the multi-disciplinary nature of the strategic committees begins to breakdown and managers and nurses begin to become the dominant players. It is at this level that consumer and purchaser representation becomes more of a feature of group composition. This tier was typified by the Quality Core Group in Shiptown, and the Quality Steering Group in Castletown. In the two groups in Castletown and Shiptown no medical personnel were on the membership lists other than (in the case of Shiptown) the Chair of the Clinical Audit Committee. Who was there as a link with clinical audit rather than as representative for the medical profession within the Trust.

Audit structures could reasonably be included in this layer of each Trust's hierarchy. Each of the Trusts visited had both medical and clinical audit structures in place; and while purchaser,

sometimes CHC (as in Castletown), and multi-disciplinary involvement, was the norm for the Clinical Audit Committees, the same could not be said of their medical audit counterparts. In each of the Trusts the Medical Audit Committee was completely made up of doctors and the purchaser input (where it existed, in Shiptown and Fishtown) came in the form of the Director of Public Health - another clinician. Interestingly, despite being underrepresented in Clinical Audit Committees as a professional group, doctors chaired three of the four Clinical Audit Committees. When the reasons why were explored with informants there were a number of reasons put forward. All of which made implicit reference to the interests of their respective professions.

Nurse Manager: The consultants get money for audit so its in their interests to make sure its spent on things that are relevant to them. The best way for them to do that is to keep the medical audit committee going.

Int: Doesn't the Health Authority money get allocated to clinical audit?

Nurse Manager: Its supposed to but in reality no. Clinical Audit are so weak that most of the money still goes on traditional audit projects. (Nurse Manager: Castletown)

Most of my colleagues feel the time is not yet right to disband entirely the medical audit committee. It is well respected and achieves the aims it sets itself year after year. The clinical audit group are not at that stage yet. (Consultant and Medical Audit Committee member: Marketown)

Int: Do you feel that having a separate medical audit committee excludes other professional groups within the hospital from participating in good quality audit?

Consultant: Let me throw that back at you. I would argue that we don't exclude anyone. Nurses have hijacked the clinical audit agenda and yet are the least well equipped to fully exploit it. They get little analytic training as juniors and they are too easily persuaded by the arguments of the commission and managers. If anything nurses have excluded us as they fear that we might take over. So no we don't exclude other people. We just feel it is an effective way of examining the quality of our work. (Consultant and medical audit committee member: Fishtown)

On the basis of these structures, and the lack of desire in any of the Consultants interviewed to see 'their' audit facility disbanded, it would appear that the policy of promotion of clinical

audit was having only limited success in the clinical professions. Indeed, based on these four sites there is some justification for stating that clinical audit could just as easily be termed nursing and management audit. Medical Audit however, had remained virtually untouched. The consequence of this for many staff was a perception that nursing was the prime focus for audit (and accountability) and that medicine had escaped the scrutiny of a managerial eye once again:

'See its all right talking about clinical audit and all that, but the reality is that our doctors have carried on just doing their own thing. Like we are all supposed to be looking at problems as a team but I can't remember the last one [doctor] who came to an audit meeting...apart from maybe the odd house officer who gets sent because they have a project to do or something.' (Staff Nurse: Marketown.)

This duality raises serious issues given that purchasers are supposed to be developing clinical audit as the sole model of audit in Trusts and funding projects accordingly. Examination of the Audit contracts signed with purchasers for last year reveals that all of the Trusts are still funding a sizeable proportion of mono-professional audit projects. In the case of Castletown this was 20% of the proposed projects to be funded by the local Health Authority⁶. Interviews with Audit Leads also revealed that informal virence was a commonplace feature of audit activity in at least one of the Trusts:

'It's [virence] something we just have to do. Its a case of spending it or losing it. I'm sure [the purchaser] knows that we have to keep supporting just medical audit, but something is better than nothing.' (Audit Co-ordinator: Castletown)

The Level of Implementation

At the level of implementing quality techniques the groups or projects were made up almost entirely of nurses or managers. Of the six Total Quality Improvement Team meetings attended in Marketown none of the participants were medical personnel. This was with the exception of one staff grade clinical assistant doing an MBA in a bid to improve the running

of his General Practice. He even suggested that he had been keenly interested in quality until he started attending the group. Comments from nurses and managers relating to this lack of involvement all drew upon a sense of 'difference' between what consultants perceived as important and the work of the groups:

'They're just not interested in taking part in the Quality Improvement Teams. I think most of them think its all about car parking and the wallpaper.' (Physiotherapist leader and ex Quality Manager: Marketown)

'The doctors used to come to the meetings in the beginning; out of curiosity more than anything else I think..it didn't last long. One of my friends, whose a consultant here, said it was just a 'talking shop', and irrelevant to most of her colleagues.' (Sister: Marketown)

From a consultant himself, the link between participation and the furthering of interests was more specific:

'I've been to the odd meeting but to be honest I don't see what use they are or why they invite me. If there were more resources on the table then it might be worthwhile but as it stands its just a way of introducing bloody silly ideas and psycho-babble into what was quite a successful unit.' (Consultant: Fishtown)

In each of the sites there were a few consultants who had initially participated in 'core' quality activities but the participation appeared to be underpinned by the link to the possibility of increasing access to what they perceived as scarce resources. In Fishtown one Urologist seemed quite keen to be involved with EFQM (unlike her colleagues) but her conceptualisation of the underlying aims and procedures attached to the EFQM framework were almost diametrically opposed to those of the manager who 'sold' the framework to her:

'Yes I was involved in the quality...erm, EFQM - is that right? - thing. Anything that increases the numbers of my nurses is worth listening to. The man from quality seemed reasonable enough and if I am brutally frank it doesn't really affect much of what the girls actually do. Its what happening with the purchasers where the real effects will be felt.' (Consultant Urologist: Fishtown)

'Selling the idea to the consultants was the biggest challenge. Getting the message across that we had to change the way we do things and the ways in which patients move through the system... actually all they really seemed bothered with was whether or not it would cost money that would be taken away from patient care...for the first time since we went Trust I think we are beginning to make real in-roads into the wards...we are having a real impact. ' (Quality Manager: Fishtown)

Thus far this section has argued that one key to understanding participation is the ability of quality to further what you perceive as your interests. However, this assumes that participation in quality is a voluntary exercise. Stakeholder accounts of what led them to participate in quality activity revealed that participation was tempered somewhat by the pressure applied by others.

Personal Choice or Extraneous Influence?

It was clear from interviews that the ability to exercise personal preference in relation to participating in quality was heavily mediated by the exercise of power. How you experienced this process, however, depended heavily on which occupational group you occupied and whether your sphere of influence was outside the immediate managerial hierarchy of the Trust.

The Occupational Dimension

For some nurses participation in quality seemed to be a result of the exercising of Lukes' third dimension of power. Many respondents classed participation in quality almost as an automatic prerequisite of their post and didn't appear to question whether or not it might conflict with their own ideas:

'I don't think its that conscious. I mean you don't really think about it [joining a quality improvement team]. Its just something that comes along and everyone goes oh quality. I mean its like primary nursing and all that. It comes and goes...its flavour of the month now and gone next year. ' (Staff nurse: Marketown)

'My predecessor she started the quality circle and it seemed a shame to just get rid of it when I started...although to be honest I didn't give it that much thought.' (Surgical Ward Sister: Shiptown)

The more distinct line-managerial hierarchy of nursing meant that even where nurses did recognise a conflict with their own preferences the ability to 'opt out' of quality activity promoted from above was not always present:

'At first I didn't agree with the idea of doing more and more standards for everything. At my last unit we had this standards group and it was just a paper pushing exercise. No one really believed it did any good or listened to what they said. But my manager made it clear that I had no choice in the matter.' (Ward Manager: Shiptown)

In direct opposition to nursing, medical staff had established several strategies for resisting managerial imposition. The two most prominent seemed to be a policy of being seen to make an effort but disguising the real lack of enthusiasm; or in the case of one group of consultants in Shiptown, just refusing:

'When they first tried to get us to take part in the [Total Quality] scheme we all nodded sagely and made the right noises. Then we went off and did our own thing anyway. You just don't have the time or the inclination to waste effort on these half-baked schemes.' (Consultant Surgeon: Marketown)

Int: So do you send anyone to the quality core group?

Obstetrician: No

Int: Were you asked?

Obstetrician: Yes. But we politely declined and that was the end of that.

Int: Didn't that rather get their backs up?

Obstetrician: Well they were a bit pissed off. But in all honesty what were they going to do?

It was clear from the interviews though that medical staff weren't above using coercion to promote those techniques which they endorsed:

'I've been pushed into loads of audit projects where you do the work and the consultant takes the credit. Its not just here, all the hospitals I've trained in were like that. They call it delegating.'
(Surgical Registrar: Fishtown)

Where you stood in the hierarchies of the occupational groups you were trying to influence was a significant factor in how you aligned yourself with an approach to quality and to what extent you could exert influence. Senior nurses and managers tended to express preferences for the 'core' activities in each of the sites. Although this could be explained primarily through the fact that their respective occupational hierarchies were inexorably bound up in the hierarchies of the quality strategies and structures themselves. Senior nurses and managers formed the predominant groups at the levels of quality strategy formation and design. Given that each of these groups also had managerial lines of accountability stretching vertically it was easier for them to implement the vision of quality which they selected in the groups over which they had influence. Given that doctors were neither represented fully in these quality-hierarchical positions and that they also have managerial structures which are both flatter and which view colleagues as 'peers' rather than managers *per se* it is easy to see how direct imposition is that much more difficult for the 'core' groups.

The 'Outsiders'

The accounts of those groups of stakeholders from outside the immediate environments of the Trusts (the CHC members, officers and DHA representatives) were characterised by the prevalence of cynicism regarding the rationale behind the selection of quality activity undertaken by the Trusts:

'Everything the Trust has ever done has been just PR since they went Trust.' (Chief Officer: Marketown CHC)

'No I can't put my hand on my heart and say that I believe in the sincerity behind a lot of what the Trust do around quality.' (Chief Officer: Fishtown CHC)

It would be easy to assume the 'consumerist' approaches promoted by Trusts such as Castletown would enjoy the CHC's support. However, the evidence of interviews with the Chairwoman preclude any such conclusion:

'If you take the Patient's Council as an example then I think its a good thing having these sorts of groups in place. But I've been to groups where the agenda is totally dominated by the person leading it. So you have to have a healthy scepticism about you when you look at them.' (CHC Chair and National CHC spokesperson - Castletown)

All the CHC Chief Officers, however, conceded that the new found 'consumerist' approaches being implemented in Trusts had their advantages; if only in that they represented a source of involvement:

'I think the involvement that we do manage with the Trust is better than nothing.' (Chief Officer: Marketown)

'We don't have a lot to do with the Trust on a daily management basis. But what we do have encourages a broader dialogue and more focused efforts on our part.' (Chief Officer: Fishtown)

'By inviting us onto the Quality Core Group it shows that they are making an effort.' (Chief Officer: Shiptown)

Representing the Community Interest?

The area of Trust activity that most concerned CHC members interviewed was the development of the 'quasi advocacy' function for managers that accompanied many of the managerially-inspired 'Total Quality' approaches selected by the Trusts. These were typified by the Patient Representative posts in Marketown and Fishtown. In each of the CHCs allied to these Trusts it was clear that this was seen as a potentially harmful development in the representation of patients/consumers within services:

'The Growth of these Patient Representatives is really worrying. Who do they really represent?' (CHC Research Officer: Marketown)

The difficulties involved in persuading patients, and staff, of the legitimacy of their function within the organisation were also recognised by the Patient Representatives themselves:

'...so I would say that sometimes its hard to please everyone. I know the Health Council think I am...what's the word...erm a traitor or something. And sometimes its difficult to convince staff that you aren't out to get them.' (Patient representative: Marketown.)

Although each representative was intended to be the 'patient's voice' within the system it was clear that at least two of the representatives interviewed did not see impartiality as a feature of their role:

'No I don't think that I have any problem with who my loyalty is to. If I am doing my job right then I please the Trust if I get good results with patients and following up their complaints. But I make it clear at the start that I work for the Trust and can't always be impartial.'
(Patient Representative: Fishtown)

'I'm not impartial, no. How can I be? when the hospital pays my salary. We talk about this as a group and it comes up every month at staff meetings. Its something you have to be aware of and be clear about.' (Patient Representative: Fishtown)

The Executives behind the creation of these posts, however, at least in the accounts proffered to the researcher, were keen to stress this element of the role:

'We funded those posts on the basis that they wouldn't carry favour. We want them to be impartial. Its vital, otherwise why bother.' (Director of Organisational Development: Fishtown)

Each of the Executives were equally keen to suggest that the role of the CHC was not being diminished by the creation of such posts - just 'enhanced' or 'augmented' in order to make the impact of consumer opinion greater. Although, with the exception of the consumer Fora in

Castletown, it was not clear how this was to be achieved other than through the monitoring of complaints, which is where most of the 'patient representation' seemed to be occurring.

Proactive consumer-opinion gathering mechanisms which were qualitative in character, or which allowed consumers to set their own change-agenda, were not a strong element in any of the Representative's work plans. The informants painted a dismal picture of community participation in Trust activity:

Quality Manager: *'We certainly had a erm a real attempt with a group of surgical patients er post experience survey. People who have been through the system and we wrote to them and erm the patients about fifty or sixty of them. We said would you mind coming along to a meeting where your views will be gone into in more detail and we got about twenty odd responses.'*

Int: *'That's quite good isn't it?'*

Quality Manager: *'It is quite good but the day itself was a disaster. You know the numbers trickled down. We tried to do all the things provided a cup of tea and sandwiches and so on and nobody turned up. It is a sad experience but maybe its not unnatural. People get through a health care experience and unless they wish to express something about a particular thing then they'll complain.'*

Int: *'What about using the CHC?'*

Quality Manager: *'We had every intention of involving them. There was an intention to share that information, from the groups I mean, with them...erm but we didn't want to overawe the group that we got initially and we thought they might have found the CHC presence a bit threatening.'* (Quality Manager: Marketown)

Castletown's Quality Manager also acknowledged these difficulties but felt that:

'The most important thing we learned was that if you are going to run fora like these then you have to do it right. Invest time and money in making them a success. We organised transport and confirmation as well as structured feedback and interpreters and stuff as well. They aren't a cheap option but we find them very effective.' (Quality Manager: Castletown)

One perception which united people from different occupational groups, levels in the various quality and managerial hierarchies and those inside and outside the Trusts' workforce, was a recognition that the type of activities carried out as part of a Trust's quality strategy defined the values which one appeared to strive towards and which to all intents and purposes made up the definition of quality.

The Struggle To Define A Disputed Concept

Colloquial Quality And The Corporate Provider

At a corporate or Trust-wide level, definitions of quality tended to be expressed in 'Mission Statements' and corporate slogans. Rarely did these speak in anything other than general terms on quality; for example, Castletown's approach to service provision was expressed as based on '*Partners in Quality Care*'; Marketown favoured '*Treating People Better*'; and Shiptown took a blunter approach in, '*To Be The Best Provider of Health Care In The Area.*' Each of these statements were accompanied by a set of aims for the service. In the case of Shiptown these included statements such as:

'[we aim] to provide services for our patients which they regard as being of high quality, accessible, effective and on time.'

Making The Intangible Tangible: Technical Quality

At the level of quality initiatives and activities specific definitions of quality started to become more explicit. For example, the development of the EFQM model in Fishtown; the Total Quality Management exercise in Marketown and the Kings Fund Organisational Audit exercise in Shiptown were all defined with reference to formal statements; although these were still quite general:

*'Quality in our work can be thought of as conforming to explicit requirements. The organisation's, the customer's and your own.'*⁷

'Customer Satisfaction, People (employee) Satisfaction and Impact on Society are achieved through Leadership driving Policy and Strategy, People Management, Resources and Processes, leading ultimately to excellence in Business Results...each of these elements is a criterion that can be used to assess the organisation's progress towards Business Excellence.' (their emphasis)⁸

Whilst these models had at their core a more explicit definition of quality, the definitions commonly only acted as reference points for the particular techniques and mechanisms taken up by individuals, or groups.

It was at this level - of the Divisions and Clinical Directorates - that the composition of 'quality' was the easiest to isolate. The broadness of the corporate Mission Statements and the general definitions of the formal models adopted were foregone in favour of particular criteria for success. These criteria commonly took the form of goals or deadlines for action; for example, the Quality Core Group in Shiptown required each Division to have completed an 'action plan' based on the findings of the King's Fund Organisational Audit exercise. Quality in this case could be thought of as the level of progress towards the standards required. A number of respondents pointed out that such 'technique-led' definitions, whilst necessary, constituted operational, but incomplete, definitions of quality. They also raised the point that particular definitions of quality were promoted by the various approaches to quality in place in the sites:

'If I ask my staff to define quality I get about fifty different answers so in the end its easier to agree about a particular approach with the staff and use the definition that's built in to stuff like Kings Fund, S.A.S. or whatever. Of course there's always gaps and people can always take issue with the way we go. But on the whole its just easier and more realistic than trying to do it ourselves from scratch.'(Medical Services Divisional Manager: Shiptown)

'S.A.S. encourages a view of quality, you know, like everything has a standard.' (Ward Manager: Shiptown)

The Impact Of Officially Sanctioned Approaches On Definition

Because each of the Trusts differed in the mechanisms used to operationalise quality it follows that definitions of quality implied by, or attached to, activities were also different in each site. For example, Fishtown and Marketown placed great store in Total Quality Management ideas, structures and activities. Therefore, definitions of quality which reflect this stance were evidenced in Trust literature and in the accounts of people closely involved with the strategic development of 'quality' in the sites. Conversely, in Shiptown the application of standards (SAS, Kings Fund, Clinical Audit, the Patients Charter) was at the forefront of strategy. Therefore, 'official' (as expressed in Trust literature and policy statements) definitions of quality tended to be based around the idea of fitness for purpose and the attainment of pre-defined standards.

This phenomenon, however, was most evident in the case of Castletown, where patient focus groups, a Patient's Council and consumer representation in official steering groups and complaints committees was right at the heart of the quality management strategy. Here official definitions of quality took on an overtly consumerist flavour:

You can sum up the Quality Directorate's definition of quality as 'making people feel special by doing the right thing at the right time and in conjunction with customers wherever possible.'

(Director of Nursing and Quality: Castletown)

I think our view of quality has a considerable impact. We try and have the courage to actually listen to what patients say about the service and not ignore it. We think that by acknowledging them and their right to have a say changes the staff's attitude of we'll treat you how we want. Or we'll decide what's best and the improvements. This is the basis for all of our work around quality in the Trust. (Quality Manager: Castletown)

*'The aim of the 6 patient fora is to facilitate listening to patients/carers and to develop each aspect of our service in ways that reflect the wishes of the public.'*⁹

Official Didn't Mean All Encompassing

The official definitions of quality promoted by the specialist 'quality management' teams in each Trust were having to co-exist with those definitions reinforced by other strands of quality activity and which were led by groups other than central management:

- TQM in Fishtown and Marketown coexisted with clinical and medical audit; purchaser standards; and CHC visits none of which 'fed' into the TQM system.
- Standards-based approaches and multi-professional audit in Shiptown went on alongside directorate 'one-offs' which the centre were not aware of, such as quality circles in the mental health division.
- In Castletown the heavily promoted and self-declared consumerist stance on patient involvement in policy implementation and development as part of a Trust approach to quality was in direct contrast to mono-professional medical audit, and managerially established contract quality standards.

There was little or no co-ordination between the centrally-backed 'core' initiatives and those which took place away from the gaze of the quality management teams. In all the sites there was a distinction made between 'quality' as the core, officially-backed, mechanisms and techniques such as audit and complaints. The major distinction was expressed as the difference between that which was considered 'hard' and meaningful, which for the professions was the question of audit and professional standards. This was countered by the 'soft' tag attached to quality as promoted by central management which was seen as concerned with elements of services which were not a direct professional concern.

The Influence Of Contact With Quality Tools On The Individual?

What emerged were patterns of common responses to the question of what quality meant to them? These patterns of responses could be grouped, not only by occupational classification (as was first hypothesised), but interestingly by the degree of contact with particular quality activities. Those people with the greatest stake in the various quality initiatives in place tended towards providing definitions which were commensurate with those definitions

underpinning the approach to quality. For example, this account from a Quality Advisor (manager) in Fishtown:

'For once I do really feel an affinity with something that we've 'imported' from outside the Trust. The European Model [EFQM] is something that I, personally, subscribe to. It mirrors a lot of my own thoughts on quality...its a system, its got definite criteria, its about being proactive and managing people and it places lots of weight behind satisfying people inside and outside the Trust.' (Quality Advisor: Fishtown)

Similarly from these two audit personnel in Castletown and Shiptown:

'I suppose its a bit of a cliché to say quality is conforming to requirements or fitness for purpose but that's what I think it is...yes being involved in audit has coloured the way I approach quality, I think it does for everyone who really believes in auditing practice... but without standards it just becomes meaningless.' (Audit Assistant: Castletown)

'I don't think I could do my job if I didn't think that what I was doing actually made a difference, and I think it does. I think part of the reason that it has made a difference in this Trust is that my own opinion of quality is very much in line with the audit philosophy anyway and so I invest a lot of time in the post. Quality is definitely a product of examining performance against standards that are already established either by one's peers or in other ways...like research or locally.' (Audit Co-ordinator: Shiptown)

The overall picture of individual accounts of quality however was a confused one. On an individual level people often made recourse to the 'colloquial' sense of quality:

'I'm not sure you should be asking me how to define quality. I don't think you can...well not properly anyway. I kind of agree with all the definitions that usually get blurted out, you know like 'first time every time' and all that. I mean they all have something to offer.' (Staff Nurse: Marketown)

These were, unsurprisingly highly individualised and subjective; but what united all respondents was a recognition that there had to be some form of collective definition to work

towards in services; even if the groups involved were moving towards different goals. The coexistence of so many competing definitions of quality, and the apparent enigma that different quality activities in sites were often moving towards different conceptual 'ends', might be interpreted as problematic. This was an enigma not lost on one member of the Executive Board of Castletown:

'Co-ordination has been the main problem, every tribe doing its own thing and lumping them together under quality. We've just appointed a PR and Communications Manager to help ensure that everyone is heading in the same direction. I think I'm being fair when I say that in the past we haven't necessarily all been aiming for the same goals... and that diversity when talking about quality is something of an understatement.' (Chief Executive: Castletown)

If the composition of the groups associated with the quality approaches in place is revisited then it becomes clear that, on a group level at least, different stakeholders were associated with different approaches to defining quality on a group level. But it was also clear that people somehow had to manage the difficult process of reconciling involvement in a group process and individual values and perceptions.

The Power Of Broader Organisational Structure And Process

Several people from the main stakeholder groups alluded to the essential conflict between personal perception and organisational reality: namely, that in the face of organisational pressure it was often difficult to use your own ideas of quality and sometimes it was easier to comply with existing systems:

'I personally have nothing against the idea of quality - sometimes I think some of the ideas like patient information leaflets in Gynae are quite a good idea. In the end though your idea of quality is what the consultant says it is. As an SHO your ideas don't really come into it...you just keep your head down and do the job. We do have audits and so on but being a relatively junior member of the firm its hard to question your boss, especially when your next job depends on what he thinks of you.' (Senior House Officer - Surgical Team: Fishtown)

'to be honest I haven't thought that hard about quality. I know that I don't always agree with what gets pushed on us from management but I can't realistically opt out on my own like. Maybe if I was the Sister I wouldn't entertain some of the stuff that gets shoved down the line, but I'm not so I just get on with it.' (Staff nurse: Marketown)

This reaction was more common amongst staff at the lower end of occupational stakeholder groups (such as staff nurses, junior managers and junior doctors); and relates directly to the exercising of direct influence in promoting certain sorts of quality activities. As stakeholder accounts were drawn from further up the hierarchies in each of the Trusts it became clear that the aligning of official definitions to mechanisms or systems of quality was one means of achieving something workable from the sheer number of personal approaches to quality that had to be accommodated:

'...half the time whether we develop an initiative within the Trust depends on the situation at the time. Like, we wanted to develop the CQI work that we had done ourselves a bit further but it was obvious that it wasn't achieving everything it was supposed to and we were all going round in different circles...each Division I mean. So the EFQM framework comes along and it was just something that we could use to put round all the stuff we were already doing. You've got to take into account what people are feeling on the wards and all EFQM did was give everyone something to get their teeth into....something that we could all latch onto and understand.' (Quality Advisor: Fishtown)

Linked to this idea of making something workable from an infinite number of definitions, was the notion expressed by a number of those managers involved in directly introducing quality activity to professional groups that in order to secure any kind of success with a quality initiative it was important to be flexible and to respect people's ability to arrive at something workable amongst themselves:

'Now I mean I can see that there are...there are different things...activities that the professional groups have been involved in and we've sort of been there supporting around those things. And what I think is encouraging erm is some of these things are starting to come together a bit more.'

[In what Sense?]

'In some certain sense we've got the doctors erm taking the lead and taking ownership for medical audit. Now the reason that's happened is because its theirs...it belongs to them, they understand it. You have to respect that and use it as a starting point that's where organisational development is different from the Quality Advisors...we respect doctor's needs to develop things which mean something to themselves.' (Organisational Development Manager: Fishtown.)

Other managers, often not directly involved in the 'coalface' process of introducing change (or the possibility of change), recognised this feature of operational managerial life, and saw the imposition of definitions of quality as a necessary evil. Particularly if dominance of powerful (clinical) groups was to be avoided and corporate goals secured:

'...all the time you're having to balance...say to yourself, 'OK what am I trying to achieve and what can I achieve realistically in terms of quality'. If you leave it just to the staff you end up tipping the scales too far away from what you are trying to achieve with the Quality Steering Group and the Chief Exec. So in the end you have to get people to sign up to something that you have done the legwork on just to get things done the way you want them...' (Director of Nursing and Quality: Castletown)

'I think yes sometimes you do have to push things on groups within the hospital. Its how you do it that matters....One thing we've found that works here is to leave the definition as broad as we can so that people can set their agendas and ways of thinking about it...we give them boundaries if you like and I suppose in reality these are more understood than used in meetings and reports. You can't do it for everyone but for people like the Obs and Gynae team it was great because it left them feeling as if they were the ones leading the thing.' (Managerial Member of Quality Steering Group: Marketown)

It was clear that techniques for influencing how groups perceived and defined quality were altered according to the levels of power of the group management was wishing to influence. The theme which recurred repeatedly in this respect was the link between quality and accountability.

Quality, Definition And Accountability

The more powerful the stakeholder group (along occupational and hierarchical lines) the less explicit the definition of quality underpinning the mechanism for quality with which they were associated became. Moreover, the less explicit the criteria for quality the easier it was to avoid being held accountable for not having attained measurable quality standards. This was a factor not lost on one senior manager when talking of consultant colleagues in his division:

'...I personally don't think it's fair to ask nurses to collect information on pressure sores as one way of measuring the quality of their work and then leaving the Doctors to just do their own thing with medical audit..but its horses for courses.... Maybe because of my nursing background - I was a staff nurse - I'm a bit biased. But now I have to manage this unit it always strikes me that you can never pin a consultant down because you never know exactly what it is that counts as a poor result for that group of patients...gallbladders or whatever. Audit doesn't help....except for themselves.' (Divisional Manager, Surgery: Castletown)

The linking of accountability to quality was also a key concern of the 'outsiders' in the sites:

'Aye that's the whole thing isn't it...the crux if you like. If you have to meet certain standards like in a driving test then its relatively easy to be held up for failing those standards. That's why the Trust always balls' it up. They have these wishy washy things they call standards and that bloody logo...have you seen it?..and everyone ignores them or even if they don't now't happens because the things are meaningless anyway...just waffle.' (CHC Chief Officer: Marketown)

Accountability was at the heart of the issue of evaluation; for informants from all occupational groups quality activity was often felt to be meaningless without evaluation of some form, and yet there appeared to be remarkable divergence in peoples' interviews and what was observed at meetings. What differentiated groups was the style, form and level at which evaluation was undertaken.

Evaluating For Quality

Evaluation of quality was generally observed at three levels within the Trusts:

- The informal
- The formal
- The individual

The Informal Level Of Evaluation

Evaluation at this level commonly consisted of face-face discussion between stakeholders where the quality of the service was the focus but where little written output was produced. This level of evaluation was most commonly seen when the stakeholders involved tended to be located towards the top of the quality hierarchies of participating organisations (senior managers, Chief Officers, divisional managers [and above] or within professional occupational groups. For example, in this case between the 'outsider' CHC chief officer and a Trust clinician:

'With surgery at the [hospital name] I have a spy in the camp if you like. If I get complaints I talk direct to him [consultant] about what's gone on. Its something we both understand and its a sort of a first step. Nine times out of ten I explain the patient's or relatives side and he fills me in on his angle and it stops there.' (CHC Chief Officer: Marketown)

Sometimes these informal evaluations made up the sole component of a particular stakeholder group's approach to actualising quality. In these cases informal evaluation was both the process and the outcome of approaches to quality adopted by groups of peers. Change arose through informal pressure applied by the group itself; as these accounts from consultants illustrate:

'...there are five consultants here and we all get together...I mean we name names in the confines of the meeting because its not written down and you get slagged off if you have a high infection rate and you have to go off and sort it... so we don't actually head hunt

although we often do know if its a list of consultants ABCDE you can often tell by the work pattern who it is and there's a fair bit of joking goes on. You know, wash your hands before surgery and stuff like that. That's really the best way of changing things as a team its not formal but it does work. Actually come to think of it that's the only thing we do as a team.' (Consultant Obstetrician: Shiptown)

'Informal medical audit for this department [urology] works well. Its relaxed and there's only the other consultants there so we can speak freely. Issues get aired and we manage to disseminate new developments and look at our work its not very scientific but it does work. We don't include others in the team like the nurses because we feel that it would detract from what is, for us, a successful technique.' (Urologist: Fishtown)

The Formal Level Of Evaluation

In contrast to the informal level of evaluation, the formal level of evaluation was visible and usually a part of a much larger system or approach to operationalising quality; examples include:

- The clinical audit 'cycle' (of standard setting-evaluation-action-standard setting).
- The EFQM model based on time-series evaluation of the organisation.
- SAS and purchaser standards based on evaluation of attainment of pre-set standards.

Formal evaluation constituted the most visible form of scrutiny; visibility in this sense referring to the release of the results into the central Trust quality networks¹⁰ and the groups associated with this. In two of the Trusts the CHC formed part of this network and so consequently had some access to these results. With the exception of the SAS standards in Shiptown and Fishtown, purchasers did not usually have access to these forms of evaluations. The reasons given for this centred around evaluation's role in exposing service weakness and the commercial implications of this.

Despite the visibility of this form of evaluation it was widely acknowledged that this level of evaluation was, of the three kinds described here, often the least effective. A variety of explanations were proffered by stakeholders but the most common centred on formal evaluation being the least utilised form of data in decision making

'We jump through all the hoops for the Kings Fund and [the main purchaser] and SAS. In the end though quite often I resort to gut feelings about a department and sometimes I've found that this is what people prefer...my boss calls it 'passion not paper' management.' (Divisional Manager: Shiptown)

This formal type of evaluation often formed the 'official' basis for Trust-wide action and was consequently a cause of tension amongst the managerial stakeholders charged with transforming the results of evaluation into action and the professional staff of whom action was expected. An example of this was the Kings Fund accreditation programme undertaken in Shiptown. The primary tensions were structured along hierarchical lines. Those managers and senior clinicians (in this case nurses, as none of the medical staff spoken to were really aware of the process) focused on the fact that action as a result of the evaluation of services was based on consensus in order to accommodate the multiple interests and needs of staff groups in services. This was seen as weakening the strategic purpose of the evaluation and diluting the original goals of the organisation:

'[the Kings Fund Scheme]...wasn't without its faults...the audit was basically sound but we've have had to water down the action plans to what is achievable rather than what we, as the Trust Board, want. Changing practice should be about leading and inspiring not endless concessions to the mob just to get things done.' (Director of Nursing and Quality: Shiptown)

This was contrasted by the views expressed more commonly by members of staff employed at ward level. Their reservations centred not on the consensual basis of the required action but on the inadequacy of the assessment in the first place. As one staff nurse explains:

'They [the Kings Fund Team] were supposed to be here for a week but I hardly ever saw them. They just use to come with clipboards and ask a few questions...mainly following up what we'd already answered in writing. I don't see how they can possibly capture the quality

of a ward in such a short space of time, or even what we do. And now we're supposed to have signed up to this action plan or whatever its called...its no wonder people get fed up with it all.' (Staff Nurse: Shiptown)

Formality as a Managerial Preserve

Formal evaluation was almost always instigated by those groups which were managerially dominated (the Executive Management group in Fishtown; the Quality Steering Group in Marketown and the Quality Core Group in Shiptown). Consequently, many staff felt evaluations focused solely, or primarily, on 'managerial issues' such as the systems in place for assuring quality; the numbers of staff on wards; the décor and infrastructure services such as engineering and catering. This was not necessarily viewed as a negative characteristic by the clinical groups and all parties involved appeared to have established an understanding whereby clinical-professional work boundaries were respected in formal evaluations by requiring adherence to very broad standards only. For SAS in Shiptown and Fishtown these included '*having individual plans of care in place for patients*' or '*clinical guidelines in place where appropriate*'.

Despite the widespread circulation of the results of these formal evaluations within the 'core' quality structures of the Trusts. There appeared to be little will on the part of external groups such as the CHCs to request information derived from this level of quality evaluations. This could be partly explained by the fact that requests for information from initiatives such as medical audit had been turned down in the past; or the information provided was expressed in formats which do not aid ready lay-interpretation. This is clearly demonstrated in the words of the CHC Chief Officer for Marketown:

'Yes we do get a copy of the report from their audit department but its no use to us... it says nothing. We get a few graphs and some areas that we might be interested in are put down. But if we ask for the details they tell us it has to be confidential and that's it, end of story. Maybe with the new bloke they get in it might change. But [name of audit chairman] that's there now has had it stitched up for the last three years.' (CHC Chief Officer: Marketown)

Better the Devil You Don't yet Know: Formal Evaluation and Professional Groups

The formal mechanism for evaluating professional-clinical work were the processes of medical and clinical audit. The key difference between the more managerially focused formal evaluations involved in SAS, the Kings Fund, or EFQM, and the professionally-focused audit processes were that results of managerially-led evaluations were available for scrutiny by management within the Trust. Audit results, however, were kept away from those who were not directly involved in the audit process itself. In Marketown this included the Audit Committees and audit departments themselves. Each Trust produced an annual audit report detailing the nature and title of some of the projects undertaken; in none of these reports were results provided. Similarly there were no anonymised findings or an accompanying narrative which would give an overview of standards achieved.

Reasons why this was the case generally centred around the need to protect an individual's or a service's identity in order to pursue the long term goal of professional involvement in quality and/or the move towards greater links between business and clinical work. Or as one Clinical Audit Facilitator expressed it:

'you'd have to be bloody mad to even paint a picture of the results of last year's audits. The clinical staff would be up in arms, ... The Commission don't really want to know and we'd lose contracts. Because...well, quite frankly...some of the results were so bad.' (Clinical Audit Facilitator: Castletown).

The link between monitoring the outcomes of professional activity and the business of contracting was an important one and most in evidence in Shiptown. Despite the wishes of the Director of Public Health, the Trust's Audit Chair and Executive Board the Trust's annual audit report revealed a less than enthusiastic response towards the linking of clinical outcome indicators to contracts as an element of the quality strategy (as desired by the purchasers):

'In July 1994 the Central Audit Facility was invited to discussions with [the purchaser] to advise on the need for clinical audit to support the clinical outcome indicators that would be in place on all contracts from April 1st. At the initial meeting a number of points were raised in relation to the indicators:

- *it had to be specified that the indicators could not be used as direct measures of the quality of service*
- *the original list was written with a view to stimulate clinical staff to define their own outcome indicators and that by no means were the original indicators to be imposed on the unit*
- *The report goes on to acknowledge that indicators on contracts 'may not be as useful as expected' due to:*
 - *...impracticalities in data collection*
 - *...no response from clinical staff involved with the indicators leaving [the purchaser] with no option than to use their indicators for that service' (my emphasis)¹¹*

At the time of leaving the site none of the contracts had firm clinical indicators in situ and there was a feeling amongst consultants (one of whom was a Clinical Director) interviewed that medical support would be difficult to secure for this 'particular tack' on the part of the purchaser.

Audit, while certainly constituting a formal means of evaluation, was far removed from the public domain. Professional quality activity therefore remained firmly linked to forms of evaluation which emphasised the restriction of the audience to those professionals immediately linked to the service being audited.

The Individual Level

The third level of evaluation took place at an individual level. Several informants made reference to personal norms or criteria for quality in judging practice on a regular basis. Often they used language and phrases such as their 'own ideas'; 'you know what's good quality'; 'you don't need to do a questionnaire on everything to make a judgement or not of

something's quality'. The primary difference lay between those accounts of individuals with the power to effect change within the Trust and those with lesser levels of influence. Within those stakeholders who enjoyed line-managerial or senior clinical authority there were several accounts of how their personal perception, as the basis for evaluation of an individual's or service's performance, was often the most productive tool for change:

'Its like I said before... I know what needs to be done and my own views on quality - believe it or not - do have a bearing on what happens in the rest of the Trust. If I say to a nurse...look my view is that your care is not good enough, she'd have to have a pretty strong argument to answer me back. It really is about being that direct...people respect that and, as long as its not every minute of the day, it carries a lot of weight.' (Director of Nursing and Quality: Shiptown)

Conversely, the accounts of people lower down the Trust hierarchy, whilst still recognising the worth of personal evaluations of performance, were characterised by a pervasive sense of powerlessness and a certain degree of futility:

'One thing I have noticed since doing the job [of Quality Advisor] is that it was easier to get things done as a nurse manager. You could always say, 'you will do it like this' because you were in charge. Now though I don't have that sway and it's sometimes really hard to get people to do the right thing...can you understand. It can be really annoying to do loads of work on something, like the patient focused care project on ENT and then for them to just ignore it or twist what you're trying to do.' (Quality Advisor: Fishtown)

Interestingly the invisibility of informal evaluation results to others did not exclude or prevent 'outsiders' from using this level of evaluation as change agent in negotiations with the Trusts.

Formality As A Tactic For Exclusion

When CHC chief officers were interviewed they all felt that individual judgements, as the basis for communication with Chief Executives or Directors of Nursing, were key means of

communicating and effecting small-scale change (as was pointed out earlier). However, if larger scale change or something on a Trust-wide basis was required then recourse to formal evaluation results or data was almost always required. This was significant, as it was at this level that the 'outsiders' of the CHC and the Health Authorities played little part. As one CHC Chief Officer put it:

'While I know I can ring up [the Chief Executive] whenever I want to and I'll always get his ear it only worked for certain kinds of problems...stuff picked up on visits or things brought to me by patients. If the same things keep cropping up again and again I'm always expected to have a survey or a research study to back it up...we don't have the resources to be able to do it for everything we want to do and yet we can't really get into the Trust decision making machinery as equal partners without it...its a bit of a catch 22 situation.' (CHC Chief Officer: Fishtown)

The pattern repeated itself in all the Trusts: formal evaluations which were managerially-led with some form of clinical support (usually nurses), were the basis of corporate changes to the quality strategy. CHCs and external consumer representatives were by and large excluded from these evaluations and so played little part in the selection or development of policy.

Where CHCs were involved in changing or evaluating policy and practice from within the Trust (notably in Shiptown¹² and Castletown¹³) there was still a feeling that the committees they were represented on were either 'rubber stamping exercises' or 'not really at the centre of the decision making process'. Each of the two CHC officers involved in the two Trusts gave accounts of feeling somewhat alienated within committees and that much work was perceived as going on 'behind closed doors' or before people arrived to discuss the agenda.

Castletown was unusual in this respect as it had built into a formal programme of evaluation a series of fora and a Patients Council; seemingly to combat this lack of direct input into corporate change from consumers themselves. However, when talking to some of the members of the Patients Council following the inaugural meeting there were still some rather cynical participants within the group:

'Yes I have been to these sorts of occasions before. It was last year on [name of ward]. It was rather jolly but I'm rather reluctant to say that it has changed much. One always has a feeling that one is here to simply rubber stamp decisions that have already been made. My wife and I were invited though and we both feel we would like to help the hospital in any way we can; especially now we have a bit of time on our hands... I think I can speak for my wife when I say that I hope we can discuss something other than car parking spaces at the next meeting.' (Patients Council Member (and retired University Professor): Castletown).

At this meeting the agenda was firmly established by the Trust prior to the meetings, and the 'facilitator' (the Director of Nursing and Quality) was keen not to divert from this too widely. A number of participants made reference to clinical events which occurred during their own hospital stays and these were quickly fielded as *'not really appropriate for this forum'* or *'better fitted in elsewhere at a later date'*. Despite the assurances of the Director that the meetings would be a direct route to the Executive Board of the Trust there were no plans to produce either a report, goals for the group, or even a mechanism for feeding back to the Trust executive other than informally through the Director of Nursing and Quality.

So even in this Trust, which undoubtedly was the most 'consumer-focused', an essential transformation occurred. The fora mechanism, which was marketed as a formal means of evaluation charged with providing a formal input to the quality-policy process, had its output mediated by an 'insider'. Moreover, the nature of its recommendations were changed to the less visible (and therefore less accountable) level of informal contact between executives. One CHC member from Castletown who was previously an administrator at a neighbouring hospital, whilst applauding the Trust's efforts, felt that it was the quality department themselves that were marginalised within the Trust.

The Limitations Of Evaluation

Managerial and clinical accounts revealed a distinction between quality activity and the core

care and treatment of the Trusts. A number of managers felt that while evaluating services often had an impact on quality activity, it was often restricted to this area and failed to influence clinical practices. There was a sense in which people *did* quality and *did* work but that the two were separate. As one Director of Nursing explains:

'People always talk about doing quality. That's something we've tried to change here...its as if people see quality as somehow separate from nursing practice as a whole. We have had to work really hard to try and get nurses, especially the sisters, to see quality and practice as one and the same. I don't mean they don't do it, they do, but its hard to explain that I can't give points for quality on its own. It means nothing if it's something separate.' (Director of Nursing and Quality: Shiptown)

This perception was reinforced by those clinical staff involved in operationalising quality in the 'front-line' of clinical practice:

'A lot of the girls take part in SAS and the quality group but getting time away from the ward is difficult. A lot of the sisters don't see it as a proper part of nursing... so you have to go after shifts or in your own time.' (Staff Nurse: Fishtown)

The product of evaluation is information; and information, as one manager in Marketown pointed out, 'is the currency of change'. The essential tensions between the accounts of influential group members around the issue of evaluation included how it should be carried out, what uses it should be put to, and who should have access to the results, all made recourse to the theme of information.

The Role And Use Of Information

Information represented a significant component in meetings at all levels to do with actualising quality in the sites. Questions such as, 'how should we get this information to people?'; 'what sort of information should we produce?'; and (in the case of Shiptown and the attainment of standards), 'how much do we want to tell people?' formed the basis of contentious, and often lengthy, discussion between the representatives of various groups involved.

The information produced by the Trusts in connection with quality fell into three broad categories:

- That which was destined for the *public domain* (i.e. outside the Trusts' business, professional and quality structures). This included clinical audit reports and Patient Charter results.
- That which was *formally* collected and controlled and remained within the confines of the Trust's business, professional and quality structures (i.e. *internal*). This included the results of SAS audits; the Kings Fund Accreditation survey results; and EFQM attainment data.
- That which was both *internal* and *informally* collected and used in the informal evaluations the earlier section of the chapter described. Examples here included the 'hot line' which one CHC Chief Officer described in relation to his ability to discuss quality matters with the Chief Executive of his local Trust if he needed to (Fishtown).

Public Domain

Information destined for the public domain was in two main areas of Trust quality activity in all the sites: clinical audit and Patients Charter related initiatives. The formats in which the results of clinical audit were disseminated varied from the production of a very polished report from the Central Audit Facility in Shiptown, to the basic 'side of A4' detailing the projects in place in Fishtown, Castletown and Marketown. In each of the sites the report had to be requested as a separate source of information from the audit departments concerned. This meant that requests for information on audit from individuals or organisations rarely came from those outside the NHS or academic environments. As one Audit facilitator put it:

'...well what's the point [of producing a glossy report] when the only people who read it are the audit people at the Commission. We send a copy to the CHC but they don't say anything about it and nobody else is that interested. We thought about sending a copy out with the annual report that information do, but at the end of the day there are better ways to spend our budget.' (Audit Facilitator: Castletown)

Audit results were always anonymised and if referred to at all then only in the form of the changes introduced as a result. This was usually in the form of the clinical change recommended; guidelines adopted; or training need addressed. One Audit Chair even saw this anonymisation as forming one of the cornerstones of the audit function itself:

'Making it confidential is vital, no one would take part if the results were not anonymised...this is a key part of my role - persuading people that they can't be identified. I know its not what the Commission want but that's how its got to be.' (Audit Chairman: Marketown)

The Patients Charter-based information was similarly anonymised and dealt with the results of scrutiny at departmental or directorate level. This scrutiny tended to be based around aspects such as waiting times, outpatient waiting, and provision of single sex wards. This form of information tended to be more accessible and generally placed in areas where patients, or potential patients, could get their hands on the material more easily. Examples of this form of information included annual Trust Reports; the quality newsletters in the main reception and outpatients areas in Shiptown; and the Quality Bulletins sent to staff to put in communal areas on the wards in Marketown. Each Trust also had some form of quality noticeboard in public areas somewhere within the Trust; although in one of the sites this was taken up by an advertisement for maternity photographs while in hospital. People associated with the quality strategy saw this sort of information as generally non-contentious and not that reliable. Occasionally the sentiment that the information was produced and collected out of statutory obligation as opposed to any sense of moral justness was expressed:

'The Patients Charter material that we release is done because we have to, not necessarily because we want to. Its the most public face of what we do for quality but the least useful to us as managers. Its unreliable, out of date, and doesn't help as a means of getting people to change the way they do things clinically.' (Matron: Marketown)

The lack of importance attached to most of this form of information can perhaps be gauged by the fact that, of the sixteen members of the Quality Core Group who attended the Quality Core Group Meeting the day the DOH Hospital League Tables were announced publicly,

only two were aware that they were either being launched that day, or that they were fifth nationally in terms of their rates of improvement for that year. This was despite having had advance notice from the Regional Health Authority.

Internal (Formal)

In contrast to this policy-driven approach, the release and production of internal-formal level of information was more hierarchically and mechanistically driven. The collection and dissemination (back to the Health Commission) of SAS material for instance was a prerequisite for the purchasers placing contracts with Shiptown and Fishtown. Similarly, where directorates undertook quality projects such as the PIER system in Castletown they were compelled by the Quality Managers involved to produce reports on the success of the project.

At the mechanistic level, systems such as EFQM were dependent on the formal evaluation of performance against standards for the implementation of the system itself. Similarly, the process of clinical or medical audit generated formally collected and analysed information. The difference between the soft 'managerial' information of EFQM and the 'harder' clinical information of audit was that audit results seldom if ever went beyond the professionals or multi-disciplinary teams involved. EFQM, PIER and the patient focused standards of Castletown, however, were fed back up the hierarchy of the quality structure to steering groups such as the QCG in Shiptown. Audit results did not routinely appear on the agenda for discussion of Clinical Audit Committees - they remained isolated within the teams carrying them out. Again emphasising the 'hard' and 'soft' distinction between the different methods.

It was this internal-formal type of information that generated the most contention amongst staff and highlighted the strongest divisions between stakeholder groups. Many professionals within the Trusts, particularly at the lower levels of their particular hierarchies, expressed reservations and doubts about the worth, validity and intent behind collecting information which they perceived as 'managerial' or 'bureaucratic':

'SAS is just bureaucratic paper pushing. We had no say whether we wanted to take part and it was just chucked at us. You don't get any feedback and its largely irrelevant to everyday nursing.' (Staff Nurse: Shiptown)

The Internal, Informal Level And Type Of Information

Compared to the *public domain* and *internal-formal* types of information within the sites the *internal-informal* level of information gathering and exchange that went on was very difficult to establish as a researcher within a case-site. Most of the information exchange at this level took place behind 'closed doors' and away from either Trust public relations machinery or the formal 'straight jacket' (Nurse Manager: Marketown) of systems such as TQM. However, while rarely observing this in practice it was quoted as a significant component in stakeholder's accounts so often that there was little reason to doubt its existence. Especially as it occurred when interviewees were speaking of evaluation; the methods by which approaches were selected; and the lines of communication promoted by organisational structures. Although gathered internally this form of information was often used in communications with outsiders such as the CHC when individuals wished to be 'off the record' in discussions on quality. This informal level of information was used within and between all stakeholder groups and took various forms.

Amongst clinical staff, informal indicators of 'quality' included one's opinion of someone else's practice¹⁴; the number of third party concerns passed to you as someone who could influence the organisation¹⁵; or simply ones perception of other's perceptions of your performance:

'The biggest influence on how I nurse?...its what other people think of what you do I think - other nurses...here we all get on and so we can say if we think someone's doing something badly without falling out. But I've worked at other hospitals where that would never happen.' (Staff Nurse: Fishtown)

This informal level of information, like the informal forms of evaluation detailed earlier, was often perceived as some of the most useful data for use in processes of change within Trusts:

'On a day to day level most of my decisions about services and quality are made a bit on the hoof. You end up using snatched conversations in corridors because of the pressures of time now. It seems to work quite well though problems are sometimes clearer if you don't have time to think to long about them.' (Director of Nursing and Quality: Shiptown)

This was linked to the fact that the informal level of information was used when other means of communicating opinion were deemed unsuitable:

'Audit suits us a team as there are many issues you just don't want spread around. Clinical practice is a touchy thing and can be misunderstood by people who aren't surgeons themselves. When flaws in technique or problems with management occur the last thing you want is to go blabbing about it.' (Consultant Surgeon: Fishtown)

'We are always being pushed to deliver more and more for less and less and so sometimes its handy to highlight the bad things that happen as it helps our chances, with money and staff and things...but we also have to realise that we are in competition, in a way, with the other directorates and so we have to be seen to be delivering on quality...so yes not everything gets said that should be said but that's how its got to be. Everyone knows the game and we all play it. My Divisional Manager knows when all is not well but we don't have to send memo's to each other about it...' (Nurse Manager: Marketown)

Amongst the managers within the case sites it was also acknowledged that while informal forms of generating and communicating information on quality were not the most desirable from a Trust point of view it was often the only option:

'It would be no good me asking the orthopods to monitor their clinical standards and give me the results on a routine basis. They just wouldn't do it. They do the minimum to get by... Patients Charter and the contract specifications and that's it. Anything else would be pushing it. What we do do here which is different to the rest of the Trust is speak to each other. I make it clear that I am here to support the consultants not have a go at them. So now I think they know they can bring issues to me and I can help. It works both ways too. If there's something

bothering me I can take it to them and we talk about it. Its practical and effective so if it isn't broken why try and fix it?' (Orthopaedic Business Manager: Marketown)

This form of communication was often driven by, and in turn reinforced through, alliances between individuals in different stakeholder groups. This was particularly the case when information had to pass to and from managers to clinicians and from consumer representatives to clinicians, and where collusion might be seen as inappropriate by one's peers:

'I've worked with Stephen [Urologist] since I got my first job in the old hospital and he was a Senior Registrar. I respect him and he respects me even if we don't always see eye to eye on everything. He's a friend as well as a work colleague if you like. He's tipped me of a few times about war parties from the consultants...for gods sake don't tell any of the other medics though.' (Divisional Manager Surgery: Fishtown)

'Some things you don't want the full [Community Health] Council to know and so they're off the record between the consultant and me. A lot of what I deal with is sensitive and involves individuals who the Council members might know, or else its a bit complicated for some of them.' (CHC Chief Officer: Fishtown)

To summarise the informal-internal form of information; it was far more alliance driven than the policy-driven public domain information in Trusts or the mechanistic or hierarchy-based information of the internal formal level. Information constituted a resource for groups which could be used and manipulated by all groups in pursuit of discrete ends such as 'selling' a managerial tool such as EFQM to clinicians; making poor audit results appear bland and anonymous in order to safeguard status or contracts; or releasing select 'sifted' information to consumer groups in order to appear as if consultation is actively taking place. Information is the currency of quality and that which is most often referred to as the product of a teams efforts.

Since the introduction of the internal market reforms of 1990 many of the members of the Trusts' management teams attested to the increased prominence of information as a requirement

for operating in the market itself; and it was the perceived impacts (positive and negative) on quality activity of the market which delineated many of its players.

The Market And Quality

The purchaser provider framework itself exerted a significant impact on the shape of each Trust's quality strategy. Each of the Trusts had in place a variety of mechanisms which were geared towards the needs of the 'market' and occasionally imposed as part of contractual requirements by purchasers themselves. For example:

- In each of the Trusts contract quality standards formed a key part of contracting between business managers in the provider units and contracting departments at the purchasers.
- Each Trust was required to feedback, in a variety of formats, the results of quality monitoring exercises (often conducted on a quarterly basis) to the purchasers.
- In Fishtown and Shiptown the purchasers had developed and implemented purchaser-led standards and means of auditing these standards on a regular basis.

The Insider Status Of Providers

The question of purchaser influence in the development and application of quality at the provider end differed according to whether the stakeholder was an 'insider' (i.e. executive manager or clinician) or an 'outsider' (purchasing authority member, CHC member). The interviews with managers and clinicians who were relatively involved in each Trust's quality strategy revealed a desire to minimise the involvement of purchasers in the on-going development and implementation of the Trust's quality strategy. This need for minimisation arose from the apparent dissonance between what providers felt were 'reasonable' demands from a customer and the demands made by the Commissions themselves.

'...they [the DHA] should have very tight outcome measures. And this is where I do struggle with the quality people at the DHA who seem to want lots of detail about the process. And I have to say to them, the problem is if you're not careful I spend longer chasing information

for you than actually managing the patch. because its easy for them. I mean they don't have the responsibilities of day-day management that do impinge on all sorts of little things...' (Matron: Marketown)

The arguments justifying this provider stance were built around the idea that as they had been 'playing the quality game' (as one Surgical Manager in Fishtown put it) longer than the purchaser their commitment to quality was proven. Moreover, many of the traditional reasons relating to the need for clinical (and more recently, managerial) freedom were deployed in relation to this new policy context. Namely, that purchasers needed to trust in the providers given their already substantive commitment - as evidenced by the efforts they expend in the name of quality. As this quote from one quality manager illustrates, the idea of Trust financial investment as an indicator of commitment was an attractive one for providers:

'Our approach is far more developed than the commission's. We started before them in 1990 on quality and have put our money where our mouth is and got on with it...they haven't.' (Quality Manager: Castletown)

Much of the dissatisfaction from the providers with the market *per se* in relation to quality stemmed from the perceived lack of synergy between purchaser and provider interests. There was a common feeling that structures of purchasing and provision, and the roles that were tied to them, fostered a lack of understanding of the other's role. Purchasing decisions were often seen as illogical or ineffective; and when they were viewed as effective, adjectives such as 'hard' and 'cold' appeared in numerous accounts. There were relatively few vociferous objections raised to the idea of having purchasers as a customer for the services on offer; rather, the objections were with the customer's themselves.

'[laughs]...when we first started the training the people from the Crosby team kept talking about sandwiches from Marks and Spencer's and being able to change suppliers if you didn't like the product as the new face of the NHS and rubbish like that. The Commission are a bit like this except that you don't usually expect Marks and Spencer's to change their sandwiches half way through a mouthful and that's what they want to do with quality and contracts. They keep expecting us to change the service before they've had chance to really evaluate it for next years contracting round.' (Divisional Manager, Surgery: Marketown)

The conflicting roles which the market engendered were seen by many informants as intimately tied to the idea of quality activity. Local purchasing and provision forced players in local quality arenas to reflect on the interaction between the various roles which people were expected to occupy. The Audit Chair in Marketown, for example, was both a surgeon, the audit lead for the Trust, and a professional colleague of the Director of Public Health (the Health Commission's audit lead). This was a source of some resentment for the CHC Chief Officer who questioned his interests:

'[the Audit Chair] he's all right he is as a doctor. But with audit he has to be all things to all men and its affected what people think of him. He comes across as weak and not at all effective. Its not his fault its because of the way its set up. He has to be a doctor and also answer for the hospital to [the Director of Public Health]. Problem is they are big buddies at the Golf Club; its too cosy. I think you know what I'm saying.' (CHC Chief Officer: Marketown)

Outside Control?

Some managers attempted to reconcile the need for freedom with the new reality of having to appease customers through a strategy of gamesmanship. Indeed, several managers pointed to the fact that a significant element of the senior-managerial role within Trusts was in allowing purchasers to think they were exerting control over the service when in reality keeping a firm grasp oneself. However, there was considerable desire on the part of purchasing managers interviewed that in the near future responsibility for quality should be devolved down to providers; thereby relinquishing some of the control mechanisms they had established around quality. The rationale for this was that the purchasing role was developing so successfully that devolution was a measure of their own success:

'In the early days controls were necessary because none of us really knew what contracting was about. But as it gets more sophisticated we should be able to pass the batten on to the providers a bit more.' (Nurse Advisor: Fishtown and Shiptown joint purchaser)

On the whole, however, this normative picture was tempered by the reality of having to be seen to be exerting pressure on recalcitrant providers. The position which emerged most strongly from interviews in all the case sites with purchasers was that the stake in the activities should, and in some cases could, be increased in the short term. Typical comments included these two quotes from purchaser quality-leads in Marketown and Castletown respectively:

'We need to give more direction and push things. We are the main purchaser and we should have more say in the shape of the services we want to purchase. I see more emphasis on making quality part of business; that means contracting; and that means us.' (Contract Negotiation Team Member Marketown Health Commission)

Director of Contracting: *As the largest purchaser for the Trust we feel a little excluded at the moment.*

Int: *Could you say in what ways?*

Director of Contracting: *Well I'm thinking of all the potential improvements we could have if we had a more 'productive' relationship between ourselves and the Trusts. It would be nice to have more sway, if only to get things done a bit quicker. Responsiveness is as important as planning and while we have the planning side sewn up the responsiveness angle is more difficult. Things take too long.'* (Director of Contracting: Fishtown and Shiptown Health Authority)

The major delineating factor that emerges from purchaser and provider accounts was that while the providers saw purchaser interest as control and interference, the purchasers were more likely to introduce phrases such as 'partnership', 'alliance' and 'co-operation' into responses. Interestingly, several lower level managers interviewed expressed a desire to see a stronger and more focused purchaser role in the quality activities of the Trust:

'We should be looking at joint ways of doing things ..they have their systems and we have ours and its inefficient. We are supposed to be looking at the same things and so it makes more sense to work together.' (Business Manager: Marketown)

Interviewees at both the provider and purchaser ends of the spectrum often recognised that there was a gap between what one purchasing manager termed, ‘the rhetoric of planning meetings’; and the day-to-day reality of trying to exert pressure on another organisation. Factors such as local personalities and ‘knowing the enemy’ were as influential in a local context as the policy guidance from the DoH:

‘Of course we all know each other. But after restructuring and them [Castletown] going Trust we are aware that we are now working for different companies if you like. Knowing your colleagues though does create problems as its hard to be business-like when the person you are dealing with was a workmate for five years; especially when you’re not happy about something or want a service changed in some way. We talk at the beginning of each year and we have this plan and that plan and such and such a way of dealing with contingencies but at the end of the day it comes down to how well you know who you’re dealing with at the other end. The rule book tends to get thrown out about September usually.’ (Contracting Manager: Castletown)

A Conceptual Objection?

This desire to enhance their respective stakes in the quality dimension of service provision - was countered by a secondary division concerning the desirability of the market itself. Executives and senior managers on both sides of the purchaser-provider divide were quick, (despite criticising the mechanics of the market) to defend the idea and- to an extent - the achievements of the internal market. However, this degree of consensus got weaker the further one went down the quality hierarchy: a hierarchical split which also had occupational/role-based dimensions to it.

Of all the frameworks and structures that impacted upon service delivery the market was the most universally disputed along occupational/role-based lines. Below the level of executive management, interviews revealed a widespread body of opinion which saw the idea of the market as incompatible with quality. This incompatibility was broadly classified with reference to two areas: the experiential and the conceptual.

The first of these two areas saw people ‘blaming’ the market for the failures of quality initiatives in the past or for failures in services attributable to poor quality. This form of disagreement was more common in clinicians who had direct contact with the market mechanisms of contracting and/or business management. This extract from one Clinical Director’s account of the quality-contracting interface in Shiptown highlights the ‘practical’ nature of objections:

‘Here it’s the Quality Core Group and [the Director for Nursing and Quality] on one hand and on the other its finance, the Divisional Manager and [the DHA]. The two are definitely separate. I see both because they compete for my time but you have to concentrate just on contracting. You have to because money is the bottom line at the moment.’ (Clinical Director: Obstetrics)

Contracting was also blamed by one ENT surgeon in Marketown, for similar reasons:

‘How can contracts help quality when last year we lost part of our ENT service to Rotherham. How is that helping quality? They take money away from the service which prevents us investing in quality this year.’ (ENT Consultant: Marketown)

Nurses at or below Ward Manager/Sister level tended to frame these practical objections in terms of the effect that the internal market was having on quality in services. Contracting *per se* was not the key feature of these accounts; more often it was the perceived bureaucracy associated with new quality structures and processes. A number of these accounts were accompanied by statements from nurses describing their alienation from the contracting process and its links with quality. As this quote from a Sister in Shiptown highlights:

‘The whole thing since we went Trust and the purchasers and that has been just one load of bureaucracy after another. We also have to do a lot of things which aren’t really nursing, like the Patients Charter returns. Its more management now at my level but at the same time we don’t get a look in when it comes to business planning and the big stuff.’ (Sister: Surgery: Shiptown)

Nurses tended not to have the same awareness of business issues that managers, and even consultants, demonstrated. Clues to this lack of awareness at the lower levels can be found in their descriptions of piecemeal information flow and a sense of being excluded from the business planning process:

'When I was a staff nurse you had a much better grasp of what was going on the hospital. But now I think its much more difficult for nurses to know what's happening. I find out and get in there because I make it my business but its very hard for a new Sister to assert herself now I think.' (Ward Manager: Fishtown)

Nurses had more in common with the CHCs in relation to their objections to the market in relation to quality - perhaps because in relation to the core business of contracting and monitoring they were effectively excluded. Along with the CHC their primary objection to the market was along conceptual lines. It wasn't just the mechanics of the market they objected to (although the CHCs all made reference to the difficulties in updating members on a constantly changing NHS) but the idea of the market itself. It was at this level that the language of consumerism was so prominent:

'They [the Trust] go on about fairness and treating people better and choice. These are noble aims but you'd be hard pushed to see them in the Trust on a regular day-day level. The purchaser-provider thing hasn't worked here and I'm not sure its worked anywhere else either... the whole idea of an NHS market downplays professional knowledge and skills and the people who suffer are the patients in the end.' (CHC chief officer: Marketown)

'Having purchasers is just not right; patients aren't comfortable with the idea or the language or just don't know owt. If they don't understand it how can we show quality. Its no good at the end of the day keep doing surveys and all that ...people want to know that their own treatment is going to be the best possible they're not bothered by what happens to everyone else.' (Staff Nurse: Marketown)

The CHCs involved, in each case, managed to link their general dislikes of the concept of a market and the practical experiences derived from *'observing it from a healthy distance'* (CHC Research Officer: Marketown).

Extraneous Factors: Politics And Local Markets

The CHCs' close links with local communities, their politics and agendas (which sometimes stretched further than the local NHS Trust) were clearly evident in relation to consumer representation in the local markets in which the Trusts operated. In Marketown the CHC Chief Officer felt he was being excluded from playing on the basis of his political beliefs; an observation that was reinforced by interviews with the purchasers and the providers:

'Its just politics. They [the Trust and the Health Authority] don't like some bits of what I did when they went Trust with the Press and everything. So they just do the minimum.' (CHC Chief Officer)

'It comes down from the Trust. [the Chief Executive] and my boss are friends and I think because on a personal level [the Chief Executive] and [the Chief Officer] don't get on, different background politically, then we just get told not to bother the CHC as much as we maybe should. I personally get on with [the Chief Officer] but my boss and he are not the best of friends'. (Nurse Advisor-Health Authority:Marketown)

'[the Chief Officer] calls a spade a spade and is a bit of a loony lefty. He's always been like that though its just his way. But he rubs people up the wrong way so the Trust don't have a lot to do with him if they can help it.' (Patient Representative: Marketown)

At the level of organisational politics one purchaser felt that his local CHC Chief Officer was 'vengeful' and had a vested interest in 'stuffing' the local Health Commission as a result of him being made redundant from a management position there. Again a view that was reinforced by an executive from the local NHS Trust:

'Our CHC is a bit different because the guy that heads it up is an ex employee of ours. You do sometimes wonder if his intentions are completely honourable and that he isn't just out to stuff us up he comes across as vengeful sometimes in meetings.' (Director of Public Health: Fishtown and Shiptown)

'[the CHC Chief Officer] is very good but I know the purchasers and he don't always see eye to eye. He used to work there you know? Maybe its coloured their view a bit.' (Director of Nursing and Quality: Shiptown)

What each of these examples show is how extraneous variables such as national, party and inter-organisational politics can interfere with quasi-market mechanisms and the central 'quality' activities that are developed locally within this. The operations of the market (like contracting and consumer consultation), while occasionally peripheral to the work of quality departments, provided one important link between the Trusts and the 'outside' worlds of the communities they served and the people who buy services on their behalf. What the market reforms have enabled is the chance to develop new structures under the name of quality which aim to promote the values of the market. However, on the basis of the four case sites examined it is not entirely clear that the synergy between service and consumer interest which the reforms heralded in policy terms is best served by these emergent quality structures.

The Role And Development Of Quality Structures

Chapter Four has already described the complex quality structures in each of the Trusts. These structures each shared a common pattern; namely, a central core (commonly a steering group of some sort) 'fed' by supporting functions such as a TQM manager (Marketown) or Patient Representatives/Quality Advisors (Fishtown) and with formal/informal links to mechanisms such as clinical audit (Shiptown) or business planning (Marketown). It was within these structures that involvement of lay and professional consumer representatives was present. This took the form of committee membership (in Shiptown and Castletown) or Patient Councils/Fora (Castletown).

Structural Separation of Quality from the Mainstream

There were strong differences of opinion regarding the separation of quality structures from mainstream managerial and professional hierarchies. The marginal nature of these structures had the effect of denying the people within them any form of line managerial power. This

isolation was a source of some frustration to people with a direct stake in quality activity and upon which their posts (or elements of their posts) depended:

Int: *'What kind of managerial sway does a Quality Advisor have?'*

Quality Advisor: *'Hardly any in reality.'*

Int: *'Does that have an impact on the job?'*

Quality Advisor: *'Of course! Its very frustrating not having the old thing of being a line-manager to fall back on sometimes. Its difficult to get people to do things occasionally and it would be nice to have the organisational clout to compel people. But I think it makes you hone your person-skills more. You have to persuade and cajole...that always works better anyway. Its not just us though its quality generally. We're not yet at the stage where people think of it as part and parcel of everyday work.'* (Quality Advisor: Fishtown)

However, those at the higher end of the mainstream managerial hierarchy appeared to view the development of 'separate' quality structures and roles carrying no line-managerial authority as a necessary part of a successful approach to quality:

'You have to remember we're dealing with well educated and powerful groups of staff. You can't just wade in and tell them what to do. We built the Quality Advisor's roles up around this as a Board... Its the reality. If you want to change the culture you have to chip away from the inside.' (Chief Executive: Fishtown)

The only Trust where day-day leadership was provided by a powerful line-managerial group was Fishtown. Their structure was headed by a central Executive Management Group. It would be easy to assume that this represented a degree of commitment to the idea of supporting quality. Indeed, this was how it was first described in interviews with the Quality Advisors and the Chief Executive. As interviews with managers became more 'relaxed' and the research presence in the site less of a novelty to the workforce, it emerged that leadership itself was pretty low down on the group's agenda. Devolution of development, implementation and evaluation to the Quality Advisors was the strategy employed. So even here the operational reality for those with a role dependent on the quality strategy was a separation of the managerial, professional and quality power structures in each site.

At the level of Clinical Divisions, Directorates and units, this structured devolution reinforced the effect of encouraging the perception that quality was separate from either clinical or managerial work; and that the only people who had an interest in making it work were the quality managers in each site. As this quote from a divisional manager highlights:

'My problem with giving up my time for quality initiatives is that the Division doesn't get any more money on the back of them they are not a core part of what we do. And as an individual the recognition you get doesn't really mean that much. Its not like you get prompted or a pay rise by being a part of the patient-focused care group.' (Divisional Manager Surgery: Fishtown)

Structural Limitations

Compounding the separate nature of quality from line-managerial power structures in each of the sites the quality structures was the problem of coverage. It was clear from interviews and observation of meetings that a sizeable proportion of meaningful activity and communication took place outside the formal confines of official quality committees or structures. This method of 'getting things done' was typified by the accounts of communication proffered by outsiders (for example, CHC Chief Officers or Purchasing Managers) and insiders such as Chief Executives or senior line managers. This 'informal' mode of communication, already mentioned in relation to evaluation, was a means of bypassing official quality structures perceived as weak:

Int: *'Why not go to the quality management department?'*

CHC Chief Officer: *'Because half the time you don't know who you're speaking to and what they have to do with the Trust. Its always changing.'* Marketown

'I'm involved in two groups at the Trust to do with quality but its obvious that neither of them has the slightest impact on quality of care so its easier to go straight to the top and get things done first time.' (CHC Chief Officer: Shiptown)

Structuring Consumer Involvement

The consumer interest in quality structures was promoted through the rhetoric of ‘bottom up’ management ideas. How each Trust defined the bottom tier of the structure, however, is what differentiated each site. In Castletown the bottom of the organisation included the end-user of services and every effort was made to get their views directly onto the service agenda through a quality structure that emphasised partnership and consultation. Shiptown took a similar view but contented itself with the ‘proxy’ views of the local CHC. Marketown and Fishtown had made a conscious decision to exclude external consumer representatives from their quality structures. Ironically, these were also the two Total Quality Management sites: where the customer is king! Moreover, these were the sites with the most developed ‘Patient Representative’ roles. The reason’s why these two sites chose not to pursue direct consumer representation in Trust-led activities centred firstly, on the perceived success of having ‘insiders’ represent external consumer interests:

‘The patient representative role is more than enough. They have good links with the community and their ears close to ground about patient issues.’ (Director of Organisational Development: Fishtown)

Secondly, past efforts at direct incorporation had failed due to the inadequacies of the local consumer body; and it was felt that the Trust’s efforts to be more consumerist would be threatened by encouraging consumer representation!

‘We thought about it [involving the CHC on quality committees] but their visits are not especially useful. We didn’t want to repeat the same mistake with EFQM or the Patient Focused Hospital work we’ve invested too much energy and time.’ (Quality Advisor: Fishtown).

The involvement of consumers in Castletown and Shiptown’s quality structures was no panacea for community representation. The groups in which consumers were involved were made up primarily of professionals and managers. For example, the Quality Core Group in Shiptown and the Quality Steering Group in Castletown. Even in those sites where groups

were purposely set up to redress this imbalance such as the Patient's Council in Castletown the Chairs or 'facilitators' were usually managers.

The CHCs in both sites felt glad to be involved but again the overriding feeling was that the quality structures were not the most influential fora with which to best effect change which met the needs of the communities involved:

'There is [his emphasis] a serious sense of partnership between the [Community Health] Council and the Trust but you have to realise that these groups are not that effective in themselves. For example, while we get lots of nurses attending patients forums we hardly ever see a consultant and the problem with that is usually its that group who are responsible for most of the grumbles I have to listen to here in the office. So in terms of change I don't know if the way things are shaping up is the route we should be taking.' (CHC Chief Officer: Castletown)

Protecting Quality: Defending the Quality Ramparts

One theme that emerged from both provider and purchaser-based interviews was that direct stakeholders were extremely fearful of the demise of quality structures. In two of the case sites (Marketown and Fishtown) a process of restructuring had occurred in both their providers and corporate purchasers. Castletown's purchaser had also undergone some major rationalisation of its quality department in the two months before the fieldwork commenced.

All the Trusts claimed that they were committed to quality. And Marketown was, in the words of the Matron, 'beefing up' its approach. In reality this seemed to mean explaining the Mission Statement to the staff and not making the quality manager redundant. Fishtown, on the other hand, was beginning to seriously question the viability of a team of four full-time Quality Advisors:

'We can't carry on funding four full timers without a demonstrable track record. A number of my colleagues are beginning to address alternatives to what is quite an expensive outlay for the Trust.' (Organisational Development Manager: Fishtown)

Fishtown's purchaser had recently shed six posts created to promote quality and there was a real fear amongst the provider's quality staff that they were next:

'You can't put your finger on it. But you know...subtle changes in attitudes and stuff. I think the move towards Organisational Development is probably a bad thing because we have trodden on their toes in the past and [the Director] makes no bones about not liking our style down here.' (Quality Advisor: Fishtown)

One strategy deployed by Quality Managers was to make their post as 'substantive' as possible; primarily by taking on more mainstream managerial roles. In Castletown the full-time quality manager realised that by combining his quality post with a 'proper' managerial function then even if the quality component was abandoned he would still have a place within the organisation:

'To be honest it was the best thing that ever happened. When I look at other quality managers in other Trusts they are dropping like flies. But here, I have two hats and they both are important. But as far as the Trust goes, the business manager one is the one that really matters.' (Quality Manager: Castletown)

This option, however, was not open to specific projects created under the banner of quality: *The Pathways to Care* project in Castletown, and the *Patient Focused Care* project in Fishtown). Both the managers attached to these initiatives recognised the risks involved¹⁶:

'Yes it was risky leaving my ward and taking this job but I thought that it was worth it at the time.' (Pathways to Care project manager: Castletown)

'Personally I would have preferred a secondment but Finance and my manager said that it would be a long term commitment and the permanent contract would remain. Now though I'm not so sure with the money troubles and everything. I supposed that's the gamble you have to take.' (Patient Focused Care Project Manager: Castletown)

There was a very real sense within the Trust Quality Management at Executive level that if quality was to be achieved in any meaningful way then structures had to be incorporated into

the more powerful professional and managerial hierarchies. This view, however, was commonly only expressed by those executives or senior managers who had a direct stake in the success of the quality strategy, such as the Directors of Nursing and Quality in Shiptown and Castletown. Their contemporaries, especially in the field of medicine, took the stance that a degree of separation was desirable. This reinforced not just the message that quality should be separate from clinical work, but more specifically that clinical work should be separate from 'quality' in the form of management-led activities such as TQM:

'Incorporation of the Quality Advisor's role, so that it becomes part of the hospital's managerial structure is not the answer. What is needed is to allow the mechanisms like audit, that are in place already for assuring the quality of our [medical] work to continue and flourish. It works at the moment precisely because it is separate from all the bunkum that my colleagues in nursing and management keep throwing at each other.' (Consultant Surgeon: Fishtown)

One thread running through all of the contested areas examined thus far is the issue of leadership. The theme of leadership constantly emerged in segments of transcripts which had as their primary focus the question of definition or evaluation.

The Question Of Leading Quality

A number of accounts from interviewees placed leadership at the forefront of challenges facing managers and clinical leaders for the future:

'...what has been lacking has been strong clinical leads to take this forward.' (Divisional Manager: Marketown)

'Here its all been reactive rather than thinking ahead. If its going to make inroads then more of a sense of leadership is crucial.' (Nurse Manager: Fishtown).

The need for strong and effective leadership was something that crossed hierarchical and occupational/role based boundaries. However, it was the nature of the desired leadership which acted as the delineating factor in people's accounts. The desirability of different

leaders was often explicitly tied to the notion of credibility. This linkage was strongest in interviews carried out with professional stakeholders who by and large saw the need for clinical credibility as an almost essential prerequisite for being involved in changing clinical practice:

'How many people involved in quality have you met that are credible in the eyes of nurses. You have to have credibility if you want to influence nurses.' (Divisional Manager: Shiptown)

This was reinforced in those managerial accounts which suggested that by becoming more credible clinically they had begun to breach the barriers constructed by health professionals:

'When I first started off I didn't know what was going on. But as the years have gone by I've got better and I feel I can talk as an equal with most of the consultants here on some things like hernias or re-admission rates. But Christ I've had to work at it.' (Divisional Manager: Surgery Fishtown)

A CHC Chief Officer made a similar point:

'Sitting on the Quality Core Group, my background at the purchasers has helped. I can comfortably listen to debates on clinical matters as long as they're not too technical. and I think that the fact that I can hold a conversation with people about the clinical stuff gets me some brownie points with a few of them at the Trust.' (CHC Chief Officer: Shiptown).

Quality managers went further and all those interviewed felt that it was definitely to their advantage to have had professional backgrounds when dealing with professional groups.

If The Hat Fits: Credibility Roles And Group Membership

At the 'helm' of operational matters in each of the sites (with the exception of Fishtown) were senior nursing managers. One of these nurses felt that the quality batten had somehow come her way through a combination of clinical background and 'enough managerial sway to achieve things': the other two had inherited the responsibility upon taking up their posts. They all felt that the quality 'hat' fitted the Director of Nursing's remit quite well but mainly

from a practical point of view based on the historical association between quality and nursing involvement:

'Nursing is the furthest down the road in terms of standard setting and tools for quality its been part of nursing now for well over fifteen years so the others can learn a lot from our experience.' (Matron: Marketown)

These operational leads were commonly supported by a 'multidisciplinary group' but analysis of these group's compositions showed that only Marketown had any form of medical representation. Links between the operational leads of nursing and medical leaders were primarily through clinical/medical audit Chairpersons or informally as an additional topic of conversation at committees dealing with other topics such as contracts or complaints. The term multidisciplinary could justifiably be redefined as managerial/nursing; with just a hint of consumer representation in Shiptown; and a determined effort in Castletown.

When the types of quality activity are analysed in terms of patterns of leadership in place within Trusts then the occupational demarcation becomes more pronounced. Clinical audit was led by a medical consultant in three of the Trusts and in the fourth (Castletown) the Director of Nursing chaired the committee responsible for deciding priorities for audit and receiving results (where available). However, all the Trusts involved here had well developed, and separate, medical audit structures in place.

The 'managerial' approaches of Continuous Quality Improvement (Fishtown), Total Quality Management (Marketown), Purchaser Quality Standards (all four sites) were all fronted by staff derived from management groups. However, when these techniques were actually implemented at the level of individual wards or units, it was nurses who comprised the bulk of the workforce. In none of the sites were medical staff directly involved in these initiatives.

These patterns of participation and leadership, while interesting in themselves do not help cast any light on the question of the impact on the face of quality of such allegiances. Four primary patterns presented themselves in the Trusts:

- The segregation of audit and managerial initiatives

- The disassociation between managerial and clinical components
- The dissonance between managers and clinicians views of the managerial role
- A narrowing of the focus of quality in any one approach

Segregating Audit

Separate medical and uniprofessional audit structures served to reinforce the view that the term audit had two distinct areas: the clinical which many perceived as ‘watered down’, and ‘the real stuff’ of medical/uniprofessional audit. One interview segment which acts as an exemplar for this sentiment was with a consultant obstetrician in Shiptown:

‘...the midwives will say to me ‘come on Miss Hare we should be auditing practice together’. So I say ‘OK that’s fine by me what do you want to examine?’ They usually come up with something like waiting times or changing childbirth related things. But in reality these are pretty pointless when what I am concerned with is complication rates for forceps deliveries or infections post-Caesar... there’s no way they’re going to be privy to that. Actually that’s not fair, the midwives probably could but the business managers who ‘tag on’, not a hope. I’m interested in the other stuff, but not that interested that I’m going to devote valuable time and energy on it they don’t need my help with finding out what women want from our community midwives.’ (Consultant Obstetrician: Shiptown).

Separating The Managerial From The Clinical

This separation into the soft-multidisciplinary areas of clinical audit and the harder ‘nitty gritty’ of mono-professional medical or nursing audit was seen by some clinicians and managers as symptomatic of a broader respect for the boundaries attached to stakeholder roles in services. On the medical front, almost all the consultants interviewed felt that even where management were included in auditing practice it was not their place to attempt to directly impose changes on medical staff:

‘We let John [the Divisional Manager for Surgery] attend on the understanding that he sees it as educational. We decide what guidelines and standards we will audit and adopt. He

understands that.. that's probably why he doesn't come that often. ' (Consultant Surgeon: Fishtown)

Managers for the most part appeared happy to play along with this perception:

'My job is to manage I leave clinical standards to the clinicians.' (Divisional Manager - Surgery: Fishtown)

'Its no good me telling them their job, but it works both ways too - they shouldn't tell me mine. Consultants seem to think its something of a one-way street sometimes.' (Divisional Manager - Obstetrics: Marketown)

That quality activity should seek to impact upon managerial and clinical components as separate arenas was seen as natural and logical by most professional groups. Bringing the two together under the guise of clinical audit was fine for examining 'big questions' such as referral patterns but would necessarily fail to get at the true picture of services as experienced by patients or clinicians:

'Clinical audit talks about the patients view 'from the reception area through to surgery and all that' but in reality patients focus on just one or two things they are unhappy with - usually some aspect of clinical care or something to do with the environment of the place like the food or visiting - by concentrating on trying to sort out everything we are wasting effort. Better to try and change lots of small things then to spend a year talking about admission protocols and then do nothing about it or everyone ignoring it.' (Ward Sister: Castletown)

The only group who wished to see the two disparate elements of clinical audit and quality pulled together through quality itself were managers. This did not necessarily mean that they wished to control clinicians directly; the issue that emerged most forcefully from the data was one of clinical involvement rather than leadership:

'...its not that I want to drag them [the consultants] kicking and screaming into line with the rest of the Region. They wouldn't let me and that's not my job, but I would like to be involved and to see how I can improve what I do for them as a manager and someone who could make

their lives easier. Its very hard to get that message out though and its a shame because I think a lot of us [middle managers] feel like that. ' (Business Manager: Marketown)

There was a sense in all the sites in which those managers with responsibility for quality who modelled themselves along the lines of the classical administrative-supportive (i.e. pre-1980s General Management) function were rewarded by a professional reaction which stressed terms such as 'helpful', 'facilitating', a 'resource to be drawn upon' and 'they're when we ask them for advice'. Those accounts from managers which portrayed themselves in heavy handed or 'gladiatorial' tones met with a professional body of opinion, which related to the managers in question as 'interfering', 'wafflers instead of doers', or even (in the case of one Ward Sister in Marketown) 'bullshit merchants'.

Consequently, when Quality Managers themselves were asked about their role and how they saw themselves the overall pattern was complicated. Almost all of them aligned themselves with the first view of a facilitative, supportive function to professionals; but at the same time felt that they had managerial incentives or pressure to 'deliver' and felt equal pressures to be strongly 'managerial'. As one Quality Advisor in Fishtown put it:

'I can't manage if I go in and start saying you will do this or you can't do that, I have to be seen as someone they can turn to if they need help or advice. That doesn't mean that I can't steer them in the direction the Trust wants them to go. I just can't let them know that I'm doing it like that. The problem is that I'm expected to manage along the conventional lines as well and to be firmer and more assertive with the staff on the wards. Its like Catch 22 if I dictate then I can't manage them. But if I don't dictate I'm seen as not managing by the boss.' (Quality Advisor: Fishtown).

A Narrowing Of The Focus Of Quality

The separation that existed between management and clinical components in quality activity led to a narrowing of the focus of quality at the operational level. This was particularly so in the case of nursing. Nursing was the predominant group involved in quality at the 'front-line' of the wards and units. Because Ward Managers and Sisters/Charge Nurses tended to be involved they had a fair degree of sway in terms of their ability to use line managerial

authority as a means of getting things done with more junior members of staff. However, because of the conceptual split between the 'clinical' and the 'managerial' quality activity was often limited to a narrower focus than quality managers would have wished.

A number of nurse accounts attest to the influence of traditional nurse-doctor power relations in reducing the ability of nurses to cajole doctors into complying with elements of the quality work on the wards that concerned them. A particular focus were the primary and named nurse systems in Castletown. In their developed forms the named nurse system means each patient has a nurse allocated to deal with all aspects of their stay in hospital and this nurse acts as the conduit through which information about the patient should flow. However, it became clear that some doctors were refusing to adapt to the new system:

'The named nurse system that's to do with quality isn't it?...the named nurse system we have here, that's a perfect example of the old Dr-nurse thing. We've been trying for two years to get the consultants to come and find the patient's named nurse if they want to see the patient or if they've been talking to them. But usually they just go straight to the Sister and tell her. We've tried everything even getting the Sister to pass them back on, and its not just them, even the Reg's and the Senior Reg's do it.' (Staff Nurse: Castletown).

Linked to the failure of quality as a vehicle with which to redress the imbalances of the traditional doctor-nurse relationship of, there was some evidence to suggest that nurses were utilising the machinery of quality as a means of distancing themselves from what was seen as an unfavourable set of 'traditional' power relations. As one charge nurse explains:

'We've tried to involve the consultants and sometimes we've had good results but we've realised that its too much like hard work. As nurses on this unit [orthopaedic], and as nurses generally, I think we're managing to become more professional in the way we do things so why should we involve the consultants in the quality work we do, if they don't involve us. I also think its a bit of a shift away from the nursely image that the unit had before I got here.' (Charge Nurse: Orthopaedics).

Consumers As Leaders?

Much Trust documentation referred to services being 'customer-led' and explicit links between quality and the wishes or needs of patients or consumers. Consumer leadership, in practical terms however, revolved primarily on gathering data relating to the wishes and desires of patients and potential patients. This data collection took place in three forms in all the Trusts:

- *Quantitative surveys of patients and ex-patients:* this was very common in all four Trusts and constituted the bulk of patient consultation in both Marketown and Fishtown.
- *Consumer representation on Trust quality committees:* these committees were seen as comparatively minor in status within the Trusts with the more major or 'powerful' committees associated with the business of contracting and executive management. Trust quality committees tended to be one level below this tier.
- *Collection of qualitative information:* through the use of patients themselves in the form of fora or, in the case of Castletown a Patient's Council.

Consumer representation in the form of patient or CHC involvement in audit was not a feature in any of the Trusts. So, on the basis of this pattern, it would be fair to say that consumer input in Trust quality activity was primarily restricted to the managerial and consumerist domains of TQM, and initiatives such as the Patient's Council in Castletown. Professional quality activity then remained largely a question for professionals themselves.

Even where consumers/patients were directly represented on committees or initiatives their views and contributions were commonly 'filtered' or mediated through the use of third parties or gatekeepers. In Fishtown and Marketown this was the role of the Patient Representatives; in Shiptown the Patient Liaison Manager and the CHC Chief Officer. This *third party* role was a source of some conflict between groups, with the consumerist (CHC Chairs/Chief Officers) view being expressed by one CHC Chair as:

'...the growth in these people who purport to represent the views of the people they [the Trust] treat is truly frightening. They control what gets put forward and fob off people who might have perfectly legitimate interests. Patients don't know which way to turn. The name

itself - Patient Representative - sounds more appealing to them than Community Health Council. Its a big talking point for some of us and one we have to address sooner rather than later. ' (CHC Chair: Fishtown).

The Trusts, and the Patient Representatives themselves saw their role as another form of advocacy for patients in the system:

'What we do is express the views of people we come into contact with on a daily basis and get them onto the agendas of people that matter in the Trust. I know it worries the CHC but part of the reason we came about at all was because, as a Trust, we felt that the CHC weren't doing that...they were ineffective and out of date. Its about using our experience and knowledge and getting things done. There's no hidden agenda...its as simple as that. I really don't see what the difference is between us doing it and them [the CHC] doing it as long as someone is (Quality Advisor/Patient Representative: Fishtown).

Without exception all the Patient Representatives employed by Trusts stated that they had, at some point, questioned their allegiance, either to the patients they were representing, or to the Organisation that employed them. The importance of the organisation's stance on their role was the factor that divided them . In Marketown the Patient Representative measured her worth in the amount of money invested in the post and the fact that she had an office on the 'executive corridor'. For her this meant the organisation took the business of representation seriously; and that meant unflinching presentation of patient views - even negative ones. Fishtown's Quality Advisors, on the other hand, had the tag of Patient Representative added to their job titles after they had been doing the single job of Quality Advisor for up to five years. All the Quality Advisors expressed reservations about this element of their role and the lack of support they could draw on if they highlighted, with as much gusto, the bad side of services as well as the good:

'...sometimes you do get the feeling that the Executive Management Group don't really give a toss what we say... I do worry about it yes, calling yourself a Patient Representative I think is supposed to give you an immediate affinity with the patient. To be frank though we get some right idiots coming through the door.' (Quality Advisor: Fishtown).

Leadership in the main groups was problem-specific; if something was seen as a 'hard' clinical issue such as righting adverse clinical outcomes then it was down to the professionals concerned to select the appropriate leader in order for any chance of success: appropriate invariably meaning another senior professional. If the problem was hard in managerial terms then managers generally sought to make it a question of managerial leadership. If, however, the problem area was deemed 'softer', then leadership usually resided in the hands of nurse-management. It was in this area of 'soft' problems that claims of consumer sovereignty were brought to the fore. As one surgeon in Fishtown expressed it:

'By all means let the punters into the 'touchy feely stuff' but god help John [Divisional Business Manager] if he tries to push em down our throat at the divisional [business] meetings.'

Conclusion

This chapter has drawn on the findings of qualitative data collection and analysis in all four case sites in order to reach its conclusions. These conclusions represent those analytical categories which run through the implementation (and therefore operationalisation) of quality in the four sites examined.

Analysis of the qualitative data paints a far more delineated picture of the social action and the perceptual ingredients which contribute to it. It has also shown how occupational grouping alone, whilst undoubtedly an influential dimension in shaping people's actions in relation to quality, cannot account for it entirely. It has been demonstrated that individuals have to equate action on quality not just with organisational-cultural, role-reinforced, beliefs of what it is to be a 'nurse' or a 'manager'; but also with factors which did not emerge in the analysis of quality in the theoretical literature. These 'extra' delineating factors which emerged included position in the Trusts' managerial and quality hierarchies; your status as an 'insider' or 'outsider' within the Trusts' local markets; and whether or not your role within the Trust was dependent on the success of 'quality' for its continuing existence. These groupings represented the players in a game of quality which appeared heavily contested and

involved a series of constantly developing conflicts. These conflicts were characterised by negotiation, disagreement, consensus and divergence in a number of key areas.

The primary split was with regard to the techniques for quality which groups aligned themselves with. This has important ramifications for shaping perceptions; as the techniques themselves were seen as powerful forces in helping clarify operational definitions of quality and how progress towards these definitions is evaluated. The techniques adopted by groups tended towards the generation of particular kinds of information which varied substantively according to quality approach. Medical audit generated rich and clinically-meaningful data, but was restricted to the mono-professional scrutiny from which it was generated. Quality Assurance surveys such as the Patients' Charter monitoring exercise generated data which was generally limited in its usefulness to services but which enjoyed widespread and public dissemination. The requirement to generate information was generally acknowledged to be part and parcel of the new, market-based, NHS. The market, or more specifically one's position within it, generally acted to define the stance you took on important factors such as information generation and use, as well as your status as an insider or outsider within the Trust.

New structures had developed in services to accommodate the rise of quality as a service emphasis. However, the general picture was one of an alienated element of the organisation which was not fully accepted by any of the occupational groupings. The separation of quality from the mainstream of managerial and clinical work, and the limited role it offered consumer-representatives was the overriding picture in its development. Part of the impact of this separation was a critical emphasis on having to prove oneself as credible as a leader in the eyes of the main stakeholder groups in services. Those that achieved this (such as the Clinical Audit Director in Shiptown) managed to shape empires which 'bucked' the trends of other sites.

The complex nature of the groups which defined this picture of conflict was most arguably a result of the complex separation of the 'stakes' people hold in services. Organisational cultures are complex entities and the ideas of professionalism, managerialism and consumerism are only some of the ingredients which contribute to them. Roles such as nurse, doctor, manager or CHC member undoubtedly draw on these but also have to reconcile less

easily mapped factors such as past experience, organisational personalities, and multiple roles such as manager-clinician and insider-Patient Representative. That levels of power and interest which impact on the shape of quality in organisations are so complex should not surprise the reader. What was a surprise to the researcher was how little recognition was paid to such complexity in the policies aimed at promoting implementation of this contested concept.

CHAPTER EIGHT: CONCLUSION AND POLICY IMPLICATIONS

This thesis has explored the manifestation of quality in four NHS acute hospitals in Northern England. Specifically, it has examined the contested nature of the concept in its NHS and public service contexts; the role of organisational cultures in shaping quality's development in the NHS; the impact of factors such as power, organisational structure; structural interests and their sponsors. The exploration was undertaken within the organising principles of case-study methodology and made use of multiple methods of collecting data from both qualitative and quantitative paradigms. The blend of qualitative data collection and Q-methodologically-generated quantitative data was an innovative one and the lessons learned from this study may prove useful to researchers examining other socially-located phenomenon. It is the task of this chapter, however, to move beyond these general achievements and to detail more specific concluding thoughts, policy implications and recommendations. Specifically the thesis represents a structured argument with seven major elements; each element represented by a chapter within the thesis.

Identifying Parameters for Quality

Clearing Semantic Space

First, the concept of quality is associated with what can be termed 'conceptual slippage'; because of this it is necessary to detail the conceptual boundaries of quality. This was the task undertaken by Chapter One. Quality was shown to have both colloquial and technical dimensions; colloquial quality being that sense of quality readily used by the general public and yet which is inherently subjective and impossible to define. This colloquial sense has a place in the NHS and is commonly found as part of Trust and Commissioner's marketing strategies. In the thesis this usage is demonstrated by Castletown's slogan 'Partners for Quality'; it implies excellence as opposed to making it transparent. Obviously quality in this sense has only limited potential as the basis for corporate managerial action. Specifically, it is

difficult to see how something so subjective can act as a framework for *groups* of workers to work towards and within. Because of this limitation, quality has developed a technical sense in order that it become part of the corporate activity of service provision itself. Moreover, quality at service level has developed into a discrete area of activity in its own right. It has developed its own language, techniques and workforce - it has been *operationalised*. There are a variety of ways of making sense of the characteristics and consequences of this operationalisation. One way is to examine the nature of the techniques of quality and to enquire as to the values promoted by these (as commentators such as Pfeffer and Coote have done¹). However, this analytic *modus operandi* inadequately addresses the social nature of the phenomenon of quality. Quality exists in a National Health Service populated by groups of workers bound by roles such as general managers, nurses and doctors, as well as consumers and their organised representatives. A useful way of articulating the flavour of these groups is as various 'tribes'². When the characteristics of technical quality techniques are examined some of the most prominent features are the ways in which quality appears to be delineated along 'tribal' lines. Consequently a strong *prima facie* case can be made that certain types of quality activity appear to be favoured by different tribal groups. It is this initial *prima facie* argument which forms the theoretical 'jumping off' point for the thesis.

Placing Quality in its Policy Context

The NHS does not operate in a value-free policy vacuum; one of the dominant policy backdrops for NHS service delivery over the past twenty years has been a process of managerialization³. This process has recast organisational structures and cultures within public services with the aim of transforming relationships of power, culture, control and accountability. Therefore, the second element of the thesis is the assertion that the rhetoric and techniques of quality are a key part of this broader process of managerialization. Governmentally-sponsored policy messages have increasingly made recourse to the language and techniques of quality as a policy goal for NHS service provision. Moreover, these messages cast the ideas, and occupational cadre, of

management in a central policy role. The structured ideas of this group, as far as can be isolated, contain a number of key positions:

- The desire for a new and explicit consumer orientation in public services.
- Alternative market-style service delivery structures (quasi-market) as the logical vehicle for delivering these new consumer-friendly services.
- Within the component parts of these quasi-markets (NHS Trusts, commissioners and the Department of Health) an emphasis on flatter, devolved decision making structures aimed around the organising principles of responsiveness and efficiency.
- Flatter structures reinforced by flexible and mobile labour forces and systems of accountability which move away from the bureau-professional legacy of the past towards more transparent systems of performance indication and systems which pull together the fields of organisational human resource management and service delivery (for example, short-term renewable contracts and individual performance review).

These ideas, and the operationalisation of them through the processes of managerialization, have made incursions into the realm of professional life. This is partly due to managers' abilities to increase their direct control of some professional groups (most notably nurses and therapists) through the application of techniques such as quality assurance and TQM. However, the apparent influence of managerial rhetoric and the apparent uptake of 'managerial' techniques such as quality assurance, can also be seen as part of a broader picture of professional reactivity to what it perceives as a challenge to its autonomy and power in the NHS. These assertions are based on an analysis of broad policy themes in the literature over the past twenty years, but the research challenge associated with this thesis was to explore these themes in the context of sound empirical data derived from the operational face of the NHS, i.e. individual provider Trusts.

Dealing With the Problematic of Researching Social Action.

The third strand of the thesis was concerned with the methodological problematic associated with observing quality in practice, exploring the ‘tribal’ association of organisational groups with differing types of quality activity, and how best to facilitate the theorising necessary to explain the evidence. The thesis outlines the essentially ‘social’ nature of quality; in that if quality is to be realised at all then it is dependent on the social action and agency of individuals and groups. With this in mind, the essential problematic can be posited as achieving an appropriate balance between the theoretical dimensions of holism, individualism, explanation and understanding. The thesis responded to this problematic by developing a multiple case site methodology using the organising principles of stakeholder analysis and between method triangulation as the essential components for data collection and analysis. Data was collected using a combined strategy of depth interviews, participant observation and Q-methodological statistical modelling. There were a number of reasons why the chosen methodology, albeit a complex one, was deemed the most appropriate means of exploration. First, the phenomenon of quality, with its social locus and poor empirical research-base, could safely be hypothesised as having multiple factors contributing to its use and development in organisations which were, as yet, unmapped and therefore could not be ‘controlled’ or foreseen; both of which would have been necessary for a quantitative or tightly structured qualitative approach.

Second, the pluralistic nature of the NHS quality picture as observed in the literature lends itself naturally to a theoretical stance which emphasises the active role of individuals and groups within organisations. The thesis, in adopting the case site approach, and within this the principles of stakeholder analysis, aligned itself with a number of key philosophical propositions:

- That reality is to some extent subjective; that is, different stakeholders will experience the nominally same phenomenon differently.

- Situations are not necessarily manifestations of single purposes and plans, but may be created by the interaction of multiple purposes and multiple agendas for achieving them.
- The post-structuralist rather than structuralist view of the generation of behaviour; that is, much or all behaviour is the manifestation of cultural software internalised by social actors as opposed to the hardware of a basic structure of human personality acting as a fixed reality across people and over time.⁴

The third justification for the multi-method case site methodology adopted relates to the enhancement to construct validity which deploying more than one means of examining the nominally same phenomenon can offer. Moreover, in mixing the qualitative approaches of interview and observation with the statistical techniques of Q-methodology the researcher is afforded the opportunity to pursue deeper levels of knowledge and understanding regarding the concept being explored. The thesis used this ‘complementary purposes model’ to gather sufficient data to enable the researcher to theorise on the salient themes which emerged from the four case sites examined.

Painting a Contextual Picture of the Case Sites

Chapter Four provided the organisational-contextual backdrop for this theorising. Each of the four sites was very different in the ways in which they actualised quality and the structures, processes and stakeholders with which quality was expected to integrate. Marketown, was a large - ‘first-wave’ - NHS Trust with a strong political heritage and a senior managerial cadre overtly sympathetic to the Conservative governmental ‘mission’ of the NHS reforms. It had attracted funding as a Total Quality Management pilot site and orientated its efforts around the theories of Philip Crosby. It placed responsibility for technical quality firmly in the hands of management and chose to formulate standards for activity which were transparent to both its internal and external customers (sic.). However, unlike the Shiptown and Castletown sites these ‘external customers’ did not include local representative groups of ‘professional consumers’ such as the Community Health Council. Instead of the

CHC, Marketown chose to use lay members of the Non-Executive Trust Board as proxies for consumers and to employ a nurse as the consumer 'voice' in the system (through her role as the Patient Representative). The overall approach was one which favoured managerially-led structures and processes rather than professional efforts. Consequently, this site secured some of the lowest medical workforce involvement. Quality was devolved down to individual clinical divisions but with the central management structure maintaining close scrutiny and control via a full-time Quality Managerial Team and direct links to the Matron (Director of Quality). Professional quality activity was heavily polarised, with nursing being the primary clinical 'voice' in the centrally-sponsored quality activity of TQM and medicine choosing to pursue a separate policy of medically-led 'clinical' audit.

This overtly managerial stance was mirrored by Fishtown. Marketown, were also committed to the ideas of Total Quality Management, although theirs was a more 'down-home' framework grounded in a European context: the European Framework for Quality Management (EFQM). Again like Marketown, the Trust had been a pilot site for TQM (but on a regional level). What most characterised Fishtown was the degree of decentralisation in place. Clinical divisions within the site had almost complete autonomy to develop the characteristics of their approach to quality. With Post-Fordist structure and strategy a defining characteristic of the managerialization process in the public sector, Fishtown was the best exemplar of all the sites in terms of observing a 'classical' Post-Fordist attempt at organisational structuring for quality. This autonomy was granted in return for the achievement of corporate objectives. More than any other sites Fishtown had invested heavily on the creation of a support infrastructure in the form of four full-time 'Quality Advisors'. These were charged with the task of integrating managerial and clinical groups in the search for unified, corporate, progress towards a shared definition of quality. However, as in the other sites the medical world of clinical audit remained largely separate from the managerially-sponsored strategy of EFQM. Like Marketown, the Trust chose not to recruit lay members of the public, in either CHC or user-representative guises, into Trust quality activity. Instead, the Executive Management Group placed consumer representation in the hands of the Quality advisors. Unlike Marketown, the reasons

why were not overtly political; rather they simply felt no conceptual or moral compulsion to include 'outsiders' on a routine and formal basis.

Shiptown shared its Health Authority with Fishtown, but the two were almost diametrically opposed in terms of the structures and processes underpinning the actualisation of quality in the two sites. Shiptown adopted a far more hierarchical approach to the strategic planning and implementation of technical quality. The decentralisation of Fishtown was replaced by a central 'core' of groups; each of which defined the parameters of, and available resources for, quality within the Trust. The Trust had chosen not pursue the grail of Total Quality Management and instead had chosen a more inductive, developmental, process of organisational audits based heavily on notions of quality assurance and performance indication. The defining characteristic of Shiptown, however, was the relative lack of separation of its clinical audit structure from the rest of the Trust. The Trust had established a strong identity within the region revolving around its innovative use of the clinical audit process, and the audit department were a widely respected resource drawn upon by all clinical groups and strongly supported. However, despite the Audit Director's presence in the central quality structure it was clear that part of the reason for the successful integration of the audit and quality structures lay in his ability to distance himself from the work of the quality groups generally.

Castletown, the fourth site examined, also rejected the Total Quality Management route to quality, although in their case this was as a result of experience rather than conceptual objection. Prior to Trust status being granted they had also been a regional pilot site for TQM. The experience, however, was not a happy one; with the widespread perception that the commercial tone of TQM rhetoric did not sit comfortably within the culture of the unit. As a result of this rejection the Trust had chosen to pursue a strategy which focussed strongly on the pivotal role of the consumer and on their choices being expressed in their own words and directly into the management system of the Trust. The primary manifestation of this strategy was in the form of patient/consumer fora within the Trust and facilitated by senior managers (usually with a nursing background). These fora, however, resulted in very

little formal output in the form of action to be taken by the Trust. Although consumer 'voice' in relation to planned changes in the form of a new hospital site meant that of all the sites it was Castletown's consumers which came closest to representing the 'empowered users' which were such a dominant feature of all the sites' quality rhetoric. None of the groups observed, however, were attended by medical staff or managers from the 'business' structures of the site. A number of consumer-attendees expressed reservations about the likely effectiveness of the fora as a strategy for realising their wishes. Not surprisingly, the local Community Health Council were the most supportive of all of the external representative bodies interviewed. There was a very real sense of partnership between Trust and CHC and this was reinforced in the active involvement of the Council in the Trust's central quality structure.

The Role of Organisational Theory

Each of the case sites represented a different cultural context with which to construct, test and modify theory relating to the delineated and structured pictures of quality evident in all four. In order to do this it was necessary to clear some further conceptual space around the key elements of the emerging theory. Chapter Five undertook this function and advanced a number of arguments dealing with the substantive components of the thesis. First, as conceptualisations of 'organisation' formed a central strand (albeit often an implicit one) of the theoretical foundations for quality adopted in each of the sites, the thesis explored the conceptual anarchy which is the dominant characteristic of theory relating to organisations. The thesis demonstrated that organisations can be variously conceptualised as social systems; negotiated orders; structures of power and domination; symbolic constructions; or social practices. What is clear, however, is that each body of knowledge is of limited utility to a discussion of quality in organisations. The heterogeneous nature of the debate meant that using the concept of 'organisation' as the basis for delineation around quality in Trusts would result in findings which would be too easily disputed and lack the depth of 'fit' necessary for a robust and valid attempt at explaining the empirical picture observed. Instead, it proved necessary to go beyond the 'organisation' as the basis for argument and to attempt to construct an analytic framework which utilised

those concepts common to each conceptualisation of organisation – namely, power structural interest and organisational culture. Chapter Five recognised that each individual has some form of ‘stake’ in Trust quality. This recognition can be recast as, ‘each individual has interests relating to quality, its definition, operationalisation and its consequences’. These interests are shaped by the structures and power relations which characterise formal organisation. The ability to suppress or oppress interests relies in part on the levels of power the individual (or their group) possesses in the organisation. However, the exercise of power is not random in nature it is influenced by social rules and resources (structures); and equally importantly, the sets of shared values which characterise social groups. Chapter Five showed how organisational cultures (or ideologies as they are sometimes expressed) are constructed by groups over years in organisations; and at the same time act as normative frameworks of meaning for people to utilise as justifications for behaviour. In NHS Trusts the organisational cultures most often identified by other commentators are those of professionalism, managerialism and consumerism. The theoretical links between manifestations of quality and these organisational cultures are highlighted. For example, the ways in which professionals have adopted clinical audit as the model of choice for assuring quality amongst their constituency is shown to relate to the core ‘professional’ values of relative autonomy in practice and self regulation. Similarly, the ‘cultural’ model of quality as expressed by ideas of Total Quality Management are shown to be closely linked to the theoretical framework of ‘Post-Fordism’. A framework which has been hugely influential in shaping the values of managerialism over the past twenty years. These ideas form the theoretical framework for the analysis of the empirical data collected and can be summarised by the following paragraph:

‘Quality as it manifests itself in NHS acute provider organisations is a function of group values found in services. These values are represented in the organisational cultures of professionalism, managerialism and consumerism. Organisational cultures help define and shape the pursuit of group interests. Moreover, because social action in the pursuit of group interests is always mediated by power (i.e. your ability to pursue your interests and the ability of others to stop you) then the ‘pure’

operationalisation of quality along organisational-cultural lines will be heavily influenced by the composition of stakeholder groups and their consequent position in the power relations of the unit.'

The Structure and Form of a Contested Concept in the NHS

The above framework was deconstructed by Chapters Six and Seven. First, the results of the Q-methodological exploration made it apparent that assuming cultural allegiance on the basis of occupational grouping is somewhat misguided. The shared perceptions of participants in the Q-sorting exercise made it clear that professionals were just as likely to align themselves with groups of statements which placed consumer interests before their own and consumers were just as likely to value those statements which appeared to grant professionals *carte blanche* self-regulation and control over services.

Whilst the sets of shared values (factors) that emerged undoubtedly represented the values one would expect from proponents of professionalism, managerialism or consumerism, the membership of the groups defining them discredited the idea that factors would be made up of homogenous constituencies of occupational stakeholders. Several explanations of these apparent 'anomalies' were advanced.

First, the apparent dominance of consumerist perspectives (accounting for the range 35.4% to 54.2% of variance in all four sites) were advanced from a position of 'self reference' in the Q-sorters. This means that even though apparent anti-consumerist values were promoted by observed behaviours in the Trusts, and these appear to negate the value stances expressed in the factors derived from the Q-sorts, the factors represent what could count as credible accounts in the cultural groups that define them. Consumerist messages formed a central strand in groups' attempts to forge a power base in each of the Trusts and as such it is perhaps not surprising that members of those groups felt the desire to sort the Q-samples in ways which emphasised consumerist approaches to quality activity. If this assertion is followed through to its logical conclusion, then consumerism, or more specifically a consumerist stance on

quality, becomes a form of moral currency to be used in power transactions and negotiations between stakeholders in NHS Trust activity. Moreover, the rhetorical links between quality and consumerist values can be seen as one means of promoting a sense of synergy between the structural interests of these stakeholder groups.

The use of consumerism as the language of choice in struggles to reconcile competing sets of structural interests within NHS Trusts, despite encouraging *synergy*, may not necessarily involve a requisite amount of *symmetry* between the parties involved. Specifically, given the qualitative picture outlined in Chapter Seven part of the attractiveness of consumerist language and expressions of value lie in the relative ease with which their operationalisation in services can be controlled by more powerful groups. Further evidence for this assertion could be found in the ways in which the overtly consumer-focussed agenda of the Castletown consumer fora were manipulated and controlled by the clinical-managerial groups present. To the extent that artificial boundaries were placed on consumer's abilities to raise issues. Whilst some of the service users present recognised the direct exercising of power and suppression of interests by a more powerful group, there was enough evidence in the data collected to lend credence to the argument that quality, like many other NHS technologies, has become a useful mechanism for a more covert form of interest suppression. When viewed along Lukesian⁵ lines, quality has become a mechanism for aiding the exercising of power in ways in which service users fail to even be aware that their interests may be threatened or harmed.

Of course the alternative explanation for the apparent prevalence of consumerist values amongst opinions on quality is that consumers, or more accurately, their representatives, are managing to fundamentally impact on the shared perceptions and ergo ideologies of professional and managerial groups. This argument, that the traditional ideological boundaries of organisational-cultural groups are becoming blurred, also retains a degree of elegance in relation to the apparent absorption of managerial ideas by professionals and the seemingly positive valuation of traditional 'professional' values of autonomy and peer review by some managers in sorting the Q-samples. However, given the qualitative picture painted by Chapter Seven, and its

role as a means of contextualising the Q-findings, this hypothesis lacks sufficient explanatory power. Specifically, it fails to offer a purchase on the motives for such apparent cross-pollination and blurring of ideological components.

The Q-methodological exploration of stances on quality activity managed to confirm the presence of several orthogonal, independent, factors. Each of these factors resemble points in the theoretical typology previously constructed portraying quality activity as segregated along the ideological categories of professionalism, managerialism and consumerism. However, at least one of the essential components of this typological theory does not 'fit' with the results. Specifically, the role-based adherents of these ideologies, clinical professionals, managers and consumer advocates, did not conform to some *a priori* hypothesis of homogeneity in their perspectives. Some potential reasons why are outlined above but perhaps the most convincing explanation lies in the characteristics of the methodology itself. Q, as a stand-alone methodology, generates accounts (factors) that *could* count as convincing amongst the people carrying out the Q-sort exercise. This would mean that if Q had been the only approach to the analysis of stakeholder perception and social action deployed in this study there would have been a theoretically significant gap in the knowledge generated. However, the multiple method triangulation, as one characteristic of the methodology adopted, enabled comparison of people's verbal accounts and individual/group action on quality with the Q-modelled perceptual map. Whilst making the analysis more complex due to the multiple sources of data it does add a degree robustness to the final analysis.

Chapter Seven's qualitative analysis demonstrated that part of the reason that the Q-based exploration failed to fully confirm the initial, albeit tentative, hypotheses is that the primary characteristic of social action and group cohesion around the issue of quality in services was one of complexity. However, in offering a more complex, (or alternatively, richer) account the data promotes the detailed exploration of the apparent heterogeneity portrayed in the Q findings.

The qualitative accounts of individuals, coupled with observed periods of stakeholder activity taking place within the label of 'quality activity', demonstrated that four main variables proved influential in shaping an individual's contact with quality and the consequent views expressed and action observed. These variables or influencing factors defined the 'stake' that the individual possessed in respect of quality activity in each site. The members of the groups within these delineating categories became the 'stakeholder' groups associated with quality in the sites.

First, in each of the sites there was evidence to suggest that the initial *prima facie* hypothesis advanced throughout the thesis had a degree of analytical utility. A person's occupational group appeared to be a strong force in shaping their participation and self-reported values on the issue of quality and its operationalised forms in services. In each of the Trusts there were common occupational patterns observed, usually revolving around the problematic nature of securing medical involvement in core, managerially-sponsored, quality activity. As a consequence of this lack of medical representation a peripheral (to the Trust management, not the doctors) strand of the Trusts' quality strategies had to be developed dealing with a 'professional' form of quality. This strand conventionally took the form of clinical audit, which in each of the sites was still a primarily unidisciplinary entity and some way removed from the multidisciplinary ideal promoted by purchasers, the Department of Health and senior Trust managers. Nurses too formed a significant strand of the audit component of Trust activity and when Trust managers made claims of uniting clinical audit and management-sponsored approaches such as standards-based monitoring, it was nurses that formed the constituency involved. This occupational demarcation applied with similar force to consumer-representative and managerial groups. Each group's level of contact with quality had a similar 'flavour' - whether the Trust subscribed to a Total Quality Management, in-house standard setting, or consumer-focussed basis for its strategy. Managers tended to align themselves with techniques which had at their core the 'managerial' values of measurement, transparency, goal setting and objective achievement. Consumer-representatives were brought into those arenas which lacked the 'hard-issue' focus of clinical work or managerially-controlled financial resources, and steered instead

towards those areas of Trust activity which the more powerful Trust groups felt were 'suitable' for lay involvement: consumer-initiated complaints, the environment of care delivery in the form of décor, and issues such as the acceptability of various waiting time options or staff uniforms in outpatient departments. This occupational group factor had enough evidence in each of the sites to suggest that it could usefully offer the researcher a partial lever on understanding likely allegiances around quality. However, it quickly became clear that occupational grouping alone was not the only factor influencing the formation of stakeholder groups around the issue of quality.

The second factor which acted to define an individual's relationship with quality in the Trusts was that of hierarchical position. In each of the sites the higher up the core managerial hierarchy an individual was, then the stronger their allegiance to the conceptualisation of quality promoted by the quality strategy of the Trust. In each of the sites the core managerial team from Chief Executive down to Divisional Managers were closely aligned to the strategy. It was at the level of decentralised divisions and clinical and managerial 'firms' within them that the major deviations from the 'managerial' strategic vision of quality occurred. Stand alone initiatives developed amongst the managerial and nurse-managerial cabals which were then applied to the nursing workforce. Significantly, it was at this level that the major professional-managerial splits occurred. Uniprofessional audits were the primary (and most valued) form of quality activity amongst professionals at divisional level, and in only one case (Fishtown's Surgical Division) routinely involved a manager and then with limitations placed on their involvement.

The third influential factor in defining allegiance was that of outsider versus insider status in the local health care market. There were limitations and boundaries on the degree to which outsiders such as purchasers or local community-representative organisations were able to access the quality machinery of the Trusts. This finding explained those negative cases where consumer representatives were seen to play a central part in the quality strategy and its processes in Trusts. For example the 'Patient Representatives' in Fishtown and Marketown were involved in 'closed' areas such as professional audits and managerial standard setting. However, their involvement

could be seen as allowable due to their fundamental difference in status from the 'outside' representative agencies of the CHC or service-user fora members.

The stakeholder split was also centred on individuals' direct links with the official quality strategy (i.e. the approach sanctioned by Trust senior management). In each of the Trusts there were individuals with a direct reliance on the operationalisation of quality for their role in the organisation. The Quality Advisors/Patient Representatives in Fishtown, the Quality Manager in Marketown and the Quality Manager in Castletown were all examples of this new managerial 'cabal' in the NHS.

Membership of this group was a powerful influence, as one might expect, on the value stance and associated action taken on quality. However, even amongst these groups there was a recognition that quality alone would not be sufficient to secure long-term credibility or a continuing role in the organisation. There was evidence that these individuals and groups sought to reinforce the links between quality and the 'bigger' concepts of 'consumerism' and 'business'. In Fishtown, Quality advisors (almost overnight) absorbed a patient representation function, a trend which featured in all the Trusts, albeit without the accompanying shift in job title. Whilst acknowledging the limitations of such responsibility there was also widespread recognition of the positive impact such a shift could have in terms of their own continuing existence within the organisation. The rationale for the linking of quality to these twin sources of legitimacy in NHS Trusts could be seen from a variety of perspectives.

One way of interpreting the alignment was due to the cultural alienation of those specifically charged with operationalising quality. Clinical professionals often perceived them as out of touch with 'their' reality and middle managers saw them as lacking in any real managerial role: i.e. they rarely had a budget or a distinct area of accountability. From this perspective the alignment of quality to the two categories of interests which are probably the most influential in the ideologies of professionalism (in the consumer interest) and managerialism (in the business interest) becomes an attempt to secure a sense of involvement with the groups most associated with these two organisational sets of values. This strategy appeared to be having only limited success however; quality activity, and therefore the activities of the quality specialists,

were acknowledged by both direct stakeholders and the mainstream professional, consumer-representative and managerial groups as marginal to the core activity of the Trusts.

If the above groups represent the primary stakeholder divisions and therefore the first dimension of the conflict that surrounds quality at the level of acute NHS Trusts, then the analytic categories surrounding the focus of group differences derived from interviews, observations and documentary analysis represented the second dimension. The study found that conflict surrounding quality focussed on eight key areas:

- The preferred means of operationalising quality
- How technical quality should be defined
- How technical quality should be evaluated
- The interaction between information and quality
- The interaction between the concept of ‘the market’ and quality
- The interaction between organisational structures and quality
- Questions of leadership In relation to quality.

It is possible to visualise the picture of the general findings of Chapter Seven along the lines of a two dimensional analytic matrix: along one axis lies the stakeholder categories and along the other lie the contested themes. It was not surprising then that this analytical matrix, which forms the basis of stakeholder analysis as an organising principle for research, yielded an overall picture which suggests that the points in the matrix were characterised by shared sets of structural interests. For example, those with a direct stake in the success of the quality strategy tended towards a fairly homogenous view of the worth of a structured approach to quality which depended on an active role for management. Similarly, it was not surprising given the encouragement of a local health care market that those with the biggest stake in relation to their ‘insider’ status felt the need to retain a sense of control over the shape, and constituency, of any evaluation of the quality of their service.

Power And Interest As Explanatory Factors

Relative power was an important dimension in shaping the interest-constituencies in Trusts. This was especially so in the case of the medical profession. They were largely free to dominate attempts to shape the pursuit of interests in Trusts. They were able to define the focus of quality activity, and what constituted quality itself in the form of professionally-developed standards. Others were less able to influence this agenda: outsiders involved in community representation being the prime examples. For consumer representatives, a measure of oppression was clearly evident in their ability to pursue interests which reflected their values. Fora involving them were controlled, membership of influential committees limited, and the marginal nature of quality itself meant, that even where consumer representatives were involved their ability to impact on the business of the Trust was again restricted.

There was evidence to suggest that quality acted as a mechanism for dominant groups to suppress the interests of others. Some nurses, for example, seemed unaware that some of the initiatives dressed in the clothes of quality, such as the Nursing Quality Index in Marketown had the potential to act as precursors to strategies which might harm their status or interests. As some commentators have highlighted⁶, such techniques can act to facilitate standard packages of care and the explicit evaluation of nursing worth.

What these characteristics show is the possibility that groups are defined on the basis of their relative power in services. What differentiates the stances and social action of the stakeholder constituencies identified was their ability to exercise power in pursuit of interests and the nature of any power they possessed. Certainly, all three of Lukes'⁷ dimensions of power were evidenced in the study and quality acted as the arena for the exercising of these dimensions. The uniting force of similar levels of position power in individuals can be seen in the hierarchical split in the accounts relating to quality in Chapter Seven. Similarly, common levels of expert power were a unifying force between groups, not just professional groups but also the 'experts' in their own spheres of operation: quality managers and consumer-representatives as well as

medical consultants and nurses. Just as vital, however, and harder to plan the research around, was the influence of personal power and charisma in shaping the direction and coverage of quality in services. Incompatible personalities, especially in Marketown within and between the CHC and the Trust, were seen to mitigate against even the most synergistic systems for marrying quality and good intentions.

The exercising of this power invariably created winners and losers in the sites. A fact which most groups recognised; unfortunately, the strategies and policies developed at Trust level did not. People appeared to recognise the impact of organisational culture on the actions of their constituencies and the constituencies of others but were somehow unable to translate this recognition into sensitive organisational policy.

Before, outlining the policy recommendations arising from the Thesis it is necessary to highlight some methodological issues which arose during the and after the analysis.

Some Methodological Reflections

During the course of the study, the feeding-back of the results and dissemination of findings to peers and colleagues a number of methodological points arose which, if the study were conducted again, would be given serious consideration.

First, there is the question of generalisability; the study was conducted across four acute Trust case sites in one NHS Region. Consequently, there is a sense in which the results are of limited use to policy makers (whether Regional, Trust or ward-based) in other areas. This is certainly true if one adopts a positivist stance on the question of research generalisability. However, the aim of the study was to explore the concept of quality and its operationalisation in NHS Trust settings. In doing so, the study has constructed an analytical framework firmly rooted in the organisational literature, and has collected empirical data as the basis for the deconstruction and reformulation of the original theoretical framework. It offers a conceptual approach to the exploration of quality which policy makers could usefully apply to their settings as a means of approaching the day-day management of quality. Based on this study, a managerial approach which emphasised likely stakeholder-group conflicts in the areas of quality

definition, evaluation, preference, structural support, information, the role of the local healthcare market, and leadership would have a degree of utility. Similarly the complementary analytic dimension, the nature of the stake which people are defined by, means that planners can incorporate likely conflictual boundaries and the nature of the structural interests represented within them into local policies.

The Q-methodological aim of grounding statements in the language and contexts of each individual site which led to the application of four separate Q-samples might also be revisited in future work. Whilst the resulting factors gave a rich and contextualised picture it would have been methodologically useful to repeat the q-sorting exercise with a more limited, single, Q-sample across all four sites. This could be based on the detailed analysis of a preliminary pilot study. The resultant data would lose little in richness (the number of replications could be increased to adjust for peculiarities in dialect or context) and the end structure of the factors would have been simpler to interpret. Although without access to greater resources for fieldwork and printing this was impossible to achieve in the current study.

Ideally, the study could have incorporated more fully the dimension of time into the analysis. Given more resources the processes of the social construction of quality in each of the sites could have been given increased depth by mapping them in 'real time' and relying less on reflection, self reported behaviour and limited observation. Every precaution was taken to cross reference where possible people's accounts with others who were involved but there is always the danger in studies of this kind that perception can re-write the reality of the situation in the absence of discursive counters. Feeding back the results of the analysis to players within the sites helped prevent this phenomenon, but a 'time-series' approach to the development of initiatives such as the Patient Fora in Castletown would have added value to the analysis. It is doubtful that the final picture would have changed significantly, but added depth could have been a characteristic of such an approach. Both of these methodological issues have been incorporated into a study of nurse's use of research evidence in clinical decision making⁸. This study will incorporate a single Q-sample and time series analysis of discrete elements of care within the research strategy.

Given the methodological weight attached to triangulation in the study it would have been advantageous to follow the logic of replication to its logical extreme and to attempt to 'validate' the analysis in a large-scale attitudinal exercise, probably a survey. Whilst theoretically possible, this had a two-fold dilemma associated with it. The first was the lack of adequate resources; the second, however, was less easy to reconcile and related to the mixing of qualitative and quantitative techniques. It can be argued that the study already mixes both paradigms via the incorporation of Q-methodological data in the analysis. However, as Chapters Three and Six showed, Q is sympathetic to both paradigms and works in harmony with the assumptions of both positivist and interpretative traditions. Moreover, the hypothetical framework 'tested' by both Q and the qualitative exploration was the same – albeit with slightly different techniques and starting points. Simply using an attitudinal survey to test theory, along conventional R-methodological statistical lines would have required a fundamentally different set of research hypotheses, i.e. ones that were already developed. At best this would have required a separate study and at the very least deserved a separate phase in this study with new sampling techniques and analytical boundaries. This was clearly beyond the scope of this study, representing, as it does, a starting point for the conceptual exploration of this contested concept.

These methodological issues lead naturally to the establishment of future areas for research. In particular, the large scale utility-testing of the analysis on a larger, randomly selected, NHS population. There are other areas which the thesis has unlocked and deserve scrutiny some of which could usefully dovetail with the NHS Research and Development strategy aims of bringing the aims associated with clinical effectiveness to NHS organisation and management⁹. One urgent example would be a controlled study of models of Clinical Governance with the aim of gauging effectiveness in changing corporate and clinical behaviour and organisational outcomes. A second study, would be a quasi experimental approach to mechanisms of user incorporation in the Trust Board Sub-Committees as suggested by the latest NHS White Paper¹⁰ would also represent a timely and proactive area of scrutiny.

Quality: The Continuing Struggle to Marry Clinical and Corporate Governance

The findings presented in this thesis have direct policy relevance. Quality, and its associated techniques and rhetoric, are once again on the ascendancy within NHS policy. The White Paper '*The New NHS: Modern Dependable*'¹¹ places a renewed emphasis on quality and does so in more detail than any other document derived from the highest policy level in the NHS for some time. In its own words the aim of Governmental policy on the NHS is to:

'...shift the focus onto quality of care so that excellence is guaranteed to all patients, and quality becomes the driving force for decision-making at every level of the service' (original emphasis)¹²

The White Paper still relies heavily on the colloquial use of quality as a marketing tool, but more than any other recent policy document, begins to make the operationalisation of quality – its technical dimension – explicit. For example, for the first time there is a set of criteria, albeit vague ones, for what constitutes a desirable organisational approach to quality:

- *quality improvement processes (e.g. clinical audit) are in place and integrated with the quality programme for the organisation as a whole.*
- *leadership skills are developed at clinical team level*
- *evidence based practice is in day-to-day use with the infrastructure to support it*
- *good practice, ideas and innovations (which have been evaluated) are systematically disseminated within and outside the organisation*
- *clinical risk reduction programmes of a high standard are in place*
- *adverse events are detected, and openly investigated; and the lessons systematically learned from complaints made by patients*

- *Problems of poor clinical performance are recognised at an early stage and dealt with to prevent harm to patients*
- *All professional development programmes reflect the principles of clinical governance*
- *The quality of data collected to monitor clinical care is itself of a high standard.*¹³

In many ways the policy recommendations of the thesis are usurped somewhat by the broad thrust of the intentions associated with the ‘*New NHS*’-based reforms. However, from a researcher’s perspective this fact is encouraging as it adds weight to the validity of the main findings and analysis.

Perhaps the most significant element of synergy between current policy on the NHS and the thesis is the potential for negating some of the effects of the ‘insider-outsider’ market-based stake in quality associated with the abandonment of the internal market itself. Although the basic, and continuing, idea of separating provision of services from the commissioning function still retains a degree of potential for tribalism. In theory at least the abandonment of the rhetoric and some of the bureaucratic machinery of the internal market should lead to a greater sense of synergy with regard to quality between those providing the services and those commissioning them. There was little doubt during the analysis that the market acted both as a primary means of defining one’s stake in quality and also as a focus for quality-based conflict within and between other stakeholder groups. However, it remains to be seen whether a simple rhetorical shift and a more flexible conceptualisation of the mechanics of the commissioning-provision agenda will be sufficient to break down the barriers created around quality.

One of the reasons why the barriers developed in the first place was the relative lack of power of those associated with operationalising quality. One of the key recommendations arising from this study has to be the positive allocation of resources to those individuals and groups with a direct stake in operationalising quality. Increasing the resources associated with quality explicitly, rather than a host of seemingly (at the ‘shop floor’ at least) rhetorically disjointed initiatives, some of

which have the term quality in and some of which don't (such as clinical audit), would have the effect of increasing the strength of the drive to operationalise this disputed concept. These resources, however, need not necessarily be financial. One of the most powerful resources managerial groups could draw on is an explicit framework of quality to draw on as a source of legitimacy and an ability to compel the disparate stakeholder groups to take a more unified approach to the concept. Governmental policy appears to go some way towards meeting both these recommendations.

In relation to an explicit framework of quality which will aid corporate governance, the new 'National Service Frameworks'¹⁴ appear to offer useful strategic means of breaking the current impasse between top-down vague policy messages of 'best practice' and the fragmentation encouraged by individual organisational innovation, or indeed stasis. The National Service Frameworks promise to incorporate:

*'the best-evidence of clinical and cost-effectiveness...together with the views of users to establish a clear set of priorities against which local action can be framed'*¹⁵.

The exact format of these frameworks remains to be established but on the basis of this study's exploration of quality they will need to establish reasonably explicit criteria if they are to avoid perpetuating the interpretation which has mitigated against a uniform approach to quality across Trusts; even where those sites share the same primary commissioner (as in Fishtown and Shiptown). This explicitness will also be required if the implicit Governmental policy of marrying the arenas of clinical and corporate governance¹⁶ is to avoid favouring clinical (and therefore, professional) governance. Vagary and lack of prescription in the frameworks will only serve to give the upper hand in the control equation to clinical professional groups and a continuing ability to define their particular brand of quality..

The lack of power of managerial and consumer 'tribes' to effect change on professional social action around quality could be addressed by giving them the statutory instruments to encourage action. Again this recommendation is partly addressed by forthcoming legislation. With regard to the influence of managers on professional activity, Chief Executives are to be given ultimate responsibility for assuring the quality of the services provided by their NHS Trust¹⁷. This shift

fundamentally alters the nature of the 'stake' or structural interest held by the Chief Executive role in relation to quality. The shift has the potential to compel Chief Executives to take quality seriously and gives them a personal stake in the operationalisation of the concept. Based on the two sites in which the Chief Executive was most closely associated with the work of the those charged with operationalising quality (Fishtown and Shiptown) there is some evidence that such an approach may go some way to achieving a greater sense of unity between managerial and clinical cabals. In both sites the Chief Executives were a powerful force in shaping the quality strategies and had managed to establish enclaves of professional-managerial co-operation (Shiptown had the central audit facility and Fishtown the collaborative efforts in Women's and Children's Services).

However, a note of caution needs to be injected into this changing Chief Executive role and responsibility. The thesis' primary finding that social action on quality remains segregated according to role-based groupings and the ideological foundations that underpin them (although as has been seen this is far from the sole delineating factor) essentially means that any strategy adopted to unite groups should not reinforce the split between them or their self-defined spheres of activity. The new powers and responsibilities given to Chief Executives, whilst reflecting the need for senior managerial control over the concept, are tied to the need to devolve day to day operational responsibility to a clinically-controlled Trust-Board sub-committee as part of the Government's *Clinical Governance*¹⁸ strategy.

The rationale for this course of action is easy to discern, and the results of this study would reinforce it; namely, that by allowing clinicians to retain management of other clinicians with respect to quality then the chances of influencing clinical behaviour will be that much higher. Certainly, in Shiptown where a respected clinician led the central audit facility, changing practice was a real possibility through clinical leadership and a sense of 'separateness' from the managerial core of the Trust. Similarly, where professionals were associated with roles subordinate to the core general management of the Trust then their professional status appeared to wither and their peers commonly spoke of them in ways which implied some form of cultural exile on their part thereby assuming the mantle of cultural outsiders. A useful example

here is the Quality Management team at Fishtown which were neither accepted as 'managers' by other managers or as professionals by the bulk of the professionals interviewed.

One of the most significant policy recommendations to arise from the thesis relates to the role of consumers in services; ironically, this is also the area least recognised by Governmental thought on NHS reform. A key finding of the study was that in no Trust site could consumers (or their representatives) be seen to play a substantive part in the corporate or clinical governance of the Trust sites. Of course there were lay members on Non-Executive Trust Boards, but with the exception of Marketown these played little part in the representation of consumer interests at the operational 'coal face' of the sites. There was clearly potential for greater involvement as demonstrated by the structural ideal of the patient fora in Castletown and a great deal of positive rhetoric from both consumer representatives, clinicians and managers. However, a role in governance *per se* was absent. It would be a significant policy step forward if the plans for Board sub-committees associated with clinical governance included more of an emphasis on consumer membership; at the moment there is none. Clearly, a great deal of the information collected by consumer representatives in this study did not find their way onto the quality agendas of Trust managerial and clinical committees due to the lack of a structural entry point for the data.

Conclusion

This thesis represents a theoretical entry point for the further exploration of the contested concept of quality in public services. It has shown how the concept has technical and colloquial dimensions and that the two are not always compatible. The central analysis shows how the concept is delineated along occupational-ideological lines but in ways which are far from 'pure' and free from mediating variables. The thesis demonstrates that mediating variables such as power and structural interest are equally as, if not more so, important to policy makers seeking to balance corporate, clinical and user demands, than rational exhortations to individuals and groups to achieve simple notions of colloquial quality. Achieving a balance of corporate and clinical governance in respect of 'quality' will require policy solutions which achieve

a balance of top-down explicitness and bottom-up innovation. The ability to move beyond managers as the constituency of choice to take charge of quality is essential if clinical involvement is to be secured in a meaningful way. However, simply handing the reigns of the quality industry over to professionals is unsatisfactory if user-led structural interests are to be incorporated in ways which remain tangible and relevant to this constituency.

Perhaps the time has come to develop a new language and suite of techniques to achieve the goals of quality and perhaps even to expel the term quality from the NHS rhetorical dictionary altogether. In an era which has seen the creation and subsequent partial abandonment of the language and structure of the healthcare market in less than 10 years then such a scenario in relation to quality is not unrealistic. The dismantling of the technical quality machinery in favour of the NHS concentrating on new ways of pursuing colloquial quality – that which we all know but cannot verbalise -might even be accompanied by an explicit recognition of structural interests in the policy development process itself. In this way the principles and processes of Clinical Governance may only represent a small step in an incremental policy shift towards a model which moves away from vague unitary solutions on quality towards an alternative, increasingly pluralistic, model of User-Governance.

Appendix One: Factor Scores and Loadings for the Four Case Sites

table 1:a - *Factor Loadings: Marketown*

table 1:b - *Factor Loadings: Shiptown*

table 1:c - *Factor Loadings: Castletown*

table 1:d - *Factor Loadings: Fishtown*

table 2:a - *Factor Scores: Marketown*

table 2:b - *Factor Scores: Castletown*

table 2:c - *Factor Scores: Fishtown*

table 2:d - *Factor Scores: Shiptown*

Table 1:a *Factor Loading Matrix for Marketown*

role	fac1	fac2	fac3	fac4	fac5
nurse	772				
manager	710				
nurse manager	660	319		303	
consumer rep	658				
nurse	649				
manager	605				
consumer rep	579				
consumer rep	558				
consumer rep	558				
consumer rep	548				
nurse	329				
nurse	320				
consumer rep	319				
consumer rep	301				
manager		936			
manager		936			
manager		758			
manager		494		416	
nurse manager		320			
consumer rep		319			
manager		312			
manager		300			
manager		300			
manager		446	485		
nurse	413	398			
manager			846		
manager			325	832	
nurse			724		
nurse			700		
nurse			540		
nurse			522		
nurse			500		

role	fac1	fac2	fac3	fac4	fac5
nurse				809	
manager		328		580	-384
manager				484	
nurse		352		455	415
manager					
consumer rep				443	
consumer rep				398	
nurse				397	
nurse				332	
nurse				300	
nurse					749
nurse			-438		675
doctor					530
doctor			-324		521

factor 1 = consumerist
 factor 2 = managerial
 factors 3&4 = middle
 ground
 factor 5 = professional

Table 1:b Factor Loading Matrix for Shiptown.

role	fac1	fac2	fac3	fac4
nurse	801			-372
nurse	763			
nurse	640		353	
consumer rep	615			
nurse manager	606	485		
nurse	600			
manager	581			
nurse	579			
consumer rep	576			
consumer rep	492			
manager	411			
manager	403			
nurse		753	353	
consumer rep		742		
nurse		628		
nurse		609		
nurse	473	594		
nurse	445	466		
consumer rep		441		
consumer rep		432		
consumer rep		431		
manager		396		
manager		383		
consumer rep			-800	
nurse	473		534	
consumer rep			527	
nurse			523	
nurse			507	
nurse			503	
manager			496	
nurse			492	
nurse			492	
nurse				903
manager				891

role	fac1	fac2	fac3	fac4
nurse				760
nurse				711
manager				603
manager				407

factor 1 = professional
 factor 2 = consumerist
 factors 3&4 = middle ground

Table 1:c *Factor Loading Matrix: Castletown*

role	fac1	fac2	fac3
manager	901		
manager	810		
consumer rep	763		
manager	754		
consumer rep	744		
nurse	733		
manager			
nurse	692		
nurse	618		
consumer rep	610		
consumer rep	603		
manager	600		
manager	597		
manager	596		
nurse	542		
nurse	539		
manager			
nurse	411		
nurse	401		
manager	363		
nurse	352		
nurse		781	
nurse		752	
nurse		606	
doctor		603	
nurse		594	
nurse		573	
nurse		570	
nurse		496	
manager			
nurse		491	
nurse		424	
nurse		367	
nurse			890
consumer rep			873
consumer rep			806
nurse			757

role	fac1	fac2	fac3
nurse			747
nurse			649
nurse	373		396

factor 1 = consumerist
 factor 2 = professional
 factor 3 = consumerist

Table 1:d *Factor Loading Matrix: Fishtown*

role	fac1	fac2
consumer rep	814	
nurse	730	
consumer rep	709	399
nurse	699	499
manager	673	
nurse	672	
nurse	597	
manager	592	
nurse	579	
manager	512	
consumer rep	501	
consumer rep	483	
manager	483	
manager	481	
nurse	356	
nurse	352	
nurse manager		836
nurse manager		720
doctor	-354	712
nurse		703
doctor		651
doctor		638
nurse		630
doctor		621
manager		607

role	fac1	fac2
nurse		577
nurse		576
consumer rep		555
nurse		549
nurse		538
consumer rep		536
nurse		531
nurse		411
consumer rep		409
nurse		393
consumer rep		391
manager		375

factor 1 = consumerist
factor 2 = professional

Note that some individuals loaded significantly on more than one factor. Please also note that only the significant factor loadings are presented to promote ease of interpretation. So an example here is that Factor five in Marketown (the professional viewpoint) is best represented in the Q-sort of the nurse who loaded most significantly on that factor (factor loading of 749). Whereas the Q-sort of the manager who loaded significantly negatively on that factor (-384) best represents the antithesis of the point of view.

table 2:a - The Q-Sample And Factor Array Scores: Marketown.

The Issue Of Defining Quality:

<i>Quality is about leaving it to the health care professionals on the ground because they know how best the job should be done..</i>	0	-5	0	0	-2
<i>Most health care professionals know good quality when they see it. Its part of being a professional that they already provide good quality care..</i>	+2	-5	0	+3	+3
<i>Quality is about meeting the customer's requirements through a concentration on actively managing the processes of service delivery</i>	+2	+5	+2	0	+1
<i>Quality is about having a culture where everybody is linked together with a common aim of doing the right thing at the right time by getting the processes right</i>	+3	+5	+2	+5	+3
<i>Quality is about promoting access to services and choice for patients in the service itself; even before they get to us so they can choose where best to go..</i>	+5	0	-1	0	+1
<i>Quality is all about responding to customers ...not just in terms of meetings but actually listening to them and adjusting what we do as a response...its about giving people who use our services more power.</i>	+4	0	+2	+2	-2
<i>Doctors consultations are often immeasurable in terms of quality. So a lot of the techniques to do with quality promotion aren't that appropriate</i>	+1	-2	-2	+2	+4
<i>National quality tools and techniques, like all the fuss over outcomes, are of limited applicability to our local context. its quite easy to demonstrate that some of them are a load of tosh.</i>	-1	-1	0	0	0
<i>Managers concentrate too much on getting people to subscribe to standard specifications or ways of thinking about quality. The problem is these don't reflect all the different groups involved in hospitals</i>	+2	-1	-4	-1	+3
<i>The problem with quality as customer satisfaction is that in the NHS the customer isn't always right...whether that's the patient, the GP, or the DHA.</i>	0	+3	-3	0	+1
<i>By involving consumers and groups like the CHC in defining what quality is about in our service you just complicate the picture and then the important things get dropped.</i>	-3	0	+1	-4	+2
<i>Its all very well talking about involving consumers in developing and defining quality in services, but when it comes down to it getting them involved in any thing other than surveys is a waste of time ... they don't want to know.</i>	-4	0	+1	0	+1

EVALUATING FOR QUALITY:

Evaluation occupied a central position in people's accounts of the quality process - as it does in the Trust's quality

<i>Professionals should use the standards of the colleges and statutory bodies as guidelines for quality. As long as the standards of the relevant royal colleges and professional bodies are upheld then the quality of service will be more than adequate for most people.</i>	+1	-3	0	+1	-1
<i>Quality can be a good thing if, as professionals, its left to us to set the standards we are judged by ... after all, we're the one with the specialist knowledge</i>	-1	-5	0	+1	+5

<i>Although quality isn't always the easiest thing to measure, that shouldn't stop us looking at our care and attempting to measure the outcomes of that care. If we actually measure what we do then quality will rise</i>	+2	+3	-1	+5	+2
<i>You can only raise quality through active management scrutiny of the whole service, its processes and outcomes. Some people might not like that but its true.</i>	0	+1	+2	+1	-1
<i>We should make more use of patients views in evaluating the quality of the care we provide...not just through surveys, but by involving them directly in judging what we do.</i>	+4	-1	+1	+4	-5
<i>Although relations with the CHC have improved over the past 18 months I still think we could, in fact should, do more to involve them as representatives of the community in looking at what we do in terms of quality.</i>	+2	-2	-1	+3	-1
<i>Professionals resent the intrusion that TQM and all the other paraphernalia of quality makes on their ability to practice...its not nice being judged all the time.</i>	-1	-1	0	0	0
<i>Quality rests on solid, measurable outcomes. The process behind those outcomes should be professionally determined - you can't have a good outcome with a crap process...but the quality people don't seem to realise that.</i>	+1	-4	+5	0	+5
<i>Despite audit's role as part of the Trust's quality strategy there is no real desire on the part of management to actually use the information, its more a case of providing reassuring messages...</i>	0	+2	-1	-4	-2
<i>Service standards haven't really changed anything, first because people are too nice to use them properly and second, because nursing and medicine haven't really 'bought in' to the idea on a Trust wide basis.</i>	0	-1	+4	0	0
<i>Consumers don't always know what they want from services so using them to make judgements about them just gives you a misleading picture ..</i>	-3	+1	0	+1	+2
<i>Using complaints as a measure of quality is asking for trouble if you provide the means to make complaining easier then you just encourage more complaints form those difficult patients and their families. Consumers don't always know what they want from services so using them to make judgements about them just gives you a misleading picture ..</i>	-4	+1	-4	-4	-4
HOW DO YOU GET THERE? THE PREFERRED ROUTE TO 'QUALITY':					
<i>Quality is enhanced by the use of audits restricted to each professional group and which are confidential. Although I don't think they should be compulsory.</i>	-2	+1	+1	-1	-2
<i>Medical audit definitely raises professional standards in hospitals and is something that should be encouraged ... provided it stays confidential.</i>	-1	+2	-4	+2	+5
<i>The best way to promote quality is through changing service cultures via tools such as Total Quality Management. I think that we've done that here to an extent and quality has gone up as a result.</i>	+2	+3	-4	+3	+3
<i>Management-set standards have an important role to play in raising hospital based quality. Obviously professionals should be involved but they shouldn't always have the whole say.</i>	-2	+1	+1	+3	-5

<i>The best way to get to be 'good quality' in a hospital is by a combination of giving patients good information, allowing people more choice, and by us becoming a bit more accountable for our action. Quality is still too provider dominated ... we don't listen to patients nearly enough.</i>	+5	+2	+1	-1	+1
<i>If the users of our services were actually involved in making decisions about the future direction of those services then you might find that quality improves ... at least people will feel part of any changes.</i>	+1	0	+2	+4	-2
<i>All this corporate quality stuff is stupid. The best way to achieve quality in hospitals is to concentrate on audit. Audit that is confidential so people will take part. People just resent all this management stuff.</i>	-1	-1	-3	0	+1
<i>TQM just gets people's backs up. Nobody likes being told what they're doing is no good but they are better ways to go about it. Like the stuff that the Royal Colleges are doing ...professionals respect their techniques because its written by people who know what they are talking about.</i>	0	-4	-1	+1	-1
<i>I wouldn't say that TQM has been a complete failure but based-on where we are now after five years I can't say that its worked either.</i>	0	+1	+3	0	+1
<i>I don't think trying to change the culture of the Trust through management is the right approach...but I'm not sure what else we can do.</i>	+1	-1	-2	-1	0
<i>The problem with all the emphasis on consumer choice and involvement is that sometimes you can't offer it and then they just feel let down.</i>	+1	+2	+3	-1	+3
<i>I just don't think that offering everyone a massive choice of food, whether they get a mixed sex ward, or whether to get involved in decision making on the ward or not really matters, I don't think quality is really affected by these sort of things...</i>	-4	0	-3	-2	-2

ISSUES OF ORGANISATIONAL STRUCTURE:

<i>Devolving quality down to quality improvement teams in clinical directorates encourages better professional standards.</i>	0	+3	-5	+2	+3
<i>The decentralised decision making that clinical directorates allow means that professionals can better promote quality provision of care.</i>	+1	0	-2	+5	0
<i>Linking managers and professionals together in the quality improvement teams in each directorate has gone a long way in promoting quality structures and attitudes that are sensitive to each directorate's priorities rather than those of the management executive.</i>	+1	+5	-3	0	-1
<i>Directorate-based quality improvement teams reinforce links between quality, structure and flexibility in the services we provide.</i>	+2	+2	-5	0	+1
<i>The broken down structure of the clinical directorates gives us much more opportunity to listen to consumers directly rather than wait for the executive to tell us what people are thinking.</i>	0	+4	-2	-1	0
<i>We should use the ability to change the structure of wards and management organisation to get closer to people who use services and to respond a bit better...then maybe this would help quality.</i>	+1	+4	0	+1	0

The quality improvement teams within the directorates haven't really altered the way I think about quality or the way I do things for patients. -2 -4 +3 +4 -3

As a professional, its more important to me what my colleagues think rather than whether or nor what I'm doing fits with what the TQM people want me to do; because in reality, the QITs don't really have much say in our priorities as nurses. -3 -3 0 +2 -2

The problem with empowering individuals within the aims of each directorate is that we have lost control to an extent. -2 -2 0 0 -1

The directorate-based QITs maybe haven't been helped by centralised training. Because people go back to the wards after their quality awareness session, then that's it...there's no real follow up. +2 +2 -3 -2 +2

The clinical directorates and QITs haven't really done that much regarding our ability to listen to consumers, and adapt what we do as a result, any better...the reasons why go much deeper than that. +1 0 -2 -2 -1

I still think there is a massive gap between what the top want and what we can deliver in terms of patient choice and things like that. Its not all about money. But just making us more responsible through directorate-based QITs and TQM isn't the answer. +3 -2 0 -1 0

INFORMATION AND ITS USE:

We should release audit results to the community at large as an impetus to improving the quality of our services. +4 0 +3 -5 +5

There is too much secrecy attached to information on professional standards in the Trust...If it was more widely available then maybe people would pay more attention to them and standards would go up. +1 -1 +4 +1 0

Information about patient satisfaction, complaints and staff attainment of standards forms the basis of a good quality management strategy and decisions for action. +4 0 0 +3 +4

A picture of patients' views on services should be the foundation of all our quality activity as managers and as a way of taking groups forward around the issue of quality +3 -2 +3 +2 -4

Quality is about meeting expectations - ours and theirs, the patients. If we give patients all the information we have we shouldn't feel bad about that. Its not up to us to judge how little or how much they need to know. +5 +1 0 -4 +2

If we don't give patients information on care and services how can they question what we do...and I think that quality will probably improve if patients are allowed to question the treatment and services we provide to them. +4 +1 0 +1 +1

I think we can give too much information to patients and relatives. They can be selective in what they listen to audit just raises their expectation of what we can deliver unnecessarily. -2 -2 0 0 +4

By giving information on quality to outside groups like the CHC we are just giving them a stick to beat us with. -1 -3 +1 -5 0

The quality of the information we can use to manage quality could be better because at the moment its unwieldy and difficult to use in any meaningful way...so quality suffers. 0 +1 +1 -2 0

You can't manage people without good information and at the moment the information is nearly useless...still I'm not sure that if the information was any better it would be easier to manage everyone. 0 -1 +1 -4 +1

We are in danger of offering people too much information. Consumers don't know how to handle the information we give them, and I don't really think they want too much anyway. -5 0 -1 +4 +1

I can't honestly see how giving patients tons of information is going to help them question what we do...not in the real world anyway. -5 +1 -3 +2 0

WHAT ABOUT LEADING THE PROCESS?

Hospitals are about providing care and treatment, and its professionals that do that isn't it...so it should be professionals that drive the process of quality improvement in a Trust. 0 -5 0 +2 +2

By giving nurses and doctors lead responsibility for developing quality in Trusts, people would be happier and quality would rise. +2 -3 -4 -2 -1

Managers shouldn't have to wait for professionals to come on board in relation to quality. I think a stronger managerial hand in the issue would be advantageous all round. -4 +4 +5 +1 0

Management should deal with recalcitrant professionals, one skin nailed to the door in the name of quality would soon get people to play along and take notice. -3 +5 +3 -5 -3

Quality in any Trust or organisation should be first and foremost led by the people who use that Trust...the customers. +5 -1 0 -3 -4

Professionals and managers should adjust how they do things in response to what patients tell them...out of all the groups involved in services it should be patients who hold the most sway. +3 -1 +1 -1 -5

The problem with quality is that it could lead to responsibility for leading the team on the ward being given to managers and outsiders rather than the people who know, like doctors and nurses. -1 -3 -3 -2 +4

I don't like the fact that outsiders are telling my team members about the quality of the service we are providing. 0 -2 -5 -2 -1

Part of good quality management is relinquishing control over the process. By that I mean we should let go a bit and leave it to others and maybe the chances of success would be a bit higher. 0 +4 +2 -2 +1

Management just respond to national priorities and objectives They have their own little agendas and do little to actually raise quality. -1 0 +2 -5 +3

I don't think making patients and the CHC the people to lead quality in the Trust is a realistic option. Its alright to talk about making providers less powerful but you need specialist knowledge about medicine and management to make quality control work. -3 0 +1 +4 +2

Patients should have a greater say in running quality in the Trust but not at the expense of people with more knowledge and skills. -1 +2 -1 +1 0

GOING TO MARKET: QUALITY AND PURCHASING-PROVISION.

The purchaser provider split has definitely helped in raising quality in professional care. The contract quality specifications system helps me set objectives for my practice. +2 0 0 0 -2

<i>From a doctor's point of view the fact that the DHA have a say in the audit agenda is a good thing . At least what gets audited is based on what they actually require to make good quality purchasing decisions.</i>	+1	+1	+2	0	-2
<i>Purchasers play an important role in setting and managing the quality specifications for a service and their influence should be strengthened..</i>	+3	0	-2	-4	-1
<i>The fact that as managers we have a good rapport with our purchasers is important. It has to be, much of what we do around the area of quality is taken on Trust, I personally think that's a good thing.</i>	0	+1	0	+1	-1
<i>Having purchasers and providers has done a lot to help make choice easier and because the health authority and GPs are supposed to involve patients in decisions then probably quality has improved too.</i>	+3	-3	+1	+1	-3
<i>Quality visits from the CHC and the DHA are probably more useful than contract specifications because it provides an opportunity for us to meet them face to face and for us to listen to what they want as customers.</i>	+3	-1	-1	+2	-3
<i>Our purchasers don't really understand about quality, or what they want from us, so they don't really alter the tings we do under the heading of quality...which is probably a good thing.</i>	0	+1	+1	-3	0
<i>Purchasers want all sorts of information on processes; information which we have to collect. I don't think that really helps because its time that could be spent at the bedside.</i>	+2	-1	-1	-3	-1
<i>Quality at the DHA is management driven with advisors pulled in generic roles when needed. Its a case of if the cap fits...we need a greater awareness of the need for technical knowledge.</i>	0	-1	+2	0	+2
<i>Patients Charter standards in the contracts are by and large inadequate but I'm not sure as managers we want any more...they create a higher workload with dubious results.</i>	-2	+2	+5	-2	+1
<i>I can see how the purchaser-provider thing might help patients in getting a greater say in services but in reality I'm not sure that it will have much effect.</i>	-4	+1	+4	+3	+4
<i>The health forums that the DHA and the CHC organise don't really achieve that much. All that happens is you get a lot of talk about what just a very vocal minority think is important. And it doesn't get fed back into what the DHA want from us.</i>	-2	+4	-2	-3	-1

QUALITY AND CONFLICT:

<i>TQM, and quality promotion generally, has been a good thing in that its got people from different professional groups talking together and reduced all the conflicts that go on in clinical teams.</i>	-1	+3	0	+5	0
<i>QITs have helped me understand better the work of others in the Trust, so from that point of view I think quality is probably a good thing and I think that over time we have developed a kind of common view on what constitutes quality in our directorate.</i>	-1	+3	-1	+4	-1
<i>Quality serves to strengthen management's hand in dealing with staff and consumer groups who act as impediments in the process of changing our culture in the trust to one which is concerned with quality first and foremost.</i>	-1	+2	-1	-2	-3

<i>Quality should be used in a positive way ... one which helps managers cope with the problems of dealing with the 'wild cards' in an organisation ... you know the ones who always think they always know best, 'their' patients and stuff like that.</i>	-4	+3	+2	+3	-3
<i>Quality and quality systems should be a means of reconciling the differences between dissatisfied patients and the hospital. If we involve patients in setting standards and, providing they have enough information, then we can show that we met the required standard.</i>	+2	0	0	+2	0
<i>By involving and listening to patients through things like health forums then there will be less disputes over quality, because they will feel involved.</i>	+4	0	-2	+2	-5
<i>Quality is just another means of preventing people working together properly. People do it but they're hearts aren't really in it.</i>	-1	-4	-2	-1	-3
<i>Part of the reason that they're are so few doctors on board in terms of quality is that the TQM thing and the people that run it just lack credibility...if you're not credible in the NHS and don't know what you're talking about then people won't respect you.</i>	+1	-4	+5	0	-1
<i>By establishing the QITs within directorates, objectives clash. Because they inevitably revolve around contracts and money is the prime mover rather than quality.</i>	-2	-2	+2	-1	+2
<i>I think a lot of clinicians think quality is a dirty word...they feel that quality is about the wall paper and the car-parking facilities. Obviously, the TQM managers and the purchasers don't so conflict is inevitable.</i>	-1	+4	+4	-3	+4
<i>By encouraging patients to question professionals and services all the time all you're doing is encouraging distrust and a sense of conflict between us and them that wasn't there before.</i>	-5	-1	-1	-2	-2
<i>TQM and satisfaction surveys don't help the patient who is really dissatisfied about his care. It just makes everyone really defensive so the quality suffers anyway.</i>	-3	-3	+3	+4	+2

QUALITY 'CONTROL' - THE PERCEIVED OCCUPATIONAL CONTROL FUNCTION OF QUALITY IN SERVICES:

<i>I think the quality strategy of the Trust has given me more professional freedom to take control of the nature of the service I am delivering.</i>	+1	+3	-2	0	-4
<i>People make a fuss about 'the managers in the quality department' taking over our work. But I think generally we have managed to keep hold of a fair degree of control over our practice and I think 'quality' helps us do that.</i>	-1	+2	-2	+1	0
<i>Quality is a means of management controlling what goes on in the organisation in ways which meet organisational goals rather than personal or professional ones. After all, organisational goals and priorities encompass these anyway...don't they?</i>	0	-2	+4	-1	-4
<i>I think allowing managers to gain control over a service through a combined multi-disciplinary approach to quality will, in the end, benefit quality.</i>	-2	+3	+4	-1	-3
<i>Quality systems should be used as a means of empowering patients, giving them more control over their experience of being in hospital. Obviously health care experiences differ according to how ill you are, but that doesn't mean that we can't at least try to offer proper choices, like between different surgeons for example.</i>	+3	0	+2	0	+1

<i>Nurses managers and doctors have too much power over what good quality is all about I think its time that patients and relatives had a say and we took a back seat...let them steer the bus for a while and see if our results improve.</i>	0	-1	+1	-1	-3
<i>Quality management is just another way of saying management control of professionals...</i>	-3	-4	-3	-3	0
<i>I just feel that quality is just another stick to beat us with for management.</i>	-2	-3	-5	-1	-1
<i>I don't think quality is really helping in management efforts to work together with professionals , its perceived as management business and as something managerial.</i>	-2	+1	+1	-3	+1
<i>Direct control through using quality systems isn't always the best way for a manager to influence what a consultant does.</i>	0	0	+4	+2	0
<i>Personally I don't particularly want some stroppy patient with no real knowledge of his condition or his medical needs controlling what counts as quality in what I do for him.</i>	-5	-1	-1	+1	-2
<i>Giving patients choice and control over food, admission times and stuff, yes...but over how I operate on them or what I do as a skilled professional, no...no way. You just can't run a service like that.</i>	-1	-2	-4	-1	+3

table 2:b - The Q Sample And Factor Array: Castletown

Defininition:

	fac1	fac2	fac3
<i>Professionals (nurses and doctors) know quality when they see it. That's why it should be left to them to define what it is.</i>	-4	0	-5
<i>You've got to make quality, and the standards you expect, explicit if you are going to try and define it in the workplace.</i>	+2	+3	+1
<i>I think quality works best when words like choice, customer-power, and voice in the system, actually mean something. If you want to define quality you've got to start with those three in mind.</i>	+4	+1	-3
<i>A lot of what I do as a professional is unmeasurable along quality lines. Quality initiatives don't always recognise this and consequently a lot of professionals see them as irrelevant.</i>	0	+3	0
<i>Part of the difficulty with quality in the Trust is that managers promote a view of quality that is 'managerial'. This doesn't refelect the opinions of other groups which are just as valid.</i>	0	+1	0
<i>You can concentrate too much on involving consumers and patients in deciding what quality is in the Trust. Its easy to forget that what we are here to do is to make people better and that's it.</i>	-2	-2	0

EVALUATING QUALITY:

<i>The only way to really ensure quality is to let the nurses and doctors on the wards set the quality standards. They are the only ones with the neccesary knowledge and skills</i>	-4	+1	-2
<i>Managers should be involved at every level, but especially in terms of deciding if a service is of good enough quality. It is their necks that are on the line if the customers get let down.</i>	+1	-1	-4
<i>The patient fora used in the Trust are an essential and notable means of listening to patients and using them to help evaluate quality in Trust performance</i>	+5	0	0
<i>If you leave it to the professionals alone to judge their work all you get is reassuring messages and a concentration on what is achievable rather than what the organisation needs.</i>	+1	-1	+2
<i>Managers concentrate too much on measuring and planning for stuff. Part of the problem with the NHS is that so much of what we do isn't that straightforward to measure or evaluate for 'quality' like that.</i>	-1	+2	0
<i>I'm not sure that most patients know what they want when they come into hospital. So to ask them to judge the quality of our service is a bit dubious isn't it.</i>	-5	-1	+3

THE PREFERRED ROUTE TO QUALITY:

<i>Properly conducted confidential internal audits which are limited to professional colleagues and exclude management are the best way to ensure quality in professional work.</i>	-2	-1	-2
<i>We've got to address real issues of ward culture, and the ways in which professionals practice if we are to make any more progress on quality as a management team.</i>	+3	0	0
<i>The best way to actually move towards quality in the Trust? - I think its about giving the people who use the services more say and a stake in those services. Not just lip service but proper control over the service where possible.</i>	+3	-2	+5
<i>What we do is quality; we recognise that. All the quality initiatives do is cloud the issue. The best way to pursue quality is to leave the professionals to get on with it.</i>	-2	-4	-1
<i>The patient forums are ok as far as they go. But as a manager I don't get that much out of them. We find that surveys are a more useful exercise in providing a base-line of opinion for developing quality.</i>	-1	0	-1
<i>All this emphasis on choice [as part of quality] does is raise patient's expectations unnecessarily. Its not always possible to meet those and so quality suffers.</i>	0	-3	+5

ORGANISATIONAL STRUCTURE:

<i>Obviously working on two sites is problematic, but from a professional point of view, directorates allow us more flexibility and freedom in terms of quality and the work of the quality champions.</i>	+1	-2	+1
<i>Having directorates and divisions means that managers and professionals work together for quality and that has to be good.</i>	+2	-5	-2
<i>Working in directorates and divisions means that we can organise fora and listen to patients more effectively than we could before. So in that respect making the divisions has helped quality.</i>	+1	0	+2
<i>Professionals care most about what other professionals think. The quality champions stuff is important but not at the expense of what colleagues think about the quality of your work.</i>	0	-1	0
<i>Having quality champions based in each directorate is unfair . They get singled out for training and get seen as high flyers . It doesn't help the idea of each directorate 'owning' their quality.</i>	0	-5	0
<i>The problem with divisions and divisional quality initiatives is that good practice doesn't go beyond that division - you don't share.</i>	0	0	+1

INFORMATION AND ITS USE:

You can tell people too much. Audit allows us to scrutinise practice but to keep the results in house. That means that quality goes up but not at the expense of trust between professional colleagues.

-1 +2 -2

Information is the key to the whole quality strategy. Surveys, patient fora and audit results should be the basis of the whole quality thing.

+5 0 -1

I think a key part of quality is about information. Proper stuff, not just patients charter rights, but how we actually do in relation to them. And also proper information about the outcomes of different wards - how can people choose when they don't have that information.

+3 +2 +2

I'm not entirely comfortable giving more information on the quality of our work to patients/carers. They don't have the knowledge and skills that come with being a doctor or a nurse to really understand a service.

-3 -1 -1

Its a bit of a joke talking about information-based management as a way of promoting quality. The sorts of stuff we collect is so limited that it really isn't that easy to use it as a way of improving quality.

-1 0 +2

Patients don't want any more information on the quality of the service we provide; it just makes them unnecessarily concerned.

-3 -3 +1

LEADING THE PROCESS:

Nurses and doctors provide the front-end care so it is entirely logical that they should lead quality in the Trust.

+1 +1 0

There comes a time when you have to say enough is enough with nurses, doctors and quality, and say 'you ARE going to do it like this' - its part of being a manager.

0 -2 -5

I think we have the right structure in place, with the CHC, the patients council and the forums; what we need to do now is make them the means by which the whole process is led.

+2 +1 -1

I think there is a danger in letting non-professional groups take control of quality in services. You need the knowledge and skills that come with being a doctor or a nurse to really understand a service.

-1 +4 -4

Putting management in charge of quality in the Trust hinders rather than helps. People just see it as another management thing.

-2 +5 +4

Patients don't want to take control of health care services as a part of a quality strategy. They want to come in get better and go home. Taking part in fora and interviews isn't on their list of priorities.

-3 +3 -2

MARKETS: QUALITY AND PURCHASING-PROVISION:

<i>The health commission by and large leave quality and audit to the Trust to sort out. Personally I think that's a good thing as they don't have the knowledge to scrutinise practice properly and so quality in the market is used effectively.</i>	0	0	+2
<i>I think its important to maintain good links with the purchasers and to include them in designing and evaluating quality in the Trust. They are an essential part of making quality work in the market - one of the customers if you like.</i>	+2	+2	0
<i>I think the purchaser-provider thing probably does help quality, in that Gps who are in touch with their patients have more of a say in the quality of services. If it isn't right they can get on the phone and get things changed.</i>	+1	+2	-3
<i>The paperwork that we have to collate as a result of the purchaser's interest in quality doesn't achieve anything in terms of quality of clinical care.</i>	-2	+5	-1
<i>The purchaser-provider market is just one lot of managers at the Trust talking to another lot at the Commission. Its all about money and nothing to do with quality.</i>	0	-1	+1
<i>Having purchasers has done absolutely nothing in terms of quality from the patient's viewpoint. Its all done for them rather than with them - choice is non-existent.</i>	0	0	+4

QUALITY-BASED CONFLICT:

<i>Clinical audit helps bring professional groups together. It gets people talking a common language and reduces the tensions you can get when doctors and nurses get together.</i>	+4	-2	+1
<i>Quality needn't necessarily be a focus for aggravation between nurses, doctors and managers. It can be used as a means of getting everyone talking the same language and moving towards common goals.</i>	+4	+2	+3
<i>The quality strategy means more people complain, because they feel able to, but more people are satisfied with the outcome of the investigation of complaints; because we make a point of actually listening and doing something about them.</i>	+2	+3	-4
<i>Quality standards, forums and quality stuff like that are just an excuse for 'consultant bashing', quality causes more arguments than it solves.</i>	-1	-4	-1
<i>Quality is pretty low down on most managers agendas in the divisions. They have to worry about balancing the books first and foremost and so there is an inevitable conflict between what they want and what they can achieve.</i>	-3	+4	+4
<i>I don't think there is any benefit in asking patients to constantly question what we do to them all the time.</i>	-5	-4	+3

CONTROL

<i>The emphasis on audit and quality has meant that nurses and doctors have been able to retain a fair amount of control in our practice. Its designed not to threaten us too much and that's a good thing.</i>	+1	+1	-3
<i>Managers need to concentrate on using quality as a means of encouraging a Trust-wide vision of quality. Its not enough just to leave it to small pockets of professionals in each directorate.</i>	+3	+1	+3
<i>The whole point of quality is to try and make patients take more control over their health care. All our efforts should be in trying to get people to take more control - and that means letting go of some of our power as a Trust.</i>	+2	-3	0
<i>All this emphasis on quality is just an extension of the managerial reforms of the 1980s. Its just a way for managers to encroach into professional life and ways of working.</i>	-1	-3	+1
<i>Quality isn't about managers 'controlling' professionals. Its more subtle than that. Its about empowering them so that they do what you want of their own accord.</i>	0	+4	0
<i>Quality is just another means of getting consumerist ideas on the agenda. But it rubs people up the wrong way. Nobody likes being told how to do something by someone who hasn't a clue about what its like to be a nurse or a doctor, or even a manager for that matter.</i>	-2	0	+2

table 2:c The Q-Sample And Factor Array: Fishtown

Defining Quality:

	<i>fac1</i>	<i>fac2</i>
<i>Its the consultants who decide what constitutes quality in medical work and this generally works well people feel accountable.</i>	-2	0
<i>It's vital that measurement and definitions of quality go hand in hand. The key to a definition of quality in a service is one in which performance can be measured and indicators developed.</i>	0	-4
<i>The only people who have any really legitimate claim to be able to define what counts as a quality service are the people who actually receive it.</i>	+4	-5
<i>Quality is too important to be left to the medics to decide. We all have a stake in the service and we all get just as much flak when it goes sour.</i>	+3	+4
<i>Managers completely miss the point when they try and define quality. They concentrate too much on textbooks and 'gurus' and paperwork and stuff.</i>	-2	-3
<i>Patients have neither the knowledge, skills or desire to start defining the quality of professional work.</i>	-4	-4

EVALUATING QUALITY:

<i>Its not up to managers to decide whether what we do as professionals is of a good enough quality. Our royal college standards and those we set locally do that already.</i>	-1	+5
<i>Judging quality is all about how we perform over time and in relation to our own measurement criteria and those set by our customers.</i>	+4	0
<i>It is vital that we increase the role of patients and the community in judging the quality of our services and not just by asking them to fill in another questionnaire.</i>	+3	+2
<i>Its all very well letting Drs and nurses decide that their work is excellent or of good quality, but not every one, patients included, is always happy to take their word for it...we need evidence.</i>	+4	-2
<i>The indicators that the purchasers and ourselves use are so crude that measuring quality is a little meaningless.</i>	1	-1
<i>getting patients involved in deciding if what we do is quality is a dangerous game. What are we going to be able to do about it if they say our service is crap?</i>	-5	-3

THE PREFERRED ROUTE TO QUALITY:

<i>Medical audit provides a good vehicle for evaluating quality...it works because it has credibility from a professional point of view.</i>	-1	+3
<i>The best way of moving towards quality is through the model we are piloting here - the EFQM and patient focused approaches. These provide a framework for action and some kind of logical structure.</i>	+2	+1
<i>I would like to see patients forums or councils established for each division and for these to have a real say in the development and evaluation of initiatives to do with quality.</i>	+2	0
<i>Clinical audit in any real sense is too limited in scope, there has to be areas which are restricted to each profession because only they have the prerequisite knowledge to participate - so audit by Drs and nurses alone is a good thing and should continue.</i>	-3	-1
<i>Quality advisors are supposed to be management's way of getting quality in to the Trust. But no-one knows what they do exactly.</i>	0	0
<i>I don't know that patients forums and things like that actually do that much. My experience at other places is that people get bogged down on the minutiae of ward routine rather than seeing the bigger picture.</i>	-3	-2

STRUCTURING FOR QUALITY:

The divisions and directorates are useful from a professional point of view as it is possible to make decisions which impact on quality without having to refer everything back to the trust constantly. +1 +3

Having quality advisors outside the divisions has its advantages. For one, it doesn't get everyone's backs up all the time, because we don't have the power to say 'you will do this', because we aren't part of the line management hierarchy. Sometimes you get more done by advising as opposed to ordering. -1 +2

The ways in which the hospital is structured is confusing for patients. Not just the physical layout but also the management and divisional structures, they don't know what everyone does - like the quality advisors. The first step towards a really quality service should be reviewing those structures. 0 +1

I think having divisions and directorates is just another means of getting 'competition' and efficiency into our work. It will do little to raise quality as communication between the divisions is made more difficult. -4 -2

I'm not sure that being part of a division has raised the quality of my work from where it was before. In fact in some ways it has made management more difficult because of the pressure from above and below that didn't seem so acute in the old structure. +1 0

As someone involved in the Trust as an outsider, I find it very difficult to go straight to the person I need to speak to. If I go to the quality advisors they aren't part of any single division so its difficult to get accurate, hard, information. 0 -2

THE ROLE AND USE OF INFORMATION:

I don't see that making our audit results common knowledge within the trust would necessarily harm us as a group of professionals, because by and large they are OK...and where we aren't we try and put things right. +1 +2

The key to a quality service is easy access to credible, up-to-date information on cost, volume and quality at all levels of the organisation. +3 +2

We give out patient information leaflets to do with health promotion and stuff, but I would like to see greater patient access to management and professional information like standards and the cost, volume, quality data we track. +1 +1

We concentrate too much on getting information and statistics on quality and telling people about them. I don't know if it is all necessary - we would be better off caring for people. 0 +3

Management information is only as good as the uses it is put to. And apart from waiting list times there doesn't seem too much of a will to really challenge people on the basis of the results we collate. +3 -4

The patient satisfaction stuff we turn out as indicators of our success in raising quality are pretty meaningless and more than a little superficial. +2 -5

TAKING THE LEAD IN QUALITY MATTERS:

There is a need for clinicians and other professionals to take the lead on decisions on quality policies and developments carried out under the banner of quality in the Trust as a means of increasing participation amongst doctors. 0 +2

Because managers have a grasp of the theory behind quality systems then naturally it should be managers that lead the process. -3 -3

We call it the 'patient focused approach' but its not as if patients actually lead the whole process. I think if we are to really give people what they want then it should be patients or consumers who take the lead. +5 -4

The quality advisors as quality leads are just a resource to be used - but a very expensive resource. I'm not sure that their function could continue like this for long. -2 -1

Quality is supposed to be everyone's business but managers seem to make it more theirs than anyone else's. We do the work as health professionals and they take the credit. -3 0

Its just not practical to make patients and the general public the people who should directly lead the quality strategy in the Trust. -1 -1

GOING TO MARKET:

Yes quality in some aspects of my work as a health professional is unmeasurable. But the purchaser-provider market isn't that much of a problem as there is no great desire on the part of the purchasers to measure it. So in that respect the reforms are probably quite good for quality. +1 +1

The purchaser's monitoring tools like SAS serve a useful role as it is important that we demonstrate the quality of our services in ways which are comparable with our competitors. 0 0

Because patients can (theoretically at least) choose between us and someone else for their care, then the market is probably a good thing from the patient's point of view. Because we need to increase our levels of quality to meet their expectations. +2 +3

Contracts , SAS and all the data that purchasers want is just bureaucracy. fundholders prefer to talk on a personal level and in my view that is more effective and will do more to raise quality. 0 0

SAS and contract specifications are OK as far as they go but no one ever lost a contract through not meeting a minor quality specification. Its just not a priority for the purchaser or us. 0 -2

Its a good thing, choice for patients. However, when the choice is here or the other local hospital then the idea doesn't look so attractive; particularly when the only information people have is the waiting list times. 0 +1

QUALITY AND CONFLICT:

<i>The patient focused quality approach has helped to get everyone focused on one framework and has reduced conflicts between groups by giving us a shared vision for the future.</i>	-1	0
<i>Formal quality models like EFQM and the training that goes with it act as a way of pulling everyone into the organisation's view of quality and not just going off down their own little blind alleys.</i>	0	+4
<i>I think that as patients get used to being given choice and information and stuff, and as we promote ourselves better in terms of the quality of what we do then complaints will actually go down and so will the us and them syndrome between the trust and the CHC.</i>	+1	-1
<i>Quality and all the training and meetings that accompany the idea takes people off the wards - people we can ill afford to lose - and so it is a constant source of aggravation between nurses and managers.</i>	-1	+2
<i>People are just burnt out with the whole quality thing. TQM then TQI then CQI; the troops have just had enough. Its a source of tension rather than multi-disciplinary cooperation.</i>	0	0
<i>The new emphasis on quality has done nothing to increase the voice of patients within the system. Alright you've got the charter but it hasn't made that much difference to the way in which people approach the customers or the outcomes of disputes.</i>	-2	0

QUALITY CONTROL: THE CONTROL FUNCTION OF QUALITY ON OCCUPATIONAL GROUPS.

<i>Its important that we allow professional groups to keep control over the issue of quality if its to benefit services in the long run.</i>	-4	+5
<i>Quality has always offered management more say in the ways that teams, including nurses and other professionals, do their work and I think that's a good thing in terms of quality.</i>	+2	0
<i>Quality is all about giving patients control and choices while in hospital. Real control - not just menus and colour televisions, obviously there are limits but we could do more than we do at the moment.</i>	+5	-1
<i>Its all very well talking about empowerment and patient focus and other management speak; but in the end quality is about outside groups controlling what we do as health professionals.</i>	-2	-3
<i>Trying to manage professionals through quality techniques doesn't work. They don't take it seriously and we [managers] talk a different language.</i>	-1	-1
<i>I don't think we should give more control to patients and consumers. They seem pretty satisfied with their lot at present, so why change it. All you do is devalue the work of the nurses, doctors and managers.</i>	-5	-1

table 2:d *The Factor Scores and Q-Sample: Shiptown*

<i>DEFINING QUALITY</i>	Fac1	Fac2	Fac3	Fac4
<i>quality in professional work is a professional issue. Its up to us to decide what 'quality' in our work is.</i>	+5	-2	-5	-2
<i>quality means managers doing the right thing by their customers. Its about getting it right first time every time.</i>	+4	+2	-1	+1
<i>involving patients more in issues of quality other than through surveys is something that we've thought about. Its a good thing but in reality I think its difficult to achieve. That shouldn't stop us trying though.</i>	+3	+1	0	+5
<i>the fact that we, as health care professionals, don't always know how the things we do actually work means that quality initiatives like SAS address only a tiny bit of the equation. All in all there bit of a waste of time.</i>	-1	+1	0	+1
<i>The type of definition of quality which underpins SAS and the work of the Quality Core Group isn't clear. What are they trying to achieve? If you don't make it explicit how can you expect people to work towards their aims and objectives.</i>	0	-2	+3	0
<i>I never see the CHC and they don't know what we do here really, so why should they tell me what quality in my work is about.</i>	0	-4	0	+1
<i>EVALUATING QUALITY:</i>				
<i>without the knowledge you gain as being part of a profession you can't possibly evaluate the quality of a profession's work.</i>	+2	0	-1	-5
<i>management should take time to look at the outputs of the services they manage its the outcomes of a service that should be the cornerstone of any evaluation of quality.</i>	+5	-1	+2	+2
<i>we've got a CHC member on the quality core group now and I think that is very important in terms of getting consumers views on the agenda and in looking at what we do in the name of quality.</i>	0	+4	0	-1
<i>Trust quality initiatives like SAS and standards and stuff just prevent me getting on with my work, it definitely means you take less risks because your always being watched, and yet its the risky stuff that sometimes gives the best results.</i>	-2	0	-4	-1
<i>Just what type of quality is it that SAS and stuff like the Kings Fund are trying to evaluate. They seem to spend a lot of time on stuff like wallpaper, clocks and magazines and not a lot on the culture of the unit.</i>	-2	-1	+1	+3
<i>Asking patients to judge the quality of surgery say is like asking me to judge the quality of rocket science - I wouldn't have a clue.</i>	+2	-4	0	-4
<i>PREFERRED ROUTE:</i>				
<i>I think audit within the profession is the most effective way of promoting quality within our work, people take notice and take part when they know that its confidential.</i>	+5	0	0	0

<i>the divisional restructuring, S.A.S. audits, quality specs and standards in contracts and all that, have helped to change the culture of the place. People are genuinely interested in quality issues at ground level.</i>	0	+2	-2	-3
<i>we live in a democratic society why should hospitals be any different. Quality is about involving patients and customers at every level, where practical, and that means them judging professional and managerial ability.</i>	+1	+4	-3	-3
<i>professional audit is credible because the people doing it share similar knowledge and experience - they're credible -all the 'initiatives' like Kings Fund do is get in the way.</i>	-1	-3	+5	+2
<i>The quality strategy we seem to have here is a bit 'wishy washy'. What we need is a more formal framework like TQM and some of the techniques they use in other units like 'the patient focused hospital'. As things stand at the moment no one knows all the activity that's going on so it doesn't really work.</i>	0	-1	+4	+2
<i>Offering patients choice and listening to complaints and stuff can only go so far in the Trust. It doesn't really get to the nitty gritty of care so it just gives the illusion of quality and that doesn't help.</i>	-1	0	-1	+4
ORGANISATIONAL STRUCTURE:				
<i>The divisional structures allow for more professional autonomy in decision making and that's got to be good in terms of quality.</i>	+1	+1	0	-1
<i>the quality core group and quality lead system provides a way of combatting the isolation that divisions and directorates sometimes feel in the current structure. I think its reasonably effective.</i>	+1	+3	-1	-1
<i>Sometimes its necessary to examine the structure of wards and departments to see if we can get closer to our customers. Not just bricks and mortar but things like how the staff are organised and does this stop patients actually seeing their doctor or nurse when they want to.</i>	+3	0	+5	0
<i>divisional quality leads and the quality core group have very little to do with the quality of my work. What my colleagues think has more impact than these.</i>	+1	-2	+1	+3
<i>The divisional structure just means that no-one knows what the other is doing. So sharing best practice and sun like goes out of the window.</i>	-1	0	-2	0
<i>The creation of divisions and making people 'quality leads' has done nothing to improve the power of patients or carers in the system.</i>	-3	0	+1	0
THE ROLE AND USE OF INFORMATION::				
<i>Giving information to outside groups like the CHC in the form of audit results would be good PR and act as an incentive to improve our work.</i>	0	+2	+4	-1
<i>managing information is management - therefore, information is quality. I don't have a problem with giving information on the quality of our service to our customers or with receiving information that helps us plan for quality changes</i>	+4	+1	0	+5

Its all very well encouraging patients to question what we do in the name of quality, but they can't very well do it unless we give them the information-tools to make use of. 0 +3 +1 +1

if you give patients detailed information on quality in the Trust, first they don't know how to use it and second you just ask for trouble with more complaints - just look at the Patient's Charter and all the hassle you get with that. -4 -3 -2 -2

Most of the information we get on quality, from a managerial point of view, is pretty useless. It doesn't make it easier to manage, it just acts as a smokescreen for the real issues 0 +1 -3 -1

People don't always want to know loads of stuff on the quality of the services we deliver. Would you really want to know the average infection rate for doctors if you couldn't really choose between them. +2 -4 -1 +4

LEADING THE PROCESS:

Nurses and doctors provide the hands-on, direct, care in the Trust and as such it should be up to them to direct the quality process in the hospital as a way of raising standards of care. +3 0 -1 0

within the NHS its managers who take the rap for quality failures so it should be managers who lead the process in Trusts. -2 0 0 -3

quality should be led by patients and potential patients first and foremost. They deserve to be represented effectively on the committees that steer quality issues, including the various audit and professional committees. -3 +5 +3 +1

Quality just means managers and busy bodies interfering in the work that professionals do. Its not up to them to tell us how to do our job. -5 -3 +3 -4

Leaving quality to be lead by managers has resulted in a poorer quality of service. -1 +1 +3 -4

At the moment we only give the illusion of giving patients a bigger say in how things get done. That's not always wrong though because they don't always know. 0 -2 +2 0

GOING TO MARKET:

The purchasers don't really SAS audit professional stuff so it doesn't really have much of an impact on our work. Personally I think that's a good thing its up to us to decide how best to meet contract quality specs. -1 -1 0 +1

Contracts and quality specifications play a vital role in our quality strategy and as such their influence should be extended to affect hands on care more. -1 +3 +2 0

I think the link between consumer involvement and the work that the CHC are doing with neighbourhood forums is vital. If they can get users views onto the purchasing agenda then this will be reflected in our quality specs in the contracts. +2 +4 -2 0

S.A.S. is just a purchaser 'hoop' that we have to jump through. No one cares if you don't have teenage magazines and stuff in the waiting room, its not like you lose a contract because of it, is it? -3 0 -3 +2

How can the purchaser-provider thing help quality when they take resources away rather than inject them when a service is seen as poor quality. It doesn't help the service or the patients. +1 -2 0 -2

It doesn't matter to us that the CHC organise community or neighbourhood forums or whatever because the Trust isn't really affected by what they say anyway. Mainly because our purchaser doesn't include any of that stuff in contracts, its all about money. 0 -1 -3 0

CONFLICT:

quality initiatives act as a means of pulling all the groups involved in the delivery of care together, it reduces all the professional politics that used to go on at ground level. +2 +1 +2 0

as a manager, quality acts as a kind of resource which I can draw upon as a means of reducing some of the tension that surrounds political issues such as how I allocate my divisional budget. +1 +2 -1 -2

linking complaints and complaints feedback into our quality strategy, and involving consumers in things like the quality core group means less dissatisfied patients and a better sense of involvement - all this means less aggro from stroppy consumers and groups. 0 +3 +5 +1

Quality creates more headaches than it solves. It gets peoples backs up and makes them worry unnecessarily about the way they work. It creates more aggravation between doctors nurses and managers than it cures. -5 0 -4 0

Quality has done next to nothing as a means of improving relationships between the clinical groups and especially management and professionals. Its just a focus for more bickering over money. -4 -1 0 +4

Nurses and doctors genuinely do want to do the right thing by people. All quality initiatives do is encourage the cynical minority to cause trouble that wouldn't be there otherwise. -4 0 -2 +5

CONTROL:

from a professional point of view I think the nature of quality management within the Trust enables me to keep my professional freedom of control over my work. +3 -1 +2 -3

Roy Lilley wasn't completely wrong when he said about questioning where your loyalties lay with the profession or with the organisation. If we are to achieve quality in any meaningful way then managers have to take control over the whole issue in Trusts. 0 +3 -4 -2

quality and customer control of the health service they receive cannot be separated. Quality is all about giving customers choices and control over those choices in the hospital. -2 +5 +1 +2

Quality, if we are not careful, just means taking control of how we do our job away from professionals and giving it to other groups. -3 -4 +4 -4

Part of the problem is that people just see quality as a means of pushy managers muscling in on their little empires. And in some cases they're not too far off the mark. -1 -3 +1 +3

Its unrealistic to expect patients to control the quality of the care we give them, basically because most of them just want to come in and go out as quickly as possible. Quality is pretty low down on their lists. +2 -5 -3 0

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12. the CHC were represented on the Quality Core Group
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