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Stakeholder quality in healthcare: synthesising expectations for mutual satisfaction

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Abstract

This thesis focuses on quality improvement in local NHS services in response to national legislation. The preparatory literature search of healthcare, change and quality theories identified the common theme of participation for success as well as a distinct gap in quality management models suitable for healthcare. Action research was used to develop, implement and evaluate such a model, combining qualitative and quantitative methods, enabling ownership of the model by participating stakeholders, and facilitating change by reflection and action.

The thesis is organised into three main parts from which key themes emerge. The first section establishes health and its care as the most basic of human needs. Healthcare delivered through public provision has a medically dominated hierarchy of stakeholders with different expectations: users pursue a social model of care, managers a business model, and providers a scientific model.

The lack of evidence on which to base provision has resulted in autonomous clinical practice which, without reference to guidelines, is difficult to assure. In a culture of professional awareness, autonomy can provide an opportunity for service improvement

The second section describes the development of the Quality Synthesis Model through participant involvement. Recent experiences of change in the NHS provided direction through: the need for clarity and agreement over quality issues, vision and values; a strategic approach; and capacity and empowerment to respond. In addition, these followed generic best practice of a conducive culture, communication, commitment and measures of progress.

Finally, in the third section, the empirical chapters describe implementation and analyses of the model in the sample semi-profession service of chiropody with older people. Quantitative and qualitative data was collected through records, repeat surveys and sub sample telephone interview. Evaluation of the model was against:

- operational criteria requirements
- compatibility with commissioning
- sound methodology
- changes in stakeholder culture.

The results suggest that the Quality Synthesis Model is a cost-effective answer to local quality management in a culture of professional awareness, respecting the influence of the ultimate power of medicine. Together with the principles of change management, and particularly the lessons learned from the implementation of previous initiatives, local NHS units could successfully move towards a sustained responsive culture through the use of the model.

Abbreviations

AC---Age Concern
BAHCHART---Barking and Havering Quality Charting
BDOPWC---Barking and Dagenham Old Peoples' Welfare Committee
BHB---Barking, Havering and Brentwood Community NHS Trust
BHHA---Barking and Havering Health Authority
CHC---Community Health Council
CHI---Commission for Health Improvement
CPSM---Council for the Professions Supplementary to Medicine
CQI---continuous quality improvement
DHA---District Health Authority
DISS---District Information Support System
DNA---did not attend
FHSA---Family Health Services Authority
GDP---Gross Domestic Product
GP---General Medical Practitioner
HA---Health Authority
HHT---Havering Hospitals NHS Trust
HMO---Health Maintenance Organisation
ICPR---Independent Clinical Peer Review
MCI---managing for continuous improvement
NHS---National Health Service
NHS Executive---National Health Service Executive
NHSME--- National Health Service Management Executive
NICE---National Institute for Clinical Excellence
OPD---out patient department
QA---quality assurance
QC---quality control
QI---quality improvement
QM---quality management
QMS---quality management system
SC---Society of Chiropodists
SCP---Sclare Chiropody Partnership
SPO---structure, process and outcome
SPSS---statistical package for social scientists
TQM---total quality management
UCP---Unified Commissioning Project

Introduction

The focus of the thesis

The focus of this research project is the management of change towards a culture responsive to the needs of key stakeholders in public sector healthcare.

The background to the problem

The background to the project was that changing needs, expectations and provision had contributed to a major reform of the British National Health Service (NHS) in 1990. The spirit of the legislation was reorientation to create a more responsive culture by commissioning services through quality, cost and volume specifications. Quality, in terms of meeting the agreed requirements of the customer, was anticipated as the most challenging concept. A letter from Duncan Nichol, the Chief Executive of the NHS Executive at the time, required District Health Authorities (DHAs) to have quality assurance (QA) in place by the end of 1989 in readiness for commissioning.

Barking and Havering Health Authority quickly realised the enormity of this task and the apparent lack of suitable models to follow. The author was appointed to the Health Authority as Quality Assurance Officer with the remit to plan a project to identify, or develop, and evaluate a model for Quality Assurance in healthcare suitable for the subsequent commissioning process. The post also offered the opportunity for academic support to evaluate the result through a formal research project. This opportunity was accepted and forms the basis of this thesis.

Background research

In preparation for the project, a literature search was undertaken on the theories of health and healthcare; quality; and change and its management.

Health and its care have become a universal political priority as a result of their impact on the national economy, the risks to health shared by the community, and a moral responsibility for equity of care within societies regarded as developed. In the UK, a post war welfare system for healthcare had begun in 1948. The medical profession had retained its dominance through autonomy of practice, a deferent public, and the "diagnostic relationship" with nursing and allied professions. This diagnostic relationship, whereby doctors have retained the monopoly on diagnosis expecting secondary professions to implement prescribed treatment, is becoming outdated as these professions mature, but is retained in the mind of both the medical profession, public and some professionals. A combination of these factors had successfully limited previous attempts to change the culture of medicine and subsequently the NHS.

Medicine has, however, been increasingly threatened by the emerging cost-effective skills of other professions together with their claims on autonomy, and the reduction in deference by successive cohorts of the public. The political interest in improving the efficiency of public services (Flynn and Williams, 1997), unprecedented medical advances (Smith, 1999) and the need for the service to meet stakeholders changing expectations, particularly improved value for money, led to the reform of the NHS in 1990 to force change through a quasi market approach which would focus activity on quality.

Ideal markets are not compatible with healthcare, with particular concerns for and protection of welfare values, public accountability and autonomy of response requiring an intermediary as purchaser. The quasi market envisaged by the 1990 reforms could address these concerns; give responsiveness and efficiency; gain public support; as well as covertly break the power of dominant professionals to resist change through competition (Sutherland and Dawson, 1998). What was difficult to address were the challenges of public sector management when faced with local continuous quality improvement---particularly short termism of the electoral cycle and interagency dependency.

These factors provide unique obstacles in the public sector which must be considered in any change programme.

Three key groups with a stake in the quality of the service emerged: purchasers responsible for the equitable allocation of funds; providers of healthcare delivering the service; and patients, carers and referrers as users of the service. The needs of the three groups were shown to differ: purchasers were more likely to pursue uncontroversial markers in relation to safety, effectiveness and efficiency---a business model (Debrah, 1994); providers, from a position of power, were pursuing a model which appeared scientific (Stocking, 1992) but was based more on established best practice than scientific evidence; and users, patients, their carers and potential patients lacking information on the technical aspect of service, were most likely to seek a social model of healthcare (Neuberger,1993). The quality goals of the three main stakeholders not only differed substantially, but were also dynamic as their needs changed during the course of an episode of care (Dickens, 1995). Each health profession has been left struggling to meet the often incompatible requirements of their employer, their profession, the courts, users and each other.

Interest had been raised in the concept of quality by a combination of factors including economic competition, environmental concerns and activity of the quality gurus, with the post war interest in human psychology facilitating an organisational response (Beckford, 1998). While there was considerable literature on quality in manufacturing, less was found on services and little on healthcare although quality has been a primary interest of most carers although not overtly remarked on, defined or researched. What was determined was the developmental process that the concept of quality had followed, from quality control against specification of inputs and output by inspectors; quality assurance by operatives against specifications; and Total Quality Management (TQM) (or Continuous Quality Improvement (CQI)) by everyone to respond to stakeholders changing needs and add value to the outcome.

The philosophy of quality management through TQM/CQI has evolved from the approaches of the quality gurus, common elements of which are described by Martin (1993) and Morgan and Murgatroyd (1994) as:

Quality is a primary organisational goal in every activity
Internal and external customers determine what quality is
Customer satisfaction drives the organisation
Variation in processes must be measured, understood and reduced
Change is continuous and accomplished though teams and teamwork
Top management commitment exists promoting a culture of quality, employee empowerment, team working and long-term perspective
Organisational commitment exists to change the culture
Consistency of message exists

With the time needed to achieve and sustain such cultural change being between 5 and 10 years

The direction the service should take on quality management had been defined from the top, even though TQM is a collaborative approach. The initiative was launched alongside the 1990 reforms and resulted in failure, mainly due to the short termism of political organisations, lack of sufficient investment in the initiative, lack of clarity of client needs and satisfaction measures, and failure to involve powerful players (Ovretveit, 1994a). The concepts may have been learnt by staff but inadequate implementation resulted in patient care being largely unaffected (Foster et al, 1994). The necessary change of culture had not occurred.

As this author's project required a change in culture to improve quality, an understanding of the failure of the 1990 attempt to change the culture of the NHS was necessary. The literature on successful management of change was pursued using a model by Clarke (1994) as a guide. The best practice indicators for successful generic change were identified as a conducive culture, communication, commitment, and measurement of progress. These were compared by this author with the reality of change through the 1990 reforms for key NHS stakeholders. It was found that the need for clarity and agreement over quality issues, vision and values (Gibson, 1990); a strategic approach (Clarke, 1994); the capacity and empowerment to respond (Hunt, 1994) were additional factors for successful NHS change.

At a local level, public healthcare is dominated by the staff responsible for delivering the service (Ham, 1996). These key professionals would need to be willing rather then coerced to pursue a quality agenda. As health is an integral part of life, participation by users in their own care, whether conscious, voluntary or involuntary, influences the outcome. Therefore, commitment by users to changes in delivery of their care has the potential to enhance their health outcome. Purchasers, mostly pursuing management best practice and needing the knowledge of providers to substitute for their own knowledge deficiency, would perceive a collaborative approach as beneficial. A participative approach that identified and met the changing needs of stakeholders would therefore find wide acceptance and could additionally benefit the outcome of care.

It appeared to this author that the commissioning process offered an opportunity to capitalise on identifying and meeting local needs through stakeholder participation in the change process. For professional providers, QA with its concept of compliance to static standards compromised their cherished value of autonomy. QA of standards that were emerging from research evidence of best practice might be professionally acceptable as well as widely expected. Much practice would remain unspecified and even the specified could be improved. It appeared that TQM (CQI) with its promise of improvement of autonomous practice by peer review on a stable base of assurance would offer an acceptable combination. The term CQI was used to convey a fresh approach and lose the connotation of a management initiative (Reynolds, 1994).

While there are numerous similarities between the approaches of the quality gurus in the pursuit of CQI, the approach of Juran (1988) is considered the most applicable to health care being service, stakeholder and teamwork oriented; incorporating quality control, assurance and improvement; and allowing for the necessary flexibility in dealing with unique healthcare situations.

The research questions

Successfully managing local change from welfare to responsive market, through stakeholder participation, is the subject of this thesis. The literature search identified the common theme of participation to identify and meet the quality aspirations of healthcare stakeholders. The research questions were therefore:

- **Can an effective CQI model for healthcare be identified, or developed, and evaluated which incorporates Juran's approach and the needs of local key stakeholders?**
- **Can local organisational change within the NHS be improved by learning from the lessons of change theory and national implementation of the 1990 reforms?**

The importance of these questions is that healthcare and quality are gaining a higher public and political profile with the consequence of a rising focus for commissioners and providers. The market culture has become established in the public sector and a method to cost effectively combine responsiveness within a quasi market requires a framework applicable for local use. The potential for wider use of the model in other public sector settings would aid interagency work, supporting another government theme.

The aims and objectives of the research

The aim of the research was to produce a simple model, which could guide local stakeholders to identify and synthesise their statutory, professional and local requirements into a unique quality improvement specification for the commissioning process in a pilot service.

The objective was that the model would be acceptable, cost effective, and adaptable for wider use in healthcare as well as other public services with guidelines for implementation based on experiences from the pilot study.

This principle of using the commissioning process to identify and meet needs, gain commitment to change, and enhance health outcome and organisational success is pursued through this thesis. The hypothesis is that:

". . . by incorporating user, provider and purchaser expectations, health needs assessment can be converted into a best quality service specification."

The absence of an existing framework for local management of quality within the commissioning framework led the author to develop the Quality Synthesis Model. This indicated how the statutory, professional and personal needs of stakeholders could be combined by participants to meet and review prioritised, achievable standards. The model could offer opportunities for evaluation; and facilitate a cyclical process for continuous quality improvement.

Within the model a unique process was developed to identify, prioritise and improve the quality of individual services. This combined existing work so that the patient's pathway through the stages of care (Ovretveit, 1994b), could be compared with accepted quality requirements (Maxwell, 1984), and service shortcomings could be identified as structure, process or outcome (Donabedian, 1988, 1989) for appropriate rectification.

A process for providers to electronically report progress in meeting the standard was named BAHCHART as an acronym for **B**arking **a**nd **H**avering Quality **Chart**ing.

Through an objective assessment of local need, chiropody services for older people were chosen for implementation of the model. Evaluation was through :

- **Quantitative data and qualitative information** on stakeholders needs
- **Collaboration of stakeholders** to convert needs into specifications
- **Quasi-quantitative methods** to establish baseline satisfaction with the specification
- **Participant involvement** to improve quality continuously
- **Quasi-quantitative methods** to establish change in satisfaction with the specification
- **A cyclical process** which would start the process over again

The results indicated that the model

- met the operational criteria expected by purchasers and providers
- provided a cyclical process compatible with and enhancing commissioning
- was viable, reliable and repeatable
- could result in stakeholder culture change towards total quality
- avoided the sins and diseases of public sector management

Consideration was also given to external validity: the ability of the model to work in other professional groups and for other cohorts of users. The literature indicated that chiropody services are both traditional in organisation as a result of a history of sessional workers (Merriman, 1990), autonomous in practice through open referral and self responsibility (Kemp and Winkler, 1983), and progressive in development through innovative approaches to try to reconcile supply with demand (Society of Chiropodists, 1995). The profession is relegated to secondary profession status as a result of lack of proven expert knowledge; being a profession divided between NHS and private practitioners as well as between those eligible for state registration and those not; existence of a vestigial medical influence on entry, qualification and regulation; and lack of a powerful collegiate organisation.

Consideration was also given to repeatability: the two chiropody services in the pilot study were only more favourable in respect of the emphasis placed on contestability within the commissioning approach used. This had resulted in two services being commissioned to provide a service, facilitating a degree of competition and opportunity as well as threat to their contract.

Older people are the largest users of NHS services (Department of Health, 2000) and in general are the most satisfied (Beaumont, 1992) and less likely to complain than carers (Allen, 1992) and young users (Craig, 1990), however users of chiropody rate their service the highest after the GP (EARHA, 1992), and determine it as the service they are most likely to complain about (EARHA, 1992). Such characteristics reflect an assertiveness more usually found in younger groups. In the author's view, successful testing of the model against such users would indicate general applicability; the issues regarding professional status would indicate applicability at least with semi-professions; with some reservations until proven in applicability with primary professions.

The tension for professional staff will continue to be that of simultaneously satisfying employer, profession and increasingly users (Johnson, 1977). The Quality Synthesis Model has been shown to effectively synthesise these expectations and reduce the tensions in the areas it has so far been used within.

The structure of the thesis

The thesis is divided into eight chapters. Chapter 1 examines the concept of health, healthcare and the evolution of the welfare- style NHS since 1948; considers the pressures of change on the service over the subsequent 40 years; and the change to a market culture which required a model for quality improvement; Chapter 2 describes the methodology used; Chapter 3 considers change management and its application to the NHS; Chapter 4 reviews the emergence of explicit quality in general; and Chapter 5 considers quality in healthcare.

Chapter 6 develops a framework for the detailed project. This includes a framework for evaluation of the project that would test the hypothesis. The model was evaluated through quantitative and qualitative methods. The process for selection of the pilot service, "Happy Feet" user satisfaction survey and sub-sample telephone interview, are described in Chapter 7.

Chapter 8 reflects on the research approach used; considers alternatives; and draws conclusions and recommendations for future development. These include a deeper understanding of how the values of healthcare stakeholders influence expectations and perceptions; how quality can be continuously improved to meet the needs of heterogeneous users within the constraints of the public sector; the use of the costs of quality as a positive influence; how the responsibilities of stakeholders will change with changes in society; and a previously unexplored opportunity for investigation into the attributes, expectations and contribution of the increasingly influential healthcare activist. Where appropriate, reference is made to international examples, and the Appendices support the various key elements of the thesis.

Since the successful implementation in the pilot service of chiropody, the Model has now been effectively used by the author in a range of different environments including a multidisciplinary Learning Disability service (including a medical component, albeit regarded as low in the medical hierarchy); social care (home bathing); a school nursing service; and in- and out -patient services of the professions allied to medicine.

Chapter 1
Health and healthcare: a prelude to understanding NHS change

1.1 Introduction

Health and its care have become a universal political priority as a result of their impact on national economy, the risks to health shared by the community, and a moral responsibility for equity of care within societies regarded as developed. The welfare-style National Health Service (NHS), created in 1948 to meet these economic, social and moral requirements, typified the expectations of the British post-war culture. By 1990, changing influences, especially raised public expectations, resulted in political focus on welfare services and the subsequent introduction of market-style provision. The aim was to enable provision of care to become customer, rather than service, led and to reduce public expenditure.

Change in healthcare presents a unique problem due to professionalisation of providers, vulnerability and ignorance of consumers and accountability required of managers. Successfully managing local change from welfare to responsive market, through stakeholder participation, is the subject of this thesis. A precondition for successful change (see Chapter 3) is an appreciation of the subject of the intended change which is explored in this chapter through a review of the culture and effect of change on health and healthcare; professions and semi-professions; and the welfare state.

1.2 Health and healthcare

Healthcare is the largest personal service in Western society, potentially available to all at any time, with access assisted by knowledge and influence. Healthcare is assumed to facilitate health (Seedhouse, 1995), although it is estimated that only around 20% of medical care is supported by evidence (20% being actually harmful (Chatham, 1998)), with an even lower evidence base in other disciplines (Firth-Cozens, 1996). As health is an integral part of life, participation by users in their own care, whether conscious, voluntary or involuntary, influences the outcome. Therefore, commitment *by users* to changes in delivery of their care has the potential to enhance their health outcome. As public healthcare is dominated by the staff (medical and others who seek to emulate them) responsible for *delivering* the service (Ham, 1996), these key professionals need to be convinced about any change in its delivery. Participative change was therefore identified as necessary for success.

The terminology denoting those who use and provide health services should at this point be clarified. "Client" is commonly used by social workers to denote empowered choice; "patient" is used by doctors to denote recipients of treatment and is regarded as undignified by others through its connotations of powerlessness, passivity and dependence (Sitzia and Wood, 1997); "consumers" are regarded as those using a commodity (Beaumont, 1992); and "customers" are buyers who have a direct impact on the transaction. The term "user" is all embracing, respecting carers and other non-patients who access health services, and is used in this context in this thesis. Deffenbaugh (1997) suggests that although inappropriate in public healthcare, it does no harm for staff to *think* of users as customers.

Providers of healthcare are usually regarded as professionals who are paid to do so, but the definition should also include those paid and trained individuals with no professional qualifications who provide most of the routine formal health care. At least part of all healthcare is funded on behalf of the community requiring accountability through managers. The key stakeholders in healthcare are therefore users, providers and managers.

1.3 Healthcare change

Changing expectations, epidemiology, technology, demography and economics are driving health service review world wide (Ham, 1985; Ranade, 1994; Zimmern, 1995; Griffiths, 1996; Hayman, 1996). Those particularly pertinent to the UK include: limited tolerance for higher taxation by workers (Allsop, 1993); rising expectations of welfare recipients; unprecedented medical advancement (Smith, 1999); a widespread belief in the right of citizens to the best available health care; availability of technology for improved biological survival and functional independence; and an ageing population with chronic disability (CHMU, 1992) (see Appendix 1). Rising expectations have been shown to be the main influence, exceeding even the more publicised impact of ageing (Abel-Smith, 1994; Editorial, 1997a).

Such challenges and opportunities have, in Osborne and Gaebler's view, led healthcare organisations world wide to consider policy change to:

> "Promote competition and income generation with public accountability controls;
> Empower citizens as customers and provide choice through information;
> Focus on outcome with goals and measures of performance;
> Encourage prevention of need for demand as well as avoiding service failures; and
> Develop a strategic direction separated from increasingly delegated operational activity"
> Osborne and Gaebler (1993)

Criticism of Osborne and Gaebler's statement includes the focus on competition instead of contestability (or conditional partnership (see section 1.9)); and the absence of recognition of the needs of healthcare providers who influence public view and implement management policy. Participation by such providers in the change process enhances both organisational and personal advantage (IPD, 1997), a powerful combination.

1.4 Professions and semi professions

An occupation is established as a profession through the public recognition and willingness to support the costs of monopoly, training and regulation of risk (Goode, 1969). The original profession was that of the church, where clergy were authorised to *profess* Christian dogma to the laity (Beckman, 1990).

Elliot (1972) notes that since the middle ages, law and medicine have also been accepted, all three exhibiting the common traits of

- Specialised skill and expert knowledge
- Control over entry and qualification
- Intellectual and practical training
- High degree of autonomy and responsibility
- A trusting relationship with clients
- Collective responsibility
- A code of ethics
- Self regulation

Whether these are what they should be to denote professional status rather than what exists is a question posed, but left unanswered, by Johnson (1977). This author considers that limitation of title should be added to ensure professional standing is not undermined by those using a title legally but without claim to the principles it implies.

The philanthropy which accompanied the industrial revolution introduced the forerunners of modern caring occupations. In response to workforce re-organisation and the perceived importance of public recognition, the proportion of the workforce considering themselves professional has trebled since the 1950's (Giddens, 1981). In the view of Goode (1969), Dentistry and Clinical Psychology have now succeeded in obtaining full professional status within the medical sphere, where those regarded as semi-professions fall short of the established criteria; are predominantly female (Etzioni, 1967); provide mainly technical services; and are without the all important independent, powerful collegiate organisation (Abbott and Meerabeau, 1998) and external solidarity to pursue their claim. The issue of gender influence is probably less significant since its identification as a constraint to professionalisation more than 30 years ago, particularly in healthcare where members of the predominantly female workforce are invading the previously male dominated areas of medicine and management. The overall result is a group of occupations who have varying power over others through knowledge, skill and scarcity.

Autonomy, bureaucracy and welfare

The professional value of autonomy has been a threat to cost containment in bureaucracies (Zola and Miller, 1973). Now that public policy largely determines welfare needs and how they will be met (Johnson, 1972), managers find the enduring image of autonomy useful to obscure rationing and maintain user deference (Harrison and Pollitt, 1995).

Specialisation of services previously provided by self contained generalists has occurred through the process of professional development with consequent accountability. This has resulted in referral for the services of others being formalised through bureaucratic arrangements.

Professionals in welfare bureaucracies therefore experience conflict in meeting the differing needs of individual client, management, and the wider community (Bertilsson, 1990) as well as the responsibilities of their professional status.

Medicine, nursing and the professions allied to medicine

Medicine is viewed as the archetypical profession, with power exercised through an agreement with the state to limit demand to the supply available (Salter, 1998). There is a hierarchy within the profession with ruthless competition for superiority between specialties, but an impressive external display of solidarity (Strong & Robinson, 1990, Freidson, 1994). The more acute the condition the more the patient relies on medical skill, with sub-acute services being viewed as more marginal (Nelson, 1989). Developments in mental health and learning disability services have emphasised this separation both within the medical profession and in relation to social work, nursing and allied disciplines who are increasingly taking a more prominent role.

The current demand for cost effective skills, responsiveness, care for chronic conditions and the pursuit of *health* offer opportunities to semi-profession aspirants (Freidson, 1973), strengthened by new models of financing public healthcare since the 1990 reforms (see section 1.7) and managing healthcare (Hart, 1998). Such aspirants bring commitment, energy and vision to their case for inclusion. This may have a positive influence on the complacency and tradition exhibited by some members of already established professions. This exuberance may also serve to unite the latter in defence of their position.

The power of nursing, although a semi-profession according to the established criteria, lay in its protection by medicine in exchange for a subordinate role; public support for the caring role with which the public can identify; hierarchical professional control; the size and low cost of its workforce; and the skills to act in a crisis. These principles have gradually been undermined in various ways. For example, the challenge to medicine by nursing for greater autonomy has, in Salter's (1998) view, resulted overall in a weakened protection for nursing although the autonomy offered by specialisation in limited areas such as key worker, triage and prescribing has however succeeded and will continue to prove attractive to the most able.

In addition, the nursing profession has begun to delegate the caring role to subordinates whilst the perceived higher status medical-technical approach is pursued. Salvage (1999a) reflects on the dilemma facing the profession: an all graduate profession supervising barely trained helpers, or an incremental career structure where each can learn to the full extent of their abilities and provide a workforce of mixed levels and experience. Rogers (1999) summarises correspondence in the national and professional press concerning the loss of traditional nursing skills and values as a result of the former. While Rogers (1999) cautions about blaming all such concerns on nurse education, she acknowledges that something has been lost and that this is no time for nursing to lose its humanity. While nurses themselves feel that an academic approach has given them a better education and more professional confidence, in a MORI poll they rate their caring and understanding higher (87%) than how patients viewed caring and understanding by nurses (79%) (Editorial, 2000).

The solution by the government to the current crisis in nurse recruitment by widening access to diploma programmes may maintain the size and low cost feature with which the profession has gained public support. Widening access is overtly aimed at those without formal qualifications. This may negatively affect the intellectual criteria for professional status, but strengthen the caring attitude revered by both patients and potential recruits, recently put off by the perception that nursing is no longer "hands on" (Rogers, 1999) .

Overall, nursing has failed to achieve the crucial monopoly, autonomy, peer supervision, pro-active work style and the much sought scientific, as opposed to sociological, knowledge base (Abbott and Meerabeau, 1998) to promote its professional position. The established profession of medicine is the gatekeeper to full professional status of nursing and is likely to consider aspirants against its own benchmark of scientific knowledge. Research funding in healthcare is directed almost exclusively to scientific research, further strengthening that position.

With reference to the professions allied to medicine (PAMs) (for example physiotherapy, occupational therapy and chiropody) their histories indicate their much earlier separation from their medical roots (Barclay, 1994). Past reliance on the diagnostic relationship with medicine, whereby doctors retained the monopoly on diagnosis, expecting secondary professions to implement prescribed treatment, is becoming outdated as these professions mature, but lingers in the mind of both the medical profession, public and some members of these semi-professions themselves. The majority of these professions are now autonomous, undertaking their own clinical diagnosis, not requiring medical prescription for practice, referring to medical colleagues when appropriate and in some cases prescribing medication from a limited list. With autonomy comes both accountability and responsibility. The relevant professional bodies are addressing the former and individuals take full responsibility for their practice, for example speaking for themselves in any court proceedings.

Some professions allied to medicine, particularly Chiropody (Finlay and Fullerton, 2000) and Occupational Therapy (Wenborn, 2000) are predominantly associated with old age, chronic conditions and rehabilitation rather than acute specialties which made them appear subordinate to more dramatic acute care practice (Maxwell and Maxwell, 1977). Some progress on this position has been made in the intervening years since this observation by Maxwell and Maxwell as a result of numeric and economic demands of older people with chronic and rehabilitation need, and especially their expectations (Abel-Smith, 1994). Public policy is beginning to follow public demand in the elevation of the status of these professions, for example by the opportunity to extend consultant status for nurses to therapists (Department of Health, 2000). Although the detail of the latter has yet to be published, an indication can be gained from that established for medicine and emerging for nursing. Phipps (2000) explains that a key function of nurse consultants will be working across professional and organisational boundaries to progress clinical governance. Consultants will demonstrate expert practice, undertake research and service development, ensure education and training supports practice development, and provide supervision and leadership.

All the allied professions are degree based, with a substantial number of graduate entrants, some from the established professions. Recruitment into training has always been competitive, and data from UCAS (1998, 1999) and CSP (2000) shows that on the basis of ratio of acceptance to applications, Physiotherapy is currently the most competitive amongst the health care professions (Table 1.1).

	Applications	Acceptance	Ratio of applications to acceptance
Pre-clinical medicine (1998)	58,819	5,119	11.5:1
Pre-clinical medicine (1999)	54,682	5,312	10.3:1
Nursing (1998)	20, 803	2,238	9.3:1
Nursing (1999)	22, 358	2,770	8.1:1
Veterinary Science (1998)	8,500	619	13.7:1
Veterinary Science (1999)	8,803	631	14.0:1
Physiotherapy (1998)	27, 985	1645	16.8
Physiotherapy (1999)	26, 316	1673	15.7

Table 1.1 Ratio of applications to acceptance for training in the health care professions (Sources: UCAS 1998, 1999; CSP, 2000)

The opportunities for specialisation, autonomy, research, international work, private practice and assured full, part time or term time employment mostly within social hours are attractive incentives.

The claims of nursing and the professions allied to medicine for full professional status have been supported through internal endeavours to develop skills, autonomy, knowledge and successful political organisation. Whilst members may regard themselves as professionals, Freidson (1994) suggests that the true definition requires monopoly over supply and subordinates, and freedom of authority over work. As semi-professions they are already subordinate and are finding it difficult to escape (Hugman, 1991).

Relationships between professions

As populations age and healthcare need moves from acute to chronic, the skills of numerous disciplines are needed. Lawler (1991) has confirmed the lack of understanding of team members about each others roles, largely due to the privacy of much skilled treatment, and the visibility of much that is unskilled.

Policies exist for all professions on their scope of practice and Allen (1998) found that in reality, there was fluidity of roles rather than negotiation and conflict between medicine and nursing to meet the need of the moment with nurses roles flowing upwards rather than doctors roles flowing downwards, except for diagnosis which both regard as predominantly a medical role. The importance of the need of the moment differed between the groups, for nurses the ward in its entirety came first, for doctors it was the priority of medical need. For the professions allied to medicine it is the total caseload which is likely to be across several wards, departments or even institutions.

Opportunity for dominance between semi-professions exists and Reed (1993) identified subtle power playing, particularly between nursing and physiotherapy. Two settings were reviewed; acute/rehabilitation where there was collaborative working; and long term care where collaborative working did not exist, and "referral", mirroring the medical model, was used by nurses to obtain their required results. Reed (1993) puts this difference down to the different philosophies at play. In acute/rehabilitation, the medical model of cure provides a united goal, with physiotherapy staff primarily dedicated to the unit. In long term care the medical and social models are inter-twined, with nurses caring and therapists attempting to "cure", with their time spread over a range of other responsibilities. The goal of cure was seen as disruptive in the nurses domain and tactics were employed by nurses to achieve their own goal of completion of ward routines rather than contribution to a therapeutic programme. Examples included refusing to let the physiotherapist take the patient from the ward; obstructing rehabilitation space on the ward with wheelchairs, trolleys and commodes; and objection to physiotherapy input to the care plan document. These tactics were described by Reed as sabotage. Discussion by this author with Reed revealed the absence of known further investigation into such occurrences, indicating the need for future research.

Threats to professions and semi-professions

Professions have been attacked by both the political left on the basis of privilege, the political right on the basis of power (Saks, 1995), and from within as distancing user from provider (Hugman, 1991). Friedson (1994) has identified additional organisational threats including demands for improved productivity through substitution; specialisation resulting in guidelines for general application; complexity of organisation of services requiring management and reduced autonomy; and changed employee status with increased management accountability. The current expansion of the private sector offers both threats, through reduced security of tenure affecting commitment and cohesion, along with opportunities for those seeking greater autonomy and change from tradition, risking the loss to the public service of such leaders.

Retention of position by established professions has been maintained through their influence, education and regulation of aspirants (Goode, 1969, Zola and Miller, 1973). Their position is threatened as skills and knowledge become more widely accessible, organisation and delivery more complex; and managers more powerful beckoning clinicians over the traditional divide into management.

Degeling et al (1998) have researched the consequence on healthcare change of such a move to management through a survey of nursing and medical clinicians, and nursing, medical and lay managers. They subsequently identified four base positions the sample related to:

Clinical purists—transparent links between resources and care will be detrimental to treatment

Financial realists—clinical decisions are also resource decisions and should not affect care

Pro work process control—those who favour applying work process control structures and methods, including quality assurance, to clinical work

Anti work process control—those who oppose applying work process control structures and methods, including quality assurance, to clinical work

The data suggested a continuum between clinical purists and financial realists; and between pro work process control and anti work process control positions. The position held by different groups was mainly due to differences in values, with some influence by institutional organisation.

These findings are displayed in Figure 1.1 which shows that nurse clinicians are more strongly wedded to a clinical purist stance than medical clinicians, and that those with managerial responsibilities, even when linked to clinical responsibilities, are inclined towards being financial realists. In the case of work process controls, clinicians favour clinical freedom and managers favour controls, more so when there is no clinical background. Even where doctors have moved into management, their commitment was still largely based on their clinical experience. Staff in adaptive, bottom up, institutions were better able to negotiate convergence between clinical and management conceptions of issues. Recommendations from the research are for discussion on cost and effectiveness to be included in education; and a management style that is collaborative.

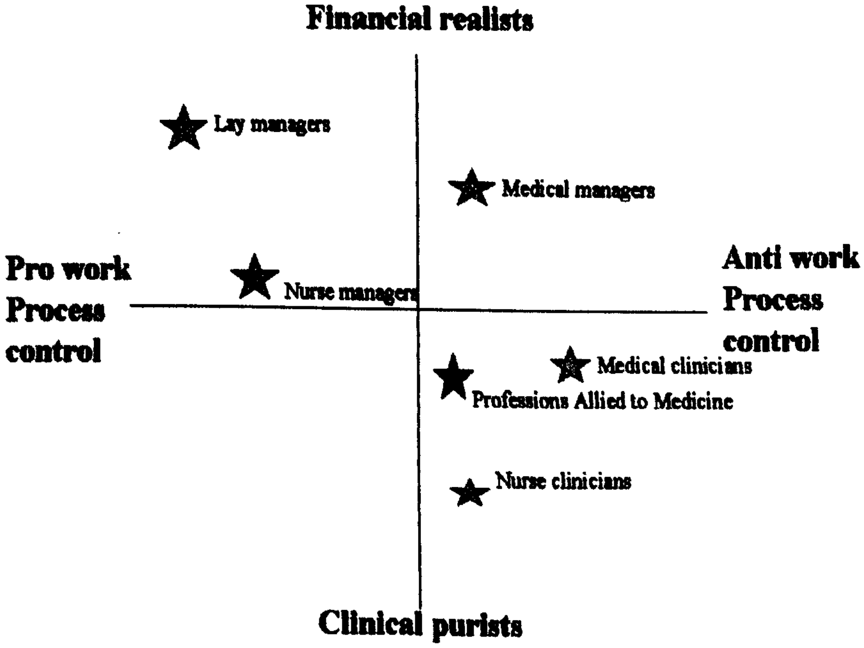


Fig 1. 1 Salient factors differentiating the clinical/management perspective of hospital staff (Adapted from Degeling et al, 1998).

Although the professions allied to medicine were not included in the sample, this authors view is that they would be likely to plot on the graph more positively towards financial realism and pro work process control than nurse clinicians due to their autonomy over their case load and therefore resource allocation decisions beyond that of individual patients; their nationally acclaimed pro-active position on quality assurance through clinical audit (Press Release H91/366, 1991, Normand, 1992); their experience of user responsiveness through familiarity with the private sector; and their planned rather than re-active work style. In view of the greater encouragement of medicine and nursing to respond likewise to change, clinicians in these professions are probably moving nearer to the clinical PAM's position.

1.4.1 A future for the professions

The circumstances surrounding the work of traditional professions is perceived as changing, particularly through their knowledge base and employment status (Freidson, 1994), protection, accountability and dependence on others (Freidson, 1973).

Knowledge and employment status

Freidson (1994), in considering the literature, thinks that knowledge and employment circumstances fail to threaten the status of the established professions: the increase in public knowledge is in tandem with that of professionals maintaining the knowledge gap; and a strong market position will overcome the constraints of salaried status.

Protection

The right to practice in a profession, by that profession, is regarded as monopolistic, reducing the natural stimulus for quality and price advantage (Nieuwenhuysen and Williams-Wynn, 1982). Although the profession may not recognise unregistered practitioners, insurers, the government, other funders and the public may. The classic case in the UK is the recognition of unregistered chiropodists by the government for NHS funding via GP Fundholder budgets, but prevented from employment via mainstream NHS budgets through the statutory Council for the Professions Supplementary to Medicine (CPSM) set up by Act of Parliament in 1960 when such a title was indeed appropriate.

Competition between members of a profession has always been resisted, on the basis that, in the view of the profession, all are equally competent (Nieuwenhuysen and Williams-Wynn, 1982). The market oriented public however, seek best value for money, and such monopolistic practice in contemporary society is viewed as stifling efficiency and progress; with lack of competition in welfare systems lowering standards through complacency (Nieuwenhuysen and Williams-Wynn, 1982). It is now clear that the public are seeking responsiveness, particularly to their interpersonal, social and cultural needs (Johnson, 1972), which some find more acceptable from traditional (alternative) medicine rather than from traditional professions (Lau, 1991).

Accountability

Control by the profession of its members has overtly been for protection of the uninformed public in vulnerable situations and has powerfully protected the position of professionals. Methods include homogeneity of membership through entry requirements and training, continuous membership, and an organisation and culture which facilitates solidarity (Johnson, 1972).

Accountability for practice has traditionally been to the profession, and in the view of Freidson (1994) leaves considerable room for improvement: the emergence of scandals has tainted the image of some professions and raised public concerns (Freidson, 1994). The risk is always that in vulnerable situations with autonomous practice and good social skills, the incompetent can be protected (Goode, 1969).

The tension for professional staff will continue to be that between employer, profession, the courts (Edwards, 1999) and increasingly users (Johnson, 1972). The reformed UK NHS is an example where clinical professionals are now accountable to *lay* managers for *clinical* governance (Department of Health, 1998). It is anticipated that lay managers will limit their personal exposure by taking stricter control over clinical practice (Edwards, 1999), assurance of agreed standards probably being the most mutually acceptable vehicle, with the associated risk of stifling initiative and the drive for improvement.

Dependence

The increase in chronic conditions and specialisation of skills through the professional development process increases the certainty of effective practice, with dependence on others for provision of skills delegated, or as Johnson (1977) pointedly states, grudgingly lost by acceptance that others may be more competent (Johnson, 1977). The latter offers the opportunity for substitution by more cost effective secondary professions. For example, nursing and limited prescribing; chiropody and minor surgery; physiotherapy and routine intrarticular injection.

Change

Professions only exist so long as society finds a use for them (Torstendahl, 1990) therefore responsiveness to changing expectations, epidemiology, technology, demography and economics is required to maintain/enhance their position (Goode, 1969) and change is now inevitable (Nieuwenhuysen and Williams-Wynn, 1982). The grateful patient is being replaced by the righteous patient who demands attention rather than waiting for it to be offered, providing an opportunity for the responsive. Jackson (1970) suggests that a new approach to conferring professional status might be to seek evidence for the claims of effectiveness and protection. At the present time, nurses are required to have available evidence of continuing professional development when renewing their registration; the professions allied to medicine will do so shortly under the updating of the 1960 CPSM Act; and the NHS Plan (Department of Health, 2000) indicates the direction in a similar vein agreed with the BMA that the government wishes to pursue with regard to doctors. All of these initiatives indicate the change in public expectation from *assumptions* to *assurance* of competence, highlighted by recent enquiries, for example Bristol (post operative deaths) and Canterbury (false pathology readings).

Public lassitude, management inexperience and political pressure are likely to allow medicine to remain predominant (Harrison and Pollitt, 1995) but less distant from aspirants. Aspirants, in the meantime, are seeking to marginalize their own competitors in the struggle for advancement, ultimately resulting in allegiance with established professions rather than colleague semi-professions and service users. A partnership with service users in developing the aims of the professions could result in the professions working with, rather than over and against, their clientele (Wilding, 1982), reinstating the necessary public support. Professionals, already experiencing excessive user demands, may reject partnership and power sharing as a bridge too far, but as Hugman (1991) suggests, mutual education between all stakeholders on limitations and possibilities that progress towards normative criteria (Elliot, 1972) will begin the process. Meeting additional criteria for professional status identified from this review as compatible with the current climate in which professional work, such as limitation of title, collegiate organisation, meeting contemporary need, a scientific approach and inclusiveness (Table 1.2) will indicate progress.

Criteria of established professions
Specialised skill and expert knowledge
Control over entry and qualification
Intellectual and practical training
High degree of autonomy and responsibility
A trusting relationship with client
Collective responsibility
A code of ethics
Self regulation
Additional criteria
Limitation of title
Collegiate organisation
Meeting contemporary needs
Scientific approach
Inclusive

Table 1.2 Normative and additional criteria for professional status

In an historic review of professions, Freidson (1994) notes that at the beginning of the twentieth century professionalisation was regarded as a way to organise the work of the middle classes, with professionals being responsible for the quality of their own work with the possibility of expanding such a culture to reach manual occupations. The current government is seeking business ideals through a responsive, cost effective workforce, with extension of roles to meet needs, with accountability to managers. Professional membership is becoming an added bonus, not a fundamental requirement. The professions in turn see the management agenda as reducing their altruism, values and cohesion (Freidson, 1994). Although evidence based practice may constrain altruism it may at the same time provide the opportunity to establish some occupations as professions through expert knowledge and specialist skill.

The government is actively pursuing policies for improved value for money, an evidence base for practice and managed services. These, together with the public concern over serious lapses in professional activity and lack of accountability, are raising the question as to whether pursuance of professional status is now so desirable. A pragmatic view might be that the professional value of responsibility for the quality of one's own work fulfils many of these objectives, together with the added value of job satisfaction

1.5 The British Health Service, policy change and the Welfare State

To understand a service of national interest it is necessary to look briefly at its history especially, when in the case of the NHS, service values are based on those of 50 years ago, and many current problems are rooted in various stages of development of the service, appropriate or the best compromise at the time.

Before the Second World War, healthcare provision in the UK was provided through a mix of compulsory insurance for workers, charity for the poor, and payment by others through voluntary insurance, subscription or direct payment (see Appendix 2). The main causes of ill health were accidents and infections; and care, rather than cure, was the main solution (McKeown, 1986). All occurred within a culture of professional (medical) power.

The need to improve the delivery of health care after the Second World War was based on the frustration of the public and some professionals with the pre-war fragmentation of services and inequity of provision; post-war concepts of efficiency, rationality, collectivism and citizenship rights (Ranade, 1994); and opportunity through changes in the class system, particularly its effect on education (Elliot, 1972).

The 1946 National Health Service Act was planned as part of the welfare state by Beveridge, a Liberal; formulated by the war-time coalition government; accepted by the post-war Conservative government; enacted in 1948 by the Labour government and implemented by the then Health Minister, Bevan (Rivett, 1998) (see Appendix 2). There was medical support as well as opposition to the nationalisation of healthcare (Pemberton, 1984), and "in return for accepting services in a system that covered the nation as a whole, doctors were given as much clinical freedom as funding would allow" (Honigsbaum, 1994a). Bevan was also aware of the demands to come, stating in 1948:

> "We shall never have all we need. Expectations will always exceed capacity. The service must always be changing, growing, improving – it must always appear inadequate." (Gray, 1993)

The key features of the service were that it should be (Allsop, 1984):

- **Comprehensive:** from "cradle to grave"
- **Collective:** tax funded and free at the point of delivery
- **Universal:** coverage of the whole population
- **Equal:** geographical uniformity.

The multi-party conception and wide public support for the NHS, which, Rivett (1998) notes, eventually touches the lives of all, gave the service sacrosanct status. Astute politicians were more likely to ignore controversial solutions to problems, or make marginal changes by stealth, obfuscation (or confusion) (Ham, 1996, p59). The 1998 Reforms exemplify this approach, where the complexity of the proposals resulted in minimal media coverage.

From the start of the NHS the basic problems, initially unnoticed by grateful users and powerful providers, were:

- **incompatibility** between central finance, local needs and professional freedom (Ranade, 1994)
- **administration,** supporting rather than challenging what was done (Griffiths, 1996)
- **perverse incentive** for staff (and later also the public) to denigrate the service in the hope of new resources voted through public concern (Rivett, 1998)
- **discovery** of antibiotics, the structure of DNA and other similarly dramatic medical progress which changed expectations from care to cure for the most common illnesses and their symptoms (Herzlinger, 1997), with unanticipated social and economic consequences
- **staff compensated** for the legal constraints and accountability of public service by considerable employment protection (Osborne and Gaebler, 1993), resulting in complacency that ultimately led to public concerns over efficiency, accountability, privileges, standards and objectives (Wass, 1983).

Strong and Robinson (1990) reflected that:

> "The NHS as created in 1948 was brilliant but partially flawed: Brilliant because it offered real and politically viable solutions to many of the key problems in paid health care delivery; flawed because, faced with the rampant power of the medical profession, it failed for nearly 40 years, to establish a proper management structure and an integrated corporate culture."

This epitomised the vision of the needs and culture of the post-war era. Access to healthcare was now available to all and, although a corporate culture did exist, it was tribal and local. Indeed, Enthoven (1985), an American economist, had noted that it was

> "more difficult to close an unwanted NHS hospital than an unneeded American military base",

although unwanted by whom was not clarified. This lack of differentiation between need and want is noteworthy, because the same author was instrumental in the fundamental reform of the NHS to come.

The point is well made that a management structure and corporate culture, which were being developed over those 40 years in much smaller private industries to meet changing customer needs, were absent in the NHS (or, indeed, in health services in general). These changes included development of niche markets, teamworking, outsourcing and worker empowerment (Herzlinger, 1997). Strategic management in the NHS was largely successful; operational management was what was found wanting (Rivett, 1998).

The situation was encapsulated by Griffiths (Department of Health, 1983, p12) in a memorable statement in his management review of the NHS that:

> "If Florence Nightingale was carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge."

Public healthcare is dominated by the staff (medical and others who seek to emulate them) responsible for *delivering* the service (Ham, 1996). Therefore, in any change in delivery, it is these key professionals who will need to be convinced. Legislation to develop organisation and management in the NHS occurred in the 1970s and early 1980s (see Appendix 2), culminating in the introduction of 'general management' in 1983, which was open to health professionals. Doctors were courted in particular in an attempt to influence the profession from within. They mostly declined, leaving the fate of the service largely in the hands of lay managers intent on efficiency and control (see Figure 1.1 above).

Despite the promise of operational management, crises continued to be met with funds in the short term, without a requirement for behaviour change on the part of any manager or provider (Gladstone and Goldsmith, 1995). For example, there was a perverse incentive to maintain waiting lists which then attracted extra funds. Users were not considered as stakeholders who could participate in behaviour change. Staff remained separated according to their role, with the service continuing to administer to their needs, rather than to those of the public. Delivery and dominance remained largely with providers, but development of managers as professionals and professionals as professional managers was pursued with a vengeance and initial reward.

1.6 The NHS in crisis

A relatively small miscalculation in the NHS budget produced a massive financial crisis in 1988. Thousands of beds were closed before a particularly harsh winter (Appleby et al., 1990), significantly ending 40 years of the sacrosanct, all-party support for the service (Levitt et al., 1995) and bringing policy, rather than just resources, into the political arena. Prime Minister Thatcher, fiercely opposed to the delaying tactics of a Royal Commission, chaired a Confidential Review Team, to which interested parties could submit suggestions.

Demand for any good provided at zero cost is bound to be infinite (Pollard and Raymond, 1999) and the main management and economic options in public healthcare had already been examined by health economists in a number of countries. Culyer and Jonsson (1986) had reviewed comparative studies, tentatively concluding that rigorously controlled public funding and private provision appeared to be the best mix for efficiency, adding the caveat that much more evidence was needed, particularly studies of health outcome.

At the Confidential Enquiry, and desperate for a radical idea, a market was pursued from a monograph by Enthoven (1985). This would encourage change but prevent instability of provider units and politically undesirable results (Goddard et al., 1997) (for example, bankruptcy of a cherished NHS service) by limiting competition to internal providers wherever possible – becoming known as an internal market. Purchasers would be Health Authorities and GPs who met certain criteria could hold funds for a limited range of services; providers would be predominantly NHS Trusts (formed from realigned existing services), with top up provision purchased from private health services through NHS funds.

It is unclear why such interest was given by the government to a model influenced by private insurance (consistently rejected as a model for the NHS by the UK public) and in crisis, rather than to European examples where public insurance in various forms is the more successful norm. For example, Herzlinger (1997) reports that US consumers view their insured healthcare as the lowest value for money among the goods and services that they purchase, with particular discontent over inconvenience, inefficiency and lack of information, although they admire its technology and providers. The explanation may rest with the concurrent "special relationship" that Thatcher had developed with President Reagan. In addition, there was right-wing Tory interest in emulation of private sector organisation in the remaining nationalised industries, including health and education (Flynn and Williams, 1997).

The Enthoven model fell into the category of supply-side pressure, with local healthcare providers, rather than users or basic NHS principles, being required to change. As such it was efficient and quick to implement, with failure envisaged as conveniently becoming a local, rather than a central, responsibility. There was the potential for the private sector to fill gaps in provision while retaining public funding.

Enthoven subsequently became a critic of the reforms based on his idea of a market, particularly the speed and top-down method of implementation (Enthoven, 1997), with separation of, rather than collaboration between, parties being the required NHS culture. The market concept was, in principle, rescinded with the change in government, the Labour party manifesto of 1997 stating that "Labour will cut costs by removing the bureaucratic process of the internal market", also stating that "the planning and provision of care are necessary and distinct functions and will remain so".

1.7 Markets

Markets are the most basic facility for exchange of goods and services, with their origins in barter. Their purpose was to level out supply and demand but prestige value has increased the price people will pay for marginal benefit; and goods and services may be excluded from a market on the basis of being beyond price or worthless (Handy, 1997).

The following are the requirements of a traditional market:

- **many buyers and sellers** (Sheaff and Peel, 1993; Smith, 1993)
- **identical goods** (Sheaff and Peel, 1993)
- **free entry and exit** (Sheaff and Peel, 1993; Smith, 1993)
- **available information** (Sheaff and Peel, 1993; Smith, 1993)
- **zero transition costs** (Smith, 1993).

The sealing of an agreement over an exchange is through a formal or informal contract. Contracts rely on the principle and agent theory in which the different, often selfish, goals of each party require confirmation to ensure implementation as agreed (Flynn and Williams, 1997). Markets do not work when the human cost of failure is unacceptable, outcomes unclear and supply limited (Handy, 1997), which would seem to compromise their use in at least some areas of healthcare – unless responsibility for failure could be further delegated, becoming the responsibility of the customer rather than supplier.

1.8 Markets in private healthcare

Markets in private healthcare have a similar profit motive to other private market situations. In general, potential users subscribe to insurance cover through which the scope of coverage is clear and the premium based on probable risk of use. Private provision is not interested in customers who cost more to service than they pay (Handy, 1997). A change in subscriber affiliation indicates that, in the view of the subscriber, their (usually interpersonal) needs are not being met. In accord with public healthcare, there is an imbalance of knowledge and power between user and provider, with the similar risk that the latter can influence service use to personal advantage, which is more likely to be financial in a private setting. The opportunity of choice of provider acts as the counter weight.

Healthcare has been described above as a basic human need. Markets for basic needs have been viewed as immoral by those who are in need but excluded, and must rely on charity or altruism; those who make a living through healthcare provision may, however, view a market as appropriate (Spicker, 1995). The issues at stake would appear to be whether a care professional should be altruistic, and the subsequent risk to the community through lack of comprehensive provision. Spicker (1995) suggests that the more essential a service the greater the moral requirement to provide it, irrespective of the financial return.

Such altruism is recognised by society through respect, until economic demands and rise in litigation risk a change in social values. In the contemporary culture of the UK, finance rather than position now secures provision of most goods and services, with the altruism of comparatively poorly paid "essential" staff being viewed as poor business sense. A market in healthcare needs a voluntary or statutory safety net for those with defined needs who are unable to participate in a market and are not reached by those providers who can afford to be altruistic.

Comparison of the three learned professions is again of interest here. Only law has managed to remain an essential service, recognised by a society that *also expects to pay* for this service, with a safety net for state legal aid paying for services for those unable to participate in the market. Theology and medicine are still expected to be altruistic on demand (the expectation of neighbours of individuals in the three groups serves as a simple example).

Perhaps the answer is that the demands on theology and medicine are frequently immediate (literally life and death), whereas legal advice may be less so, immediate law *enforcement* having been delegated to a secondary profession (police) to implement within the rules laid down by the law. Such delegation is emerging in theology as well as in medicine (for example, lay readers, and emergency service paramedics) and this may serve to increase the power of a smaller number of members of the learned professions, who risk pricing themselves out of the market if their remaining services are not perceived by users to be necessary to meet users needs.

1.9 Markets in public healthcare

Public healthcare is provided by virtually all national governments to at least protect the community from risk. Some, including the NHS, are much more comprehensive.

Such a market approach in public healthcare is controversial because of the following issues:

- **Monopoly** of provision exists; there is limited entry and exit of providers; little information; and transaction costs result from the need for public accountability.
- **Resources** are not directly linked to consumption and frequently there is a perverse spend in that those in most need (children, disabled, unemployed and elderly) are paying the least into the system.
- **Perverse incentives** exist, for example, the identifier, purchaser and provider of services necessary to meet a need may be one and the same, such as the GP (Clarke and Newman, 1997).
- **Profit** to private providers is from public funds.

A comparative review by this author of the ideal market principles with the situation in private and public healthcare indicates considerable problems for public services (Table. 1.3).

Ideal market characteristics: for profit	**Private healthcare market characteristics: for profit**	**Public health market characteristics: not for profit**
Multiple, rational buyers	Risk adverse (Appleby et al., 1990)	Comprehensive, uncertain demand (Appleby et al., 1990; Ranade 1994), public accountability, media interest (Smith 1993)
	Assessment of need and risk (Ovretveit, 1995), a consumption good.	Assessment of need and health gain (Ovretveit, 1995), wider than health care (Scheaff and Peel, 1993), an investment good
	Planned use, clear scope	Insatiable demand (Scheaff and Peel, 1993), infinite scope (Scheaff and Peel, 1993; Smith 1993)
	Moral hazard (Appleby et al, 1990)	Moral issues, especially equity (Ranade, 1994)
	Influence of those accepted as users (Hunter, 1989; Light, 1994) and choice of exit on each occasion (Pfeffer and Coote, 1991)	Provider influence (Ranade, 1994; Hunter, 1989; Ovretveit, 1995), limited exit (Scheaff and Peel, 1993), in line with contract (Pfeffer and Coote, 1991), mainly "voice"
	Increased demand during improved economic performance (Feldbaum and Kratz, 1995)	Increased demand during economic recession (Feldbaum and Kratz, 1995)
Free entry and exit of multiple sellers	Professional and routine statutory regulation	Professional and complex statutory regulation (Ovretveit, 1995)
	Monopoly, autonomy and opportunity of new	Monopoly, autonomy and barrier to new (Ranade, 1994; Scheaff and Peel, 1993; Smith, 1993)
	Limited responsibility for sustaining uneconomic services.	Responsibility for sustaining a service (Handy, 1997)
Identical goods	Provider induced demand for profit (Appleby et al., 1990)	Provider induced demand through altruism (Appleby et al., 1990)
Perfect knowledge by buyer and seller	Imbalance of knowledge; autonomy as proxy for evidence	Considerable imbalance of knowledge (Appleby et al., 1990; Scheaff and Peel, 1993; Smith 1993); autonomy as proxy for evidence
	Emphasis on cure (Ranade, 1994) with some user involvement	Cure demanded but mainly care needed (Ranade, 1994) with considerable user input
Unlimited quantity to decrease price	Increased use accompanied by increased resource	Increased use not accompanied by increased resource; cost containment pressure for increased efficiency (Ranade, 1994)
Zero transition costs	Transition costs balanced by risk and information (Ranade, 1994)	High transition costs (Smith, 1993)
Process improvement driven by market	Process improvement driven by market (Feldbaum and Kratz, 1995)	Process improvement driven by reform (Feldbaum and Kratz, 1995)

Table. 1.3 Characteristics of generic markets, healthcare markets and public healthcare markets

The differences highlighted particularly for public healthcare are unlimited demand, the need to sustain a service, the need for a driving force for change as proxy for a paying customer, the threat to equity, and the reliance on autonomy in the absence of evidence.

Equality was a value in the 1948 NHS whereby all but those in extreme need would gain or suffer equally with change in national circumstances. This reflected the prevailing war-time culture of chance, where death and damage were indiscriminate. *Equity* has replaced equality as a general social value, reflecting a culture of certainty of product performance and reward for effort, but acknowledging inevitable disadvantage. The different values implicit in the private healthcare model, particularly pre-selection of users, would sit uncomfortably within a culture that values equity.

Formalisation of equity in public service has been compromised by the following: lack of evidence to indicate what *is* equitable; the stronger value of autonomy; the loudest voice of the least needy; the demand for just return on tax invested by those who probably have the least need, that is, the employed; and the gradual cultural change towards individualism since Thatcher. Government intervention can ensure equity based on current knowledge; an unregulated market may exclude it to the ultimate detriment of the wider community. A market in public healthcare is therefore a misnomer, being managed through a third party and regarded more correctly as a quasi market.

The main role of the government is in raising the funds for third-party commissioning, regulation as a result of monopoly provision, and in facilitating the sharing of scarce resources (Propper and Le Grand, 1997). The advantages of economy of scale, the requirement for comprehensive scope, the political risk of spare capacity and bankruptcy, and the existence of monopoly provision lead Propper and Le Grand (1997) to conclude that competition in the NHS is inappropriate. These same features influenced the original need for welfare-style provision fifty years ago to replace the market then existing—reflecting the natural cycle of change described by Schumpeter (1939) (see also section 3.2.2, Chapter 3).

Figueras et al. (1997) cite other examples of managed competition where vouchers based on need have led to those most in need (i.e. those with the most vouchers) becoming the courted users, influencing responsiveness as well as equity within welfare provision. The identification of need and allocation of appropriate resources where evidence is thin would be another controversial, and costly, hurdle to overcome.

1.10 The 1990 NHS reforms

The Confidential Review of the NHS (see section 1.7) resulted in White Papers entitled "Working for Patients" (Department of Health, 1989a) (see Appendix 3) and "Caring for People" (Department of Health, 1989b), both of which were enacted in 1990. The former led the change to a more responsive culture through a managed or quasi-market, limited to internal competition; the latter addressing the implications of reprovision in the community of people from long stay institutions. Responsiveness was mainly directed at identifying and meeting the largely assumed needs of users by competition between providers.

The Patients' Charter

Information to empower service users was provided in a Patients Charter (Department of Health, 1991). This detailed seven existing rights for patients: to receive healthcare on the basis of clinical need; to be registered with a GP; to receive emergency medical care at any time; to be referred to a consultant if thought necessary by a GP; to be given a clear explanation of any treatment proposed; to have access to health records; and to choose whether or not to take part in medical research. Three further rights were to be implemented; detailed information about available services including quality standards and maximum waiting times; guaranteed admission to hospital initially no later than 2 years, then eighteen months with a target of one year; and the right to have any complaint investigated and to receive a prompt written reply from the chief executive of the Trust, Health Authority or Family Health Services Authority (FHSA). In addition, local charter standards were introduced to minimise waiting times and all front line staff were to wear name badges.

A major review of the Patients Charter was undertaken by the Kings Fund in 1997 (Farrell et al 1998), concluding that the advantages of the existing charter were that it had:

- Raised staff awareness of patient needs, issue and rights
- Helped set standards and identify priorities for action
- Set comparable standards for reviews of performance
- Helped to move the NHS culture towards a "user perspective"

with disadvantages of

- Lack of clarity about its aim—this engendered wide scepticism
- Insufficient user or staff involvement in creating the document
- Too much emphasis on quantitative standards
- Ignoring clinical standards and outcomes
- Some standards irrelevant to patients' real needs—especially the vulnerable
- Difficulty in monitoring—data costly to collect, sometimes fudged and/or ignored
- Hospital services dominating at the expense of Primary Care
- Low patient awareness of the Charter
- Patients' expectations unrealistically raised
- Little emphasis on patients' responsibilities

Quality or power break

Although the superficial message of the reforms was user responsiveness, a more coercive theme is detected by some authors. It was known that Thatcher had a deep distrust of the professions, particularly those with autonomy, public support and detail she did not understand (Gladstone and Goldsmith, 1995). A focus on "quality" would therefore gain public support, at the same time attempting to break the power of professional cohesion (Sutherland and Dawson, 1998) and improve efficiency. A letter in June 1989 from Nichol, then Chief Executive of the NHS Executive, had required District Health Authorities (DHAs) to have quality assurance (QA) in place by the end of that year.

The reforms were seen as a two pronged attack to raise quality of care and efficiency, firstly through competition and secondly through informing and empowering users (McSweeney, 1994). At the same time as quality in the NHS was being promoted by the government, older people pursuing private sector care, mostly for reasons of quality, were given tax relief on their insurance. A hidden agenda was thought to have been to sway the public away from the NHS, but this was not realised because, when tax relief stopped in 1997, 100,000 older people gave up their health insurance (Fletcher and Hibbs, 1997). The spend had been based on *opportunity* not principle.

Support by NHS users for their interests to be met through a market is not apparent. The Conservative government thought that choice through a market culture would be welcomed in the changing climate, but they underestimated public suspicion of the government's motives; fears that it would lead to rationing; and above all the continuing appeal of the NHS to most of the British public (Rivett, 1998). The situation is neatly summarised by Rivett (1998) as follows:

> "The NHS was the creation of a particular epoch, in particular, a post war collectivism which seems particularly anachronistic in an age of rampant individualism and instant gratification. The survival of the NHS in such a context represents a supreme paradox, hard to comprehend let alone explain"

although some would take issue with whether "rampant individualism" is a national culture or confined to a political vision with a limited following. The latter definition might explain the consistent support by the majority for the NHS.

Implementation

The 1990 NHS changes were announced without consultation, basic research or necessary information (Walt, 1994). Although Enthoven had proposed a pilot and Clarke, then Secretary of State for Health, had described them as "experimental in nature" (Gladstone and Goldsmith, 1995), they affected the whole service and there were no overt measures for success. Implementation was to be by "smooth transition", felt by Wistow et al. (1996) to be inconsistent with a market model aimed at provoking change through choice. The intent, if not the understanding, of the government must be questioned.

The overt aims of the 1990 reform were:

- **to retain the advantages of the NHS** (universal coverage, effective cost control)
- **to achieve quantifiable health gain** (Ovretveit, 1993)
- **to expand consumer choice and improve efficiency by competition** (OECD, 1994).

There was to be an NHS Policy Board for strategy and NHS Management Executive (NHSME), later the NHS Executive, for implementation.

The objective was to change the culture of the NHS from provider to customer focused through a more business-like approach, using the commissioner or GP fundholder as proxy for users' needs. There was no evidence that commissioners could reflect users' needs (Propper and Le Grand, 1997), and no advice on how to deal with the fact that the values of efficiency, competition and user choice are potentially contradictory (Clarke and Newman, 1997); for example, users may wish to choose a service that happens to be inefficient. The fundamental difference between public and commercial services – that the relationship between satisfaction and efficiency is reversed – was to be met by money following the patient.

The capacity of purchasers and providers to deliver such change was largely ignored. For example, training was limited in quantity and coverage, and no framework was suggested to ensure a comprehensive scope for commissioning, agreed priorities and measures of success; confrontation rather than collaboration was expected.

1.10.1 Commissioning, competition and contestability

Commissioning

Commissioning is the cyclical process of identification of needs; specification of response based on quality, cost and volume components; agreeing a contract for provision; and monitoring of results. It is an example of the use of a third party to stimulate an internal market. It has the potential for rational planning based on need and shared values, pivoting on the fulcrum of quality in the drive to balance need with resource (Fig. 1.2). Quality may be at risk in the drive for short term gains, or enhanced by the longer term competition for customers (Drummond, 1990). Where quality is unspecified it runs the risk of being excluded from negotiations which become based on the more easily quantified and understandable cost and volume measures.

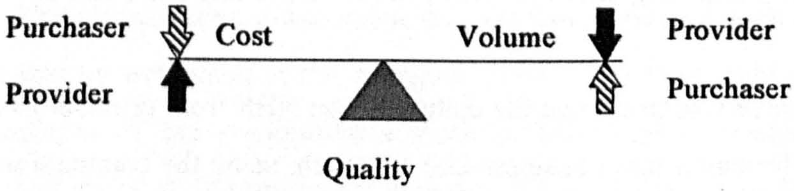


Fig. 1.2 The fulcrum of quality in commissioning

In retrospect, it was naïve to think that the NHS could work in such a way as:

- **Need identification** was limited to epidemiology largely based on questionable mortality data, ignoring morbidity of chronic conditions from which people frequently suffer but rarely die.
- **Specification** was a totally new concept requiring not only broad service knowledge but also highly refined documentation skills. Specification of complex, largely unsubstantiated healthcare provision to meet equally complex needs that do manage to be identified is fraught with difficulty.

- **Agreeing a contract** defined by purchasers for providers, who were likely to have more knowledge of their services, realigns power positions and limits scope for negotiation (dominance potentially remaining with delivery).
- **Effectiveness measures** were largely absent, and qualitative measures rarely sought at all, making monitoring a subjective view that lacked credibility.

Williams and Flynn (1997) conclude that contracting with the preferred provider is a complex legal, economic and social process. The last is particularly important where specification is immature and flexibility to meet changing needs essential. The problem within the new environment was that, just at a time when personal relationships were relied upon for mutual survival, efficiency measures were affecting posts, resulting in changes within contract teams forcing reliance on objective controls.

Competition

Competition is a traditional feature of markets, but Deming (1982) refers to the "diseases of public sector management", which militate against competition in that environment. These include: conformance to policy; resource-led; short-term; problem focus; monopoly; reward for empire not results; employment benefits; complex interagency links; lack of targets; process focus; specialisation rather than teamworking; and hierarchical management style.

A major concern of Ham (1996) is the assumption that a market *requires* a competitive culture. Competition can focus the mind on improvement, but an organisation will expend resources on improvements to elevate itself above that of rivals on issues that the (generally poorly informed) purchaser wishes to see.

Contestability

Contestability provides incentives to improve performance and is promoted by Ham (1996) as a more productive approach than traditional competition. This approach facilitates partnership for continuous quality improvement, but retains the opportunity of switching partner should goals fail to materialise. Such environments particularly lend themselves to development and evaluation through an action research approach (Checkland, 1997) (see Chapter 2).

While the "rules of the game" in the reformed NHS were being determined, frank competition was evident and expected but, by 1995, the NHS Executive was seeking "mature relationships" with "creative tension and robust negotiation" (Goddard et al., 1997). It has emerged that there is now a reluctance to pursue "hard" contracting, which undermines mutual trust, and increasing support for "soft" contracting, which enhances collaboration but retains contestability (Williams and Flynn, 1997).

Contestability would avoid most of Deming's "diseases of public sector management". For example, the 1990 reforms have affected monopoly by access to alternative NHS and private providers through NHS resources, and therefore started to curtail provider dominance and to reward results (albeit cost and volume) rather than empire, drastically reduced employment benefits – the job for life no longer exists, provided targets, promoted teamworking alongside specialisation, and started to change the management style from a hierarchical role culture to that of matrices for specific tasks. Public accountability did, however, demand a vestigial hierarchy.

Chiropody, the service in which the model developed in this thesis was tested, has 50% of the profession working in the private sector. Unlike other health professions, this interest is predominantly primary rather than secondary income; doctors and physiotherapists, for example, having a much smaller percentage working solely in the private sector, but a significant number employed primarily in the NHS, supplementing their income with private patients. Chiropodists could therefore, through their professional organisation, publications and personal survival skills, have a greater awareness of the issue of user responsiveness.

1.11 Reflection on the 1990 reforms

It was generally acknowledged by managers that there was much ground to be covered in the pursuit of a responsive service but that learning from, and appropriately applying, the experience of other industries in their quest for quality management – identifying and meeting the needs of the customer – could perhaps facilitate implementation.

Resource constraints are a fact of tax-funded public healthcare life, although there was the opportunity for expansion at the expense of adjacent providers and different styles of funding, such as amenity top-up, could be productive. It is of particular interest that the reforms have *increased* conformance through contract specification and monitoring. Deming's "diseases" are in need of updating in the light of management responses to cultural change in the public sector since 1986; but the "diseases" of conformance, short termism and inter-agency links probably remain intractable in the public sector as it currently stands.

It was anticipated throughout the service that, in the light of the difficulties to be overcome, the ultimate extent of the change resulting from the reforms might be limited. This was confirmed by Caines (1996), Personnel Director of the NHS Executive at the time of reform implementation, when he stated that:

> "Major change in the public sector is not fully achievable in view of its size and pressure of the electoral cycle."

Despite such reservations, and in the absence of a rationale for the change beyond ideology and rhetoric, or measures for evaluation of its effect, the NHS reforms have now influenced several countries in east and west Europe (Figueras et al., 1997).

The reforms continue to be widely reported in the media, particular focus being on the market style, competition, implementation and transaction costs. Despite this, or because of the style of reporting, 33% of the public think Trust hospitals have been privatised, and a similar proportion believe Trusts buy health services on behalf of the population (Grampian Health Council, 1994). The 'obfuscation' of policy making described by Ham (1996, p59) which avoids public understanding, discussion and debate can be confirmed. The suspicion by the public of a progressive creep towards privatisation is strengthened.

1.12 NHS change, the next stage

Fifty years of the NHS were celebrated in 1998 and the King's Fund-sponsored review at the close of the first half-century records that:

> "Something has got to give. We are in an era of uncertainty and a clash between social obligation and personal autonomy. It is arguable whether the present system in this country can contain the pressures for increased expenditure much longer. We may have to face the unpleasant possibility that in the second 50 years of the NHS, the ever growing opportunities and costs will make it impossible for health services to maintain themselves outside the laws of cost, supply and demand that influence the distribution of services and products elsewhere in society." (Rivett, 1998)

Credibility for this view can be gauged from the fact that the author, a GP, is now an official at the Department of Health, and that the foreword to the book was written by Prime Minister Blair.

A survey of the public before the 1997 general election revealed continued faith in the NHS concept, satisfaction with professionals, unhappiness with government handling of the service, and a growing perception that the quality of hospital care is decreasing. A poll by MORI, also in 1997, showed a public sense of trepidation for the future of the NHS. A Gallup poll in 1998 (King, 1998) reports that 48% of those questioned put health at the top of the public agenda. This was the first time in 20 years that healthcare had been ahead of the traditional focus on education (30% of respondents) and unemployment (29% of respondents).

There appears to be support for improving quality and efficiency but that market principles are not the answer. The political aim of presenting failure as being clearly a local responsibility has failed. The experience of other privatised national amenities (water, gas, railways) where profits have boosted executive salaries to "fat cat" status has already begun to become an accusation of the NHS.

The 1998 reforms that aim to make the NHS "modern and dependable" can be said to have met Ham's (1996) criterion of obfuscation; they were so complicated as to have received little media coverage after the launch date. In brief, the following are principles outlined in the White Paper (NHS Executive, 1997):

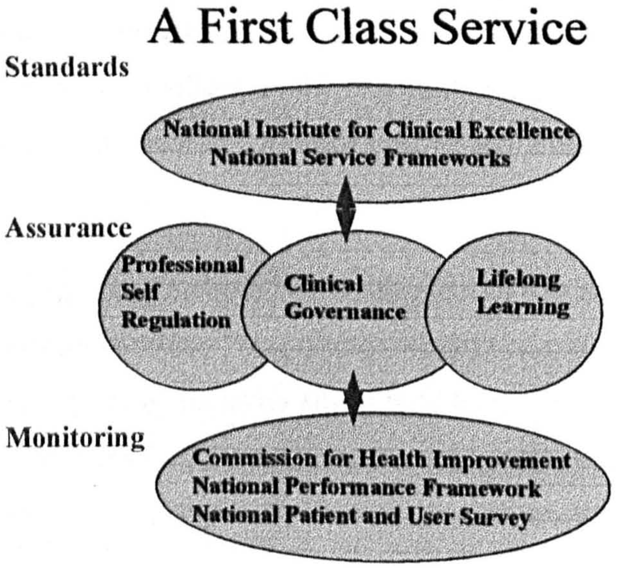
- **National policy**: keep what worked; discard what failed; improve quality and performance through promotion of clinical governance.
- **Primary care groups**: to promote health and integration, to commission (plan) through contestability. They can become Trusts.

Although the principle of the use of contestability as the key for improving quality is welcome, there are concerns that the advantages that the NHS has gained since 1948 – bringing into one national service a range of disparate groups – may be reversed by immature use of the opportunity.

With reference to clinical governance, this was eventually defined six months after publication of the White Paper as:

> ". . . a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (Department of Health, 1998)

Statutory responsibility for clinical performance is, for the first time, allocated to chief executives; and three linked stages of standards, assurance and monitoring are envisaged in the pursuit of reducing geographical and clinical variation through a change in thinking rather than by ticking checklists (Department of Health, 1998) (Fig 1.3).



Setting standards

National Institute for Clinical Excellence (NICE): wide membership to produce cost-effective *clinical* practice guidelines.

National Service Frameworks: for best *organisation* of services.

Assurance

Clinical governance: process to assure *clinical* decisions.

Lifelong learning: tools for effective, high quality care.

Professional self-regulation: sets, enforces and ensures professional and clinical standards.

Monitoring

Commission for Health Improvement (CHI): rolling programme of independent reviews, focused reviews, with power to intervene.

National framework for assessing performance: to monitor *delivery*.

National survey of patient and user experience: monitor *experiences*; results could trigger reviews.

Fig. 1. 3 Setting, delivering and monitoring standards.

(Source: adapted from Department of Health, 1998.)

The spirit of the 1998 reforms is centralist in nature, a trend not lost on at least one Community Health Council that strongly advocates user input to all three stages of standards, assurance and monitoring (Greenwich CHC, 1998). For success, internal mechanisms for improving clinical performance are to be in place and, fortuitously, the quality improvement process developed in this thesis meets this requirement and is already being put to local use in this new context.

With reference to the evidence-based approach that the National Institute of Clinical Excellence (NICE) will be pursuing, it can only be hoped that quasi-experimental and qualitative research will receive the support already given to scientific research, although the NHS research and development strategy almost exclusively supports positivist models (Meyer and Bateup, 1997) (see also Chapter 2).

A publication accompanying the reforms (NHS Executive, 1998) indicates the national performance framework that will be used to monitor quality, which is also strongly centralist in nature. The content of this publication can be summarised as follows:

- **Health improvement**: social and environmental, all agencies, influence behaviour affecting population health.
- **Fair access**: geographical, socio-economic, demographic and care group equity.
- **Effective**: evidence-based, appropriate, timely provision, compliant with standards, by competent staff following best practice
- **Efficient**: cost per unit of care/outcome, productivity of estate and labour.
- **User experience**: responsive to needs and preferences; skilled care, continuity, wait and access; involvement, information and choice; environment and courtesy.
- **Health outcome**: reduce risk, meet need, avoid complications and premature deaths; improve quality of life.

The tone of the document is largely prescriptive and may fail to capture the hearts of those who have relished empowerment since 1990. The document does, however, provide some suggested frameworks for evaluation, rectifying an omission in the 1990 reforms.

1.13 Conclusion

One of the requirements for successful change is an understanding of the topic and culture of the organisation being changed. This chapter has identified that health is a universally desirable state, delivery of healthcare is not immune from general influences for change, and traditional healthcare providers may have difficulty with adapting to changing needs resulting from their professionalisation process. The NHS has responded to these influences by changing from welfare- to market-style provision where the pursuit of quality management would be the goal. Ideal markets are not compatible with healthcare, with particular concerns for equity of access and autonomous response. Managed markets, through informed third party commissioning, could however influence supply to meet demand.

While the government seeks a “modern and dependable “service, there remains a widening gap between what the public expects and what service personnel are able to offer. The nursing profession, as the largest part of the workforce and on whom much depends to deliver the national agenda, is in crisis (Salvage, 1999b): support for nursing has begun to be lost from the medical profession (Salter, 1998); tens of thousands on the register are working outside the NHS either pulled because of their generic skills, pushed because of dissatisfaction with pay and conditions to other sectors (Rowden, 1999), or moved sideways to the booming independent healthcare sector (Salvage, 1999b); those threatening to leave outnumber recruits and returners (O’Dowd, 1999). Recruitment levels can only be maintained by widening access criteria. Such entrants will require greater supervision, diverting senior staff from their clinical and research roles. This in turn risks disillusionment and departure of senior staff and a consequent reduction in skills, supervision and research activity, the essential platform for quality improvement.

The result could be a return to the widely supported caring role, subordination and retention of semi-profession status. The consequences for both the most able within the profession and the advancement of comprehensive healthcare practice are in the balance. The author's own view is that there will be a clear divide between those caring and those supervising, with academic progress being pursued as an independent activity. As professions only exist so long as society finds a use for their uniqueness, the risk to nursing is that society will wish only to support continued semi-profession status.

Moving participants from a healthcare culture of welfare to managed market can be achieved by either coercion or collaboration. The next chapter reviews the change process and consequences for such different models. The social component of the commissioning and contracting process offers an opportunity to capitalise on identifying and meeting participants' needs through stakeholder participation, with the added advantage of enhancing the health outcome of users.

This principle of using the commissioning process to identify and meet needs, gain commitment to change, and enhance health outcome and organisational success is pursued through this thesis. The hypothesis is that:

". . . by incorporating user, provider and purchaser expectations, health needs assessment can be converted into a best quality service specification."

Chapter 2: Methodological overview

2.1 Introduction

The preceding chapter has identified that the delivery of healthcare is not immune from the general influences for change. Also that the NHS has responded to these influences by reform in 1990, changing from welfare- to market-style provision where the pursuit of quality management would be the goal. The commissioning and contracting process offered an opportunity to move participants from a healthcare culture of provider dominated welfare to one of responsive managed market if stakeholder interests could be identified and responded to. The author's post was created with the remit to plan a project to identify, or develop, and evaluate a model for quality management in healthcare suitable for the commissioning process. Through an assessment of population need by the Health Authority, chiropody for older people was identified as a high profile unfulfilled need, and the quality model was piloted and evaluated in that service.

This chapter reviews the literature search and methods chosen to develop, implement and evaluate the model for quality management. The theme is clearly that change in the NHS is likely to be more successful with stakeholder participation; a quality improvement approach would attract crucial clinical support; specific factors were necessary for successful change in the NHS; objective selection of the pilot site by assessment of need would eliminate sample bias with any provider differences requiring additional review; and that quantifiable results would facilitate acceptance of the pilot example and promote wider implementation.

2.2 Literature review

In preparation for the project a review of the literature on health and healthcare, change management and quality was undertaken. Although much was found on change management and quality in manufacturing, that on services was less and in public healthcare minimal. This research will make a contribution to the void. The key databases used were Social Science and Humanities; Health and Health Care; and Business Management. The detail of the relevant findings on Health and Health Care were described in Chapter 1; that on change management is in Chapter 3; with quality in Chapter 4. The findings are summarised below.

Public healthcare was determined as a unique culture because of the lack of evidence on which practice is based (Firth-Cozens, 1996); the subsequent power given by society initially to doctors, and latterly to some other healthcare professionals, to make autonomous, often life and death, decisions in the best interest of the vulnerable patient (Goode, 1969); and the conflict that autonomous professionals experience between professional and public accountability (Bertilsson, 1990). It appeared that there had been little incentive for the most powerful group of professionals, doctors, to change from dominance to responsiveness. External social (user) and financial (purchaser) pressures were making change in clinical practice an economic, and ultimately professional, imperative. Involvement of autonomous professionals in the formation of this new culture would need to be secured collaboratively rather than coercively for any change to be successful. They would need to be able to see personal, professional and patient, if not also corporate, advantage to their involvement

A comprehensive framework by Clarke (1994) guided the review of the extensive literature on change management. The outcome was that successful change is achieved through collaboration between stakeholders and reinforced through a management system appropriate to the organisational culture. Such a system is usually based on the philosophy of total quality, and sustained through continuity (Peters and Waterman, 1991). The difficulty of measuring progress towards the quality culture aspired to has been reduced by using Crosby's (1980) Quality Management Maturity Grid containing statements with which to compare the position of the organisation.

The best practice indicators for successful generic change were identified as a conducive culture, communication, commitment and measurement of progress (Clarke, 1994). This author compared these with the reality of NHS change through the 1990 reforms to inform the approach for implementation of the planned model. It was found that the need for clarity and agreement over quality issues, vision and values (Gibson, 1990); a strategic approach (Clarke, 1994); and the capacity and empowerment to respond (Hunt, 1994) were additional factors for successful NHS change. These generic and service specific indicators, together with those specific to the cohorts and care groups involved, would need to be incorporated in the proposed model for successful change and comprehensive stakeholder satisfaction with the process.

The management approach for reinforcement of the change also needed to be integral to the model. Quality Assurance through conformance to independently developed standards had initially been pursued in the reformed NHS as the basis of commissioning, and was indeed the title of this author's post. Such an approach to quality management proved unacceptable to providers who felt their autonomy for practice improvement was compromised (Morrison and Helneke, 1992). At the same time more evidence for best practice was emerging through collaborative, and therefore more acceptable, national initiatives involving representatives of the relevant professions. This allowed for the development of acceptable protocols and guidelines which could then be audited for quality assurance.

Total Quality Management (TQM) for continuous improvement was subsequently viewed by the government as the national way forward, offering the potential for collaboration and an opportunity to improve on the protocols and guidelines. The results from the 17 pilot sites were disappointing mainly due to the short termism of a political organisation, lack of sufficient investment in the initiative, lack of clarity concerning client needs and satisfaction measures, and failure to involve powerful players (Ovretveit, 1994). At a local level, under the refreshed name of Continuous Quality Improvement (CQI), thereby losing the "management" connotation (Reynolds, 1994), the philosophy remained a serious option to be considered.

Some lessons from the failed national initiative could still be learnt from and these were: lack of sufficient investment, clarity and involvement. The remaining lesson, short termism of political organisations, is inherent in public services. The failure of the initiative was compounded by the "diseases" of public sector management militating against competition (Deming,1982), and barriers to business like performance, described as "sins" by Drucker (1980). A solution to these sins and diseases of public sector management, which would otherwise risk the failure of quality programmes in public services, was proposed by Milakovich (1991). He suggested the following key changes in policy that would also need to be incorporated in the model:

- Costs of quality should be assessed
- Internal and external customers and their needs should be identified
- Protection should be provided for minority group interests
- Customer-driven measures of quality should be used.

The theme from the three reviews is clearly that change in the NHS is likely to be more successful with stakeholder participation. Participation is based on the assumption that those affected by a situation are best placed to determine how to change it and make implementation work (Street, 1995). Participation should be voluntary, foster equity of contribution and facilitate mutual respect (Street, 1995). Participation has the added opportunity of harnessing skills and experience (Street, 1995), providing a test ground for ideas (Street, 1995), developing confidence (Lees, 1975; Clutterbuck, 1993) and building bridges between groups (Berry et al., 1986).

The challenge was to develop a flexible, cost effective quality management model that was acceptable to public healthcare stakeholders. The approach by Juran (1988) to CQI in services appeared to offer that flexibility as well as acceptability to providers; comprehensiveness from the users viewpoint in that every stage of the business process is considered; and incorporated the mutually acceptable quality assurance standards sought by commissioners.

2.3 The research questions

The research questions, which continuously surfaced, were:

- **Can an effective CQI model for healthcare be identified, or developed, and evaluated which incorporates Juran's approach and the needs of local key stakeholders?**
- **Can local organisational change within the NHS be improved by learning from the lessons of change theory and national implementation of the 1990 reforms?**

2.4 Hypothesis

This thesis tests the hypothesis developed from the theories of health and healthcare, change management and quality that

". . . by incorporating user, provider and purchaser expectations, health needs assessment can be converted into a best quality service specification."

2.5 Development of the model

In the absence of an existing appropriate quality management model, a group was convened by the author representing purchaser, provider and user stakeholder interests. The result was the Quality Synthesis Model (Fig 2.1) incorporating core, care group and service specific standards synthesised from quality intelligence to meet the needs of the three stakeholders, with feedback on progress to stimulate continuous improvement.

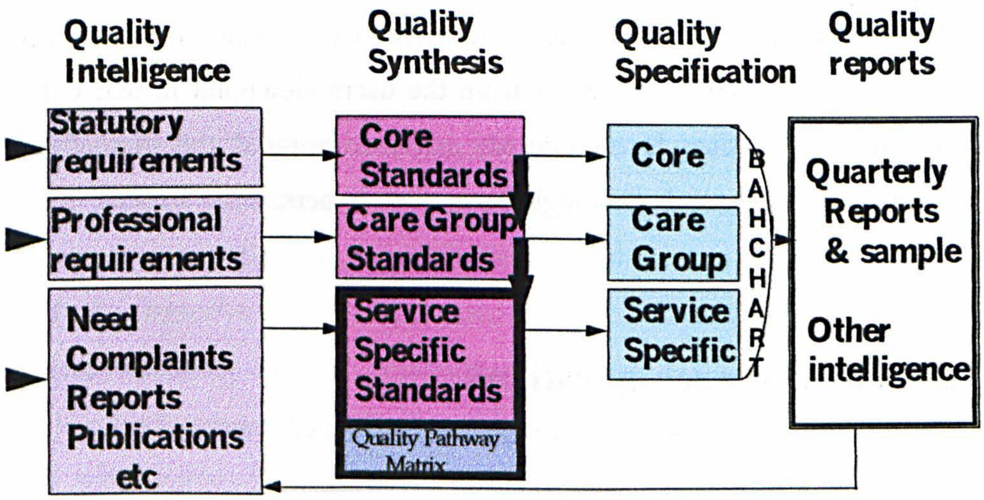


Fig. 2.1 Quality synthesis model

2.6 Research design

The design of the project to implement and evaluate the model required a sound methodology, the established criteria being that it was valid, reliable and repeatable. The traditional research strategies are experimental and interpretative Each has different philosophies, uses, data collection instruments and levels of compliance with the established criteria and are summarised in Table 2.1.

Design and description	**Instruments**	**Criteria met**
Experimental		
Classic experimental: two comparable experimental and control groups.	Scientific measurement	High validity, reliability, repeatability
Pre-experimental Case: subsequent to phenomena; insight Pre-test/post-test: compare same variable; maturation risk Post-test comparison groups: intact groups, one experimental; non -comparable	Structured interviews and surveys	Uncontrolled internal and external validity. Inferences are inconclusive
Quasi experimental Contrasted groups: partly comparable; subtle differences Time series: serial measures, single group Control series: compare with non -equivalent; shows natural trends	Structured interviews and surveys	Weaker internal validity than experimental, but stronger internal validity than pre-experimental
Interpretive		
Ethnographic: real-life situations	Diary, observation, case studies, unstructured surveys and interviews	Unreliability from subject error (seek to please), observer error, bias Internal validity: strong External validity: weak Repeatability: strong

Table 2.1 Overview of research design

2.6.1 Experimental research method

Nachmias and Nachmias (1987) describe experimental research as being based on the classic scientific method that assists understanding of the logic of all research design. It uses two comparable groups, one experimental and one control, and follows a logical pattern from developing a hypothesis and collecting and analysing data. The results allow the investigator to draw causal inferences and observe whether the independent variable caused change in the dependent variable, the latter being dependent on the former for its condition, for example, treatment and outcome. The hypothesis is then accepted or rejected and the theory reviewed in the light of the findings.

There are social, political and ethical considerations which may restrict the use of the pure experiment in certain situations; for example, in healthcare, being able to test the groups before illness or denying potentially beneficial treatment to one group. Pre-experimental and quasi-experimental designs can be used in such situations but are considered to be less valid than experimental designs.

2.6.2 Interpretive research method

An interpretive approach uses ethnographic methods to obtain insights, or interpretations by individual subjects in their own words. For example, issues rated for satisfaction in a survey can be probed to understand why such opinions were held (Cole, 1994). Interpretive theory supports the view that multiple realities exist, not finite truths, accepts all information and does not attempt to control variables (Carpenter, 1997). Social research does not set out to prove or disprove but to find evidence to support the hypothesis and infer that it can be generalised (Hicks, 1988). Triangulation can be used to view the results from different angles and increase the validity of the ultimate interpretation. Methods used for qualitative research include case studies and surveys which Yin (1994) refines by the form of the research question, need for control and contemporaneous nature of the event (Table 2.2).

Strategy	**Form of research question**	**Requires control over behavioural events**	**Focuses on contemporary events**
Survey	Who, what, where, how many, how much	No	Yes
Case study	How, why	No	Yes

Table 2.2 Strategies for different research situations. (Yin, 1994)

2.6.3 The experimental-interpretive debate

The debate between experimental and interpretive methods is based on two fundamentally different epistemological positions. On the one hand, positivism is a belief that the methods of natural science are appropriate to social science, in that the differing reactions of people can be recorded in a scientific way so long as they are ***observable*** and enough observations can meet positivist criteria (Winter, 1989). On the other hand, interpretive research is an approach to the study of the real world that seeks to describe and analyse the culture and behaviour of humans and their groups, from the point of view of those being studied (Bryman, 1995). Although some may be observable, most is reported behaviour that is open to interpretation by individuals and analysts.

Bryman (1995) argues that the two methods are probably a lot more complimentary than researchers give them credit for, that interpretive studies incorporate experimental measures, and that triangulation accommodates both approaches. There is growing interest in what each approach can offer to the other, while still respecting the differences (Bryman, 1995; Robson, 1997) and the need for methods appropriate to the situation and sound methodology (Bryman, 1995). For example, interpretive data can indicate an issue for experimental enquiry, followed by interpretive probing into the implications of the findings.

Both experimental and interpretive methods introduce varying amounts of researcher subjectivity, which, in experimental research, could be by the researcher's choice of methods. Susman and Everard (1978) emphasise the need to understand the way that individuals and researchers undertake any interpretation, because all come with some inherent values

The concern of some researchers is that, although an opinion has been stated, it reflects only the view through the eyes of that person (Stanley and Wise, 1983) and responses may be given to achieve alternative aims. Such aims, for example, include satisfaction with hospital clinic waiting time may be reported as *dissatisfaction* in the hope of preventing deterioration to a level that would *actually* be unsatisfactory to that individual; alternatively, denigration may be used in the hope of investment in a cherished service. Positivists would find such results unacceptable, believing that all phenomena are potentially measurable in a direct quantitative format.

2.6.4 Productive combination

Reason (1995) uses the term co-operative enquiry to describe various approaches to research *with* rather than *on* people which have become part of a new paradigm of social research.. He provides examples of:

> **Participatory research**— to enable researchers to appreciate practical and cultural need
> **Action science**—which enables participants to learn from experiences
> **Experimental enquiry**—which respects personal experiences

These approaches aim to facilitate change as part of the process, rather than leaving the opportunity for change as optional to readers of the published research, or imposition down through the hierarchy. The researcher and subjects work together to analyse the situation that they wish to change; the involvement and empowerment of subjects overcomes traditional resistance to change; and the opportunity to learn about research, and involvement of the researcher enables understanding of the subject (Webb, 1996).

2.7 Choice of method

As the objective of this research was behaviour change by stakeholders in unique settings, experimental and interpretive methodologies were explored. A solely experimental approach was rejected on the basis of the need for empowered change in behaviour and ethical considerations on its use in healthcare. Quasi-experimental methods could be used to obtain baseline data through structured surveys and interviews. Apart from quantitative characteristics, other data from such structured questions would be subjective and therefore at the interpretative end of the continuum.

These exclusive experimental and interpretive methodologies were rejected as too rigid and therefore not appropriate for real-world management research. Action science, more commonly known as action research, offered a framework whereby a combination of methods could meet the practical need and uphold research principles. The method would therefore be predominantly experimental, carry the risk of high internal but low external validity, although it could be transferable in *principle* if not in detail (as a result of the uniqueness of individual cases) to other situations.

2.7.1 Action research approach

An action research approach facilitates change that can occur with minimum conflict through the voluntary involvement of different stakeholders in the change process based on research. The integral continuous feedback loop in action research goes beyond investigation to action and reflection, reducing the traditional separation between research and practice. A bias towards research can ensure that facts influence the basis for change and its subsequent sustainability, but the requirement for meticulous methodology and attention to detail risks frustration of some participants and ultimate marginalisation of their contribution (Smith, 1975).

Action research was taken up initially in education, where teachers have sought to answer the perennial question regarding how student learning can be enhanced (Altricher et al., 1993). A definition by Rapoport (1970) gives emphasis to this concept of involvement in the process of change:

> "Action Research aims to contribute both to the practical concerns of people in an immediate problematic situation and to the goals of social science by joint collaboration within a mutually acceptable framework."

Hart and Bond (1995) describe four types of action research as:

Experimental as in the scientific approach, which is used *on* people to discover laws of life and their application to policy planning.

Organisational which is used *for* people focusing on organisational issues, particularly overcoming resistance, improving relationships.

Professionalising which is used *for* people for improvement in professional status through development of research-based practice

Empowering which is used *with* people who are included as full participants; it is associated with community development and work with vulnerable people.

The types of approach are not exclusive, with dominance fluctuating as research requirements change. The longer a project lasts the more likely it is to be weighted towards *empowering* as engagement is maximised through time (Hart and Bond, 1995). Meyer and Bateup (1997) note that the traditional autonomy of teachers within their classroom makes the empowerment model particularly suitable. The evolving NHS culture of responsiveness indicates empowerment should also be the most dominant in that domain.

The empowerment approach was used in this research as the goal was equal involvement of all key stakeholders with the aim of mutual education and change acceptable to, and supported by, all concerned. The alternative action research methods were biased towards the needs of individual stakeholders and were therefore rejected.

Empowerment, the delegation of power or authority, enables people at all levels to feel that they can make a difference and more likely to act on what they have freely decided to do. There are also risks to full empowerment, particularly in healthcare where individual irresponsibility can have community-wide results, for example, in the spread of tuberculosis. For empowerment to be successful, there must be clarity of the scope of autonomy, joint acceptance of risk and a feedback system to avoid chaos (Peiperi, 1995–6).

Debate so far has focused on the issue of empowerment of *employees*. Wickens (1995) and Randeniya et al. (1995) define this in Western cultures as power that is given by the centre and can therefore be taken away, particularly by managers who feel threatened (Hart and Bond, 1995). A more cynical view is that it merely cuts supervision costs (Judge, 1996). Wickens (1995) prefers the terms "responsibility", "authority" and "accountability", which he feels are more durable.

There is scant consideration in the literature of the possibility of empowering other stakeholders, for example, public healthcare users. The fact that this is now on the agenda unfortunately owes more to the concept of public accountability to reduce demand for healthcare and increasing pressure for self-responsibility for health than to a conscious and positive delegation of power and authority. The upcoming knowledgeable, energetic, financially secure, health-promoting health activists already commissioning database searches on their health topic of interest and confronting providers on a more equal, and in some cases superior, knowledge basis, will not wait for the invitation but demand involvement.

2.7.2 Constraints to action research

Inevitably there are constraints to action research which are described in Appendix 5 and summarised as

Appropriateness—to capacity of subjects and acceptable to sponsors
Validity—rationale for change recognisable to participants
Reliability—of data
Repeatability—of principles
Scope—almost limitless, potentially uncontainable
Conflict—incentives, manipulation, exposure, unexpected direction
Resource—amount and duration of input
Balance—between action and research
Commitment—to change when result unpredictable

2.7.3 The principles and problems of action research

Action research is based on the principles of practical actions based on research to achieve measurable change and is described in Appendix 5. These issue closely mirror the indicators for successful change in the NHS—clarity, strategy and capacity—with the added issue of unpredictability of scope, direction and outcome accompanied by the risk of manipulation.

2.7.4 Action research in the NHS

The NHS could be seen as the ideal action research environment with practical issues and intellectual imperatives in an (emerging) evidence-based culture. Sponsor influence, management fear, participant reluctance and general lack of knowledge have limited its use to date. Ham (1986) has described a small number of examples in wider healthcare which indicate the range of possibilities within the service. From a participant's view, Hart and Bond (1995) note the similarity between action research and the client assessment process used by healthcare staff, but that, despite this similarity, nurses have been reluctant to use it. A number of reasons have been cited:

- **Perceived "devaluing"** against medical scientific research with which nurses seek to align themselves (Hart and Bond, 1995).
- **Traditional lack of empowerment** so that change is compromised by power issues (Meyer and Bateup, 1997).
- **Varying levels of autonomy** in multidisciplinary teams (Meyer and Bateup, 1997).
- **Self-reflection** may not be established by all staff (Meyer and Bateup, 1997).

These issues would need to be reviewed and addressed in the local environment to maximise success.

2.8 Choice of the pilot service

During 1991, the Barking and Havering Unified Commissioning Project (UCP) was set up between the Health Authority (HA) and Family Health Services Authority (FHSA). This was as a special joint initiative to promote working relationships between the two authorities through assessment of population need in the seven localities of the District and commissioning of appropriate services. Priority groups (women, children and elderly people) in the most deprived areas (Barking, Dagenham and Rainham) were targeted for attention (Haffenden, 1992), and the care group of older people selected for this project.

The quantitative data through formal assessment of need obtained on older people across the District for the UCP showed that the key demographic and health issues were: the number of very elderly people was increasing; the number of their potential carers was decreasing and the greatest deprivation and health need was in Barking. Qualitative data was obtained through Rapid Appraisal and community meetings.

Rapid Appraisal provides an insight into the quantitative data through qualitative information (Ong and Humphris, 1990). This method was originally designed for use in developing countries, where researchers could obtain information on a range of social issues through qualitative methods from key informants who would not normally be consulted (Rutt, 1994). The method has been refined by Annett and Rifkin (1988) for use in healthcare. The advantage of the method is its speed and low cost; the disadvantage in healthcare is that such need is very personal and "key informants" may only be given selective information by community members. Community meetings likewise may produce selective information from those with the physical, financial, time and commitment resources to reach them, unlikely to be representative of the local population. The methodology of both approaches would need to maximise equity.

The assessment of need in this case identified footcare as the greatest unmet need, particularly in three of the seven localities. As a result, state registered providers were invited to tender for the additional work which would supplement that already being provided by the Chiropody service of Barking, Havering and Brentwood NHS Trust (BHB). The process resulted in a private state registered provider, Sclare Chiropody Partnership (SCP), being awarded the contract. Chiropody provision to the population was therefore through two, nominally competitive, services (BHB and SCP) in three of the seven localities which complicated the evaluation.

2.9 Evaluation of implementation and use of the model

The preparatory work established that the Quality Synthesis Model should be evaluated in the following ways:

1. **That the model met the operational criteria expected by purchasers and providers.**
2. **That the model provided a cyclical process compatible with and enhancing commissioning.**

From the point of view of validity of the research process, it was also necessary to ensure:

3. **That the model was valid, reliable and repeatable.**

Additionally, it was necessary to ensure:

4. **That the process could result in stakeholder culture change towards continuous improvement of agreed quality.**

5. **That the model avoided the sins and diseases of public sector management through:**
   - costs of quality assessed
   - internal and external customers and their needs identified
   - protection provided for minority group interests
   - customer driven measures of quality used.

The following addresses each of these issues in turn.

2.9.1. That the model met the operational criteria expected by purchasers and providers.

The issues raised in the literature reviews regarding quality management and implementation would be considered by purchasers and providers against the results of the project.

2.9.2. That the model provided a cyclical process compatible with and enhancing commissioning.

The model would be reviewed by the commissioning team against its compatibility with the commissioning cycle from assessment of need using Rapid Appraisal and community meetings; development of success markers through stakeholder survey; achievement against success markers through documented outcome; user satisfaction with the specification through a user survey; and evidence of continuous progress in quality improvement by the success of cyclical implementation of the model.

2.9.3. That the model was valid, reliable and repeatable.

In line with established best practice, the design would be measured against the requirements of validity and reliability (Bryman, 1995). While an exact replication is not a desired outcome of action research, the application of the model to other elements of the health service and other groups in the population would be advantageous but needs to be tested. The profession of chiropody would be reviewed against the key criteria for professional status (Table 1.2, Chapter 1) to consider any which might influence the result and might affect the application of the model in different circumstances.

2.9.4. That the process could result in stakeholder culture change towards continuous improvement of agreed quality.

The original and subsequent culture of the focus organisations would be compared with the statements on the Crosby Quality Management Maturity Grid where comparison with the summary statements would identify any change. (Table 2.3).

Measurement categories	**Stage 1: uncertainty**	**Stage 2: awakening**	**Stage 3: enlightenment**	**Stage 4: wisdom**	**Stage 5: certainty**
Summation of quality posture	"We don't know why we have problems with quality"	"Is it absolutely necessary to always have problems with quality"	"Through management commitment and quality improvement we are identifying and resolving our problems"	"Defective prevention is a routine part of our operation"	"We know why we do not have problems with quality"

Table 2.3 Summary positions of Quality Management Maturity Grid.

(Source: Crosby, 1980)

To investigate another dimension of commissioning, a review of purchaser/provider relationships would be undertaken using a model developed by Leader et al. (1995). This seeks the views of each party on a range of issues. These are then discussed between the two parties to reach an agreed score. The summary score provides a statement of position and suggested action for improvement. The very recent publication of the model at the time of the research prevented a comparative view with the original position.

2.9.5. That the model avoids the sins and diseases of public sector management

The four issues identified by Milakovich (1991) would be used to evaluate the model further, to ensure that it did not fall into the trap of public sector programme failure.

- costs of quality to be assessed
- internal and external customers and their needs to be identified
- protection provided for minority group interests
- customer driven measures of quality to be used.

The outline cost of the model would be calculated as a percentage of the contract value; internal and external customers and their needs would be identified as part of the needs assessment process; the response to minority group interests identified through the assessment of need would be measured by their inclusion in the model; and customer-driven measures of quality would be identified through the surveys. Assurance of clinical standards requires external peer review to ensure independence and facilitate benchmarking against national best practice. Surveys and peer review would then be the main source of data and the principles of each are described below.

2.9.5.a Surveys

Surveys are designed to obtain, analyse and indicate data response patterns. Respondents are asked the same series of questions related to the topic through unstructured, semi-structured or structured questioning, face to face, by telephone or by questionnaire. Factual data can be encoded for statistical analysis and for generalisation of results; the sample size must be representative and of sufficient size to be significant. Exploratory data requires qualitative analysis and can be reported using frequency, synthesis or quotes; it remains the personal view of the respondent and is not generalisable (Hakim, 1988).

Surveys are as problematic in healthcare as elsewhere and are largely dependent on the structure of the tool. Breakwell and Millward (1995) summarised conventional good practice as:

- **Design** with the particular respondent in mind.
- **Introduction**, including purpose, actions, benefits, anonymity.
- **Layout** pleasing and logical.
- **Language** suitable, avoiding ambiguity.
- **Sensitive questions** avoided, or placed at the end.
- **Encode** where possible, minimise open questions.
- **Return instructions** including date, prepaid envelope, offer of report.

The encoded fact-finding questions can have "yes/no" or attitude responses. For the latter, the Likert scale provides a range of possible attitudes from negative to positive, and should be sufficient in number to avoid global statements or excessive discrimination. A range of five is considered to be adequate. Another approach is semantic differential where pairs of descriptive positions are separated by a scale of 1–10. In addition to conventional good practice, issues of particular note for healthcare situations are:

- **Effect of health problem:** on respondents, over time.
- **Type of user**: current, potential, past, carer, referrer, gender, age.
- **Type of service**: life threatening, mental health (McIver, 1991).
- **Knowledge of NHS culture**: staff, public (McIver, 1991), duration of contact.
- **Special needs**: elderly, vision, dexterity, mental ability (McIver, 1991).
- **Need for specific questions**: not just "overall satisfaction".

A pilot survey was undertaken in 1992 to test both the tool, its acceptability, implementation and analysis methods, baseline issues and satisfaction levels.

Telephone interviews

The methodology of interview by telephone has been described by Frey (1989) in a review of the use of the telephone in social and economic life and its use as a survey medium. Frey promotes this method because of the wide availability of telephones, the efficiency of their use for interviewing, and the minimum loss of data quality between face-to-face and telephone interviewing. Pike and Barnes (1996) indicate that telephone surveys provide the most concurrent information; participation is not avoided by "paperwork"; and honesty of response is as high as questionnaires, and above face to face, with the opportunity to assure anonymity. Other researchers have shown that, so long as the methodology is sound, face-to-face and telephone interviews provide an equivalent response (Lofland and Lofland, 1984). Concerns include the lack of time for reflection or provision of answers aimed at achieving a quick conclusion (Pike and Barnes, 1996) but this must be balanced with the reduced costs of travel. Telephone interviews are particularly advantageous for use with older people (Ormond, 1993) who have wide telephone access as well as a fear of front door callers.

To test the telephone interview technique on the sample for this research, a random approach was made to two people in each of the three age bands (75-79, 80-84, and 85 and over) in a single locality who had indicated willingness to be interviewed. One of each pair was interviewed face to face and one by telephone, both interviews being tape-recorded with the agreement of the patient. The transcriber of the recordings reported no discernible difference between the two styles. This supports the work of Frey (1989), and telephone interviewing was pursued for cost-effectiveness.

The sample

The population consisted of all the current users of Barking and Havering NHS-funded chiropody provision for those aged 75 and over. The take-up of chiropody in each of the geographic localities was noted as equitable with demographic need, with the balance between men and women remarkably stable at around 48% for men and 53% for women; and epidemiological and socio-economic needs, with provision to around 24% of the population, rising to above 30% in Localities 6 and 7 which had an older population and greater deprivation (Table 2.4).

Locality	Total pop'n	Men	Women	75+	85+	Total 75+	Chiropody	Chiropody (%)
1	69,760	33,743 (48%)	36,017 (52%)	3,530 (5%)	1,003 (1%)	4,533	1,068	23.5
2	47,927	22,962 (47%)	24,965 (53%)	2,702 (6%)	541 (1%)	3,243	769	23.7
3	56,635	27,566 (48%)	29,069 (52%)	2,772 (5%)	841 (1%)	3,613	890	24.6
4	55,170	26,893 (49%)	28,277 (51%)	2,351 (4%)	482 (1%)	2,833	676	23.86
5	30,100	14,388 (48%)	15, 427 (52%)	1,350 (4%)	369 (1%)	1,719	425	24.72
6	52,503	25,053 (48%)	27, 450 (52%)	3,266 (6%)	822 (2%)	4,088	1,259	30.79
7	61,340	29,490 (48%)	31,850 (52%)	3,779 (6%)	934 (2%)	4,713	1,521	32.27

Table 2.4 Locality age and gender profile (percentage of total population in brackets)

In the 1992 pilot study, overall satisfaction with the service was reported by 69% of the sample. This result was used as the basis for calculating 95% confidence intervals to determine the most appropriate sample size for the main surveys (Table 2.5).

Possible sample	Indicator ± SE x 1.96	Range ± 69% at 95% confidence interval
500	69% ± 2.07 x (1.96) = 4.06	64.94–73.06%
750	69% ± 1.69 x (1.96) = 3.31	65.69–72.31%
1000	69% ± 1.46 x (1.96) = 2.86	66.14–71.88%

Table 2.5 The 95% confidence intervals on sample size for 69% indicator

On the basis of these results a sample size of not less than 750 was considered to provide sufficient accuracy for the main study, with due regard to the resource and time available. The number of chiropody patients in each locality and for each provider (SCP and BHB) was identified, and 10% of each taken as the sample. Where the number of patients in a locality for a service was small, a higher percentage was taken (Table 2.6).

Locality	**Number over 75**	**10% sample**	**Comments**
1	1,068 BHB	107	
2	796 BHB	78	
3	890 BHB	89	
4	676 BHB	68	
5	322 BHB + 103 SCP	64 BHB (20% sample) + 61 SCP (60% sample) = 125	Small locality
6	892 BHB + 367 SCP	90 BHB + 74 SCP (20%) = 164	Greatest need
7	939 BHB + 582 SCP	93 BHB + 58 SCP = 151	Greatest need
Totals	6,556	782	

BHB and SCP refer to the two chiropody providers.

Table 2.6 Sample of chiropody patients by locality and provider

Analysis

The data on characteristics (age, gender, locality and provider) and variables of related interest (categorised under health gain and satisfaction) would be cross-tabulated using the Statistical Package for Social Sciences (SPSS). Chi-squared tests would be calculated to determine the probability of an observed association between two variables occurring by chance. Where the probability is small, conventionally taken as one in 20 ($p < 0.05$), this is taken as a real as against a chance relationship, using the chi-squared test to assess the statistical relationship. Those showing a significant association, would be investigated further to identify the significant contributor. Expected frequencies of less than five in any cell in the contingency table used for the calculation invalidates the test and would be excluded or, where appropriate, aggregated and the data recalculated. Where the chi-squared result is significant and above the critical value for the presenting degrees of freedom at the 95% confidence level, the result would be accepted as a positive association between the two variables and not due to chance.

2.9.5.b Peer review

The need to incorporate review of autonomous practice by those with the relevant knowledge and experience, that is peers, enables continuous improvement along with the necessary autonomous practice. Roberts (1987) feels that peer review gives the best assessment of quality and describes the characteristics of peer review as:

- conducted by clinicians knowledgeable in the practice being reviewed
- characterised by an objective analysis of the clinical facts of a case(s)
- focused on evaluating the quality of care
- protected from unwarranted legal intrusion and resource control objectives
- removed from decisions concerning corrective action.

To implement this a participative approach to the development of a process acceptable to stakeholders would be needed which would result in independence of assessors; a cost effective method; representative sampling; and timely reporting with indicators for continuous improvement. This was successfully achieved and the method formed the basis of a national multidisciplinary initiative.

2.10 Problems anticipated

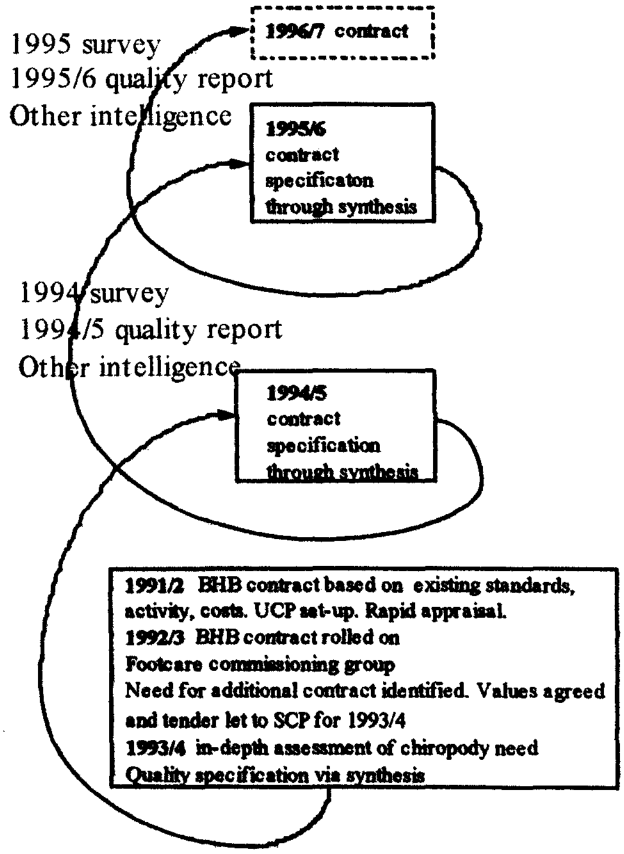
Problems with implementation and evaluation of the model were anticipated as stakeholder participation; response by older people to the survey and interview; and stakeholder change. On reflection, participation was positive and change resulted. The response by older people to the surveys was 76.4% in 1994 and 65.2% in 1995, both well above the norm and the telephone interview sub sample was equally positive. The quality of both types of response was acceptable. The problems that were encountered and subsequent action were as follows:

1. **Difficulty in obtaining patient data from incomplete manual records.** This resulted in a data quality standard being developed and implemented with a peer audit tool and a computerised system subsequently being purchased.

2. **Difficulty in preventing inclusion of deceased patients.** This was initially because of poor provider record systems. The problem was minimised, but not eliminated, in the second survey by improved recording and computerisation, along with manual checks against the report from the local Registrar for deaths. The high death rate for the cohort studied (older people), the long interval between treatments (related to the natural speed of nail growth) and the failure of relatives to advise the service (not a priority when dealing with bereavement) resulted in a hard core that were impossible to exclude within the resource available, resulting in distress for relatives.

2.11 Conclusion

The need to develop a quality management model suitable for the commissioning process resulted in a literature review of health and health care; change management and quality. The outcome was that change in the NHS is likely to be more successful with stakeholder participation. An appropriate model for quality management was not found to exist, resulting in the need for development by stakeholder facilitation. Implementation of the model would be by an action research approach to incorporate participative change. Evaluation would be through quasi-experimental methods to meet the requirements of the NHS and the methodological rigour of validity, reliability and repeatability. Figure 2.2 provides a diagramatic overview of the methodology.



UCP, Unified Commissioning Project; SCP, Sclare Chiropody Partnership; BHB, Barking, Havering and Brentwood NHS Trust.

Fig. 2.2 Quality synthesis action research cycle in service specification.

The model would need to

1. **Meet the operational criteria expected by purchasers and providers.**
2. **Provide a cyclical process compatible with and enhancing commissioning.**
3. **Be valid, reliable and repeatable.**
4. **Enable stakeholder culture change towards continuous improvement of agreed quality.**
5. **Avoid the sins and diseases of public sector management**

The implementation and evaluation of the model should be able to answer the research questions:

- **Can an effective CQI model for healthcare be identified, or developed, and evaluated which incorporates Juran's approach and the needs of local key stakeholders?**
- **Can local organisational change within the NHS be improved by learning from the lessons of change theory and national implementation of the reforms?**

In the view of the researcher, the hypothesis that:

> **". . . by incorporating user, provider and purchaser expectations, health needs assessment can be converted into a best quality service contact"**

could be answered in the research situation. What remains is to test the hypothesis and ensure that the principles of the model are repeatable in different clinical and managerial situations beyond that of a research location.

Chapter 3
Change management: application in the British NHS

3.1 Introduction

The culture of, and pressures affecting, the NHS have been described in Chapter 1, along with the legislation to drive change to a more user-focused service through a market environment. It was identified that for the change to be successful, the implementation of the legislation would need to follow established generic best practice, adapted appropriately to the unique features of the organisation. This chapter reviews the structure of organisations, established best practice for their change and compares the principles with the reality of national implementation of the 1990 NHS reforms. The emerging factor is that while the basic values of public healthcare were fundamentally congruent between participants, business values were held by managers and largely ignored by the remaining stakeholders---providers and users. The purpose of this review is to learn from the experience of 1990 to guide implementation of future change compatible with the unique features of the national and local NHS. The strongly emerging theme is for informed participant involvement.

3.2 The process of organisational change

Change is the only constant in a changing world (Clarke, 1994) where more people compete for scarcer resources. They communicate their views through technology, influencing more people to compete (Pritchett and Pound, 1997), and so continue the process in a progressive spiral of activity.

Managing the response to the continuous pressure for change enables sustained organisational success. Clarke (1994) states that the key to success of any change is in identification of the givens (environment and strategy) and opportunities for leverage (people, systems and structure). Clarke (1994) regards “strategy” as the matching of the given organisation resource (people, systems and structure) to environmental opportunity. Given that Clarke places organisation resource as open to leverage, and that “environmental opportunity” is open to the direction an organisation will select based on its resource, it could be argued that only “environment” should exist in the category as a true given, with strategy falling with in the category of “open to leverage”.

Styles of leverage were summarised by Etzioni (1964) as varying between coercive and normative, with responses varying between alienating to moral, depending on the culture of the organisation (Table 3.1). Few organisations will pursue a single approach, an eclectic mix being more usual with emphasis varying with the need of the moment.

Responses **Power**	**Alienating: grudging compliance**	**Calculating: calculating involvement**	**Moral: identify with regimen**
Coercive: based on punishment			
Remunerative: based on positive incentives			
Normative: based on agreed rules			

Table. 3.1 Organisational control and response.
(Developed from Etzioni 1964)

Change that is sustainable through stakeholder commitment (moral/normative) is normally considered the most successful, although other models may have their place in different circumstances, for example, the penal system. The objective of identifying the needs of stakeholders to enable their involvement towards achieving a shared vision is crucial to success. Opportunities for leverage will be dependent on the issues that interest stakeholders and the stance they take on them.

All those involved need to understand the process of change and be able to identify and appropriately deal with potential barriers in their unique organisational culture --- typically, who will gain and who will lose prestige and resources (Cook, 1995). Where participants include service users who are outside direct management influence, not only should their view be central to the vision but more subtle methods of achieving their involvement may be required.

To assist participants understanding of the various theories of change for practical application, Clarke (1994) has produced a comprehensive and visual model, providing a simplified map of a complex process. This model was considered by this author to incorporate all the key stages in the process for successful local change and a condensed version was derived for this project (Fig. 3.1). This adaptation may be regarded by experienced change agents as an oversimplification of the issues, but the introduction of such a new concept to traditional, complex NHS organisations required a simple vision to secure attention.

Fig. 3.1 The process of organisational change.

(Adapted from Clarke, 1994)

The model was used to guide a detailed literature search for comparison of the NHS position with conditions generally established as necessary for such major organisational change.

3.2.1 Understand the organisation

Organisations are concerns constructed at a particular time for a particular purpose, with the risk of divergence of interests as organisational, employee and customer needs change through time. Organisational culture is described by Schein (1984) as:

> ". . . the patterns of basic assumptions that a given group has invented, discovered or developed in learning to cope with its problems of external adaptation and that have worked well enough to be considered valid."

In this author's view, the statement adequately incorporates the common concept of organisational culture through which the identification and meeting of customer and supplier needs (quality management) can occur. Employees actively seek environments that have a similar culture to their own (Handy, 1985), further strengthening the culture of the organisation (Lewin, 1952). In the case of the NHS, it is also influenced by the dynamic national culture as a result of its tacit total population membership; a political environment; and a tripartite structure.

Four distinct organisational cultures have been identified by Handy (1985), reflecting different management styles (Table 3.2). Again this is a simplistic view but one that has the virtue of having captured the imagination of those new to the concept, inspiring their deeper investigation. In this author's view, the failure of the model is its concept of exclusive categories without the facility for the mixed and dynamic cultures of the real world, which particularly characterise national public organisations, such as the NHS.

Culture	Management style
Power	Family business: few rules, fast, result oriented
Role	Public services: rule bound, slow, process oriented, safe
Task	Self-managed project teams: fast, short term, adaptable, result oriented, costly
Person	Social groups and families to serve their own needs

Table 3.2 Basic models of organisational culture. (Source: Handy, 1985)

Before 1990, the NHS was predominantly a "role culture" with order and rules; subcultures were powerful "person culture" provider groups and less powerful "person culture" passive recipients. Alford (1975) had similarly identified three distinct interests in health politics: professional monopolists (the medical profession who were the dominant interest), corporate rationalists (managers who were the challenging interest) and repressed interests (patients and the community population). These two complementary views suggest that although order and rules might have been the overall culture, professional (medical) staff held the power.

There is a myth that public services are not business-like, and have inadequately skilled staff and intangible results (Morgan and Murgatroyd, 1994). The reality is that public services have tried to respond to the often contradictory requirements made of them. Drucker (1980) identified six inherent barriers to business like performance in the public sector, which he described as deadly sins. Avoidance of these sins does not guarantee success, but two of which would certainly cause a quality programme to fail (Drucker, 1980). Many public organisations appear to Drucker to commit all six. These sins are:

- **Lofty objective,** such as "healthcare", which lacks detailed performance measures.
- **Multiple projects,** without clear priorities.
- **Overstaffing and process orientation,** rather than understaffing and outcome focus.
- **Lack of experiment,** with national implementation before local testing.
- **Lack of timely evaluation,** so nothing is learnt from experience.
- **Reluctance to abandon programmes,** despite evidence of ineffectiveness or extinction of the original need. This is regarded as the most common and most damning sin.

Ten years after Drucker penned these thoughts, they were probably an appropriate reflection on the NHS limiting the capacity to improve productivity even in the small areas of known benefit.

Crosby (1980) recognised the problem that organisations have in their objective measurement of staff management to improve service quality. He developed a "Quality Management Maturity Grid" (Table 3.3) to meet this need in which five stages of maturity were described together with six management categories that qualify the positions of maturity. Summary statements provide a useful overall picture. Although the objective was to assist the private sector, the descriptions are equally valid for the public sector. The one exception is "costs of quality" where comparison with sales is referred to. The subsidies received by the public sector and other political influences would need to be taken into account here. The date of the model also precedes emerging worker and consumer empowerment and the model could be seen to represent a top down approach, but in the absence of an alternative remains a useful guide.

An internal analysis of the NHS in 1990, using the Handy and Crosby tools, would probably have identified a stagnant role and person culture confused over quality issues (Table 3.4) – the most basic and "uncertain" level of management maturity on the Crosby matrix.

Handy's cultures	Role culture typified the organisation overall with the clinical staff person subcultures with their demand for autonomy (Wattis, 1996)
Crosby's management maturity	The organisation was widely regarded as frozen, and could be likened to Crosby's first stage, summarised as "We don't know why we have problems with quality" (Crosby, 1980)

Table 3.4 Internal analysis of the NHS in 1990

Measurement categories	Stage 1: uncertainty	Stage 2: awakening	Stage 3: enlightenment	Stage 4: wisdom	Stage 5: certainty
Management understanding and attitude	No comprehension of quality as a management tool. Tend to blame departments for "quality problems"	Recognising that quality management may be of value but not willing to provide money or time to make it all happen	While going through improvement programme learn more about quality management, becoming supportive and helpful	Participating. Understanding absolutes of quality management. Recognise their role in continuing emphasis	Consider quality management an essential part of company system
Quality organisation status	Quality is hidden in manufacturing or engineering departments. Inspection probably not part of organisation. Emphasis on appraisal and sorting	A stronger quality leader is appointed but emphasis still on appraisal and moving the product. Still part of manufacturing or other	Quality department reports to top management, all appraisal is incorporated and manager has role in management of company	Quality manager is an officer of company; effective status reporting and preventive action. Involved with consumer affairs and special assignments	Quality manager on board of directors. Prevention is main concern. Quality is a thought leader
Problem handling	Problems are fought as they occur; no resolution; inadequate definition; lots of yelling and accusations	Teams are set up to attack major problems. Long-range solutions are not solicited	Corrective action communication established. Problems are faced openly and resolved in an orderly way	Problems are identified early in their development. All functions are open to suggestion and improvement	Except in the most unusual cases, problems are prevented
Costs of quality as percentage of sales	Reported unknown. Actually 20%	Reported 3%. Actually 18%	Reported 8%. Actually 12%	Reported 6.5%. Actually 8%	Reported 2.5%. Actually 2.5%
Quality improvement actions	No organised activities. No understanding of such activities	Trying obvious "motivational" short-range efforts	Implementation of the 14-step programme with thorough understanding and establishment of each step	Continuing the 14-step programme and starting Make certain	Quality improvement is a normal and continued activity
Summation of quality posture	"We don't know why we have problems with quality"	"Is it absolutely necessary to always have problems with quality"	"Through management commitment and quality improvement we are identifying and resolving our problems"	"Defect prevention is a routine part of our operation"	"We know why we do not have problems with quality"

Table 3.3 Quality Management Maturity grid. (Source: Crosby, 1980)

3.2.2 Appreciate the reasons for change

Both the external and the internal environments influence change. With regard to the external environment, Schumpeter (1939) advanced the theory of economic cycles, the Kondratieff version of which suggested a natural cycle, covering around 50 years. The cycle is initiated by a clustering of technical and commercial innovations (for example, steam power, railways, electricity) (Table 3.5).

Kondratieff long wave cycle model	
First decade	Deep slump
Second decade	The upswing starts
Third decade	New world dawns
Fourth decade	Doubt sets in
Fifth decade	Fluctuations and setbacks

Table 3.5 The Kondratieff long wave cycle of organisational change. (Source: Schumpeter, 1939)

The post-war era in public service had also been influenced by: political values, such as the welfare state; Keynesian intervention in the economy by government expenditure changes to influence demand; and tentative introduction of a self-regulating market economy. All had created uncertainty over the government's vision for the NHS by the main stakeholders – users, purchasers and providers – as well as opportunity. Today's catalyst for final movement from setback and slump to resurrection is the clustering of knowledge, based on information and communicated by technology (Booty, 1997) with customer expectations as the information source. These social, technical and political influences made a considerable contribution to the perceived need for the 1990 NHS reform, together with the influences of demography, epidemiology and economics (see Chapter 1).

Although the wave of change depicted by the Kondratieff cycle is a helpful vision, the timescales are unrealistically long in the contemporary context; five decades have probably been reduced to one or less. The 1998 radical restructuring of the 1990 NHS exemplifies this new pace (See Chapter 1).

With regard to the internal environment, Greiner (1972) suggested that endogenous changes are also influential (Fig. 3.2). These changes occur as an organisation goes through predictable phases of evolution and revolution as it ages and grows; being "homespun" they have the *potential* to capture the heart of participants.

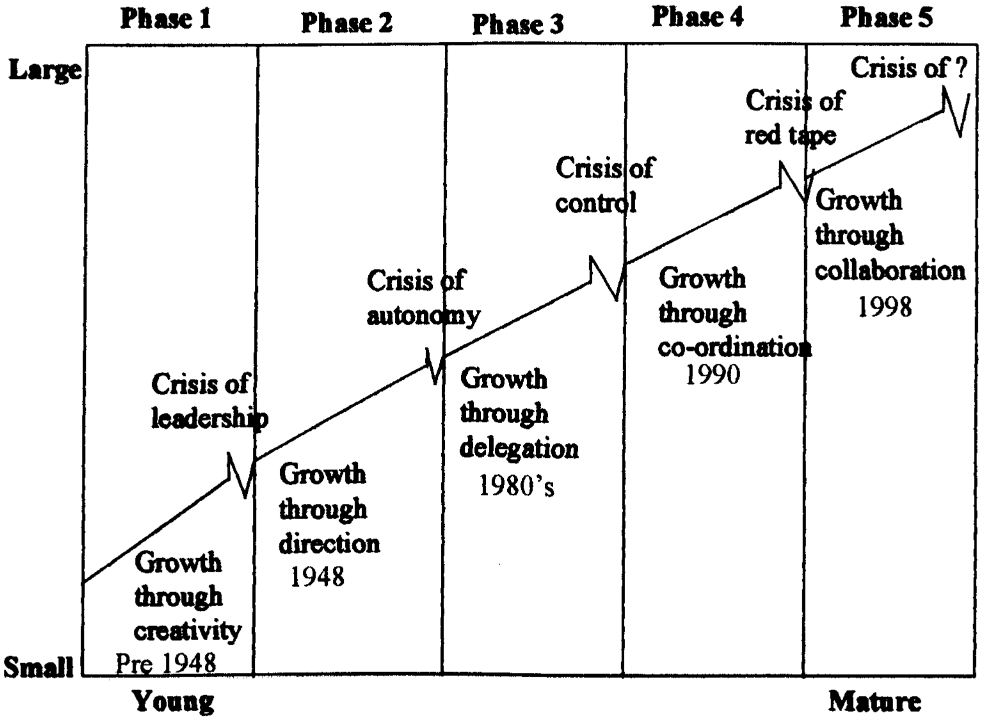


Fig. 3.2 The five phases of growth of the NHS.
(Adapted from Greiner, 1972)

This model seems to reflect the stages that the British healthcare system has gone through (see Chapter 1) with internal crisis being responded to initially by uncoordinated attempts to meet need, then by organisation-specific legislation first to direct a disparate service by nationalisation (1948); to delegate responsibility to control autonomy through the opportunity for general management by peers (1980s); to co-ordinate provision through commissioning to reduce inadequate historic arrangements (1990); and currently to move from competition to collaboration to reduce bureaucracy The NHS therefore reflects the phases of evolution and revolution experienced in other organisations.

Ham (1996) reported that both main political parties in the UK are agreed on the *principles* of healthcare, the disputes being over *process*. Perhaps the crisis to come will be exposure of the true division of views between government (and their agents – managers), providers and user---a crisis of values.

3.2.3 Know the process, and anticipate reactions and responses

The process

The process of change can be at two levels. First-order change is regarded as tinkering, for example, reorganising office layout. Second-order change is a strategic, fundamental approach, for example, posing the question: Do we *need* the office at all?

Up to 1990, the changes in the NHS had been widely regarded as tinkering. The 1970 reforms had promised consensus management which proved so difficult to achieve that the status quo was retained (Ham, 1985; Ranade, 1994); and Community Health Councils, the public healthcare watchdogs, had little power with which to make an impact. Even the 1983 introduction of general management failed to make sufficient change or contain costs (Sutherland and Dawson, 1998). Tacit collusion between managers and clinicians enabled continuation of clinical autonomy, protecting services and avoiding public disquiet. The 1990 reforms were, however, universally determined as being strategic.

Turbulence to focus the mind on the need for change can be opportunistic or created, short or long term (Lascelles and Dale, 1992), but must be noticed. Provided the content is sufficiently influential, turbulence is easy to create –

management of the consequences is the challenge (Clarke and Newman, 1997). Legislation in public services is a traditional turbulence; implementation to reflect and sustain the intended spirit in tandem with maintaining a service is the difficulty (Cook, 1995).

To achieve a process of change that meets its objectives and is therefore regarded as successful, Conner and Patterson (1982) propose that it is necessary to have the following actors:

- **Change sponsor**: with power to legitimise change.
- **Change agent:** responsible for the change process.
- **Clear change target**: required to alter personal knowledge, skill, attitude and behaviour.

Successful change agents require "a long time horizon, conviction in an idea, no need for immediate results or measures and a willingness to convey a vision of something that might come out a little different when finished" (Kanter, 1983). Conner and Patterson (1982) note that the main cause of failure to achieve desired change is lack of commitment by sponsor or target, the agent frequently being over-optimistic.

Although these categories are not in practice exclusive, they can be aligned to healthcare stakeholders, with the sponsor as purchaser, nominally on behalf of stakeholders through the democratic process; the agents as professional *and* clinical managers, and the targets as providers *and* users. Providers therefore have a dual key role as both targets and implementers of change, although as already shown professional managers will be more progressive than clinical managers who still retain traditional clinical values (See section 1.4, Chapter1). Organisational success is very largely dependent on provider understanding, acceptance and implementation of the vision. In health service change the biggest obstacle is lack of commitment of powerful (mainly medical) providers (Wilcock and Campion-Smith, 1998).

The professionalisation process of providers has resulted in a group force to be reckoned with, group effectiveness being proportional to the level of professional standing (Section 1.4, Chapter 1) . Group reactions are powerful (Lewin, 1952), resulting in a solid or "frozen" organisation that needs to be unfrozen to enable fundamental change and then re-frozen in the new position (Lewin, 1952). This new position is now considered to be flexible, facilitating continuous adaptation to the changing environment.

The intention of the 1983 legislation (see Appendix 2) was that new NHS general managers from inside and outside of the NHS would be appointed as the primary change agents, because of their identified skills in achieving responsiveness to change influences. They could appreciate the challenges on the horizon (see Appendix 1) but were unsupported in their need for a model that acknowledged the difficulties of achieving change in such a large organisation (Smith, 1993). The targets of the change, providers (and later users), had a poorer appreciation of these factors (Stocking, 1992; Hunter, 1994), through a mixture of lack of information, reliance on welfarism, and traditional resistance to change from the familiar.

Barriers to a collaborative approach between stakeholders exemplified the problems that the NHS faced, such as mistrust of management (Gibson, 1990), differing values (Gibson, 1990), financial constraints (Gibson, 1990; Freemantle, 1993), professional secrecy (Freemantle, 1993), and the imposed short termism of the electoral cycle focusing on short-term gains (Farmer and MacMillan, 1981). Some of these form the "diseases" of public sector management, which compromise competition (see Chapter 1), and "sins" that compromise quality project success (see above). There are therefore fundamental stakeholder issues to be addressed.

Stakeholders are defined by Clarke and Newman (1997) as "those who can make a claim on a service", and by the British Quality Foundation (1996) as "all those who have an interest, whether financial or not, in the organisation's activities and performance"; the former reflect dependency, the latter more a comprehensive and proactive approach. In this research, the latter view is used and stakeholders are limited to the key roles of purchaser, provider and user. Clarke and Newman (1997) acknowledge that there is a hierarchy of interests for each stakeholder so that, in advance of collaboration between them, overt definitions of their perceived stake, inclusions, exclusions and power positions must be clarified.

A problem for public services is that imposed change through legislation is common; investment in resource for implementation is rare; and short-term success valued, often resulting in long-term costs to the targets and, perversely, reward such as promotion for the apparently successful agent. This reflects the coercive power and alienating compliance noted by Etzioni (See section 3.2). Provider scepticism of the Patients Charter (see section 1.10, Chapter 1) resulted from such a position of imposed standards on issues that were low in their hierarchy of assessed need.

Reactions: natural feelings and emotions

Human reaction to change is based on the existence of values, beliefs and assumptions (Mahmood and Munro, 1998) resulting in actions that become natural and comfortable habits, hence the "agony" of changing them (Heller, 1986). The classic reactions to changing comfortable organisational habits are sequential and necessary, described as the transition curve by Adams et al, (1976) and passing through Immobilisation, Disbelief (shock/frozen), Depression, Acceptance of reality, Testing (new behaviours, new life style), Search for meaning and Internalisation.. The traditional values of the NHS were shared by users and providers; the new values remained predominantly with managers.

The impact of change on the culture of an organisation is proportional to the closeness of values between the individual (and the groups they form) and the culture expected to result from the change (Womack et al., 1990). Values are the most difficult personal characteristic to change but provide the strongest bond when congruent between agent and target (Silbiger, 1993). The values held by the main change targets in public healthcare, providers, were what they had entered the service with – altruism and autonomy (see Chapter 1). Both of these *clinical* values were perceived as threatened by the change from welfare to market. Healthcare providers received support from the public (the minor change targets), who also felt threatened by the loss of the clinical response they had become used to and unsure of what else to expect.

Since the 1988 funding crisis (see Chapter 1), the *organisation* of the NHS had no longer been sacrosanct and immune to public criticism. There was simmering anger at the way the NHS was being handled and appreciation of alternative models of healthcare delivery through travel, improved communication and media coverage. There was growing experience of responsive services in general and access through employment packages to the private healthcare sector beyond the traditional upper/middle classes gave experience of what customer care, as a proxy for clinical care, could be provided. Overall satisfaction with the running of the NHS had been going down (from 49% in 1983 to 33% in 1994), and interest in the service was now top of the public's agenda (King, 1998).

The point at which the public in a welfare system is ready for change is probably reached only when the gap between expectation and experience moves beyond tolerance for at least the vocal minority, with a ripple effect conducted through the media. To the frustration of the radical reformers from the political right, support for the *principles* of the NHS outweighed concerns over *organisation*, obstructing the traditional social lever for change in non-profit organisations

It is unclear what would create the "final straw" of intolerance in a comprehensive, collective, universal and respected service within a traditionally tolerant, deferent and equitable culture. The only comparative example is the intolerance of fragmentation and inequity of pre-war health services, which contributed to the creation of the NHS in 1948. The proposed legislation set out in 1998 risks a return to fragmentation, but an opportunity for improvement in equity. The eventual direction has yet to evolve and public reaction, from a cultural base which has changed in some respects since 1948, will largely decide the future of the service. Smith (1999) suggests that the demise of the NHS could be triggered by loss of confidence and movement to the private sector by the middle classes, taking resources and, crucially, political/media attention with them. This loss of confidence would need to be *clinical*, which a government responsible for the service would be politically unwise to allow to emerge.

Although adequate time to experience the process of natural reaction should be allowed, much can be done to condense the process by participant involvement in, rather than imposition of, change.

Responses: considered actions

The usual response styles by agents and targets have been categorised by Rogers and Shoemaker (1971) who also note that 70% of people fall into the categories of "early and late majority":

- **Innovators** are quick to adopt new ideas and change accordingly. They are also risk takers as some of the new ideas may prove to be mistaken and/or difficult to adapt and put into place. They may be regarded as eccentric.
- **Early adopters** follow closely behind the innovators, but are rather more respectable and try to conform with social norms. They are respected and influential.
- **Early majority** take on change once it has started to become accepted.
- **Late majority** are more conservative and wait to see all the effects before adopting change. There is verbal promotion of change.
- **Laggards** are very suspicious of change and are slow to adapt. They are traditionalists and need a crisis, exceptional leadership and 30% staff turnover for the necessary cultural change.

Each will have, probably subconsciously, considered the following in planning their response:

The desirability of the outcome
Confidence that the specific actions will provide the outcome
Evaluated the appropriateness and difficulty of the behaviours
Belief in capability of producing the required behaviour
Sense of self worth or permission in relation to the required behaviour and outcome

The primary agents in the 1990 reform were general managers who could be likened to "naturals" and "aspirants". They find change stimulating, but failure to appreciate the stress on others, caused by inappropriate speed and lack of recognition of their different values, will risk the capacity and support of the latter. This was the reason for Enthoven's criticism of the reforms that he had inadvertently created (see section 1.6, Chapter 1).

Beyond the influence and response of participant groups come those of the individual, who is potentially the most powerful self change agent, knowing the problems and accepting the solutions through involvement (Beckford, 1998). The skill in management is to enable targets to want to drive themselves towards the new vision. Such passion results in adding value to the organisation, product or service, and individual.

The resistance of the fearful will be variable and concerned with what hurts them psychologically, economically, socially or symbolically. Public scrutiny makes some unwilling to risk the innovation needed for change. Again, the most effective action is by resistors themselves when they are allowed to develop their own evidence-based solutions (Celemi UK Ltd, 1995). It has already been noted that there was lack of consultation, research and information to facilitate such action in the case of the 1990 reforms (see Chapter 1).

Another paradox emerges from this review in that, if there was such strong reason to change the NHS (Chapter 1), why was resistance equally strong? The reason appears to lie in the lack of appropriate information received by the public and providers from which they could judge the likely consequences of action and inaction. This author has reflected on her own reactions and responses in different roles to NHS legislative change, while a clinician, commissioner and latterly trust manager, concluding that understanding of the *reasons* for change has influenced the most positive response and has been a stronger force than tradition.

Evidence that these empowering solutions have failed will be shown by grievance, turnover, poor efficiency, low output and anti-management feelings (Coch and French, 1952). The last, in the NHS, has been particularly highlighted by the media, where resentment towards the central reforms, seen as top-down implementation by managers, has been capitalised on. Cost effectiveness is a particular objective of the 1998 refinement which, perversely, will require considerable mature management skill to implement. Particular concern is the commitment required to implement the promised continuously revised guidelines developed by the National Institute for Clinical Excellence (NICE) and to meet the ongoing compliance requirements of Commission for Health Improvement (CHI) (see section 1.12, Chapter 1).

At the time of writing both these new organisations are in the process of formation, the intention showing considerable promise of an objective and comprehensive approach to quality improvement through clinical governance.

Response by staff

Many staff found the transformation from welfare to market difficult, particularly professionals when it compromised the internalised values that attracted the current staff to the service (Thomson, 1995). There was a failure to appreciate and respect the differences expected of the two staff groups. To managers, professional providers were a group of staff like others; to providers their autonomy made them unique. Within the provider category, semi-professions saw opportunities for advancement through strategic alliances and medically focussed challenges (Chapter 1).

Response by users

The reforms gave an opportunity to users to indicate their needs. The promise was undermined by flawed policy which introduced the concept of welfare users as consumers---a contradictory mixture of political and economic positions; population need assessment which was to be undertaken by purchasers; and partnerships which became those between agencies rather than comprehensive between stakeholders (Rhodes and Nocon, 1998).

In addition, not all individuals or groups relish the opportunity to consult or contribute. Current users are the best informed, but they may feel compromised or physically unable to respond (Sutherland and Till, 1994); they may lack information and the skills to communicate effectively and participate as equals (Poole, 1992); they may have such low expectations that satisfaction is misjudged (McIver, 1991); they tend to be asked about clinical outcomes when their skill is in evaluation of process (McIver, 1991) and functional outcome; campaigners may feel compromised by being party to agreements that they will then find difficult to challenge (Swaffield, 1992;

Davies, 1993); and individuals generally continue to feel that the professionals know best (May, 1992) – which traditional professionals grasp and enthusiastically commend, further strengthening the relationship.

Participation also tends to favour the already privileged (Doyle and Gough. 1991) – the most healthy and autonomous of their peer group who are willing and able to participate, but whose views may be biased. It should be remembered that the classic experience in consultation on healthcare carried out in Oregon, USA, resulted not only in 60% of participants being provider staff but also in their influence on the scope of care *away* from disability (Klein, 1992).

Public service managers have a real difficulty in truly involving users and potential users when the result is not increased profit potential, but more probably increased demand and/or overtly restricted access. Such a situation requires sharing of knowledge for informed consultation and having alternative measures of achievement, such as progress in reaching agreed goals.

Donaldson (1995) reports that, on the basis of evidence from commissioners, the NHS is getting better at contacting its users, but what response such improved contact is providing is unclear. Potential users are more difficult to contact because they seldom see themselves as such; the prospect of health need is generally denied (Hart, 1998), resulting in superficial interest. When pressed, they support issues temporarily affecting some of "us", rather than peripheral problems permanently affecting most of "them" (Carpenter, 1994). Consequently "hips, hearts and hernias" will triumph over "disability and dementia" in the race for resources.

Recognition of these difficulties resulted in central guidance, entitled *Local Voices* (NHSME, 1992) – implying public voices. This indicated the four essentials of listening, informing, discussing and reporting back. It listed a range of proactive and reactive techniques for obtaining user information, noting the importance of seeking out the silent voices of the housebound and disadvantaged, who are often those with the greatest health need. Unfortunately, *Local Voices* became more about local purchaser and provider voices communicating the inevitable to the public than about collaborative planning or participatory purchasing (Paton, 1997).

In a few instances a glimpse of the future health activist is being seen and heard (Herzlinger, 1997): knowledgeable; promoting his or her own health; demanding the best service and organisation at times of health failure; and with the physical, mental, financial and time resource and a lifetime of experience and contacts to enable success. In this author's view, the potential size of this group of newly/early retired, who have much to give and little to lose, is an influence seriously underestimated by the service of which they are the largest users. To the relief of the radical reformers, the NHS risks not only losing a collaborator, but ultimately magnifying the problem by responding reactively, having lost the opportunity for proactive partnership.

In summary, the reactions and responses by stakeholders as a result of the 1990 reforms has resulted in a change in power relationships from medical domination to more equal stakes as depicted by Mascie-Taylor (1998) in Fig 3.3. Such equal division of power is acknowledged by Mascie-Taylor as indicative and not substantiated.

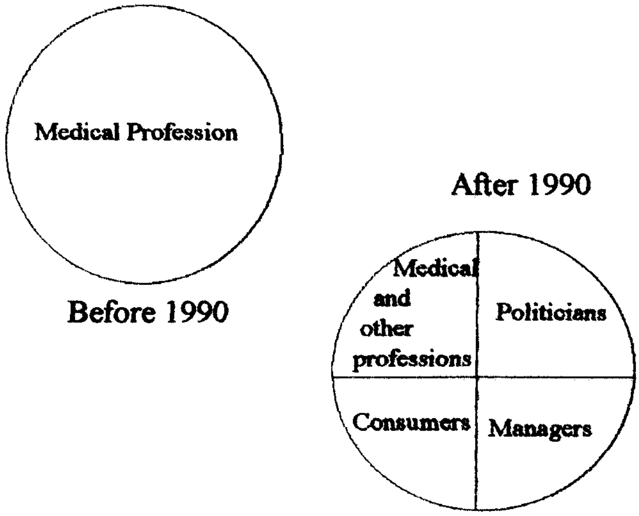


Fig 3.3. The power cake before and after 1990 NHS Reform (Mascie-Taylor, 1998)

3.2.4 Visionary leadership

All organisations have variable levels of administration, management and leadership, but change needs leaders (Turrill, 1986). For success these leaders will need to demonstrate the new culture in everything that is done in a consistent and committed way (Clarke, 1994). The four classic leadership styles are described by Clarke (1994) as follows and, like the change actors above, should not be seen as exclusive:

- **Artisan**: the bureaucrat or professional, distanced from the real world.
- **Hero**: relied on as leader, no time for vision.
- **Meddler**: knowledgeable, cannot delegate, monitoring instead of development.
- **Strategist**: visionary, monitors, motivates and develops.

The strategic approach will maximise success (Clarke, 1994). Although leaders provide the vision for change, it is the managers who provide the physical effort of implementation. Where organisations fail to manage change successfully, the problem results in part from imbalance at the top, being over managed and underled (Zeithaml et al., 1990).

These leadership styles could be considered to relate to the organisational cultures described by Handy (1985) (see section 3.2.1) and are combined in Table 3.6. For example, the Secretary of State for Health was visibly committed to the 1990 reforms in a heroic leadership style and experienced general managers, trained in strategic leadership and loyal to their paymaster (power relationship), were required to deliver the change. Below them in the hierarchy, functional and clinical managers could be likened to the artisan, distanced from the real world and influencing their staff by established, but ad hoc, communication. The overall result within the organisation was probably a balance between leadership and management. Excluded from these arrangements were the public and clinicians as change targets, who were left unengaged by the government in the proceedings, but occasionally courted locally by exceptional leadership.

Organisational Cultures	Leadership styles
Power	Hero
Role	Meddler
Task	Strategist
Person	Artisan

Table 3.6 Organisational Cultures and Leadership Styles
(Sources: Handy, 1985, Clarke, 1994)

3.2.5 Communicate

Having collaborated to identify the gap that needs to be overcome to meet the new organisational goal, clarification and communication of the resulting mission, vision and strategy should ensure consistency in both policy and behaviour of all participants. The four leadership styles will approach communication in different but not exclusive ways (Clarke, 1994):

- **Artisan**: ad hoc.
- **Hero**: outgoing, poor responder.
- **Meddler**: top down, calculating.
- **Strategist**: planned, two way.

The strategist is again the preferred approach, and again reflects maturity to "Wisdom" status in the Crosby model (see Table 3.3). The main benefit of good communication for the organisation undergoing change is feedback to inform management decisions (Roebuck, 1994), in the true spirit of a quality organisation. For effect it must be heard, seen to be acted upon and the position re-evaluated.

3.2.6 Measure progress

Uttal (1983) recommends that change should have modest objectives. Such objectives are unique to the individual organisation and must be clarified, measurable, communicated (MacDonald, 1993), measured and documented (Peters and Waterman, 1991), so that quantified rather than assumed progress is reported.

Peters and Waterman (1991) undertook an extensive survey of companies in the USA regarded as successful against established criteria, and found common features. The subsequent failure of some of these major companies indicates that the magic criteria for organisational success remain elusive for most organisations. However, there is some agreement that vision, strategy, personal qualities of the leader, conducive environment and opportunity provide at least part of this magic formula (Zeithaml et al., 1990; Lascalles and Dale, 1992). The latter is a particular stimulus for the entrepreneur, who still requires power to implement the innovation (Cook, 1995).

The publication of the Patients' Charter (Department of Health, 1991) listed, for the first time, citizens' rights and national and local standards, which could be expected from the service. This resulted in a more critical customer with the confidence to bring providers and purchasers to account against documented standards. These standards were largely limited to conformance to visible and superficial organisational goals rather than ongoing clinical and organisational improvement. For example, reward was for short waiting lists rather than criteria for inclusion on the list, prioritisation of what was waiting or effectiveness of the resulting intervention.

Anecdotes and prejudice have generally substituted for systematic evaluation of the NHS 1990 reforms in the absence of progress markers within the legislation (Le Grand, 1994). Some independent attempts at measurement have been undertaken, and the following serve as examples.

Providers

Providers felt that their traditionally unconstrained altruistic values had been compromised (Thompson, 1991; Ranade, 1994); and were confused by what purchasers wanted (Tulip, 1996).

Purchasers

Purchasers were regarded by others as underdeveloped, politically submissive, poorly informed and largely reliant on provider information (OECD, 1994; Timmins, 1995). Front-line staff within provider organisations did not know of the standards that had been set for them to achieve (Baeza and Calnan, 1997).

Patients and the wider public

Patients and the wider public proved to be ill informed about the changes (Grampian Health Council, 1994; Payne, 1995), unheard in their response (Consumers Association, 1995), and unconvinced about the advantages (Brindle, 1995), but, true to tradition, they remained generally satisfied with the service (Moore, 1996).

There was a clear mismatch between government aspirations and actual capacity of the NHS to deliver the required change (Hunt, 1994). This can be graphically displayed by comparing the actual and aspired summary positions on the Crosby grid (Table 2.3). This would indicate the position of "uncertainty" that the organisation felt itself to be at during the stage of implementation, and the position of "wisdom" where sponsors thought it to be. The progress through awakening and enlightenment would need to be swift and comprehensive if the pace of the reforms was to be successfully met.

Given the complexity of, and stamina needed for successful change, it is not surprising that it continues to remain elusive for some. Machiavelli was under no illusions as to the problems of change management when he wrote *The Prince* in 1513, stating:

> "There is nothing more difficult to execute, nor more dubious of success, nor more dangerous to administer than to introduce a new order of things; for he who introduces it has all those who profit from the old order as his enemies, and he has only lukewarm allies in all those who might profit from the new. This lukewarmness partially stems from fear of their adversaries who have the law on their side, and partly from the scepticism of men who do not truly believe in new things unless they have actually had personal experience of them."

The lukewarm nature of the response to the 1990 health service reforms can be related mainly to providers as main targets, and also to users who were not convinced about the advantages or made aware of the limitations. For example, the much vaunted "choice" was, in practice, choice for purchasers (Pfeffer and Coote, 1991), possibly influenced by the aggregated views of users; and quality was limited to safe process issues within the Patients' Charter rather than more challenging structure and outcome issues.

3.3 Results of the 1990 NHS reform

Two independent concurrent surveys of Health Authorities and Trusts on quality management provide a confusing picture. Wakeley (1997) found that at least 80% of both groups reported giving serious commitment to quality, but

Paton (1997) found that a hierarchy of cost, volume and *then* quality were important to Trusts in view of Health Authority (HA) emphasis, with block contracts dominating; Wakeley (1997) found that 80% of HAs would switch provider for improved quality, whereas Paton (1997) found alternatives to be largely absent. In the absence of enlightenment from the reports, it would appear that Wakeley's respondents were *theorising* and Paton's were *reporting fact* and exposing service concerns about the goal of customer responsiveness, central to the reforms.

Another feature of the reforms was devolvement and fragmentation. In reality the essentials have been retained centrally, and the inessentials delegated locally (Clarke and Newman, 1997), with reorganisation and fragmentation dividing previous power bases to facilitate change. Although direction from the centre has multiplied, despite the objective of devolvement, the loss of traditional hierarchies has meant that cascade is now more complex and costly (Paton, 1997), compromising the communication essential for change and leaving the public largely reliant on the media for information. Mutual gain can be achieved when the communication needs of all parties are identified and met.

A further feature is the effect of contracts that promised the parallel development of working relationships, but these have been plagued by problems of information, monitoring and regulation; in themselves, they have had limited influence (Sutherland and Dawson, 1998). Management, rather than the market, created influence through the shower of central policies (Checkland, 1997).

Where change has been successful, mainly as a result of exceptional local leadership, further time is needed to embed the new style into the culture of the organisation, to prevent project collapse at departure of the key individual. Consolidation could facilitate creation of a "learning organisation", reflecting and learning from its activities, as envisaged by Peters and Waterman (1991).

The history of organisational change in the public sector shows that, once the immediate political pressures are relaxed, old-style behaviour emerges and long-term and unconsolidated change fails (Goddard et al., 1997), with the electoral cycle itself being the greatest restraint on consolidation of change within the services that the government itself is responsible for. This "disease" of public sector management is implied rather than specified in Deming's list (see section 1.10.1, Chapter 1).

It would seem that, from this analysis of the implementation of the reforms against accepted good practice in change management, the participants had to overcome particular organisational challenges within the NHS, including:

- a stagnant role and person culture confused over quality issues
- uncertainty over government vision for the service
- experience of change limited to tinkering rather than turbulence
- change agents in two groups: managers and providers who had mixed personal views
- change targets in two groups: resistant, confused providers; high tolerance users
- leadership and communication heroic rather than strategic
- mismatch between government aspiration and service capacity
- rhetoric and reality of devolvement.

and most importantly, in this authors view, that

- basic values of public healthcare of the three change actors were fundamentally congruent, although business values were largely limited to managers
- opportunity existed for empowerment of resistors and the unsure through involvement

These issues reflect the problem of political aspiration for efficient, fast implementation within the political reality of a short timeframe and constrained resources. They also reflect the need for those involved to develop congruent values based on evidence through time-consuming empowerment and research.

The concerns of Enthoven (1997), the author of the reforms (see Chapter 1), are substantiated over the speed and method of implementation.

An additional review against Drucker's "deadly sins" (see section 3.2.1), contained in the culture of the pre-1990 NHS, shows that projects abounded, stimulated by bids for targeted funds, and national implementation of the reforms was undertaken without any experiment. In the view of Drucker (1980), the existence of two such sins predict programme failure. Success has been at least partially achieved on other Drucker sins as follows:

- **Performance objectives**, although not necessarily appropriate for most people (the length of wait for an appointment being less important than the competence of the intervention), had started although scope was unspecified.
- **Overstaffing** is a distant memory and extra resources less likely, unless targeted.
- **Evaluation** of activity has been stimulated through contracting; evaluation of quality is largely absent although focus on outcomes has increased, but the service is still strongly process driven.
- **Abandonment of programmes**, despite changing needs, continues to be fiercely resisted by vested interests but is more easily influenced by purchaser power.

3.4 Reinforce the change: management of the chosen culture

The literature indicates that successful organisations in the future are likely to follow the quality gurus and blend scientific and human relations approaches within their unique management style, to satisfy continually both customers' and employees' needs.

As with any theory, individuals have proposed their own approaches and Bendell (1992) has analysed the common factors (Table 3.7).

1. Management commitment and employee awareness	Deming, Peters, Crosby, Moller
2. Facts and figures including costs of quality	Juran, Crosby
3. Cross-functional teams	Peters, Crosby, Ishikawa
4. Tools for problem-solving and continuous improvement	Ishikawa
5. Technical tools	Taguchi, Shingo
6. Management tools	Crosby, Ishikawa, Feigenbaum
7. Customer focus	Juran, Crosby, Peters, Deming

Table 3.7 Common factors of the quality gurus. (Source: Bendell, 1992).

Contradictions between these gurus are felt by Bendell (1992) to be mainly the criticism by Juran of inadequate quality awareness campaigns that lack substance, and the concern of both Crosby and Juran with the naïve use of quality circles. The various concepts of the quality gurus have contributed to the philosophy of total quality management (TQM) in which every member of an organisation pursues quality in every action.

There is a tendency for organisations to select an approach to quality management without consideration of compatibility with its needs. Ghobadian and Speller (1994) lament the lack of a framework to help, and suggest linking key factors (Table 3.8), so, for example, the Juran approach would be more appropriate than that of Deming for health services: Juran incorporating variation for heterogeneous customers unique needs in a service environment, Deming pursuing conformance to specifications to reduce variation in a manufacturing environment.

Reliability paramount	Deming approach which minimises variation
High contact service	Juran approach with team work and projects

Table 3.8 A framework for selection of a QM approach

Dickens (1995) has stated that "quality in human services must be tackled in a systematic way involving all aspects of a service and have workforce commitment". This begins to separate out the approaches between systematic (comprehensive) and reductionist (component) (Beckford, 1998). The lack of such a systematic framework to manage change in the literature relevant to the NHS focused this research on the Juran approach. Juran (1988) saw quality as intrinsically linked with every stage of the business process; he had particular concerns about the faithful translation of customer requirements and training of quality managers. He summarised his approach in a 'quality planning road map' in which customers and their needs were identified, and a process developed and put into operation to produce a responsive product.

It was envisaged by this author that the Juran approach would enable the expectations and experiences of the three main participants in any healthcare intervention – users, providers and purchasers – to be established and objectives set for quality improvement that would reduce the gaps between them and lead to more comprehensive (total) satisfaction.

3.5 Total quality management for continuous quality improvement

Whichever style of quality management is pursued, the goal is for a corporate approach. TQM has been defined by many, the key themes being that it involves all people at all levels in all functions (Pike and Barnes, 1996). The definition by the American Federal Office of Management and Budget in their 1990 Circular is a useful example:

> "A total organisation approach for meeting customer needs and expectations that involves all managers and employees in using quantitative methods to improve the organisation's processes, products and services."

TQM here is aimed at improvement of all aspects of the organisation through totality of involvement, quantitative measurement and subsequent action. It does however fail to indicate how external customers' needs and expectations will be identified, or that those of providers and managers will likewise be addressed.

The philosophy of TQM is about inspiring the behaviour and interactions of people in work situations, through their attitudes, aspirations and motivations, to produce a quality product or service (Pike and Barnes, 1996). This differs from quality control (specification to requirements) and quality assurance (confidence of satisfaction).

The elements commonly associated with TQM are:

- **Quality**: is a primary organisational goal in every activity
- **Internal and external customers**: determine what quality is
- **Customer satisfaction**: drives the organisation
- **Variation**: in processes must be measured, understood and reduced
- **Change**: is continuous and accomplished by teams and teamwork
- **Top management commitment exists**: promoting a culture of quality, employee empowerment, team working and a long-term perspective
- **Organisational commitment exists**: to change the culture
- **Consistency**: of message exists.

Martin (1993); Morgan and Murgatroyd (1994)

The value of TQM to the business sector is in pulling together a number of important components. This requires time and has transition costs, both of which are commonly underestimated during change. Evolving such a cultural change typically takes 5–10 years and requires considerable commitment. It is typical for an initiative to run out of steam at two years after the initial enthusiasm, and Pike and Barnes (1996) recommend a focus on support, reward, audit and surveys to maintain momentum.

The philosophy of TQM led to an award, developed by Baldridge in the USA, for success in business excellence. This was subsequently adapted by the European Foundation for Quality Management (EFQM) for public healthcare providing a framework for local implementation (British Quality Foundation, 1996). The initiative acknowledges the political constraints and need for involvement of all stakeholders, but, in this author's opinion, is paternalistic, stating that users are "recipients or beneficiaries of the activities, products or services of the health organisation", and not therefore noting its own advice of knowledge and partnership.

As with the concept of markets, there are some difficulties with TQM and public sector healthcare (Table 3.9),

Features	**Manufacturing industries**	**Public sector health**
Structure and culture	Proactive management-driven. Profit-oriented. Competitive	Diffuse decision-making. Welfare-oriented Non-competitive. Reactive
Activity	Do right things, reduce variation	Do things right, increase variation
Systems	Experience of QC and QA at least in production. Performance indicators geared towards output. Productivity rewarded by profits. Some experience of managing on the basis of (mainly quantitative) information	Little experience of QC and QA. Performance indicators based on administration of inputs and quantity of outputs. Perverse incentives whereby improvements in productivity penalised by lack of increases in funding. Poor information systems and technology
Staff	People have been recruited, trained, motivated and rewarded on basis of output-oriented, profit-driven culture	Most people in organisation still from era when welfare and service aspects dominated. Not primarily motivated by profit or efficiency motives
Customer base	Customers purchasing power. Quite well informed about *desirable* aspects of goods and services	Customers dependent. Little choice. Poorly informed

Table 3.9 Comparison of TQM features in manufacturing and public health care (Joss and Kogan, 1995).

In this comparison, Joss and Kogan have used TQM features as indicators for comparison between manufacturing industries and public sector health. The distinct classification of management into proactive in manufacturing and reactive in public health is too severe, particularly with regard to the recent date of the reference. In this author's opinion, public sector management has become much more proactive, and in some areas it is regarded as being ahead of the private sector.

An oft-quoted example of transfer of techniques from the public to private sectors is the structure, process and outcome (SPO) approach to acquisition of information (Donabedian, 1988, 1989), enabling setting of clear standards and criteria so that consumers know what to expect from their encounter, and can compare with their experience and therefore rate their satisfaction. This approach, which started in healthcare, has also proved valuable in other industries such as manufacturing (Moores, 1993).

The most significant difference is the integral need for variation in activity in healthcare. This should relate to the ability to meet heterogeneous need and also to provide a consistent approach to similar need. The remaining issues in the comparison are political and managerial and had the potential for reconciliation through the reforms. The question must be asked that if by pursuing a TQM approach in public services market style features are incorporated and, if so, whether the concerns over issues such as threat to equity in healthcare markets (see Table 1.3, Chapter 1) can be overcome by such a quality management approach, for example, clearer access criteria.

The NHS TQM initiative was launched alongside the 1990 reforms. In comparison with similar initiatives in the private sector, miniscule funding was offered to 17 successful District Health Authority bids (Hart, 1996). In addition to the issues noted above by Joss and Kogan (1995) (Table 3.10), there are particular problems for the public sector in that fluctuating political influence affects clarity of goals, compromising the long-term perspective necessary for the TQM philosophy (Osborne and Gaebler, 1993), there is existing bureaucracy (Redman et al, 1995) which acts as a brake and filter, and difficulties in measuring the results of social goals (Redman et al., 1995).

In the NHS there is the additional feature of "white coat" staff whose allegiances are at least partly to other reference groups and who did not give whole hearted support to the initiative (Hart, 1996). From a clinical perspective, QA has some congruence with the traditional professional approach if standards are defined by experts without the need for change and challenge to the status quo. TQM, however, empowers all, including juniors and users; allows for autonomy; challenges the status quo; and facilitates teamworking, all of which threaten the established order of power and influence to varying degrees, seen by Kitchener and Whipp (1995) as the crux of the initiative.

Foster et al. (1994) report that evidence from research by the Audit Commission indicates that, among managers, and at least a proportion of the clinical NHS workforce, there had been considerable success since 1989–90 in transmitting and learning the concepts of quality management. They add that "however there is little firm evidence of returns in terms of better patient care". As best patient care is the objective of the service, time spent in "transmitting and learning the concepts of quality management" which fail to progress the organisation's main objective must be questioned. Perhaps, in addition to addressing the power concerns of clinicians, the time frame between transmission and results needed to be longer than the four years reviewed by the Audit Commission. It has already been noted above that five to ten years is more typical, but that this is likely to be influenced in the UK by the five year maximum electoral cycle, where a swing towards any party influences continuity and strength of public policies.

3.6 Opponents and contradictions of TQM

The TQM philosophy also has its opponents. For example, Purcell and Hutchinson (1996) found that, in some studies, TQM is seen as a threat to middle managers because their authority is undermined; in other studies middle managers felt empowered by greater inclusion in the decision-making process. Yet another view is that an initiative that challenges power bases risks marginalisation (Clarke and Newman, 1997). Purcell and Hutchinson (1996) put this diversity of opinion down to the lack of research and the fact that local circumstances, particularly leadership skills, influence responses.

Other accusations are that it is expensive, damaging and outdated, and that the lack of results has reduced enthusiasm (Redman et al., 1995); the development in blue collar organisations make it inappropriate for white collar let alone white coat organisations (Hart, 1996). Heller (1993) has similar reservations and suggests that "smart initials, sweeping claims and envy of Japan", where success through TQM is regularly reported in some parts of the private sector, may provide the attraction. Heller concedes that, despite this, some major international organisations have found that it worked. The key remains appropriateness of approach for the target organisational culture (Pike and Barnes, 1996).

3.7 Results of the NHS TQM initiative

The NHS TQM initiative is not regarded as having been a success, although there have been notable exceptions. The fact that it was a top-down initiative rather than an organisational philosophy was an indication of conceptual ignorance. Ovretveit (1994a) ascribes the failure to the short termism of a political organisation, lack of investment in the initiative, lack of clarity of client needs and satisfaction measures, and failure to involve powerful players. Ovretveit did not note the conflict over variation and information; or the issue of baseline organisational maturity (Pike and Barnes, 1996). The theoretical decentralisation of the service provides an opportunity for progress through a reduction in bureaucracy, but carries the risk of uncoordinated empowerment (Kitchener and Whipp, 1995).

Botterill (1990) regards the measurement of TQM as important and difficult, but noted that, without such an analysis, there can be no evidence that the right problems are being addressed. A difficulty with TQM is keeping track of direction and achievement, particularly in a large organisation. Corporate progress can be measured using the Crosby Quality Management Maturity Grid (see Table 3.3 above) with components probed for evidence for the reported satisfaction of internal and external customers (Hegarty, 1993).

With reference to Crosby's Grid, the NHS can at least be seen to have moved forward from "uncertainty" to "awakening" at the time of the TQM initiative, summarised as "Is it absolutely necessary to always have problems with quality?" (Table 3.3), but progress has been painfully slow and there is still much ground to cover. It cannot be said whether even this meagre progress was as a result of the initiative or was a coincidental natural progression in a quality focused wider environment.

Lessons from the failed NHS TQM experience include the importance of acknowledgement of existing strengths, recognition of existing covert quality practice and sophisticated mutual understanding of the total organisation and the need for consistency of policy (Southon and McDonald, 1997).

Where there has been failure to implement the TQM philosophy, commonly the reasons are:

- Mismatch between enthusiasm of promoter and capacity of organisation (Charron, 1996)
- Application of the wrong model
- Lack of understanding by participants (particularly targets)
- Initiative not sustained; abandoned too early

- Failure to achieve cultural change
- Expectation of early, high and sustained financial gains (Baker, 1993; Baron and Walters, 1994; Redman et al., 1995).

The failure of the initiative in the NHS would appear to embrace all these possibilities, particularly the capacity to respond, the lack of understanding of the principles of change by all except the general managers and, above all, a lack of conceptual understanding of the importance of participant involvement in change. There was also evidence of confused policy, with on one hand expectations of conformance to specifications and standards (QA), and on the other empowerment and responsiveness (TQM).

Pike and Barnes (1996) use continuous quality improvement (CQI) synonymously with TQM, although Reynolds (1994) differentiates TQM from CQI as the difference between a philosophy for managers to meet customers needs and a philosophy for everyone to meet all stakeholders needs. Reynolds (1994) also suggests that the exclusion of "management" in the term CQI may make it more palatable to some staff; gives a more dynamic vision; and that refreshment of the concept with a new title may revive those who have become complacent. The alternative view might be that the appearance of yet another change may produce despondency. It would appear however that the need for professional staff to allow for continuous improvement of autonomous practice to meet changing needs might find an easier association with CQI. Despite the pedantics, Messner (1998) has pointed out that culture change remains a requirement.

3.8 Reflection on the success of the 1990 NHS organisational change

The stages in the process of organisational change through the condensed Clarke model have been applied to the implementation of the 1990 NHS reforms in this chapter and are summarised in Table 3.10.

Change management principles	NHS in general	Explanation
Understand the organisation	Yes	Culture of staff compatible with traditional culture of NHS
Appreciate the reasons for change	Yes	Reforms had been introduced with national and local presentations for mainly senior NHS staff.
	No	Some lower grade staff and public remained unconvinced
Know the change process, anticipate reactions and responses	Yes	Understanding mainly restricted to highest levels – change sponsors and agents. Mostly professional providers
	No	Change targets – providers and patients – less commitment, particularly users
Existence of visionary leadership	Yes	Leadership clearest at highest levels
	No	Unclear below
Established communication	Yes	Established within function
Measure progress	No	New measures required to move from output to outcome
Reinforce the change	No	National failure of NHS TQM indicated advantages of local initiatives

Table 3.10 Summary of implementation of the 1990 NHS reform through the process of organisational change

The key generic best practice indicators can be summarised as conducive culture, communication, commitment and measurement of progress. Table 3.11 indicates that there was an understanding of the target culture, and appreciation of the reasons, action needed and leadership by higher grades of staff. Functional communication was established, although re-organisations may have subsequently affected this. Lack of commitment by change targets (providers and patients), along with failure to identify the goals, measure progress or reinforce the change achieved revealed a lack of partnership. Of particular note should be whether the need for change was understood, given that the vast majority of the public and NHS staff were not behind it. These issues of conducive culture, communication, commitment and measurement of progress are noted by this author as best practice markers for improvement in implementation of subsequent NHS change; together with NHS specific requirements for clarity and agreement over quality issues, vision and values; a strategic approach; and the capacity and empowerment to respond.

It cannot, however, be disputed that change of some sort was needed. Milakovich (1991) suggests the following key changes in policy to overcome the problem of failure of quality programmes in public services:

> Costs of quality should be assessed
> Internal and external customers and their needs should be identified
> Protection should be provided for minority group interests
> Customer-driven measures of quality should be used.

These issues are pursued in subsequent chapters of this thesis (see Chapters 4 and 5). Of particular note is the reference to internal and external customers, which *could* be taken to include NHS purchasers, providers and users, whereby identifying and meeting their needs could avoid the lack of commitment and apparently differing values described above.

3.9 Conclusion

Successfully managing change from welfare to market is reliant on an understanding of the subject (see Chapter 1) and the change process. The latter has been explored in this chapter. This indicates best practice markers of a conducive culture, communication, commitment and measures of progress. A model that promised behaviour change was used to guide a literature search to compare best practice with reality for the key NHS stakeholders, purchasers, providers and users, towards a quality culture. The result revealed: the need for clarity and agreement over quality issues, vision and values; a strategic approach; and the capacity and empowerment to respond. Evaluation showed high aspiration but low achievement, particularly the method of reinforcement.

The conclusion is that national total quality management is an *inappropriate* model for reinforcement and that local continuous improvement, which allows for strategic leadership and communication, provider autonomy and above all participant involvement may be the answer. The 1998 NHS reform (see Chapter 1) promotes collaboration with contestability which could capitalise on such an approach, but the proposed national performance framework appears to rein back on progress, indicating a return to quality assurance at best and quality control at worst. The thesis continues with the theme of participant involvement for successful change, pragmatically including measures of performance in anticipation of such requirements.

Chapter 4

Need, choice, satisfaction: reflection on quality concepts

4.1 Introduction

The focus of the 1990 NHS reforms was the development of a service that was responsive to patient need through a market environment. Quality had always been implicit in healthcare; the need now to specify and monitor it was widely questioned by autonomous providers. It was noted in Chapter 3 that a quality improvement approach, through participant involvement, rather than the more prescriptive quality control and assurance, could allow for the necessary autonomy and variation to meet unique clinical, organisational and personal needs. This chapter begins to provide the theoretical background to the subject of quality and its continuous improvement as a contribution to answering one of the questions raised in Chapter 3:

> **Can an effective CQI model be identified, or developed, and evaluated which incorporates Juran's approach and the needs of local key stakeholders?**

This is achieved through a review of the concepts of quality, need, choice and satisfaction in manufacturing, service and public service sectors.

4.2 The concept of quality

Interest in quality has been raised by a combination of factors including economic competition, environmental concerns and activity of the quality gurus, with the post war interest in human psychology facilitating the development of personal and organisational response (Beckford, 1998).

A major problem with the concept of quality is that the term has informal and widespread use, is dynamic and contextual, and like, health, "is difficult to define but easy to recognise" (Bird, 1985), even though without such definition it cannot be measured. As a first step it is attempted below to define the interchangeably used terms "qualities", "of quality" and "quality".

The qualities of a product or service are its attributes or characteristics, which may or may not satisfy the needs of an individual (Seedhouse, 1994). These attribute(s) may be "of quality", commonly considered to indicate exceptional achievement, although the origin of the measurement criteria to support such claims may be obscure. If the need is not satisfied, the feature is not a quality attribute to that individual. Alternatively, the attribute may be commonly considered to be of poor quality, but meet the need and be a quality attribute to that individual.

In the overall assessment of a product or service all the noticed attributes are considered in response to individual need(s) (Seedhouse, 1994). Choice is made when the customer compares the characteristics of the identified need with the promised qualities, or characteristics, of the available solutions. Where the individual is unable to form an opinion on technical quality, proxy measures may be used or assurance may be sought from a competent third party.

4.3 The concept of need

Need, the concept which quality, choice and satisfaction are to meet, is defined as wanting something (Collins Dictionary), setting an expectation to be met by a responsive supplier. Maslow (1943) reported a hierarchy of human need that required linear satisfaction from physiological to self-actualisation, conceding that some levels of the hierarchy may be reversed in exceptional circumstances. Other views have postulated on ultimate needs, for example, quality of life (Inglehart, 1990). Health, liberty and autonomy are now considered to be the basic needs that humans must satisfy in order to lead fulfilling lives.

Once satisfied, a need can reassert itself either if it has ceased to be satisfied for some period of time (Schuh, 1979), or as Maslow (1943) observed, humans are perpetually wanting and never completely satisfied. The scope of expectation also expands with progression through the hierarchy. Drucker (1991) added that this increasing and expanding progression requires a disproportionately greater response, with potential dissatisfaction likewise increasing.

Bradshaw (1972) described a model of social need that could be felt, normative, expressed and/or comparative (Table 4.1).

Felt need	**What is wanted by the individual:** strength of feeling is influenced by availability of service and willingness to expose the need; feeling of need may be inflated by those not in need.
Normative need	**Measurable against a standard defined by experts:** experts may not agree; subject to changing social values; a need may be felt but not meet normative criteria; a need may exist but not be felt; need may be identified via screening against explicit criteria.
Expressed need	**Action taken on felt need:** may include those not in need as well as not include those in need who have not felt and expressed it.
Comparative need	**The population in receipt of a service** are used as a measure of need to identify those with similar characteristics who are not in receipt but still in need, whether felt or not; used as an indication of service shortfall; need may be identified via screening against user characteristic criteria.

Table. 4.1 Taxonomy of Social Need.

(Source: Bradshaw, 1972)

Kano et al (1984) categorise needs to be satisfied as basic, expressed and unanticipated to explain the responses which they categorise respectively as expected, wanted and exciting.

Basic needs

Basic needs are generally unnoticed by users, as are the assumed responses that may be technical and defined by experts.

Expressed needs

Expressed needs are described by the customer; they must be heard and understood by the supplier to elicit the wanted response which should also include the response to integral basic needs. These wanted responses are foremost in the customer's mind, are generally functional and symbolic, and will have strongly contributed to the "choice" decision to engage in the activity.

Unanticipated needs

Unanticipated needs are shown in responses over and above those wanted and expected. These may be exciting for suppliers to pursue and can elicit an excited response from users---so long as the integral basic and expressed needs are met.

This categorisation of need and experiences can be compared favourably with Bradshaw's taxonomy of need described earlier (see Table 4.1). Comparing them in this way should focus service responses on *basic* and *expressed* needs which demand *expected* and *wanted* responses; they are triggered by identification against overt normative criteria and result in satisfaction (Table 4.2).

Kano needs	**Bradshaw**	**Kano experiences**
Basic	Normative unfelt, comparative unfelt	Expected
Expressed	Felt, expressed, normative, comparative, unmet	Wanted
Unanticipated	Normative unfelt, comparative	Exciting

Table 4.2 Comparison of Kano's and Bradshaw's categorisation of need. (Sources: Bradshaw, 1972; Kano et al, 1984)

The flow of need from unfelt to felt incorporating Bradshaw's and Kano's models is depicted in Fig. 4.1, where lay influence may result in the need becoming expressed. The responsiveness by the supplier may result in the need being met. Where normative criteria between users and providers differs, the expected and wanted response will be denied, risking dissatisfaction. The barriers to expressing and responding to need include information and ability.

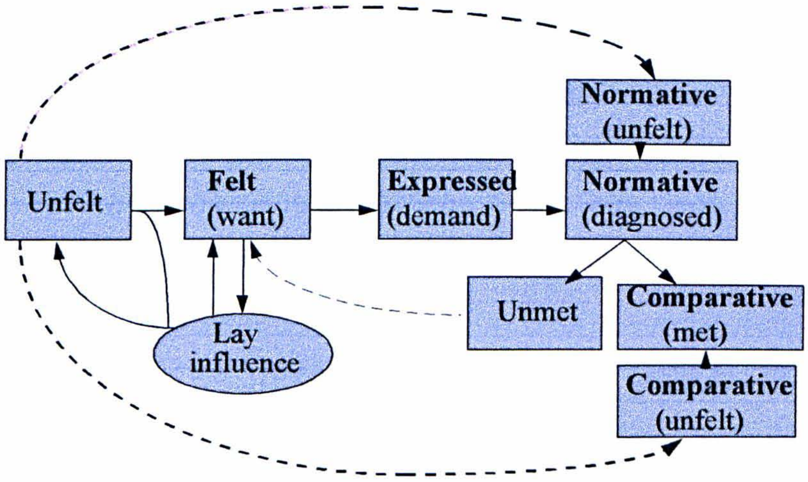


Fig. 4. 1 The flow of need incorporating Bradshaw's and Kano's models

The components of exciting provision and experience can be shown graphically in an adaptation of a diagram by Kano et al. (1984) (Fig. 4.2).

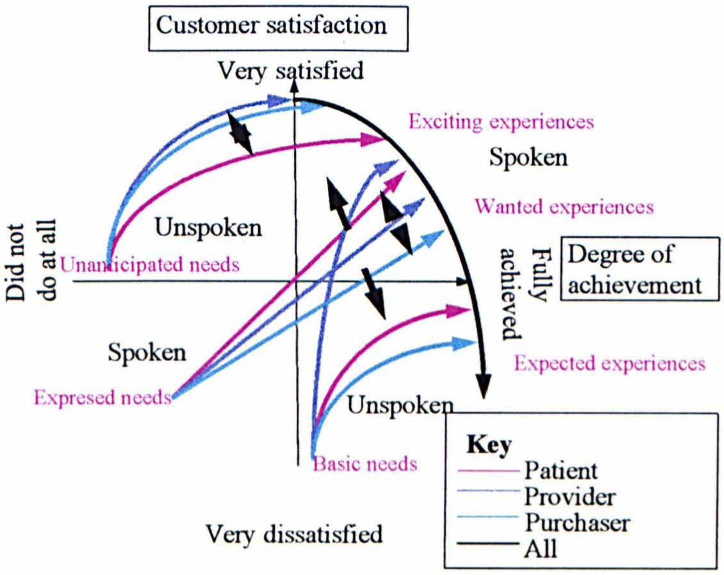


Fig. 4.2 Divergence of basic, expressed and unanticipated needs of healthcare stakeholders. (Adapted from Kano et al., 1984)

Figure 4.2 shows that unspoken needs could achieve satisfaction or dissatisfaction, depending on the interpretation of the participants. Only expressed needs have the potential to consistently achieve mutual satisfaction, underlying the importance of encouraging articulation of needs by stakeholders. The risk of falling into the pit of dissatisfaction *when basic needs remain unmet* is forever present, irrespective of the higher level of need met. When unanticipated needs are met *in addition* to those expected and wanted, customer satisfaction is maximised (Kennedy, 1991).

4.4 Matching customer and supplier needs

Understanding the potential mismatch in customer and supplier expectations is a crucial key to comprehensive satisfaction in any sector. It places particular emphasis on the need for early stakeholder education; clear product specification or service access criteria; and standards, information and appropriate supplier skill mix to facilitate cost-effective satisfying work, together with an appropriate reward system. Job satisfaction and career enhancement can be gained by improvement of work “needed”.

4.5 The concept of choice

The decision to pursue a product or service is made by customers after the following: their comparative assessment of its qualities against those of their identified need; measuring the congruence; comparing the benefit and sacrifice to provide a value; and then making a choice on action (Naumann, 1995). Customer choice is influenced by advertising, competition, changing expectations, experience, the total package and the personal resource implications, with information via the Internet gaining ground for computer-literate cohorts.

For tangible goods, the characteristics most sought after can be searched for in advance of the experience (Walsh, 1991). They are consequently known as search goods. For intangible services, experience cannot be separated from service delivery so that choice has to be made before consideration of all the information is possible. They are consequently known as experience goods. Qualitative information (Zeithaml et al, 1990; Walsh, 1991; Reynolds, 1994; Naumann, 1995), especially from the experience of self or others, and trial use being particularly influential

The possibility of having a choice is appreciated by the customer, whether it is exercised or not. The wrong choice appears to lead to dissatisfaction with the product/service rather than with the self who made the choice. Where the choice for an individual is made by another, the choice process is further complicated, the supplier of the chosen service again becoming the focus of any reaction. The more that can be specified and adhered to, the less opportunity there is for disappointing mismatch between customer expectation and perception, although such conformity will compromise professional autonomy of some suppliers, lessening their satisfaction.

The absence of personal power in public services to lever responsive change magnifies frustration. Such frustration has led some users and providers to the private sector. Anecdotal evidence shows that the same individual supports equity to some extent when receiving public services, but sees only *their* episode of service in the private sector---whether service user or supplier, creating harmony over the need of the moment.

Bennett (1993) has described the "moment of truth", when, as a result of expressed need, the customer comes into contact with the supplier and an exchange of the functional and symbolic values between the two takes place, forming the experience. The experience is compared with what was expected and wanted and influences the measure of satisfaction.

4.6 The concept of satisfaction

Satisfaction is described as the difference between expectation and perception. In services which are ongoing, experiences during service receipt further change expectations of the attributes (Cronin and Taylor, 1992, Dickens, 1995, Conway and Willcocks 1997), making the links between original need, expectation, choice, experience, revised expectation and satisfaction complex and unpredictable. Such a dynamic process does however offer the opportunity for rectification of dissatisfaction, once it has been identified, which is not possible with a tangible good produced to specification.

The ratio between expectation and perception of the experience results in a level of satisfaction for the individual making the judgement. The differentiation between experience and perception of the experience is important; the *perception* is what counts. The customer therefore *is always right* as they compare *their* perception of the experience with *their* expectation (Pike and Barnes, 1996), any dissatisfaction being caused by inappropriate expectation (either through commission or omission of information in an appropriate medium (Walsh, 1991) or inappropriate provision – both being a *provider* responsibility. The consequences of these different levels of knowledge are depicted in Table 4.3.

		Degree of difficulty for user in evaluating quality	
		Low	**High**
Degree of difficulty for producer in evaluating quality	**Low**	Mutual knowledge, e.g. food	Producer knowledge, e.g. professionals
	High	Consumer knowledge, e.g. user-led care plans	Mutual ignorance, e.g. public services

Table 4.3 Information differences between producer and user (Walsh, 1991)

"Mutual ignorance" is common in public services where need is dynamic and outcome latent, difficult to measure and even outside the remit of the service, such as improved housing to improve health. Ignorance was omitted from, but should now be added to, the "sins" of public sector management described by Drucker (1980) (see section 3.2.1, Chapter 3).

In a commercial market, continued customer allegiance through improved quality is the goal; it is harder and more costly to replace or mollify dissatisfied customers. Dissatisfaction is shown by "exit" (Hirshman, 1970); this becomes "voice" when an alternative within one's personal capacity is not available. Leavers and vocalists are likely to magnify the failure of provision through their wide reporting (Naumann, 1995), influencing the search by potential customers described above. Where the capacity of customers is reduced, for example, reduced financial circumstances or reduced space for consumables, the provider must be innovative (reduced price, smaller size, niche market) to meet the changing need, otherwise the failure is, and will be reported as, of *provision*.

Stakeholders' perceptions and their relationships in different situations must be understood and measured by providers to ascertain and continually improve customer satisfaction (Price and Gaskill, 1990): continuous customer feedback through analysis of concurrent quantitative and qualitative surveys; comments and compliments as well as complaints; and other routine intelligence which can affect quality, can then be used to "listen to the voices" and focus service responsiveness (Walsh, 1991; National Consumer Council and Consumer Congress, 1995; Naumann, 1995).

4.7 Management and measurement of quality

The development of expectations of quality has changed from product conformance against manufacturer-defined specification to responsiveness to customer-influenced requirements. This has reversed, in theory, the original chain of requirements to customer-led and provider response through staff empowerment. Clarke and Newman (1997) dispute such a utopian approach, finding that the politics of quality make it a top-down reality, with TQM in the public sector an intellectual technology to link government policy with organisational reality (Reed, 1995), the opportunity through provider empowerment waiting to be grasped.

Management of quality is undertaken by the use of a range of tools to identify need and measure the cause and effect of variation (see Appendix 4). Although little used in the public sector to date, many of these generic tools are applicable and some are used in this research.

The major cause of variation is chance, estimated by Juran to cause 85%, and by Deming 94%, of all variation (Neave, 1992). Chance variation is attributable to common causes, such as temperature change of materials, for which workers can make adjustments if empowered to do so, making it an issue of the *style of staff management*. In healthcare this could relate to access criteria which the autonomous practitioner can override in the light of surrounding circumstances. The remaining 6–15% of variation is the result of unpredictable special cause or instability, such as machine wear (Martin, 1993). In healthcare this could relate to unpredictable demand from major accident, epidemic or weather.

Quality management arrangements have also changed, progressing through quality control and quality assurance to continuous quality improvement (see section 2.7, Chapter 2) to meet ascending and expanding needs (See section 4.3). Linear quality control was developed to inspect and re-work products determined as defective against manufacturers specification at the end of the mass production process. This separated the producer from inspector, denying the former the learning process from non-compliance.

Quality departments became costly, but essential, sections of organisations, although low in the hierarchy (Arrington, 1990) because of their reactive rather than *value-adding* function. Concerns over the escalating costs of these quality control empires in the 1950s resulted in the development of pre- and intra-production quality assurance (Ellis, 1991a). This enabled only raw material guaranteed by the supplier to be of the correct specification to enter the process, and each subsequent stage to be monitored against specified procedures. Refinement, rather than improvement, of the original specification, on the basis of the information gleaned from end inspection, to decrease variation during production was pursued. Shewhart (1939) depicted these linear and circular approaches graphically (Fig. 4.3).

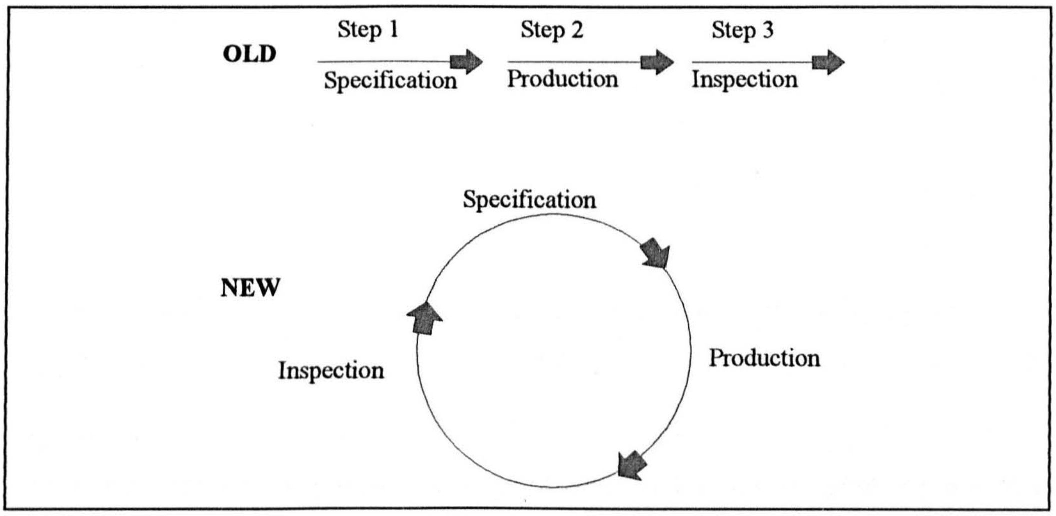


Fig. 4.3 Linear and circular quality control. (Source: Shewhart, 1939)

Quality assurance by employee observation of, and appropriate action on, variation from the specification during their part of the manufacturing process was developed by Deming and Juran in the USA. Such a route was depicted by Deming who added the "action" component to Shewhart's cycle, becoming known as the 'Plan/Do/Check/Act Deming Cycle' (Fig. 4.4).

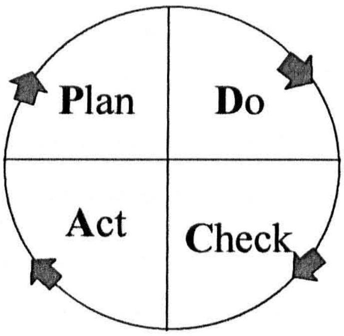


Fig. 4.4 The Deming Cycle

As customers needs have been shown to be dynamic, the result of all this activity should not be limited merely to assurance of compliance with the specification, but used to improve quality to at least meet, if not exceed, ascending and expanding expectations. Quality improvement advances the quality process by investigation of issues that fail to meet *changing* needs, identified through complaints, returns or lack of sales.

The new position becomes the minimal standard and continuous quality improvement can again move ahead. This ascending motion has been depicted by the Deming Cycle ratcheting quality up the incline of expectations, securing each improvement in a standard with audit and review programme (Fig. 4.5). This should ensure that basic needs remain incorporated whilst higher needs are explored.

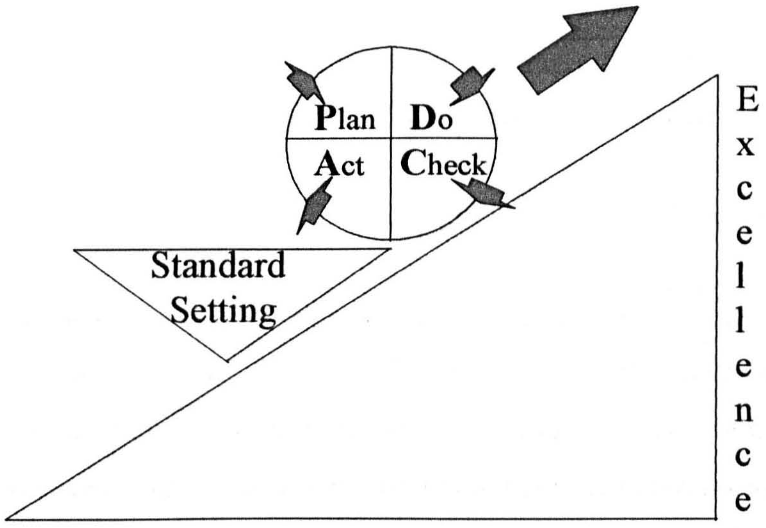


Fig. 4.5 Ascending quality improvement. (Source: Koch, 1990.)

While quality control and quality assurance can be achieved, quality by its responsive nature to changing needs can never be achieved. However, a culture of CQI is achievable where employees continuously seek to reach the ultimate position of self actualisation in Maslow's hierarchy so that the activity to satisfy the changing needs of the customer matters to the individual rather than carried out purely for monitoring purposes (Beckford, 1998). This concept is particularly attractive to autonomous practitioners who can assure managers, colleagues and the public that routine work is carried out correctly, leaving opportunities for exciting research and development which in themselves may result in best practice standards from which to progress further.

4.8 Costs of quality

Competitive organisations will need to balance effectiveness of an initiative with its cost, and cost of quality improvement is no exception. The calculation of quality costs is complex and four categories are generally used: negative costs of external and internal failure, and positive costs of prevention and appraisal.

As with other issues of quality, there is a manufacturing bias in the literature. For example, Peach is recorded (Deming, 1982, p175) as describing the negative cost of quality as when

> "... the goods come back but not the customer."

In services, the customer and service are inseparable and most of the latter intangible so that only the customer, in the main, has the option of return. Where tangible evidence does exist (documentation, equipment) they may acquire disproportionately high status in comparison with similar components of an all tangible product. Service providers probably underestimate the value customers put on these tangibles. Also in services the cost, in its widest form, may escalate as a result of the poor experience, with rectification costs and possibly greater needs to be met as a consequence of the previous service failure.

In public services there may be little alternative but for the disgruntled customer with his or her integral problem to return to the service that is perceived as having failed. Users of health services generally lack information on alternatives and, particularly in healthcare, have considerable faith in providers. Use of public services is also generally unplanned so that established routes will be followed in an emergency. Return may be accompanied by greater needs along with expectations sharpened by past experience, both requiring greater satisfaction. The costs of poor quality in services are largely unknown (Deming, 1982).

The conversion of service failures into financial data can convince management of the need for change (Moores, 1993). It has been variously calculated that 5%, 25% and even 40% of negative quality costs to an organisation can *initially* be saved through continuous improvement measures (Jordan, 1992). Expectations that this level of financial benefit will be *ongoing* are exaggerated, leading to disillusionment with quality initiatives by cost-focused senior management in succeeding years, influencing the early cessation of projects and compromising the 5-10 years consolidation time needed for culture change.

The calculation of quality costs is complex and four categories are generally used (Table. 4.4): negative costs of external and internal failure, and positive costs of prevention and appraisal. The aim is to reduce the negative costs of quality by increasing preventive costs and minimising appraisal costs. In a non-quality organisation it is common for 75% of costs to be on negative issues with 5% on prevention and 20% on appraisal (Anderson and Daigh, 1991), clearly indicating that attention needs to be focused on negative costs such as negligence and process failures. Complaints can be a valuable source of quality intelligence and should not be universally obliterated; repetitive complaints *for the same topic* are the costs to be addressed and eliminated.

Costs of quality	**Example**	**Cost calculation**
External failure costs	Complaints	Estimate time to deal with and make good (Ovretveit, 1991). Consider potential complaints – one letter represents up to 27 who did not write (Lisswood, 1989)
	Negligence claims	Base on worst case scenario (Ovretveit, 1991)
75% of quality cost	Lost custom	Competition risk (Ovretveit, 1991) Re-attraction costs up to five times more than retention (Liswood, 1989; Naumann, 1995) Reputation – one dissatisfied talks to up to 15 others (Liswood, 1989; Baines, 1992)
Internal costs	Waste, duplication, delays, down time, correction, re-inspection, rework, diversionary activities, urgent calls	Use of a flow chart can estimate the problems and amount at each stage and cost. (Ovretveit, 1991) Such costs are usually hidden within the budget, are often difficult to calculate and may even be valued by peers (Ovretveit, 1991)
	Costs of non-conformance	Re-work, disposal, customer relations (Ovretveit, 1991)
Prevention 5% of quality costs	Planning Design Education Training Market research	Analyse and cost the removal of main cause (Ovretveit, 1991) Cost all activities undertaken to prevent defects in creating a product / service and during the business cycle (Crosby, 1980)
Appraisal and assurance 20% of quality costs	Surveys, audit, analysis, documentation, testing, maintenance	Costs of determining conformance to specification (Crosby, 1980)

Table. 4.4 Costs of quality and their calculation

A particular area of concern with positive costs has been appraisal. Here, those charged with monitoring quality have attempted to record progress on an unprioritised plethora of issues, by copious, paper-based methods with only 20% likely to be read by the intended audience (Collard and Sivyer, 1990) – hence, the accusations of the bureaucratic costs of quality.

4.9 Quality management systems (QMS)

For long-term success an organisation-wide, ongoing and cost-effective system should be developed, incorporating comprehensive coverage, views of all stakeholders, logical focus and action on results. Systems suitable for unique organisations are rarely "off the shelf" and will have to be developed/adapted for the unique culture of the organisation (Hurst and Carr, 1995). Such an approach provides the opportunity for stakeholder participation and ownership adding additional value to the initiative.

4.10 Accreditation

Certification of suppliers' quality management system by an accredited third party gives assurance (Wall, 1995) and makes purchaser inspection *of the area covered* redundant (Moores, 1993). This ultimately reduces appraisal costs of quality (see section 4.8) by investment in prevention.

At issue is whether the quality system meets the requirements of all participants, that action occurs on issues of non-compliance, and that there is evidence to ensure that structures and processes which comply with specifications reflect ultimate requirements. A major risk is of returning to debilitating bureaucracy through static procedures (Healey, 1996) and not pursuing CQI. Scrivens (1995), however, found that staff willingness to participate and the actual process of certification were beneficial to the culture change needed for CQI – another endorsement for participative change.

The common concept of product or service quality as the "totality of features which satisfy the needs of the customer" remains the benchmark. The differences that may be found when products, services or public services are the focus are now considered. The different needs of stakeholders within public services are reviewed in Chapter 5.

4.11 Quality expectations of products, services and public services

The division of organisations into manufacturing *or* service categories is regarded as false, because each normally incorporates at least some of the other in its product (Price, 1993); the issues surrounding each do, however, differ. To date, the drive for advantage has largely focused on consumables, but, as the limits to tangible possibility, such as paint colour, are reached, it will be the *service* component of products that become the differentiator (Zeithaml et al., 1990; Baines, 1992). Service quality is a newer consideration and Gummesson (1989) noted that, as recently as 1987, no mention was made of it in any title contained in the 1,167 pages of the proceedings of the European Organisation for Quality Control.

4.11.1 Product quality

Products, or goods, are described as tangible, movable and not usually consumed as produced (*Collins' Dictionary*). Garvin (1987) identified eight measures of product quality:

- **Performance**: primary operating characteristics such as prompt service.
- **Features**: such as optional extras.
- **Reliability**: dependability, accuracy, consistency, risk of breakdown.
- **Conformance**: to pre-established standards.
- **Durability**: level of use before breakdown.
- **Serviceability**: speed, courtesy, competence, ease of repair.
- **Aesthetics**: look, feel.
- **Perceived quality**: where the customer lacks information and must make subjective assessments.

Competing on all eight measures is generally not possible without a very high price. Companies therefore choose a "quality niche" based on their interpretation of customer needs and the opportunity for competitive advantage (College of Estate Management, 1997).

A tangible product is likely to be obtained from a single, complete contact with the chosen *end supplier* rather than with the many links in the supply chain. For example, a new car is usually bought from the salesperson, not from a series of contacts with members of the production line. This reduces the risk of interaction variation and provides a focus for investment in customer care training. Customer reaction received by the salesperson must be fed backwards along the supply chain for appropriate attention, assuming an empowering style of management. A short chain facilitates the timely response expected by customers and contributes to the explanation for organisational restructuring towards flat management structures.

Defining the qualities of a tangible product is relatively easy in comparison with a service. Tangible products have the advantage – or disadvantage in a competitive environment – that qualities can be accurately copied between similar products (Naumann, 1995), although the initiator can often keep the lead by product name (for example, "Hoover"), reputation and development to maintain market position. Complacency of market leaders is their potential downfall.

4.11.2 Service quality

Services differ from goods in the purpose for which they are produced; and how they are produced, consumed and evaluated. The British Standards Institute defines service industries as:

> ". . . the results generated by activities at the interface between the supplier and the customer and by supplier internal activities, to meet customer needs:
>
> 1. Supplier or customer may be represented at the interface by personnel or equipment
> 2. Customer activity at the interface may be essential to the delivery of a service
> 3. Delivery or use of tangible goods may form part of the service
> 4. A service may be linked with the manufacture and supply of a tangible product."

Adding this view to those of numerous authors identified through this review has resulted in the features of services being described as intangible, heterogeneous, inseparable, invisible, intimate, fluctuating, latent and labour intensive (Table 4.5).

Intangible	Difficult to specify and advertise (Haywood-Farmer, 1988); cannot be verified in advance (Walsh, 1991); cannot be stored (Walsh, 1991)
Heterogeneous	A unique event (Naumann, 1995); inconsistency of provider and user in performance and over time (Parasuraman et al., 1985); different views of participants which can change rapidly (Haywood-Farmer, 1988); difficult to standardise interactions (Speller and Ghobadian, 1993)
Inseparable	The interaction requires both customer and provider, no third party buffer, and forms the service, creating immediate reaction (Deming, 1982); poor participation affects result (Haywood-Farmer, 1988)
Invisible	May only be noticed by omission, makes evaluation difficult, the process may be as important as the outcome; tangibles used as proxy measures (Haywood-Farmer, 1988); may be focused on customer absence such as security services (EFQM, 1993)
Intimate	Personal needs which can be met only by individuals for individuals (Walsh, 1991)
Fluctuating	Demand and supply are variable (Walsh, 1991); slack inevitable to user and/or producer (Handy, 1995)
Latent	Sold before consumed (Morgan and Murgatroyd, 1994); expanding a service is difficult due to time lag of the components (Walsh, 1991)
Labour intensive	By both provider and user with no overt management control of user component (Haywood-Farmer, 1988); characterised by high-volume throughput, processes and procedures increasing opportunity for error (Deming, 1982)

Table 4.5 The characteristics of a service

Apart from labour, documentation, environment and perhaps supporting equipment, services are intangible and it can be appreciated that dissatisfied customers will focus on these indisputable tangible features in their comments, both positive and negative.

The service industry requires staff to deal with the objective need as well as the personality of the customer. This is not only psychologically demanding but success through customer satisfaction relies heavily on the relationship developed between them (Pritchett, 1991), satisfaction being largely influenced by the interaction (Conway and Willcocks, 1997). In healthcare, such satisfaction has an additional and positive psychological effect which, in turn, can have a positive effect on physical health, maximising outcome.

Heskett (1986) has noted a perverse relationship between perceived quality and service utilisation. Clark (1989) provides the example of the leisure industry where there may be a perception of low quality when a service is under-utilised (a half-full theatre or restaurant), is maximised at 75–80% capacity and deteriorates again beyond that, reflecting a difference when a *social element* is added to leisure or health needs. This would include the value of human interaction at an intensity that individuals find acceptable; an empty shop may make some customers feel self-conscious and others able to search more freely; a crush at sale time may physically prevent some customers making a purchase, but others are stimulated by the atmosphere to spend more. These measures may have become almost indistinguishable from the primary goal (a purchase) but become established by users as a measure of satisfaction of the total event.

The service is also likely to be one in a series from the supplier, multiplying the interaction potential for concern or satisfaction, with choice or expectation strongly based on the *initial* contact. Ultimate satisfaction is based on the total experience – failure of any part of which affects the whole. The focus for investment in customer care training being almost infinite. In view of these complex characteristics it is not surprising that Zeithaml et al. (1990), confirming the findings of Gummesson (1989), noted that the literature on quality is almost exclusively devoted to tangible goods.

When a service is sought, it will be expected to meet a need, as a tangible product would, but its intangibility produces different success markers. For services, similar expectation criteria to tangible products (convenience, control, choice, effectiveness) exist. However, effectiveness of the service cannot be guaranteed in advance and any subsequent mismatch between expectation and result can be due to inappropriate choice or failure to note instructions on participation.

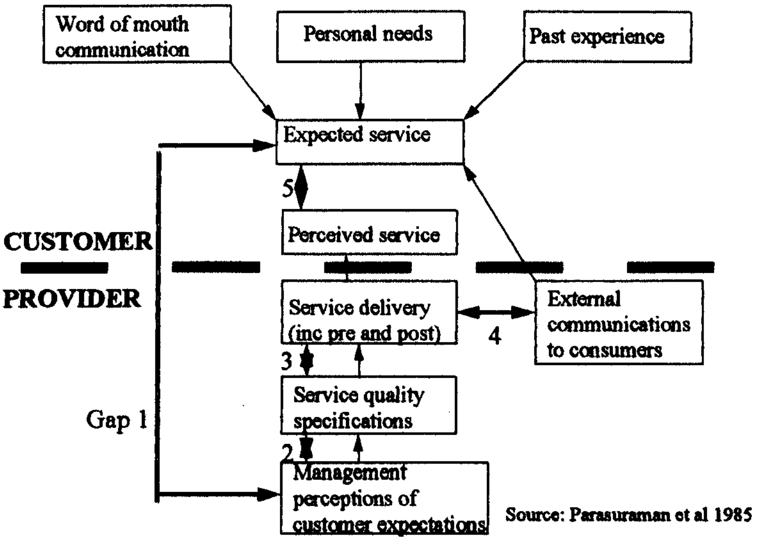
To gain an understanding of the criteria used by service customers to measure satisfaction, Parasuraman et al. (1988) developed the SERVQUAL tool based on an extensive study of customer/supplier interactions. Parasuraman et al. (1988) found that the ranked criteria used by customers, regardless of type of service, were:

- reliability (32%): perform service dependably and accurately
- responsive (22%): helpful and prompt service
- assurance (19%): knowledge, courtesy, trust and confidence
- empathy (16%): caring, individuality
- tangible (11%): appearance of buildings and equipment.

Poor quality was similarly ranked so that reliability was the most negatively ranked when absent (Zeithaml et al., 1990). The model has been used in the NHS by Youssef et al (1996) who found reliability and assurance to be the most critical feature, and the feature with which users were most disillusioned. What is particularly interesting from these lists of general characteristics and sought qualities is their *differences*. For example, reliability, the most important quality and the one that gives highest dissatisfaction when not met, is difficult to secure from a service that is by definition intangible, heterogeneous, fluctuating and labour intensive. Assurance against prescribed standards also fits uncomfortably with an intangible, heterogeneous, inseparable and invisible provision; autonomy guided by protocols would be more appropriate, but may have been outside the concept of respondents at the time of the Parasuraman et al survey (1988). An important difference between the Garvin (product) and Parasuraman (service) measures is the addition by the latter of empathy which is consistent with the interpersonal characteristics of services.

To address the potential mismatch between expectation and perception Parasuraman et al. (1985) have developed a conceptual model for service quality, identifying potential gaps in the process, their causes and proposed solutions for their improvement (Fig. 4.6).

Public Service Quality Model



Source: Parasuraman et al 1985

Gap	Explanation	Cause	Solution
1	Management perceptions	Management do not understand correctly what customers expect from the service	Marketing
2	Service quality specification	Not translating knowledge of customers' expectations into service quality specifications, standards and guidelines	Service design
3	Service delivery	Guidelines or specifications for service delivery are not adhered to	Human resource management, training and development
4	External communications	Failure to communicate effectively to customers about the service	Public relations
5	Customer expectation/ perception gap	Customer expectations based on word-of-mouth, need and past experience and related to the five criteria	Understand expectations

Fig. 4.6 Service quality model. (Source: Parasuraman et al 1985)

The information provided by this model identifies the need for information and understanding, but appears to focus on management and customer, excluding the staff who deliver the product or service. Gap 5 provides a particular opportunity not only to understand the gap between customer expectation and perceptions but also to act on the information, which was not noted by Parasuraman et al.

Cronin and Taylor (1992) criticise the service quality model of Parasuraman et al. on the basis that there is little research on causal link between quality, satisfaction and purchase intention with satisfaction likely to be influenced as much by the transaction as the product/service. The exchange process in services remains far from clear.

Once the requirements of a unique service are known, responses can be specified and implemented. The resulting perception of the service is again compared by the customer with their expectation to give a satisfaction value. This process for quality improvement by specification, monitoring and review should be continuously repeated to maximise mutual satisfaction (Agar, 1986). Rectification of a poor service can improve its quality rating above the norm, so that identification of problems and their resolution can be productive.

Parasuraman et al. (1985) described service quality as undefined, unresearched, elusive, not easily articulated by the customer and not easily measured. When these services are provided by members of the learned service professions (law, theology and medicine) their autonomous status (Section 1.5, Chapter 1) complicates adherence to specifications. This increases the difficulty of quality assurance, although there is considerable opportunity for quality improvement.

When quality management occurs within the public sector, problems described above are magnified (Pfeffer and Coote, 1991) partly by the involvement of a third party to ensure public accountability, partly by other sins of public sector management (section 3.2.1, Chapter 3), and partly by the additional sin of ignorance. These elusive elements within the complex area of public services are only just beginning to be explored and this research will expand the sparse literature.

4.11.3 Public service quality

A public service is an end-product, not the means of selling, delivering or enhancing a product for profit, although service providers may have vested interests in maximising demand for such reasons as status, job protection and, in some cases, overflow to parallel private work. Users and providers generally do not have the power of information to specify, or direct financial transaction to regulate, supply and demand. Clark (1989) feels that this mismatch between supply and demand epitomises many public services, leading to frustrated customers and demoralised employees.

Pfeffer and Coote (1991) are among the few who have extended the quality debate to welfare systems. Their concern is with the lack of consensus by participants on the meaning of quality in a given situation and the uses to which different views can be put (Fig. 4.6). Of particular note is the potential separation of views of the three key stakeholders within this model, further strengthening the need for collaboration. To reduce the likelihood of such divergence this author has added a category of an "inclusive view", where there is mutual desire for satisfaction; agreed choice of topics for evaluation; and a shared approach to improvement.

Traditional view	Prestige and advantage; class origins such as reference to the upper class as "The Quality"; excludes equity – the cornerstone of welfare
Expert view	Standards set by experts; supporting evidence may be sparse
Management view	Desire of managers that customers are satisfied; topics chosen to meet management needs; quality assurance may be unilateral
Consumerist view	Desire of users to be satisfied; topics chosen by users

Inclusive view	Mutual desire for satisfaction; agreed choice of topics for evaluation; a shared approach to improvement

Table 4.6 Differing meanings of quality

(Adapted from Pfeffer and Coote, 1991)

In addition to the features of generic services (see Table 4.5), the characteristics for public services have been summarised by Collins (1991) as standardised, compulsory, diverse, constrained, monopolistic and imbalanced in power. Collins fails to note the dependency created by public provision (Strong and Robinson, 1990), or the fundamental difference between public and commercial services in that the *relationship between satisfaction and efficiency are reversed.* In the public sector, increased satisfaction does not increase efficiency through profit (Pfeffer and Coote, 1991) and may increase demand and result in reduced quality. In Collins' defence, his paper was written from a Police service viewpoint where dependency on Police intervention in crime may be encouraged, although personal dependency for crime prevention should not. The issue of satisfaction is also unique in that even less people than in healthcare actively seek the reactive part of the police service, satisfaction being a very challenging concept for an apprehended individual.

These complex characteristics of public services, enhancing the work by Collins (1991), are shown in Table 4.7, complementing and expanding the "sins" of public sector management already described in Chapter 3 .

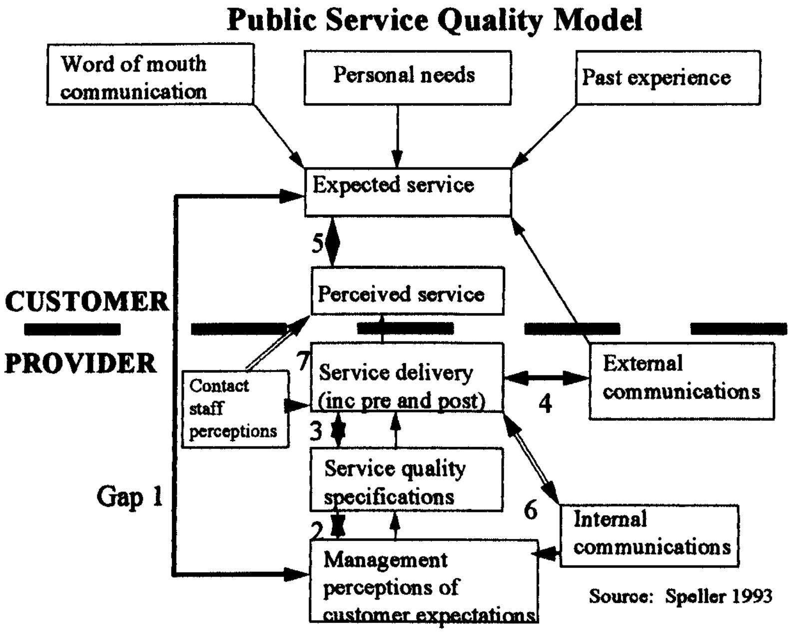
Standardised	Often at lowest acceptable level to meet all contingencies within resources
Compulsory	May be necessary for personal or greater social benefit
Diverse	Absorption of incremental demands, unclear purpose
Constrained	Budget centrally set in competition with others; scope limited, short-term vision
Monopoly	Historically/legally no other provider
Power imbalance	Provider supremacy through knowledge and discretion; user experience of routine services
Economic imbalance	Satisfaction and efficiency are reversed.
Dependability	Dependence on provision rather than own resources

Table 4.7 Characteristics of public services.

(Adapted from Collins, 1991.)

The managed market in public sector services introduces a third player, the purchaser. The requirement overtly to match information, need and supply is essential for mutual satisfaction. The opportunity, through this research, to explore and resolve such stakeholder diversity in healthcare to maximise mutual satisfaction was timely.

Speller and Ghobadian (1993) have enhanced Parasuraman's five-gap model for services, referred to above, for applicability to public services (Fig. 4.7). They have identified two additional gaps based on the need for a seamless service and responsive providers which could begin to rectify problem areas.



Gap	Explanation	Cause	Solution
6	Internal communications	Failing to listen to contact staff about what the customers think of the services delivered	Staff communications, human resource management.
7	Contact staff perceptions	Failure to empower staff and train them in delivering service to customers	Human resource management, training and development

Fig. 4.7 Conceptual model of public service quality. (Source: Speller and Ghobadian, 1993.)

The additional information provided by this model (gaps 6 and 7) promotes the concept of staff who deliver the service as integral to the process, requiring appropriate management, training, development and facility for participation in comprehensive communication. This reflects the Juran approach to Total Quality Management where quality is intrinsically linked with every stage of the business process.

4.12 Conclusion

The concept of quality, through information, need, choice and satisfaction, is widely discussed but marginally understood. It is evident that a hierarchy of need exists, the most basic needs always requiring satisfaction whatever level of sophistication the service has reached. Although the needs of most healthcare users remain basic, those of actively developing professional providers tend to escalate, risking a satisfaction gap. Where providers can focus their responses on expected needs that demand wanted responses, satisfaction will be maximised and quality management said to exist.

There is public pressure to change to a more responsive public healthcare model which, in the UK, has introduced a third party, purchasers, who have their own expectations. An opportunity exists to learn and adapt from other, more experienced sectors where CQI is emerging as an appropriate model incorporating the dynamic needs of all stakeholders for mutual satisfaction. Such a proactive approach secures market position, motivates employees, may enhance patient outcome, and attracts clinicians' attention by encouraging quality improvement through autonomy.

Where stakeholders interests differ, understanding the viewpoint of others provides a platform for synergy and a clarification of direction (Williamson, 1992). This includes evidence-based criteria and procedures allowing for provider autonomy in selection of response for unique situations; at the same time this ensures consistent procedures within the response as well as consistent responses in similar situations.

This chapter has begun to provide the theoretical background to the subject of quality as a contribution to answering the questions raised in Chapter 3.

- Can an effective CQI model for healthcare be identified, or developed, and evaluated which incorporates Juran's approach and the needs of local key stakeholders?
- Can local organisational change within the NHS be improved by learning from the lessons of change theory and national implementation of the reforms?

Chapter 5
Quality in public healthcare: stakeholder perspectives

5.1 Introduction

This thesis has established that delivery of healthcare is not immune from general influences for change. The NHS has responded to these influences by providing the incentive for the service to be more responsive to patients' needs through a market culture. To maximise business success, consideration should be given to the needs of key stakeholders – users, providers and purchasers. A quality improvement approach to identify and meet these comprehensive and changing needs through participant involvement was identified as an appropriate model in healthcare. This would incorporate established professional autonomy to meet unique healthcare needs and facilitate commitment through participation of the affected.

At a deeper level of enquiry, the detail of quality requirements was investigated. This revealed that experiences that are wanted are *expressed* and on a platform of silent, expected needs, which are *basic*. The content of these needs is developed by individuals and groups from a range of past experiences for particular circumstances, resulting in both generic and industry-specific requirements. Excitement may be experienced when unanticipated needs are satisfied in addition to those regarded as basic and expected. The previous chapter concluded that the expectations of different stakeholders within a specialised industry needed to be probed if the goal was to be mutual satisfaction.

The unanswered questions that remain to be explored in this research are:

- **Can an effective CQI model for healthcare be identified, or developed, and evaluated which incorporates Juran's approach and the needs of local key stakeholders?**
- **Can local organisational change within the NHS be improved by learning from the lessons of change theory and national implementation of the 1990 reforms?**

This chapter reviews the concept of quality in healthcare and the expectations of the three key public healthcare stakeholders – users, purchasers and providers, as a further contribution to answering the first question.

5.2 The concept of quality in public healthcare

A definition clarifying the meaning of quality in healthcare has been the "Holy Grail" for many and Ovretveit (1992) describes quality in public heath care as:

> ". . . fully meeting the needs of those who need the service most, at the lowest cost to the organisation, within limits and directives set by higher authorities."

This incorporates goals, cost-effectiveness, priority, constraints and, assuming that "fully meeting" incorporates knowledge, competence and availability, is a concise and comprehensive definition which has become widely used in the NHS.

All stakeholders in healthcare will have overt expectations, which are not necessarily similar. Because stakeholders are inseparable in provision of a service (see section 4.11.2, Chapter 4) any divergence between expectation and satisfaction of any stakeholder will contribute to mutual dissatisfaction.

5.3 Stakeholders' perspectives

Stakeholders have already been defined (see section 3.2.3, Chapter 3) as:

> ". . . all those who have an interest, whether financial or not, in the organisation's activities and performance."
>
> British Quality Foundation (1996)

Ovretveit (1992) categorises the main interested parties in public healthcare as users, providers and purchasers, each having the possibility of subgroups, depending on the circumstances.

It was explained in Chapter 4 that all individuals have generic needs. Such individuals also have service-specific needs. For example, in healthcare, participants will have generic service needs and specialised healthcare needs, in addition to those for their user, provider or purchaser position. The last are not naturally consistent between groups, but the strong and essential interrelationships between the stakeholders in healthcare, particularly patient and provider, adds an imperative for them to agree basic principles to achieve mutual satisfaction. Individuals also have various and multiple stakes in the service with additional needs that accompany those positions

These generic, service specific and stakeholder needs will be further subdivided into basic, expressed and unanticipated, further complicating the picture. This complexity of the concept of quality in healthcare is reflected in the sparse literature. This results in poorly understood cause of dissatisfaction and risks inappropriate resolution. A review of available literature for each group follows.

5.3.1 Users

> "What clients and carers want from the service (individuals and populations)."
> Ovretveit (1992).

Although only a small percentage of the population use the health service at any one time, availability is of interest to all – the public in general, users and their carers. Ovretveit's definition excludes referrers, who in the author's opinion, are also users, and a section is added for them.

Irrespective of these user categories, Herzlinger (1997) draws attention to the knowledgeable, energetic, financially secure, health-promoting health activists. In the USA, such individuals are undertaking or commissioning database searches on their health topic of interest. Their aim is to confront providers on a more equal, and in some cases superior, knowledge basis. This can feel threatening to staff (Berwick et al., 1992) who traditionally assume a superior position, although it has the potential for mutual benefit through partnership.

The public

In general, the (British) public are poorly informed on healthcare issues (Strong and Robinson, 1990); their beliefs have been influenced by experience, hearsay (WRHA, 1991) and the mass media (See Chapters 3 and 4). The history of the British health service (see section 1.5, Chapter 1) from charitable to welfare provision, through a strong medical model and within a culture of deference to authority, encouraged by providers, has largely contributed to this situation.

The influence of the mass media results from the custom that can be gained from crisis (Dickson, 1991). This results in human stories, most of which are superficial, short-lived and in general magnify rather than create public concern over real-life failures. The popularity of televised medical documentaries has resulted in fictional serials which give a:

> ". . . distorted, sanitised version to up to a quarter of the population confirming popular conceptions of the NHS as a good thing run by good people with a sense of permanent crises and inevitability that there won't be enough money."
>
> Butler (1995)

Recent research of such televised medical fiction has compared depicted survival after life-saving resuscitation as 77%, with that in real life of is 25% (Hall, 1988), creating a real-life expectation gap.

A literature search has shown that the public appear to have *basic* needs which can be categorised as follows and which become *expressed* when a response is wanted as personal needs become threatened:

- **Availability**: presence of medical care resources; accept that resources are limited, affecting decision-making (Hopkins et al. 1994) – for others.
- **Environment**: comparison with standards and amenities experienced in other (private) services such as banks, bakeries, restaurants and hotels (Vuori and Roger, 1989; Ellis and Whittington, 1993; Brindle, 1994), particularly convenience, control and choice (Herzlinger, 1997).
- **Finances:** investment in healthcare – but vote to pay less tax (Allsop, 1993); effective, rather than necessarily *cost*-effective, treatments.
- **Scope:** might or might not be expected to include those who pursue activities that push the boundaries of life beyond reasonable limits (Rivett, 1998) without enhanced contribution.
- **Preservation:** of services and particularly premises that they or their family subscribed to build, for example, the rural Cottage or War Memorial Hospital (Banyard, 1997), which the community feel should be retained irrespective of inefficiencies.

The unexpected but exciting needs include:

- **Technical advancement**: irrespective of quality of life.

Patients

Defining healthcare recipients as "patients" is regarded by Herzlinger (1997) as a bad start to consumerism. The historic definition refers to endurance, tolerance and understanding, in addition to a person "receiving" rather than participating in their medical care (*Collins' Dictionary*). All these definitions place the subject in a dependent, powerless position, but continue to be used in the absence of either change in healthcare culture or adoption of more appropriate terminology.

Short-term patients, both elective and emergency, represent the majority of healthcare episodes, although not the greatest costs. Such transient use weakens interest and influence; it is the area most likely to be compared with the private sector; and incorporates mainly reluctant users – avoidance of ill health being the norm. Long-term patients represent the greater comparative cost resulting from the content and especially duration of their episodes; they and their carers are the most knowledgeable about their condition and the service, but their consumerist power is weakened by physical dependence and smaller numbers. The few unrepresentative complex patients raise the most interest amongst providers.

Media interest also varies between the groups, predominantly highlighting *success* in the complex and short-term and *scandal* in long-term services. Injustice is particularly felt when it is believed that basic human need could be, but was not, met (Doyle and Gough, 1991),

Patients, as a subgroup of the public, generally see healthcare as an art (Neuberger, 1993); they are experts in assessing human and social qualities (Haines and Iliffe, 1993), and have undertaken many of the routine caring, domestic, home-making and organisational tasks that they will assess others performing with an experienced and critical eye; they are also the least satisfied with cleanliness (Hardy and West, 1994). The state of the non-staff toilet is frequently viewed as an indicator of management performance (Chadda, 1994).

Maxwell (1984) conceptualised six dimensions of healthcare, which have traditionally been *basic* needs, as follows:

Accessible	Overcoming boundaries of geography, money, time, age, language, etc.
Relevant	The match between the communities' patterns of disease or handicap, and the service given
Effective	Optimising the prognosis for the individual patient
Equitable	Fair allocation between patients or communities
Acceptable	What the consumer thinks about the manner of care
Efficient	The lowest unit cost per unit of output.

These are fast becoming *expressed.* Ware and Davies (1983) particularly emphasise the importance of the "interpersonal" component of acceptable service delivery. The remaining two (relevant and equitable) are particularly pertinent to a welfare system and will probably only be *expressed* if the threat is perceived as personal.

The interpersonal component

Interpersonal senses are heightened in illness (Ovretveit, 1990) and the need for interpersonal satisfaction increases with the use of technology within care (Albert, 1989). The subject usually features strongly in any patient survey on human services. The interpersonal component includes the way in which providers interact personally with patients, particularly their:

- **attitude** (Donabedian, 1980; Enthoven, 1988)
- **information** on treatment and risks (Hopkins and Maxwell 1990), options (Lawrence, 1992), choice (Seedhouse, 1995), and consent (Rigge, 1997)
- **adequate time** with provider (Lawrence, 1992)
- **individualised attention** (Calnan and Cant, 1993)
- **involvement as partner** (Patients' Association, 1995) on discharge (Hopkins and Maxwell, 1990; Lawrence 1992; Hopkins et al. 1994) and other decisions (Hopkins and Maxwell, 1990)
- **consistency of message** (Calnan, 1987).

Every interpersonal contact has the potential for concern or satisfaction; each also influences subsequent contacts by revising the expectation baseline (Dickens, 1995) (see section 4.5, Chapter 4). The policy to increase community-based care will have particular consequences for the interpersonal skills of staff, who will increasingly work within the *patient's* domain and expectations.

The experience of this provider/patient interaction can be shattered in a number of ways, for example, the values of the patient are assumed by staff (Robinson, 1978) and vice versa (West, 1988), based on their own personal values (Avis, 1992). Consequently, staff overestimate the importance that patients put on continuity and waiting time, and underestimate the knowledge wanted, the location and dietary aspects (Donabedian, 1980). There is often little agreement on problems (Uhlman et al., 1984) and priorities (Calman, 1987).

It appears from the sparse literature that UK healthcare patients increasingly value and expect services that offer high, non-technical attributes, that is, a *social* model of healthcare. In the absence of more meaningful measures of success, patients apply proxy social and tangible measures, such as short waiting times and more quantity (Hopkins et al. 1994), the last developing in tandem with commercialism, but without the accompanying investment.

Context of care

The context within which care is delivered must also be considered. In a public system, humanity is sought whereas those seeking private care appear to want continuity, fast access and technical quality (Ware and Davies, 1983). Within the British system, NHS users choose the private sector for elective, routine care, the power of payment in such circumstances may assure acceptable attitudes, continuity and access. Citizenship rights to the NHS are retained, particularly for GP and emergency services, and consequently compared.

It is unclear whether satisfaction results from provision or the *tone* of provision. It would seem probable that tone, and therefore the interpersonal component of an interaction, is dominant. Technical quality is commonly assessed by proxy social measures, although it seems that there has been a *lack* of correlation with the technical quality of the actual care given and interpersonal satisfaction (LeBow, 1974; Locker and Dunt, 1978). High-level interpersonal skills may cover up poor practice and vice versa.

Cohort and care groups

Within generic and specialised healthcare needs, there are those of particular cohorts (people having a personal characteristic in common) and care groups (people with a health need in common). Entry into a cohort is usually insidious, for example, by age.

Older people were the subjects for implementation of this research, and in such a cohort Cornwell (1989) found that co-ordination of multi-agency/multi-service healthcare, consistency of message and empathy were sought. Partridge et al. (1991) found that the same group also sought someone who listened and took account of individual perceptions and family dynamics, confidence in the treatment, individualised delivery, continuity of the carer and making the patient feel at ease. Luker and Waters (1993) found that explanation, undisrupted routine, slow pace and individualised care were sought. Most of these are *expected*, perhaps due to the characteristics of the cohort described. The needs of other cohorts may differ and might also be more clearly *expressed*.

Entry of individuals into a care group will, in general, have been overt and result mainly from functional needs; their expectations are therefore more likely to be focused, expressed and gaining support from peers. An example of the needs of a care group are those used for this study, patients who seek chiropody. This group have an expectation of life-long treatment, including nail cutting (Jay, 1987), by competent staff with good social skills (Hares et al., 1992); with the health gain objective of comfort in wearing shoes (Kemp and Winkler, 1983), reducing foot pain (Jay, 1987) and improving mobility (Cartwright and Henderson, 1986).

Members of cohorts and of care groups may be combined into a powerful force that have achieved national and charitable status, are financially secure (often through government grants which *can* be a threat to independence), may have political and media support, and can run sophisticated campaigns to get their needs recognised. For example, older people who are chiropody care group members through support from the charity, Age Concern England, succeeded in getting government endorsement of social nail cutting (NHS Executive, 1994).

Rich data for improvement in health services could be gleaned from observing and understanding the expectation setting process that all users go through at each contact in each stage of their healthcare episode. The problem is in the identification of the dynamic non-clinical needs of specific groups in unique, often intimate, situations, how they are measured, and what weighting they apply. This is at present in its infancy compared with food retail, where customer characteristics are monitored via credit and debit card purchases and shopping behaviour recorded on video. Both are used by retailers to improve understanding and responsiveness.

Carers

Unpaid carers are an increasing part of the unit of care both for the ageing population and for people of all ages with disabilities. Some have anticipated their role (caring for ageing parents, fostering disabled children), but some have not (caring for a partner or child with disabilities). Surveys have consistently shown that carers are predominantly women over 50 who are married, with some caring for more than one dependent. Changing employment circumstances are likely to affect the gender of carers as work traditionally undertaken by women increases in demand and that by men decreases, leaving some available for care duties; this has its own consequences, including experience of, enthusiasm for, and acceptability of, provision of personal care in some situations. Changing social expectations, particularly in a welfare system, are likely to change willingness to *provide* care. A change in style of provision, for example, grades of insurance premium or enhanced benefit, may encourage it.

Carers are becoming increasingly assertive in their service demands, which many find easier to make on behalf of a third party in a welfare system. If this expressed need is added to that of the local or national group representing those for whom they care (for example, people with multiple sclerosis), the pressure for a response can be substantial.

Carers basic, and increasingly expressed, needs include:

- **Information and advice** (Lewis, 1993).
- **Comprehensive response** through systematic patient-centred care packages (Lewis, 1993).

Carers expressed needs are:

- **Recognition** and response to the resulting personal, physical, psychological and social consequences of caring, wanting respite, information, physical help, money and continuity of contact (Anderson, 1987).

Referrers

As healthcare has become more formalised, specialised and complex, referral systems exist to enable access to appropriate skills. Registered practitioners of most disciplines are now legally autonomous and referral may occur freely between them. For efficiency and effectiveness, the scope of practice, referral criteria, agreed goals and progress reports from those to whom patients are referred are the minimum standard that should be expected. Although responsibility and accountability are integral to autonomy, referrers will increasingly wish to be assured of the competence of those to whom they refer their patients and whom they may employ; this will be particularly important where known providers have been replaced as a result of competitive tendering.

The 1998 NHS reforms give funding and referring responsibility to primary care groups, the key medical and nursing members of which will carry a caseload and listen to patient preferences on a daily basis. They will influence placement of business accordingly. Health Authority commissioners have been too far removed from this valuable qualitative intelligence, relying, to the potential detriment of the service, solely on quantitative evidence, unrepresentative anecdotes and complaints. These qualities that referrers expect of their providers are encompassed within the Maxwell six dimensions above, and will be more likely to be *expressed*.

It would appear that, overall, users are ambivalent in their expectations, for example, supporting services under threat as well as seeking change. The issue at stake appears to exemplify the public sector sin of reluctance to abandon programmes (Drucker, 1980), in this case as users (see section 3.2.1, Chapter 3), and that, in the absence of other quality markers, more means better.

5.3.2 Providers

> **"Whether the service meets needs as defined by professional providers and referrers, and whether it correctly carries out techniques and procedures which are believed to be necessary to meet client needs"**
>
> **Ovretveit (1992)**

This definition incorporates two issues – doing the right thing, and doing things right – both of which are strongly influenced by the view of the *provider*.

Doing the right thing

Normative need in healthcare, is now widely accepted as

> **"The known ability to benefit from healthcare at reasonable risk and acceptable cost"**
>
> **Bowling (1991)**

To be able to do the right thing three basic issues have to be addressed: the need for consistency where evidence exists which can then be objectively audited; the flexibility of autonomy to differentiate between what is consistent with evidence, what should be treated on the basis of best practice, with decisions subjectively reviewed by peers; and the best use of skills to ensure cost effectiveness.

---Consistency where evidence exists

Common cause of variation in healthcare can be reduced by evidence based criteria for access and treatment. This approach can be compared with the quality control of materials entering the production line in manufacturing industry (see section 4.7, Chapter 4). Such evidence will be developed through the work of the National Institute for Clinical Excellence (NICE) with monitoring by the Commission for Health Improvement (CHI). The risk is that QC and QA to meet set criteria will fail to excite professional interest for quality improvement.

There are also concerns by providers that litigation may be encouraged when more objective evidence is available with which to compare practice, resulting in secrecy and defensiveness (Morrison and Helneke, 1992), compromising a quality culture. At present, evidence is largely reliant on the Bolam ruling of peer consensus on actions in similar hypothetical circumstances (Dimond, 1998).

---Autonomy to differentiate and treat the unique

Although access criteria may be invoked, heterogeneous customers require the right response to their changing needs, rather than a response that meets static specifications. Providers therefore need the freedom to asses and re-asses the situation, identifying and treating according to the evidence or accepted best practice available, with the opportunity to continuously improve the response based on experience. This should ensure that there is consistency of response in situations assessed by the practitioner as comparative. Autonomous decisions can be subjectively reviewed by peers.

The lesser cause of variation in healthcare outcome can be attributed to idiosyncratic patient response (special cause) (see section 4.7, Chapter 4), the "raw material" being in various states of disrepair (Melymuka, 1991). Even in the most focused service, variation in patient response is likely to be higher than the 6–15% found in manufacturing (Donabedian, 1992). Attempts to accord some responsibility to the patient for his condition and recovery has, in the past, been regarded as "victim blaming" and socially unacceptable. Responsibility for failure in health now appears to be seen by the public as jointly shared between provider and the individual. When no evidence can be produced to support a decision, healthcare failure has been widely seen by users as provider incompetence (Robinson, 1978). In a fail-safe technological world, it is difficult for the public to think otherwise (Sewell, 1996).

---Cost effectiveness

Evidence, protocols and procedures resulting in a quality assured approach threatens those with previously needed higher, autonomous skills but offers opportunities to others. The reluctance that some professionals have in accepting the greater competence of other perhaps non-traditional but suitably qualified, cheaper and equally effective entrants has been discussed (section 1.4, Chapter 1). Skill review will not only be expected for cost-effective provision, but should also provide more satisfying work for practitioners which, in itself, positively influences outcome.

---Clinical audit

To audit the use of autonomy and implementation of evidence and skill mix, locally organised, topic-based clinical audit has been developed as a mutually acceptable method for review of practice. Clinical audit is defined as:

> ". . . a systematic process for improving clinical outcome by comparing what is done within agreed best practice and identifying and resolving problems in the service delivery process"
>
> Ovretveit (1990)

Generous government funding has ensured central accountability and local responsibility (Maynard, 1993). Maynard (1994) viewed the clinical audit experience so far in the UK as a poor result in terms of publication and implementation for the £213 million that had been spent on it between 1990 and 1994.

The issue of establishing the "right thing to do" is therefore complex. There needs to be the following: sufficient resources to undertake the work on research-based criteria and guidelines; invoking access criteria based on evidence of known benefit (quality control); collaboration between stakeholders to ensure that the "right thing" is also universally accepted and implemented (quality assurance); and an allowance for autonomy sanctioned by peer review within established limits to deal with the unique needs of individuals along with the drive to improve practice (continuous quality improvement); and ongoing skill review. Only when such measures are routine will clinical staff be open in their practice to the true spirit of a quality culture, and any blame apportioned fairly. Quality control, assurance and improvement can then work together, providing the best approach to quality management in a unique autonomous culture.

Doing things right

There has been far more attention to "doing things right" as established by the founders of the professions. Professions evolved through peer controlled entry to maintain such implicit quality (Okma, 1994). The range of values accumulated by members, are collated by this author in Table 5.1 (see also section 1.4, Chapter 1).

Clinical autonomy	Granted by society to act on intuition (Ellis, 1991b)
Mutual respect	Aspired to between professionals (Ewan, 1985)
Technical skill	Mostly unproved although much non-technical care occurs (Stocking, 1992). Mastery of the new clinical skills (Ellis, 1991b)
Legal practice	Within ethical boundaries (Ellis, 1991b)
Rewards	Remuneration, status and responsibility (Ellis, 1991b)
Altruism	Best interest of patient, although moving to protection of practitioner in the light of increased litigation (Ellis, 1991b)
Tradition	Founder effect of teachers, regulation, vested interest and rewards (*Editorial*1988), much being tacit, giving the impression of mystery (Sutherland and Dawson, 1998)
Patient survival	Despite the human inevitability of death (Ellis, 1991b)
Unconstrained	Rationing is unethical, micro-view (Pollitt, 1990)
Protection of status	Restrict competition from potential entrants (Ranade, 1994)

Table. 5.1 Accumulated professional values of clinical practitioners

The values of autonomy, mutual respect, technical skill, legal practice, just reward and altruism are values that *could* have wide stakeholder acceptance, provided that they were based on proven practice. Tradition, unconditional survival, unconstrained use of resources and protection of status are becoming outdated in the changing, competitive world and "will increasingly sound like the worn out arguments of yester year" (Nieuwenhuysen. J and Williams-Wynn, 1982). Achievers of, and aspirants for, professional status must continuously review their position in the light of research, education, legislation (Goode, 1969).

The basic needs of providers are:

- **Altruism:** best interest of patient.
- **Patient survival:** against the odds.
- **Technical skill:** sophisticated practice.
- **Individual health gain:** improvement in clinical condition as a result of intervention.

Their expressed needs are:

- **Autonomy:** freedom to act on initiative.
- **Unconstrained:** by policy and resources.

Their unexpected, exciting needs are:

- **Advancement** of provision and career through specialisation and recognition.

These needs parallel the career path of clinicians where, on qualification, basic needs are inherent; through ambition, more political needs are overtly expressed; with the goal of advancement through specialisation ahead. This in itself can be problematic, when unrepresentative but exciting conditions are pursued resulting in public demand (Ikegami, 1985). The way that these traditional values have been influenced through change is poorly understood and the result of a Kings Fund project to identify current values of NHS staff is awaited with interest.

5.3.3 Provider/user interface

Healthcare occurs in the presence of both provider and user. This will increasingly be through participation (Donabedian, 1992) as users become more active partners, either through empowerment or requirement, and as conditions move from acute to chronic, treatment from hospital to home, and responsibility from staff to family. It has been acknowledged that, since the openness created by the 1990 reforms, the expectations of NHS users have been raised by such participation (Department of Health, 1997), frontline staff feeling the gap most keenly.

The contact between these two key players forms a crucial part of the care process. The average patient in a general hospital has been found by Langan (1997) to come into contact with up to 47 different, mostly junior or student, members of staff, in a typical five-day stay. Each staff member potentially providing multiple contacts increasing the potential for concern or satisfaction (See Section 4.11.2, Ch 4). It is unclear whether this research included support staff who have a major, often unrecognised, contact, providing patient-sought added value.

In addition to the visible components, healthcare also has integral invisible and semi-visible processes. The quality of these contributes to the perception of the whole and to levels of satisfaction. Brooks and Wragg (1993) have provided a customer service blueprint comprising visible and invisible components. This is adapted in Fig. 5.1 for a notional health episode.

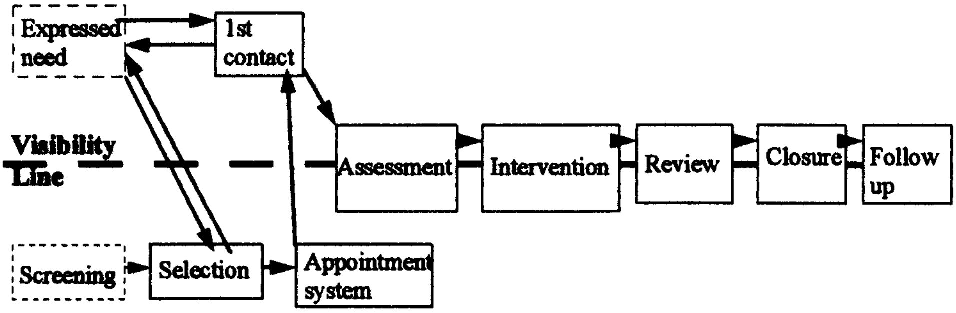


Fig. 5.1 Visible and invisible components in an episode of healthcare. (Adapted from Brooks and Wragg, 1993)

The flow shows the detail of the normative need or screened need process and starts with expressed need from which visible direct access or an invisible selection process results. The patient may be accepted or rejected by the service and may not even know that the process has occurred. The rest of the process is on the borderline of visibility; any stage can fall either way. It seems to this author that, in general, there has been a welcome move in recent years to have more visibility at every stage. This is a two-way process, with more assertive patients seeking visibility and responsive professionals wanting to provide it. There are, however, instances where invisibility is sought by the patient, for example, in denial of a malignancy, and by the provider, for example, dubious autonomous practice. There still remain too many examples where treatments, especially tests and medication, are undertaken without any explanation at all.

For assessment of satisfaction, participants need to have a baseline against which to judge the interaction. Walsh (1991) has shown how such knowledge in healthcare differs between user and provider, as well as types of services, being maximal where standards can be specified and understood (see Table 4.3, Chapter 4). Therefore the current work on improving delivery must be complimented by work on expectations if the satisfaction gap is to be minimised (Smith, 1999).

Unspecified services attract and attempt to meet the needs of clients for whom they were not designed (Ovretveit, 1992); consequently, they may disappoint those who had expectations of effective and efficient participation. The specification of services should be based on evidence, but the lack of evidence already referred to must result in more qualitative decisions. This lack of clarity on scope of provision is another public sector "sin" (see section 3.2.1, Chapter 3) and a particular characteristic of the NHS. In a move in the direction of "mutual knowledge", Johnson (1994) suggests that the current, more sophisticated patient expects an adult/adult relationship, with success most likely when both get a return from the partnership, for example, the patient receiving physical comfort and the provider professional satisfaction (Wade, 1995); or the excluded patient receiving a full and consistent explanation for the decision.

In the public healthcare sector, customer loyalty is a difficult concept. Where resources are based on history or need, not use, patient allegiance is either a disincentive to an overburdened service; or an incentive to keep the predictable and to exclude or queue the unpredictable. In such monopoly situations, voice may be the only option to record dissatisfaction (Pfeffer and Coote, 1991), demotivating providers and influencing the expectations of potential customers who have limited choice of an alternative and therefore arrive with biased expectations. Again, this is actually provider failure to secure resources to meet changing needs and/or to educate and specify the scope that can be provided within the resource. There is a risk of committing two of the Drucker deadly sins of public service (Drucker, 1980) (see section 3.2.1, Chapter 3): lack of priorities and reluctance to abandon programmes despite extinction of the original need.

Bennett offers a model for health services to understand the qualitative components of values that are part of any exchange – function (what it does) and symbol (what it means). The model shows that the functional aspects are about the *delivery* of care by specialist staff; the symbolic aspects are about the *process* of care, in general delivered by support staff (Fig. 5.2).

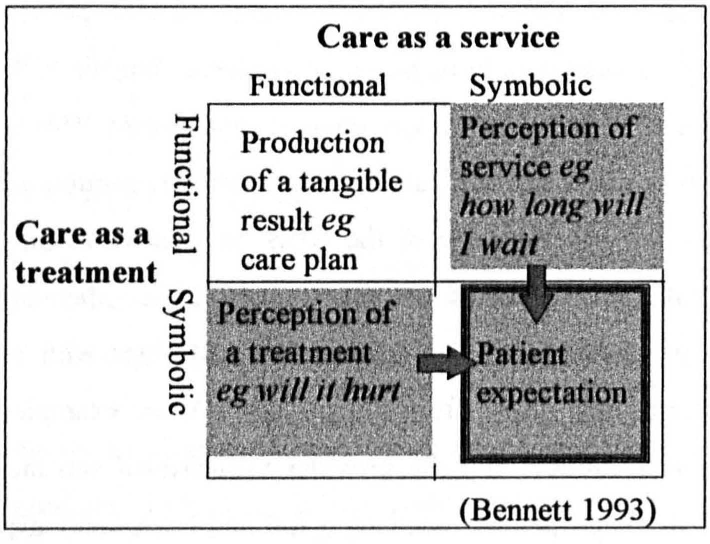


Fig. 5.2 Symbolic and functional values in healthcare (Bennett, 1993)

Bennett draws particular attention to the fact that three of the four boxes are related to symbolism, played down by traditional healthcare providers but a key to user satisfaction, especially when exceeded. A common example of symbolism in healthcare is where a medical consultation may be the necessary function, but the patient expects it to take place in an appropriate environment (a hospital) with a mature (male) doctor in a white coat accompanied by a (female) nurse, with measurement of at least blood pressure, plus a blood test and radiograph, and ending with a tangible product – prescription, appointment or piece of equipment.

5.3.4 Purchasers

> "The most efficient and productive use of resources, within limits set by higher authorities/purchasers" (Ovretveit (1992)).

Users in a managed market rely on the purchaser to ensure quality (Ovretveit, 1995), both non-clinical and clinical. Such purchasers may or may not have a clinical background. Where they are clinicians, they may have little or no accredited expertise in the field under review or will have only a rusty knowledge of the service (Pollitt, 1990). They will have been appointed on the basis of other skills, for example, knowledge of health policy, analytical skills, management experience and, particularly, the ability to make objective decisions based on the often poor evidence provided (Herzlinger, 1997).

In a quality-managed quasi market, the purchaser is responsible for ensuring that the values and expectations of the three parties are identified, understood and acted upon. Resolution will be needed between potential conflict of values. For example, the purchaser remit of cost-effectiveness will sit particularly uncomfortably with the user value of functional effectiveness irrespective of cost, and the provider value of lack of constraint.

Purchasers are more likely to pursue uncontroversial markers within safety, effectiveness and efficiency (Vuori and Roger, 1989; Stebbing and Dixon, 1992; Wilkes, 1993; Debrah, 1994) – a business model. Where purchasers have extended their vision to more qualitative measures, they will require the expert help of users and providers to synthesise dynamic and contextual expectations into prioritised, meaningful, acceptable, achievable and measurable quality standards. As has been noted, values and expectations are dynamic and contextual and their acquisition should be appropriate and continuously fed into the process for service improvement.

Basic needs of purchasers are:

- **Clinical and non-clinical quality:** provision within statutory requirements.

Expressed needs are:

- **Objective decisions:** based on indisputable fact.
- **Equity:** of provision on the basis of evidence and morality.
- **Resource constraint:** to meet central objectives.
- **Cost effectiveness:** to maximise value of the resource.

Unanticipated and exciting needs are:

- **Population health gain:** aggregated response to basic and expressed needs.

5.3.5 Purchaser/user interface

The main focus of the purchaser/user interface has been assessment of epidemiological need. This has often been undertaken in isolation by epidemiologists and statisticians based on their local interpretation of national mortality data, with which there are concerns for accuracy and appropriateness (Bowling, 1991). Planning services on morbidity data are of more value to service users, particularly as conditions move from acute to chronic. Attempts at undertaking more appropriate qualitative and quantitative assessments of need have been made, but are costly, lengthy and consequently inform subsequent plans, leading to dissatisfaction because user needs have by then progressed.

The 1998 NHS reforms (NHSE, 1997) intend a twofold effect in this respect. Primary care groups as planners will be able to complement epidemiological need with the qualitative information that they acquire from concurrent daily clinical practice. Members will then be in the unenviable position of advocating for individuals as clinicians but rationing for the population as managers. Progress on needs led planning could be compromised by replacement of the current annual contracts with ones for three to five years, the original data on need gradually becoming out of step with provision. The solution will be regular revision of specifications, with consequent transaction costs – which the government is at the same time committed to reducing. Innovative and cost-effective systems to meet these requirements will be in demand.

Complaints can be another source of user intelligence for purchasers. They are predominantly about provision, and therefore dealt with by providers, rather than about amount of provision which would be dealt with by purchasers. Health Authorities (HAs) are required to monitor the complaints of their residents. The annual report of the Health Ombudsman, to whom unresolved complaints can be referred, continually indicates that the vast majority reaching that level fall into attitude and communication categories, providing some opportunity for focused improvement through contract specification.

The heading of this section may be inappropriate in that inter*face* between current purchasers and users is rare. Few users access HA staff in person and, when the HA initiates public consultation, participation reflects experiences elsewhere in that audiences consist predominantly of elected public representatives and healthcare professionals. Tribal language between these groups may be disconcerting for any member of the general public present who feels excluded from a club that is determining their needs and how they will be met.

If the purchaser/user interface is to be a serious relationship, action needs to be taken to improve interface communication by mutual education and support. Such openness does improve confidence and therefore the likelihood of complaints (viewed by the managerially immature but influential levels of the higher echelons of the service as negative). It could also increase responsiveness, which, if more realistic measures than "waiting time" could be developed, could be used to balance the weight of complaints, for example, achievement of goals agreed between user and provider.

All of this requires commitment and resources, both of which could eventually be released from activity of unproven value. The pump priming investment to investigate the latter in order to achieve the former has not been, and seems unlikely to be, forthcoming, NICE being committed at present to consideration of *new* technologies. Such costs of quality (see section 4.8, Chapter 4) are rarely considered in healthcare, although the introduction of health economists and risk management will begin to focus attention on this issue and its causes, bringing pressure to bear on evidence-based practice, access criteria, policies, procedures, skill mix and audit.

5.3.6 Purchaser/provider interface

In a market system, there will be inevitable tensions between the cost, volume and quality components of healthcare commissioning of provider services, particularly where the last is unquantified (see section 1.10.1, Chapter 1). The main problem remains paucity of data and, even when cost and volume are explicit, it may be unclear what healthcare has been obtained (Gill, 1993), and to what effect. A common expectation is for measures of improvement. This is unrealistic in an ageing population with chronic conditions where meeting agreed goals – sometimes just to be able to cope with basic personal tasks in a deteriorating situation, or death with dignity – should be regarded as a positive outcome.

Managers rely on the ability of clinicians to prioritise, delegate, contain costs and prove effectiveness (Ewan, 1985). The development of collaborative (Shaw, 1986) and non-intrusive (Ovretveit, 1995) quality systems should ensure that arrangements are in place to audit such ability.

Patient-centred care

Patient-centred care is the objective of modern healthcare. It can be seen from the discussion above that the **B**asic, **E**xpressed and **U**nanticipated exciting needs of stakeholders (Chapter 4) tend to differ both in interest and level of need, compromising this objective. These are collated in Table 5.2 by this author where the numerous points of mismatch lead to potential dissatisfaction by the participants.

Users	**Purchasers**	**Providers**
Users: public		
Available (B)	Resource constraint (E)	Altruism (B)
Environment (B)	Quality (B)	
Finances (B)	Resource constraint (E) Cost-effective (E)	Autonomy (E) Technical skill (E)
Scope (B)	Cost-effective (E)	Autonomy (E)
Preservation (E)	Cost-effective (E)	Autonomy (E)
Technical advancement (U)	Equity (E) Resource Constraint. (E) Cost-effective (E)	Technical advancement (U) Carer advancement (U)
Outcome (E)	Population health gain (U)	Individual health gain (B)
Users: patients		
Access (B/E)	Equity (E)	Altruism (B)
Relevant (B)	Objective decisions (E)	Autonomy (E)
Effective (B/E)	Cost-effective (E)	Autonomy (E) Technical Skill (B) Individual health gain (B)
Equitable (B)	Equity (E)	Autonomy (E)
Acceptable (B/E)	Quality (B)	Survival (B)
Efficient (B)	Resource constraint (E)	Unconstrained (E)
Users: carers		
Information, advice (B/E)		
Comprehensive (B/E)		
Recognition (E)		
Users: referrers		
Access (E)	Equity (E)	Altruism (B)
Relevant (E)	Objective decisions (E)	Autonomy (E)
Effective (E)	Cost effective (E)	Autonomy (E) Technical skill (B) Individual health gain (B)
Equitable (E)	Equity (E)	Autonomy (E)
Acceptable (E)	Quality (B)	Survival (B)
Efficient (E)	Resource constraint (E)	Unconstrained (E)

(Key: B = basic, E = expressed, U = unanticipated)

Table 5.2 The challenge of generic patient-centred care.

This comparison indicates that, in addition to potential dissatisfaction from differences, there are also omissions, particularly the soft interpersonal and environmental needs of users unmatched by providers; and the needs of carers unmet by health providers, although some will be more appropriately directed at social care providers. Similar problems of matching stakeholder needs to cohort and care groups over and above this generic health baseline can be anticipated and require consideration, if mutual stakeholder satisfaction is to be seriously pursued.

5.4 Satisfaction of patients, providers and purchasers

The purpose of a quality improvement programme is that it satisfies its stakeholders. Of the three main stakeholders in healthcare, the expectations and satisfaction of patients are the most sought after where they are usually measured at the interface between the ultimate user and end-provider. A mismatch between patient and provider on interpersonal needs has already been shown as a potential issue for dissatisfaction. Satisfaction of providers, purchasers and other users is rarely given consideration.

Little has been written on the concept of comprehensive stakeholder involvement. Ulrich (1987) is unique in emphasising that when quality tools have shown what is happening and management tools why, only stakeholder input can decide what if any change is needed. Satisfaction with delivery of healthcare is viewed by Ware and Davies (1983) as an ultimate outcome of healthcare along with health status; where satisfaction is a dependent variable, it reflects on structure, process and outcome of service, and as an independent variable it reflects on the behaviour of users. Apart from the commercial advantages, satisfaction can also facilitate the outcome of care.

5.4.1 User satisfaction

Patient satisfaction has been investigated by Sitzia and Wood (1997) through a comprehensive review of the literature which directed much of the following. The first consideration must be of what is being measured. The aspects of care have been described by Donabedian (1980) as falling into structure (the organisation), process (the treatment) and outcome (change in health status attributable to the structure and process). Patient satisfaction is largely sought on process, with a growing interest on their view of outcome.

Unfortunately, the concurrent view of the patient on the process of their care is rarely included as part of the clinical record (Donabedian, 1992) and may be an inappropriate intrusion at that time due to such factors as the urgency of the intervention, vulnerability of the situation and the patient's ability to respond at all. Consent to treatment, although implicit through voluntary and/or emergency participation, does not necessarily equate with satisfaction. Qualitative research methods, such as a diary record, could be an approach both acceptable to the user and illuminating to the provider, although few are recorded concurrently with the event and are fraught with subjective influences (Sexton, 1998).

Surveys which have tried to contemporaneously measure satisfaction have been condemned for the resources that they consume and the intrusion inflicted, but they have the potential to enable responsive change, likened to circular quality improvement in industry (as outlined in section 4.7, Chapter 4). Satisfaction is more usually sought solely as an independent and retrospective exercise open to contamination of responses by reflection and circumstance, and delaying responsive change.

There is widespread concern among clinicians that seeking satisfaction levels of patients will threaten vested interests, uncover widespread dissatisfaction, and be inappropriately undertaken and used. Although the former may well be warranted, widespread dissatisfaction is rarely found. The concerns over inappropriate methodology will be circumstantial and based on what is being sought and how. Attention should also be given to who is being asked, for example, the characteristics of respondents indicate that only age is a key influence, with older people being the most satisfied. In a UK context, it is not clear if this is a pre-NHS cohort effect, or part of the ageing process, but the former is suspected by Sitzia and Wood (1997) on the evidence to hand. As the "new" elderly will have no pre-NHS experience, the implications of future reduction in traditional satisfaction of this largest user group is an issue for serious consideration.

Another influence is the corporate image of the organisation as seen by the user (Dickens, 1995). This could be a particular concern in the NHS where a culture of denigration in the hope of additional resources has already been noted (see section 1.5, Chapter 1). Yet again, staff, particularly nurses, are seen as "angels", highly respected and, until recently, rarely criticised. It is at present unclear as to whether public reaction to strikes and protest marches will result in any change in support of this group, with a knock on effect on associated semi-professions.

Common influences on satisfaction are categorised by Brant (1992) as halo (happy as better), Hawthorne (getting attention) and helpless (grateful and vulnerable) although a true definition of the Hawthorne effect would have been change in behaviour as a result of the attention. Findings by other authors can be categorised under these three headings as follows

- **Halo effect**: happy as better and cannot find fault (Dickens, 1995).
- **Hawthorne effect**: got attention, (Rigge, 1991); want to please (LeBow, 1974); attention gained through the surveying process (Dickens, 1995).
- **Helpless effect**: grateful, fear retribution, dependent, submissive (Michie and Kidd, 1994); fear service withdrawal (Vetter, 1995); sympathy for staff and unwillingness to criticise "scarce" and "free" services (Allen, 1992; Dickens, 1995); staff overworked (Rigge, 1991); providers doing all they can (Locker and Dunt, 1978; McIver, 1991); low expectation (McIver, 1991); and unable to be more discriminating (Dickens, 1995).

Those most likely to be satisfied are:

- older people, women and those who are married (Beaumont, 1992)
- lower socio-economic groups (Calnan, 1987)
- minority groups (ethnic, social and physical) (Craig, 1990).

These characteristics equate with the least influential and those most in need and dependent on the service (Hardy and West, 1994).

Overall satisfaction with the NHS by users (Consumers' Association, 1995) and the population in general continues to be high (OECD, 1994). Satisfaction is greater for general questions (usually around 80%), lower for specific (Ware and Davies, 1983; McIver, 1991; Michie and Kidd, 1994; Dickens, 1995), (see section 4.11.2, Chapter 4) and least for management and organisation (see section 1.12, Chapter 1) but the gauging of satisfaction can be perverse. For example, new mothers were reported as happy with discharge after 24 hours – because the maternity ward was so appalling (Cole, 1994).

These examples emphasise the importance of sound methodology in seeking levels of satisfaction (Michie and Kidd, 1994), and that such surveys should not be used in isolation from other quality intelligence (Bruster et al., 1994) such as complaints and audit results. An interesting example of comparative intelligence is that, although surveys show that outpatients are more satisfied than inpatients, a review of complaints shows the opposite picture (Locker and Dunt, 1978), perhaps related to the less dependent outpatient feeling more free to complain.

5.4.2 User dissatisfaction

Although "voice" is virtually the only option for the dissatisfied in public healthcare (see section 4.6, Chapter 4), complaints reflect only the tip of the iceberg of dissatisfaction. For example, 40% of NHS patients have wanted to complain at some time, with only 4% taking action (Newman and Pyne, 1995), but probably all the dissatisfied relay their storey to at least ten other people. The reason why so many who are dissatisfied fail to complain is ascribed to perceived powerlessness, barriers (knowledge) and personal reasons (not a complainer, other problems) (Mulcahy and Tritter, 1994), and low expectation. It is unclear whether deciding to complain is (Cole, 1994; Williams, 1994) or is not (Mulcahy and Tritter, 1994) linked to the seriousness or consequences of the event. It appears that individuals have a personal tolerance level – the substance of the final straw probably being irrelevant.

The dissatisfied are disproportionately influential (Locker and Dunt, 1978) and those most likely to complain are:

- **higher socio-economic groups** with higher expectations (Calnan, 1987) and capacity
- **carers** (Allen, 1992) who will fight more for a third party than for self
- **young users** who are less tolerant (Craig, 1990)
- **those who were refused** what they felt was their right to expect (Scott, 1994)
- **those requiring complex interventions** (Hall et al, 1990).

The last issue was an unexpected finding because it could be assumed that complex need would have equated with dependence, and therefore satisfaction as above. The type of complexity might be the issue – acute or chronic – the former acting on their dissatisfaction due to the reduced likelihood of dependence and not worn down by experience; the latter through knowledge of what is possible.

The characteristics of the dissatisfied should be seriously noted because those within each group are all likely to increase in the light of demographic, epidemiological, social and political change. Of particular note should be carers, who will form a much larger part of healthcare provision within the policy of community-based care. They have little to lose and much to gain by their action, as opposed to relatives of traditional "in" patients who fear retribution.

Most complaints are about specific issues which a lay person can confidently relate to such as:

- **Interpersonal skills** (Darby et al., 1995) where a breakdown in relationship marks the limit of threshold of tolerance (Mulcahy and Tritter, 1994);
- **Misunderstanding**: more likely when services are not specified.
- **Patient/provider disputes**: resulting from a decrease in professional power and increase in patient assertiveness (Williamson, 1992).
- **Policy issues** (Beaumont, 1992), developed for, rather than with those affected
- **Interface discontinuity** in the "chain" of healthcare amounting to around 75% of complaints (McKenna, 1995).

Technical complaints have until recently been rare, but patients are beginning to use informed sources for advice and support to take their clinical concerns forward (see section 5.3.1 above). The 1998 reforms will ultimately make information on evidence based practice more accessible opening up opportunity for comparison and objective complaints.

The chain of care issue as a focus of complaint is of particular interest, not only because of its greater frequency of concern, but also because of the fact that the complete health and social care chain comprising an episode of care may be unknown to any one provider, and probably solely to the patient, with criteria of each aspect changing unilaterally with supply and demand. Even the recipient may be aware only of the visible components (see Fig. 5.1).

In 1992, the public healthcare complainant was reported as seldom wanting money but the truth, assurance of non-repetition of the unacceptable occurrence, disciplinary action for the culprit and therapy for results (Beech and Robinson, 1992), with 70% just seeking an apology (Ovretveit, 1992). The national change towards consumerism, the introduction to the UK of the "no win no fee" legal representation, reports of large settlements particularly in the United State and increasingly in the UK, and what has been described as the "lottery" temperament of those seeking to get rich quickly, are influencing such nobility of temperament.

Visible resolution of complaints can provide satisfaction; but continuing dissatisfaction if the resolution is not apparent (Audit Commission, 1993), emphasising the need for communication. For example, temporary service users may never experience the change that their complaint subsequently effected, and base their perception, which they communicate to others, on their original experience, unless they are informed otherwise. The Police Service have a similar problem in wishing to encourage opportunistic public reporting of crime and have instituted a feedback system on the initial result of the response to encourage continued public diligence.

Although complaints should be welcomed by management in a quality-conscious culture, repetition of the *same* complaint indicates ineffective resolution and should be a cause for concern. The focus of the dissatisfaction (individual, institution or system) must be clarified in advance of remedial action (Locker and Dunt, 1978; Foster, 1993). Processes and systems are the major culprits (Hall and Dornan, 1988) known to be the main cause of concern to users (see Chapter 3) and, as already explained, can be rectified and resolved by empowered workers locally. Whatever the cause of dissatisfaction, it sullies the whole as quality of care is viewed as a total experience (LeBow, 1974) by individuals, their carers and people with whom they communicate.

The simultaneous nature of healthcare means mistakes usually happen in the presence of the patient (Lin and Schneider, 1992). Although an immediate resolution may be wanted, thorough investigations into unique situations takes time. There is no reason why an immediate acknowledgement cannot be made, as indeed the 1991 Patients' Charter requires, with regular updating and a full explanation when the results of investigation are to hand. Peer review has traditionally played a large part in such investigations, but Herzlinger (1997) has added a word of caution because she describes the process as "group think which excludes deviants, however much their view is proven". This characteristic of established professions (section 1.4.1, Chapter 1) further explains the difficulty of moving provision from doing things right to doing the right thing (see section 5.3.2 above).

5.5 Responsibilities of patients, providers and purchasers

The previous section puts much responsibility on providers and purchasers to achieve patient satisfaction. Herzlinger (1997) has introduced the concept of stakeholder responsibilities in the delivery of the "new healthcare". In particular:

- **providers** should be customer focused, have effective systems, capitalise on the potential of IT for measurement and comparison, and provide services which are focused, efficient and ethical;
- **purchasers** should welcome innovation, and empower and audit their providers; and
- **patients** should be informed, assertive, promote their own health – and be good customers (courteous and prompt).

Most of these concepts have been noted in various sections above. Probably the most encouraging addition here is the need for patients to be good customers as their contribution to the new healthcare culture. This is a welcome change from the past context of behaving in a manner acceptable to a monopoly provider, to being an informed and equal partner. Such sentiments were included in the UK Patients' Charter, but have been weakly pursued in the culture of welfarism which expects a dependent patient but is experiencing an activist. It would seem that pressure *also* to be a good customer is not out of place, and expected in other industries, for example queuing at checkouts.

5.6 Total quality

The general factors resulting from the perspectives of stakeholders identified in this comprehensive review are that

Users are pursuing a social model---as a result of reluctant and deferent use; cohort experience; poor information; media influence; importance of attitude; and proxy measurement of non-technical aspects. There is an assumption of infallibility of the body/clinical care, the provider being blamed for failure.

Providers are pursuing a scientific model as a result of protection of professional values; and assumption of user values. Lack of evidence to support a scientific approach results in failure being blamed on the idiosyncratic user

Purchasers are pursuing a business model as a result of public service equity values; lack of clinical experience; and the drive for business success factors. The lack of evidence to support clinical practice leaves the purchaser reliant on provider autonomy.

These positions provide the ammunition for both healthy collaboration and unhealthy conflict. The former will ensure that the changing interests of the groups are represented, with participatory education and specification reducing the interface gaps over time.

Graham (1995) has traced a number of aspects of quality in healthcare in the USA over the last 70 years, including the changing views of stakeholders, noting the convergence towards total quality (Table 5.3).

	1920 Structure and outcome	1920–40 Process and structure	1940–60 Process and structure	1960 Process and structure	1970 Process and structure	1980 Process, structure and outcome	1990 Process, structure and outcome
Model	Professional	▨	▨	▨	▨	▨	▨
				Bureaucratic	▨	▨	▨
						Industrial	▨
				Regulations	▨	▨	▨
Measures	Implicit Peer review			Explicit Case review	Analysis	Patient satisfaction Quality of life	
People	Physicians are physicians, patients are patients			Physicians are vendors Patients are beneficiaries		Physicians are partners Patients are customers Evidence-based purchasing	
Quality definitions	Absence of defect	Minimum standard capability	Structural standards Capacity to give good care		Requirement	Expectation	
Public expectation	Other concerns		Growing interest	Increased expectations	Interest in accountability	Total quality	

UK position	1948–1960s			1970s	1980s	1980's	1990's Local QA/CQI

Table 5.3 Changing stakeholder perspectives in USA and UK healthcare. (Adapted from Graham, 1995)

Of particular note in Graham's model is that it can only be assumed to refer to the insured USA population, because the utopian vision of "people" as beneficiaries and customers in the 1980s and 1990s does not reflect the experiences of the 40% of US citizens who are uninsured. Although the USA system is fundamentally different in organisation, the similarities in the cultural development of the NHS are remarkable and a suggested chronological position is added to the Graham model (Table 5.3) and supported in Table 5.4 with reference to Appendices 2 and 3. Total quality is mirrored in the UK model by moving towards local QA and CQI.

1948–1960s	1946: NHS Act: a professional led structure and process model; deferent post war public culture; state registration of professionals; professional organisations promoting structure and process standards of practice
1970s	1973: NHS reorganisation: added bureaucratic layer 1976: Royal Commission: quality expectations defined: structure, process and outcome 1976: Resource Allocation Working Party: resources to be equitable 1978: winter of discontent, public began to take a critical interest
1980s	1982: Community Care Act following public concern 1983: general management to improve information, effectiveness, responsiveness and quality management (audit) 1988: winter bed crisis, public interest intensified
1990s	1991: NHS reform: managed market; patient satisfaction; quality assurance and TQM initiatives 1998: NHS reform: collaboration replaces competition between purchasers and providers and improved with other agencies, evidence-based planning replaces commissioning

Table 5.4 Changing stakeholders' perspectives in UK healthcare

This indicates up to a 10-year time lag in most areas, although outcomes were mentioned in the UK 1976 Royal Commission, but not noted in the USA by Graham until the 1980s. This 10 year time lag is consistent with other trans-Atlantic issues and provides the opportunity to learn from both successes and failures within the US experience, although little is apparent. For example, while the UK pursues an internal market and private provision of some services, the US makes proposals for a more comprehensive welfare system.

As the definition of total quality is that a corporate philosophy exists, and it is noted above that the US service is regarded by users as inequitable and inefficient, the position of total quality reported by Graham as having been achieved can only be viewed as ambition rather than actual.

5.7 Quality management

Both the UK and the US systems are having to respond to changing demands. Success in developing a responsive culture will centre on understanding and meeting not only the changing quality perspectives of each stakeholder, which have been outlined above, but also, in such a highly interactive service, their interface requirements. Figure 5.3 portrays these relationships and indicates that, when stakeholder needs are congruent, a continuous quality improvement service could be said to exist. Congruence will depend on equal partnership, reciprocal education, common assessment of need, shared information, mutual understanding, agreed values and clear specifications.

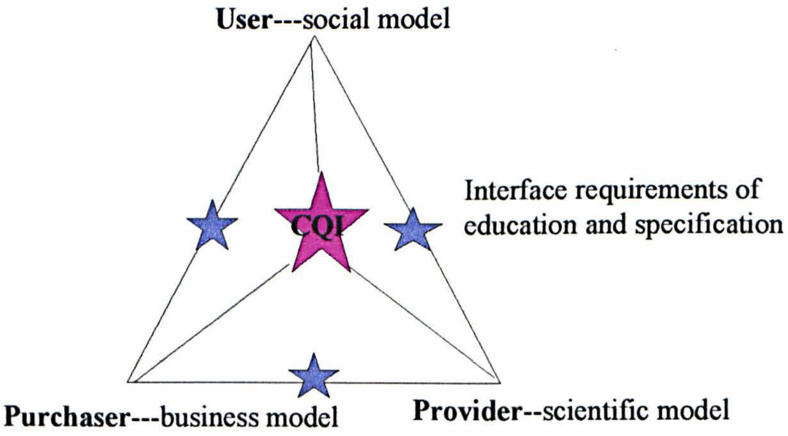


Fig. 5.3 A continuous quality improvement healthcare service

The introduction of management of quality through the philosophy of TQM in the whole NHS (see sections 3.5, 3.6 and 3.7, Chapter 3), at a time of fundamental organisational change and financial constraint, is now felt by many to have been a mistake. TQM is only cost effective in certain cultures (Pike and Barnes, 1996), and in general the culture of the NHS was felt to be unfavourable. The work cited earlier by Degeling et al (1998) showed that staff in adaptive, bottom up, NHS institutions were better able to negotiate convergence between clinical and management conceptions of issues, indicating that in some settings, the appropriate culture does exist (see section 1.4, Chapter 1).

Debrah (1994) maintains that in considering the national TQM initiative it would have been better to at least start with local programmes, perhaps addressing one service; CQI (TQM) for continuous organisation wide improvement could then have a launch pad, the programme being replicated to cover every action within every part of the organisation. Whatever the approach, the problem is still defining what constitutes quality in healthcare, documenting the criteria and measuring the results (Le Grand, 1994).

5.7.1 Theory into practice

As the local lead NHS commissioner, Barking and Havering Health Authority were required to pursue a quality management approach through commissioning and made funds available for the identification, or development, implementation and evaluation, of such a local model. This required background research into health and healthcare (see Chapter 1), change management (see Chapter 3), need, choice and satisfaction (see Chapter 4), and general quality in public healthcare (see above) to set the scene. The practical use made of this information in the development of a local CQI model for healthcare is developed in subsequent chapters.

5.8 Conclusion

It was explained in Chapter 3 that all individuals have generic needs. Such individuals also have service-specific and cohort needs and also various stakes in the focus service. In public healthcare clients are pursuing a social model, providers a clinical model and purchasers a business model. Within each group there are subgroups with more specific needs.

Misunderstanding of quality in healthcare results in dissatisfaction from poorly understood causes and risks inappropriate resolution. Understanding the potential mismatch in customer and supplier expectations is a crucial key to comprehensive satisfaction in any sector. It can be seen that there are potential differences at the interfaces between these three group which without congruence cannot provide comprehensive satisfaction. Such congruence is dependent on equal partnership, reciprocal education, common and dynamic assessment of need, shared information, mutual understanding, and agreed values and specifications. Although a national CQI (TQM) organisation was the vision to achieve these ends, local developments ultimately contributing to the whole is now seen as being more practical.

The first unanswered question raised through this preparatory work regarding identification of stakeholders needs can now be partly answered.

- **Can an effective CQI model be identified, or developed, for healthcare which incorporates Juran's approach and stakeholders needs?**

In part answer to this question: stakeholders' needs have been identified and CQI confirmed as an appropriate model in healthcare. As the local lead NHS commissioner, Barking and Havering Health Authority were required to pursue a quality management approach through commissioning which is developed in the next chapter.

The remaining questions are:

- **Can an effective CQI model for healthcare be identified, or developed, and evaluated which incorporates Juran's approach and the needs of local key stakeholders? (part)**
- **Can local organisational change within the NHS be improved by learning from the lessons of change theory and national implementation of the 1990 reforms?**

Chapter 6. A framework for the project

6.1 Introduction

Barking and Havering Health Authority was required by the 1990 NHS reforms to pursue local quality management through commissioning. Background research identified that continuous quality improvement (CQI) was an appropriate model in healthcare. This would facilitate full participant commitment, implementation of established best practice and incorporation of established professional autonomy to meet unique healthcare needs.

This thesis has so far established that the three main participants in a public healthcare market are purchaser, provider and user, and that each has different needs which, without congruence, cannot provide comprehensive satisfaction.

The questions being explored in this research are:

- Can an effective CQI model for healthcare be identified, or developed, and evaluated which incorporates Juran's approach and the needs of local key stakeholders?
- Can local organisational change within the NHS be improved by learning from the lessons of change theory and national implementation of the reforms?

This chapter completes the answer to the first question by the theoretical development of the Quality Synthesis Model. This occurred through an action research approach facilitated by the author for Barking and Havering Health Authority. The effectiveness of the model in practice is reviewed in Chapter 7.

6.2 A profile of the Barking and Havering Health District 1991

The London Boroughs of Barking and Havering lie on the east of the capital adjacent to the Thames and the M25 motorway (Fig. 6.1) and have a population of approximately 373,000. The boroughs were coterminous with the then Barking and Havering Health Authority (BHHA) and Family Health Services Authority (FHSA). These four agencies had divided the area into seven health service localities. During 1991, the Barking and Havering Unified Commissioning Project (UCP) was set up between the HA and FHSA as a special joint initiative to promote working relationships between the two authorities through assessment of population need and commissioning of appropriate services for the most vulnerable groups in the most deprived areas, focusing on the west of Dagenham.

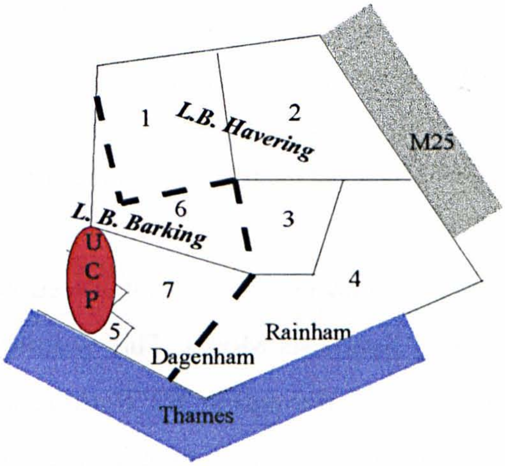


Fig. 6.1 Map of Barking and Havering, localities and UCP target area

The localities were developed in consideration of electoral wards for public health data availability, recognisable communities, current service provision boundaries and links with GPs and Primary Health Care Teams (Hamilton, 1992). A profile of the localities in 1995 is shown in Table 6.1, where those under four years of age made up 6.8% of the population, 65–75 year olds made up 9.8% and those aged over 75 years 6.6%. Of the total population, 4.6% were from ethnic minorities. Overcrowding, as proxy for deprivation, affected 2.6% of the population. Variations to the average that are of note are the following: the concentration of those aged under four years in locality 5; those aged over 65 years and deprivation in localities 6 and 7; those from ethnic minorities in locality 7; and greatest health needs in localities 2, 5, 6 and 7. The adverse health conditions were in line with the demographic and deprivation profile.

	District	**Locality 1**	**Locality 2**	**Locality 3**	**Locality 4**	**Locality 5**	**Locality 6**	**Locality 7**
Population	373,000	70,000	48,000	57,000	55,000	30,000	52,000	62,000
0–4 yrs	6.8%	6.5%	Average	Lowest	Average	11%	7%	6.5%
65–74	9.8%	8.6%	12%	average	8.8%	9.1%	11.1%	17.8%
75+	6.6%	6.5%	6.8	6.4	5.1%	>9%	>10.4%	>11%
Ethnic minority	4.6%	3.5%	2.32%	2.63%	4%	16%	4.6%	4.3%
***Over-crowding**	2.6%	1.8%	2.5%	0.9%	1.7%	4%	3.5%	4.4%
Long-term illness		Below average	Above average	Below average	Below average	Highest	Above average	Above average
Adverse health		Stroke Suicide Cancer	Stroke Cancer Suicide Accidents	Cancer Suicide	Heart Stroke Suicide Accidents	Heart Cancer Suicide Accidents	Heart Stroke Suicide	Cancer Accidents

*Overcrowding as a proxy measure of deprivation calculated as density over one person per room from 1991 Census.

Table 6.1 Demographic, social and health profile of Barking and Havering (Source: Keynes and Congdon, 1995).

The District was below the national average for the number of GPs, who also tended to have large lists (fourth highest in the country), and a poor infrastructure, with many practices being run single-handed (Watts, 1995). There was a particular focus on the expectations of older people as a result of national concerns over changing needs (see section 1.3, Chapter 1 and Appendix 1) and their rising proportion in the local population.

Within the local elderly population, women outnumbered men over the age of 85 years by 3:1 (Beaver, 1994), there was geographical mobility of their children, and a concentration of ageing ethnic minority groups in the west of the district, with their different healthcare needs. These factors were largely as a consequence of a major population move to the area 50 years earlier, from the 'East End' of London, to work for the Ford Motor Company at Dagenham, and the subsequent departure of their children for better job opportunities (Haffenden, 1993).

Local NHS health care providers were Barking, Havering and Brentwood Community Healthcare Trust (BHB) and Havering Hospitals NHS Trust (HHT). In the spirit of the 1990 reforms, contracts had also been let to over 40 other major and minor providers.

6.3 Quality management through commissioning

For successful progression of quality management, the changing requirements of all interested parties should be included (see section 4.6, Chapter 4). Figure 6.2 gives an impression of the incorporation of these interests within the NHS into the commissioning process, whereby the NHS Executive (NHSE) sets the strategic objectives for the service; the purchaser, whether the Health Authority, GP fundholder or other, should additionally seek to agree objective requirements of potential providers and users as well as of their own officers. These requirements, which include quality, cost and volume components, then become the backbone of the commissioning process ultimately to meet local and central strategic objectives. The contracted provider is required to work the agreed standards through the quality cycle to meet or exceed the contract specification. The outcome of the commissioning process is then fed back to the interested parties and the process starts all over again. In a managed market (see section 1.9, Chapter 1), the focus will be the purchaser who needs to be able to synthesise the needs of all groups to maximise mutual satisfaction.

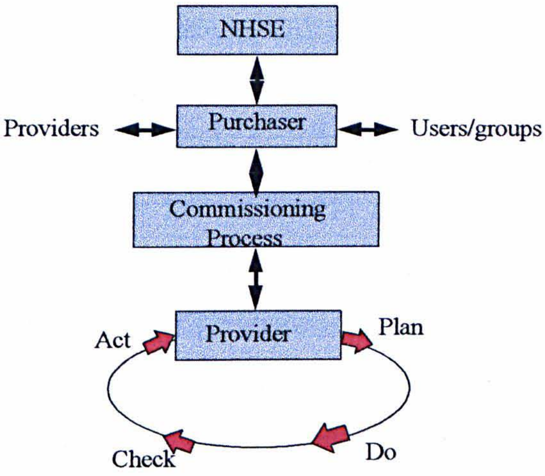


Fig. 6.2 Flow chart of quality issues

6.3.1 Hypothesis

This principle of using the commissioning process to identify and meet needs, gain commitment to change, and enhance health outcome and organisational success is pursued through this thesis. The hypothesis was that:

> "by incorporating user, provider and purchaser expectations, health needs assessment can be converted into a best quality service specification."

6.4 A framework for the project

It was considered by the author that the project to identify (or develop), implement and evaluate a model for local management of quality through commissioning, needed to have the following components:

- Identification of criteria for the quality management model
- Search for an existing model, or development of a model
- Implementation
- Evaluation.

The first two stages are developed in this chapter.

6.4.1 Identification of criteria for the quality management model

The fast implementation of the 1990 NHS reforms required local units to develop their own commissioning tactics. Stakeholders have been defined by the British Quality Foundation (1996) as "all those who have an interest, whether financial or not, in the organisation's activities and performance"; Clarke and Newman (1997) acknowledging that each will apply a different weighting of interests. Purchasers and providers *for* Barking and Havering residents began to grapple with the enormity of the commissioning task, the speed of the change set by the reforms, and the lack of business expertise among some senior staff, who had often fallen by default through reorganisation into new roles.

The needs of the population were largely based on public health data, previous service activity and purchaser assumptions. Progress in meeting identified need was initially measured by the speedy launch of purchaser and provider processes, rather than service effectiveness or satisfaction of other stakeholders. This necessarily resulted in the often hasty, sometimes vague, unilateral and superficial setting of goals and monitoring methods. Where quantitative performance measurement was commonplace, it was based on Patients' Charter standards. Qualitative measures were regarded as being of most importance to patients as well as more difficult to measure. Major providers (where at least half of any specialty provision was contracted by the BHHA) responded with thick textual reports, hoping to satisfy vague purchaser goals. Minor providers had their standards set by their own major purchaser and for the most part failed to report to the BHHA at all.

Initially, none of the responding providers to the BHHA indicated that they had completed the quality cycle for any standard, seemingly being content with implementation rather than its evaluation. This was in line with national findings (Dalley et al., 1991). Complaints and clinical audit were reported separately, denying a comprehensive view.

To rectify this situation, a working group representing purchaser, major and minor providers, and users was convened by the author. It has already been identified that participation by those affected by change is the key to success (Chapter 3, section 3.2.3).

The result of the initial specification setting was unanimously felt by the group to have been inadequate, the process being:

- costly in paper and time
- top-down and unilateral
- superficial, with focus on visible issues
- not easily comparable progress between similar providers
- unclear on achievement – creative writing
- subjective in evaluation
- slow in process as a result of being a paper-based system
- static, making in-year changes difficult
- concealed – stakeholders unaware of the information available.

It was felt by the group that the rich quality intelligence that could be gleaned from stakeholders should be used to inform subsequent commissioning, to ensure responsiveness to ongoing changes in need as well as continuous quality improvement. The model would, therefore, need not only to reverse the above problems but to meet the additional critical requirement of:

- a cyclical process compatible with and enhancing commissioning.

6.5 Identification of an existing model

The next stage of the project was to identify, or develop, a model for local management of quality through commissioning which would meet these requirements. At the time of this stage in the research, Dalley et al. (1991) published the results of their major survey, commissioned by the Department of Health, of quality assurance activities within the NHS. Responses were received from 148 of the 199 District Health Authorities (DHAs) surveyed, which revealed 1,500 activities that were being pursued with varying degrees of success. Fifteen DHAs were visited by Dalley et al. to probe the survey information from which they reported:

- Conflicts in developing a comprehensive approach between top-down strategy and bottom-up enthusiasm.
- Focus of quality depended on background of champion. This was commonly clinical for professional staff and organisational for managers, with tensions between.
- Ambivalent feelings by staff between a commitment to quality and scepticism about management motives.
- Lack of evaluation.

It is not surprising that the results of the analysis by Dalley et al. were largely disappointing. This can, in part, be explained by the short time-scale since implementation of the reforms, and by the size and culture of the organisation (see section 3.2.1, Chapter 3). Dalley et al. concluded that the most significant factor was failure in the management of change, emphasising the need to incorporate the principles of change management in quality projects, already outlined for this research in Chapter 3. These issues – the need for comprehensiveness, commitment, communication and evaluation – mirror the issues noted by the BHHA group, although Dalley et al. made no comment on the need for systems also to be efficient.

Subsequent literature searches and exploratory visits, both within the UK and the USA, failed to identify a robust system in use in public healthcare that would meet the BHHA criteria. Concerns by a number of organisations visited by this author mirrored the experience at the BHHA that a comprehensive, dynamic and flexible model in healthcare was so far elusive. Models that were identified had been developed for specific purposes and fell into the categories shown in Table 6.2 which were not exclusive.

Statutory	Statutory inspection , for example, Fire, Residential Home, Mental Health Act, Health and Safety
Subjective	Member visits by Health Authorities and Trusts, Community Health Councils and Voluntary Organisations. Expert visits by organisations such as the NHS Health Advisory Service
Top-down	Systems designed without collaboration with other stakeholders
Partisan	Representing up to two of the three stakeholders, for example, consumer groups, Royal Colleges, management organisations.
Organisational	King's Fund Organisational Audit
Clinical	Hospital Accreditation Programme of care group standards based on national best practice. Clinical, Organisational and Training Accreditation, Clinical Audit
Reactive	Complaints

Table 6.2 Range of existing quality models

Registration of the project with the NHS-funded Outcome Clearing House did not bring forth any further information on suitable models in use. Registration did, however, elicit a number of enquiries from others who had registered for help in tackling the same void. In an effort to validate the research, progress on the evolving model was shared with interested enquirers.

During the period of the project, the review of the literature has been ongoing. Some new approaches have been described, with none as yet fully meeting the criteria. One example is the Consumer Group initiative in Newcastle, funded by one stakeholder (purchaser) but reported as not unduly influenced by them. The Authority chose particularly challenging services: mental health, learning disabilities and HIV/AIDS. Although responsiveness to Consumer Group reports is recorded, there is concern by the report author about the cost, stress and demands that it makes. The report on the Newcastle project (Craddock, 1993) does not include incorporation of other quality intelligence, goals or objective measures of progress.

This lack of an "off the shelf" model could be seen as an advantage because there is a tendency for selection of an existing approach to fast-track implementation, without consideration of compatibility with the needs of the organisation or ownership by its members. Both factors are crucial if long-term culture change is the objective. The disadvantage was the total resource needed for such innovative research.

6.6 The research question

The research questions for the project were:

- Can an effective CQI model be identified, or developed, and evaluated that incorporates Juran's approach and needs of key stakeholders?

- Can local organisational change within the NHS be improved by learning from the lessons of national implementation of the 1990 reforms?

These objectives and their components indicated to the author that a model was required that would provide the following:

- **Quantitative data and qualitative information** on stakeholder needs.
- **Collaboration of stakeholders** to convert needs into specifications.
- **Quasi quantitative methods** to establish a baseline of satisfaction with the specification.
- **Participant involvement** to improve quality continuously.
- **Quasi-quantitative methods** to establish change in satisfaction with the specification.
- **A cyclical process** that would start the process over again.

6.7 Development of a model

It had been noted by Clarke and Newman (1997) that much of the politics around quality management is about which approach and model to use. The Juran (1988) "Quality Trilogy" – of planning by assessment of need and process design; quality control through specification, measures and monitoring; and quality improvement by systematic project selection – has already been noted as relevant to healthcare where variation for heterogeneous customers' unique needs is a requirement.

To simplify the task of design of the model for the BHHA, it was agreed by the stakeholder group that future quality specifications would consist of three parts, which was in line with national developments:

1. **"Core"** standards developed for all providers as a result of statutory requirements or central guidance such as the Patients' Charter.
2. **"Care Group"** standards drawn from national best practice for all providers of that service to the authority; this would also include national accreditation schemes.
3. **"Service Specific"** standards developed from the unique quality improvement needs of individual providers to meet local stakeholder requirements.

These would be monitored, the results added to other quality intelligence and the process repeated, in the spirit of the Juran approach.

6.7.1 The Quality Synthesis Model

A quality synthesis model was developed through facilitation by the author to demonstrate how the key components might fit together (Fig. 6.3). Although Winter (1989) had advocated collaboration rather than synthesis, the former does not necessarily produce a *result* from "working together" (Collins Dictionary), whereas the latter "combines ideas into a complex whole" (Collins' Dictionary). The model would enable *participants* to convert copious intelligence into clear, prioritised, documented, measurable and achievable standards, enabling personalisation for unique local needs; it also offers opportunities for evaluation and facilitates a cyclical process for continuous quality improvement.

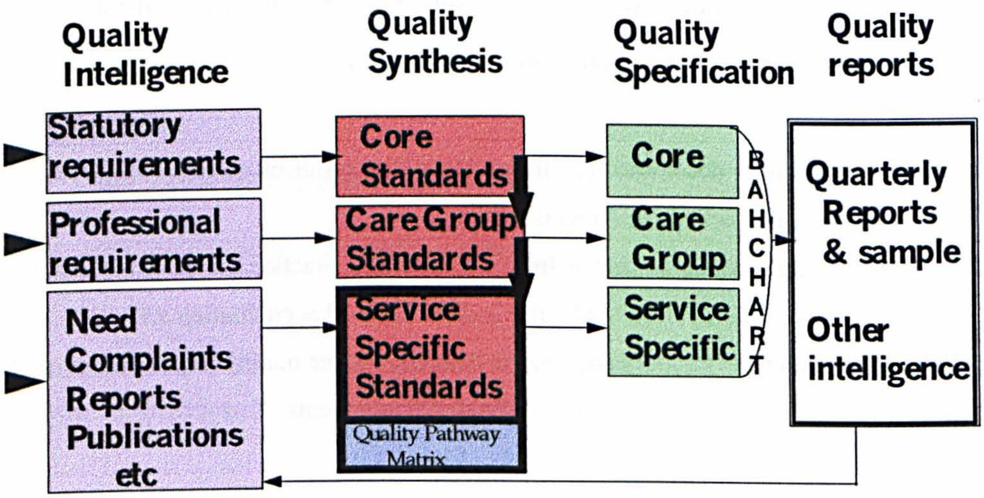


Fig. 6.3 Quality Synthesis Model

The analysis of the gap between expectation and perception in public services was considered in Chapter 4. It was shown that potential gaps could be reduced by marketing (needs analysis), service design (specification), understanding expectations, public relations, internal communication and staff development. The synthesis model explicitly facilitates all but public relations, internal communication and staff development, which are dependent on how the information is acquired for contribution to the model and the results communicated and implemented. Repetition of the cycle will identify where this has failed through review of selective quality intelligence (for example, complaints or staff turnover).

A particular concern was the comprehensiveness of service-specific standards to ensure that both visible and, often more importantly, invisible stakeholder requirements were being addressed to sustain a comprehensive approach. Service-specific standards became the key to the synthesis as the impact of core and care group issues on more local requirements had to be accommodated within the service-specific component.

6.7.2 Planning by assessment of need and process design (Juran)

A process for selecting topic(s) for standard setting, from almost infinite options, is emphasised by Juran (1988) as the key to successful continuous improvement. Identification of users' epidemiological needs was becoming well established, but identifying the other needs of stakeholders was in its infancy. Commissioning authorities, who would not wish to assume in-depth knowledge of all specialties and disciplines within their responsibility, need to have an overview as well as detailed information about the services that they are charged with purchasing to avoid assumptions.

Overview information can be obtained initially through a resumé by the *current* provider prior to the commencement of detailed commissioning. The established provider has an incentive to rise to the occasion. Such initial resumés of contracted services are more likely to reflect perceived rather than actual user needs, in line with the traditional paternalistic culture of the service, but will at least serve to provide a backdrop created by *demand* on which to form services that are more responsive to *need*.

As healthcare has a value for the whole population, and the ultimate processes and encounters are measured by end-users, more detailed health service quality must be viewed from both the macro (service) and micro (episode and encounter) perspectives (Pollitt, 1990; Spitzer 1991; Ranade, 1994). Two complementary approaches are commonly used: the Maxwell Six criteria at a macro level and the Donabedian structure/process/outcome approach at a micro level.

As expectations are likely to differ at each stage of the care process, each stage will need to be considered separately; Ovretveit (1994b) has provided a visual cue – the patient's path (Fig. 6.4) – to cover the stages in an episode of care from selection and assessment, through treatment and review to discharge. In practice, this model has been successfully adapted for a number of situations, for example, community nursing and outpatient physiotherapy. An omission from the original pathway is service development. Such an exclusion indicates a static rather than a progressive philosophy and has been added by this author.

Macro service quality (Maxwell)

Quality in healthcare is multidimensional (Maxwell, 1992) and there is some agreement on these dimensions (Maxwell, 1984), or elements (Shaw, 1986), that are particularly relevant at the macro/purchaser level (Sheaff and Peel, 1993) which act on behalf of patients. Maxwell (1984) described the dimensions as accessible, relevant, effective, equitable, acceptable and efficient (See Chapter 5, section 5.3.1)

Field testing has shown the comprehensive coverage and face validity of the dimensions, assuming that psychological needs are integral to the criteria. Martin (1993) has noted the problem that some of these attributes may be antithetical and gives the example of outcome and accessibility, risking "client creaming" to improve outcomes while compromising wider accessibility. Enthoven (1988) indicates a problem with equity that *can* be considered with efficacy but *cannot* be considered with efficiency, due to the uncertainty, monopoly, asymmetry of information and economy of scale in operational healthcare. Therefore, those unique dimensions of the user and focus service will require continual review and informed trade-offs in an "abacus" of healthcare (Maxwell, 1992). A service can be audited against the expected macro service quality requirements (Maxwell, 1992) once they have been thoughtfully documented.

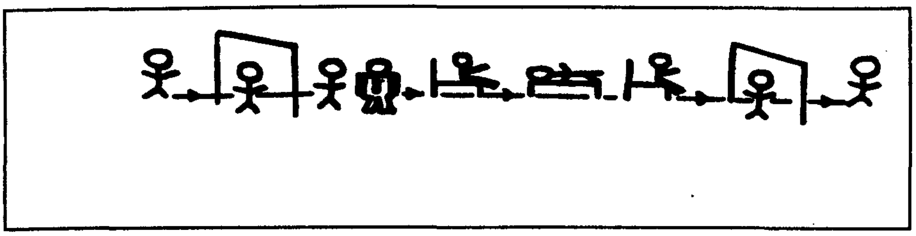
Approaches to micro service quality (Donabedian)

Donabedian (1988, 1989) has proposed a structure, process and outcome (SPO) approach to acquisition of information for description and evaluation at the micro episode of care level. There are assumed links between the SPO components, for example, adequate preconditions are more likely to produce an acceptable process and outcome (Vuori and Roger, 1989), because at least the structures of staffing and organisation are present, and particularly that adequate process produces an acceptable outcome (Donabedian, 1988). Although these have yet to be proven, common sense makes them seem likely to be conducive to a higher quality of service. The SPO approach enables setting of clear standards and criteria, so that the consumer knows what to expect from their encounter, can compare this with their experience and therefore rate their satisfaction.

The Quality Pathway Matrix

The early stage of the discipline of quality management in healthcare had resulted in the Maxwell and Donabedian models (see above) being pursued independently. It seemed feasible to this author that Structure, Process and Outcome (SPO) (Donabedian model), should be considered within each Ovretveit "stage" of care. The changing views of the three main stakeholders: user, provider and purchaser should also be considered at each stage --- a triangle icon was used to act as a reminder. It also seemed appropriate for each Ovretveit stage to be compared with each Maxwell dimension as stakeholders set their expectations at each stage in the process, not once and for all at the start, although the initial expectation is influential in setting the scene.

The Quality Pathway Matrix incorporating Maxwell and Donabedian models and the views of stakeholders at each Ovretveit stage of care evolved as a valuable working model (Fig 6.4) and is incorporated into the Quality Synthesis Model (Fig 6.3).



	Selection S/P/O ▽	Entry S/P/O ▽	1st contact S/P/O ▽	Assessment S/P/O ▽	Intervention S/P/O ▽	Review S/P/O ▽	Closure S/P/O ▽	Follow-up S/P/O ▽	Develop S/P/O ▽
Effective									
Acceptable									
Efficient									
Accessible									
Equitable									
Relevant									

Fig. 6.4 Quality Pathway Matrix

After experimentation, a column for "development" was added to the original matrix to ensure that planned service changes were similarly addressed, so that quality becomes an integral part of planning. This is in line with the "Quality Planning Road Map" promoted by Juran (1988), who saw quality intrinsically linked with every stage of the business process.

The matrix has the potential to avoid the expectation/perception gap in service delivery identified by Parasuraman et al. (1985) (see Fig. 4.6), by information and understanding. It also incorporates the enhanced solutions added by Speller and Ghobadian (1993) to the Parasuraman model, by staff being integral to the process (see Fig. 4.7).

Using the Quality Pathway Matrix

Working with the provider, particularly the relevant managers (thereby facilitating involvement as well as an informed view), the hypothetical patient can be tracked through the system, each step being audited against stakeholders' perceptions and evidence of achievement on the relevant quality dimension. Definitions of each point in the quality pathway matrix were used on a larger working sheet by the quality teams (see Appendix 6). The relevant tools from the generic quality toolbox are then used to address problems identified (see Appendix 4).

The lack of agreement within and between disciplines on criteria and interventions makes the patient's journey along this "chain" of healthcare difficult (Buchan et al., 1990), increasing inequitable variation, decreasing satisfaction, confusing service scope, compromising meaningful audit and raising more questions. Such chance variation, already noted as the major cause of quality problems, is redeemable by empowered workers and the ultimate aim in healthcare would be to have all these key stages in the process specified on the basis of evidence and visible to the patient and other interested parties for appropriate action. The lack of evidence for such specification has already been noted as a major drawback.

A record of the sequence followed by the group to produce a topic for a quality improvement standard or goal proved invaluable when either the length of time or change in personnel resulted in loss of knowledge of the original intention. Local variable codes emerged as a shorthand for identification of influences (Table 6.3), which may vary for other unique settings. These concerns were both reactive, for example complaints, and proactive, for example current media interest anticipating national investigation of an issue. The appropriate code(s) being placed in the relevant matrix box.

A. Previous concern from report or visit by purchaser, provider or user agency	E. Central issue (i.e. NHS Executive)
B. Previous omission	F. Untoward incidents
C. Key contractual issue	G. Complaints cluster
D. Media interest	

Table. 6.3 Local variable codes

The resulting list of concerns could then be prioritised by the number of codes, the total giving the priority position of the issue. In the absence of a recognised weighting system, each concern was given equal weight. This issue of more relevant weighting is a serious issue for future research. Prioritisation by participants ensured that any reduction of the list of issues during contract negotiation, perhaps by those external to the process, would remove only those already agreed by the stakeholders to have the lowest priority.

The next issue was collection and collation of information to raise standards identified via the matrix. As a result of the collaborative culture that the group had developed, it was agreed to share relevant documents that stakeholders had access to from numerous sources, and develop a "reference bank". These were used for quality intelligence.

6.7.3 Quality control through specification, measures and monitoring (Juran)

Starting with the highest priority, the issues were developed into standards or goals following recognised best practice of meeting SMART and RUMBA criteria (specific, measurable, achievable, relevant, theoretically based, understandable and behavioural).

The resulting standards, including wording and the pace of implementation, was agreed by purchaser, provider and patient representative. This meant that the implementation stages of any project, depicted in the Deming cycle (see Fig. 4.4, Chapter 4) as plan, do, check and act, could be timetabled over the contract year by mutual agreement with due regard to need. The final document formed part of the contract specification which in the NHS is a public document. The process provides mutual support for any item that may raise public interest, avoiding laying of blame. The next stage was for the provider to plan their project for implementation of the contracted standard.

Each standard had a numerical target and/or agreed tolerance where appropriate (for example, 90% achievement; or not more than 5% non-attendance at a clinic), together with a reporting requirement (for example, quarterly progress position on that issue). The "Storyboard" method for reporting progress towards the target (Gitlow et al., 1990) was used, first, to indicate performance *expected*, which was agreed within the contract, and then to report on *actual* achievement. This requires the "story teller" simply to report the current status by indicating the relevant stage of the Deming cycle reached during the period covered by the report (Table 6.4), together with numerical achievement where appropriate. This proved a highly efficient and effective process in that reporting was brief but informative.

P = Plan: completed indicates a plan is in hand
D = Do: completed implies plan executed
C = Check: completed implies plan monitored
A = Act: completed implies results incorporated into a time-tabled action plan with review

Table 6.4 "Storyboard" progress positions

Exceptional findings, that is, those outside agreed tolerance, and a brief report on progress during the quarter could be voluntarily included, and/or position statements might be required by the purchaser on topical issues. For key issues, a direct link can be made with the complaints report, for example, asking the Trust and Community Health Council (CHC) to break down their total complaints by the same categories (see Appendix 7). This is an important link because provider compliance does not necessarily result in user satisfaction – speed of discharge being a common example.

Barking and Havering IT strategy

At the same time as quality was being pursued on the clinical side, the national Information Management and Technology strategy (IM and T) was produced for business quality to which the Authority responded with an IT strategy. A cross-directorate team within the Health Authority was charged with the task of implementation. One of the phases covered the introduction of the locally named "**OLE**" system, which consisted of the following:

- **O**ffice systems, using Microsoft Word, Excel and Power Point.
- **L**ocal area network, conforming to IEEE 8802.3 standard.
- **E**-mail, using Microsoft Mail for messaging and information exchange.

These systems enabled the Health Authority, two main Trusts and the FHSA (before integration of the two authorities) to communicate more easily. Part of the strategy was the development of a District Information Support System (DISS), to ensure access to timely and accurate information in support of the business of the Authority. After the initial phase, which primarily covered inpatient and waiting list activity, a trawl of initiatives was undertaken. The Directorates of the Authority produced 20 schemes, of which quality monitoring was deemed to be the priority, indicating top commitment to quality management.

Based on the manual system, software was developed to enable the quality progress reports to be input by the provider and sent by E-mail to the HA where "read-only access" was available to all DISS users. A competition held to name the product resulted in BAHCHART (**B**arking **A**nd **H**avering Quality **Chart**ing) and completed the synthesis model (Fig. 6.3)

6.7.4 Worked example of the quality synthesis model

The experience with one provider of services for adults with learning disabilities has been used as an example of the total process.

Step 1

A resumé of the service currently provided, predominantly based on history and demand, was documented by the provider (Table 6.5).

Resumé of the service provided by the Trust
The service is contracted to provide a health assessment, habilitation and continuing review of adults with learning disabilities. This involves close liaison with Social Services as most clients have joint needs.

The service consists of
Residential care
Domiciliary nursing
OPD medical clinics at health centres/day centres
Day services for residents within the complex
Community-based residents at local resources, e.g. Church Hall
Short-term care: Respite
Short-term assessment admission

Table 6.5 Resumé of service for people with learning disabilities

Step 2

National best practice for these areas were identified through critical appraisal of collaborative literature searches

Step 3

Issues for standards were identified, prioritised and selected and Table 6.6 shows one example covering the outpatient medical clinics.

	Selection S/P/O ∇	Entry S/P/O ∇	1st contact S/P/O ∇	Assessment S/P/O ∇	Intervention S/P/O ∇	Review S/P/O ∇	Closure S/P/O ∇	Follow-up S/P/O ∇	Develop S/P/O ∇
Effective									
Acceptable			CDEG						
Efficient									
Accessible									
Equitable									
Relevant									

In this example the acceptability of first contact is of concern attracting codes which reflect concerns over the length of wait.

Issue 1: wait in clinic
At present the wait in clinic to see the doctor exceeds the Patients' Charter requirements of 30 minutes.

Table 6.6 Topic identification

Step 4

Core, care group and service specific quality standards, their goals and expected progress were jointly developed and negotiated within the contracting process. A "workbook" of the final version of the full quality specification was produced for the provider. This enabled data collection and a hard copy in case of IT mishaps. Progress on each goal, together with essential text, was to reach the purchaser by electronic mail by the 20th of the month following each quarter.

Step 5

Progress in each quarter provided the current position against that expected (Fig. 6.5), enabling identification of exceptional issues for applause and/or further investigation providing a focus for quality improvement.

Learning disability

Issue 1: wait in clinic
Standard: monitor and improve waiting time to comply with Patients' Charter of 90% compliance with patients seen within 30 minutes of appointment time.
Report and Measure
Quarterly progress report.
Annual report to include results of investigation and plans for further improvement

Plan	Do	Check	Act	
1st Q	2nd Q	3rd Q	4th Q	Expected position
1 and 2 Q	3rd Q	4th Q		Actual achievement

Additional comments
Exception report attached yes/no

1st quarter
Plans for monitoring being discussed. Current compliance 60%.
2nd quarter
Plans for monitoring continue to be discussed to obtain agreement of all parties. Current compliance 70%.
3rd quarter
Monitoring plans agreed and implemented. Current compliance 80%.
4th quarter
Checking findings from monitoring data. Current compliance 90%.

Fig 6.5 Extract from service-specific quality specification and monitoring services for people with disabilities

An example of the graphic screen view of the resulting comparative data across providers available to all DISS users within the Authority (Fig. 6.6) easily indicates exceptional issues. Providers have a similar view restricted to their own data.

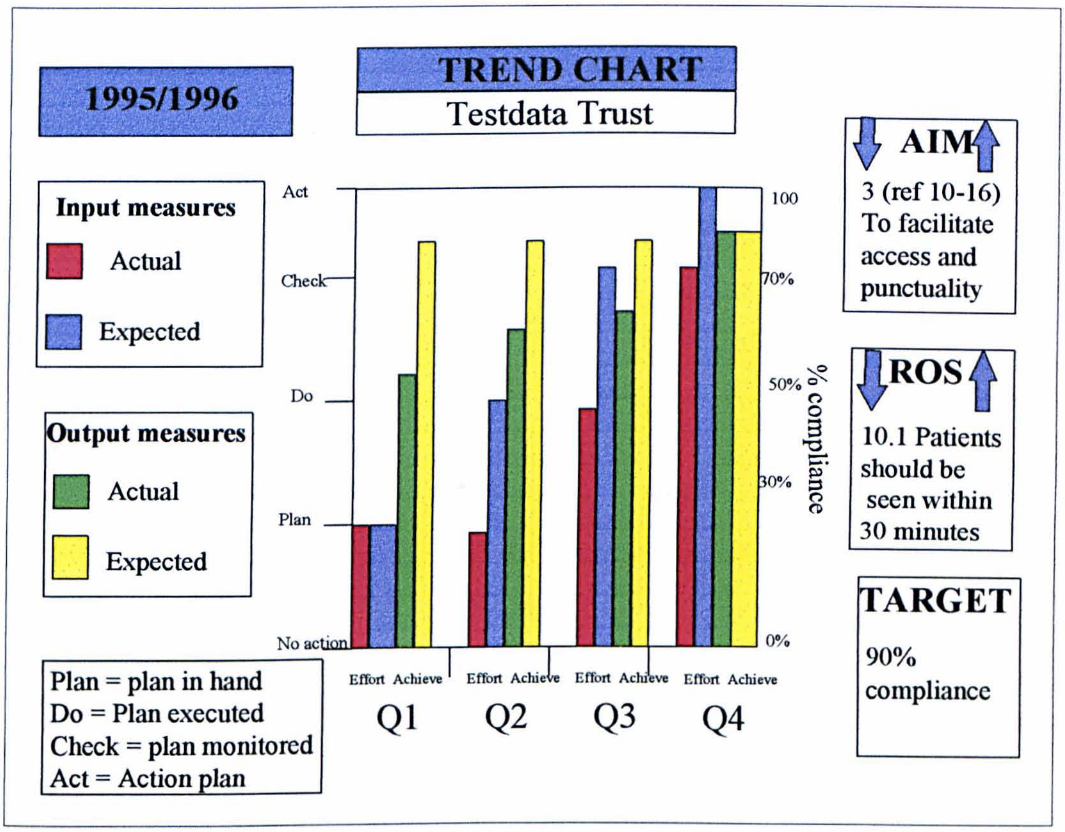


Fig. 6.6 Screen view of progress on quality standard

ROS: right or standard	**Actual status**: plan/do/check/act achieved
Aim: aim of the Right or Standard	**Expected output**: numerical target expected
Target: numerical target for compliance	**Actual output**: numerical target achieved
Expected status: plan/do/check/act negotiated position	Q1.95, Q2.95, Q3.95, Q4.95: quarters in 1995

Explanation for Figure 6.6
The commissioning aim which the right or standard supports has a target measure. The agreed pacing of the quality cycle is depicted as expected input, and can be compared with that achieved depicted as actual input. The expected output compliance and actual output compliance achieved are compared.

Table 6.7. Key to Fig. 6.6

In the example, the standard and its aim are documented. It was jointly anticipated that there would be 90% compliance each quarter. During the year the provider would have a process for quality improvement in hand, the anticipated progress on each standard being negotiated as part of the contract. In this example, a plan will be completed in the first quarter, implemented in the second, monitored in the third, with action on findings in the fourth. What actually occurred was progress as agreed in the first quarter, no progress in the second providing an indicator for possible investigation, implementation in the third quarter and checking in the fourth. Action on the results was not achieved within the period and 90% compliance was only reached in the fourth quarter, being 60% in the first quarter, 70% in the second and 80% in the third. Any lack of compliance might trigger a focussed investigation.

Sampling

A number of issues concerning the model remained to be addressed, for example: the risk that providers would just "tick the box" for quality, assuming compliance or lacking commitment to the concept; the constraints on purchaser time for comprehensive monitoring; the risk of not monitoring; and the need to identify issues for quality improvement. It was also known that there was the positive "Hawthorne" effect of known observation identified by Mayo (1949). To address the issues and capitalise on the internal energy from observation, the purchaser negotiated to sample a certain number of issues each quarter.

Selection of topics for the sample was by application of the list of variables (Table 6.5 above) to the report, so that concerns and imperatives were objectively, identified. Short but reasonable notice to be given by the purchaser was agreed as two weeks. The sample issues were then probed to compare findings with those reported, and any critical recommendations as a result of the sampling converted immediately into quality improvement goals within the reporting system. Less critical findings could be held for consideration as part of the general quality intelligence until the next contracting round. Although a partnership approach was being pursued, confirmation of the reliability of reports was sought by the Health Authority and found to be at a generally high level. Successful findings were widely applauded and help provided in areas of difficulty, and the domino effect of a single sampling visit was anecdotally reported as highly effective.

Annual report

The statutory annual report required of Trusts and Commissioning Authorities could be developed from the information produced during the BAHCHART process, being brief, informative, agreed and including an overall view of progress, together with specific, supported examples. Both Trusts in the project and the Health Authority were able to download charts from the system to complement their reports---and those of each other.

6.7.5 Quality improvement by systematic project selection

At the end of the contracting year, quarterly reports, sampling results and other quality intelligence were brought together and the process started over again. The quality synthesis model was used to objectively identify the areas for quality improvement, the patients pathway matrix enabling prioritisation of projects and BAHCHART facilitating progress reporting.

6.8 Conclusion

It had been established that the key stakeholders in publicly funded healthcare had differing needs and that quality improvement was the most appropriate way to meet them. The diverse needs required synthesising to obtain an agreed baseline from which to commence improvement. The international search both through literature and field visits failed to identify a model that would meet generic and unique local stakeholders' requirements.

The *Quality Synthesis Model* was developed through an action research approach, which would theoretically meet focused stakeholders' needs. The key to the model was the opportunity for personalised specification of core and care group standards, which would facilitate ownership and implementation. Parallel national and local developments in information technology enabled the reporting system to be programmed, through locally developed software entitled BAHCHART, obliterating the need for paper-based reporting, the bane of most quality systems.

The model combines existing work by Ovretveit (1994b), Maxwell (1984) and Donabedian (1988, 1989). It has the potential to avoid the expectation/ perception service delivery gap of information and understanding identified by Parasuraman et al. (1985) (see Fig. 4.6, Chapter 4) as well as incorporate the enhanced solution to that model added by Speller and Ghobadian (1993) of staff involvement (see Fig. 4.7, Chapter 4). This development has built on the pioneering work of these researchers and, in this author's view, especially through its simplicity and objectivity, could theoretically make a significant contribution to the pursuance of quality improvement.

The questions to be explored in this research are:

- Can an effective CQI model for healthcare be identified, or developed, and evaluated which incorporates Juran's approach and the needs of local key stakeholders?
- Can local organisational change within the NHS be improved by learning from the lessons of change theory and national implementation of the reforms?

A CQI model for healthcare has been developed which incorporates Juran's approach and the needs of local key stakeholders, contributing further to answering the first question. The remaining questions to be explored are the local lessons to be learnt from national implementation of the reforms; and the cost and effectiveness of the quality synthesis model.

Chapter 7
Implementation and evaluation of the Quality Synthesis Model

7.1 Introduction

This thesis has so far explored healthcare, change and quality management, and concluded that, for local NHS units to respond successfully to external and internal influences, they require an appropriate participatory model for continuous quality improvement (CQI). The research has sought to answer two questions:

- **Can an effective CQI model for healthcare be identified, or developed, and evaluated which incorporates Juran's approach and the needs of local key stakeholders?**
- **Can local organisational change within the NHS be improved by learning from the lessons of change theory and national implementation of the 1990 reforms?**

The Quality Synthesis Model incorporating Juran's approach was developed to complement the commissioning process and would theoretically meet stakeholders' needs to deliver CQI. Evaluation of the model to measure effectiveness would complete the answer to the first question.

To enable evaluation to occur, the model had to be implemented. Key pointers from generic best practice were identified as: conducive culture, communication, commitment and measurement of progress. Those specifically for the NHS were additionally: the need for clarity and agreement over quality issues, vision and values; a strategic approach; and the capacity and empowerment to respond. These lessons are considered in parallel with implementation of the Quality Synthesis Model through an action research approach, enabling the second question to also be answered.

The preparatory work had established that the Quality Synthesis Model should be evaluated in the following ways:

- **That the model to establish and respond to patient, purchaser and provider expectations meet the operational criteria expected by purchasers and providers.**
- **That the model provide a cyclical process compatible with and enhancing commissioning.**
- **That the model was valid, reliable and repeatable.**
- **That the process could result in stakeholder culture change towards continuous improvement of agreed quality.**
- **That the model avoided the sins and diseases of public sector management**

Evaluation was through quantitative and qualitative methods and showed that the model is comprehensive, dynamic and visible; is compatible with the commissioning cycle; is valid, reliable and generalisable; can result in culture change; and can avoid the sins and diseases of public sector management within the given constraints of the NHS.

These findings resulted from implementation of the model in a Chiropody service, and consideration was given to factors which might affect its wider implementation.

Chiropody is categorised as a Profession Allied to Medicine (PAM) and defined as a semi-profession. Within a hierarchy of the three main clinical staff groups, at the time of the research the professions allied to medicine in general were likely to be more positive in responsiveness to healthcare change than medicine and nursing due to their high autonomy over their caseload and therefore resource allocation decisions beyond that of individual patients; their national pro-active position on quality assurance; and their experience of user responsiveness through familiarity with the private sector.

Public sector chiropody was also one of the most traditional in service organisation as a result of a history of sessional workers who had little incentive to move the service forward and lose their contracts. Private sector chiropodists had the most experience of the private sector within the PAMs group. Chiropody was therefore placed towards the middle of the PAM's group, autonomy still being counterbalanced to some extent by tradition although sessional work has now largely ceased. The recent encouragement for medicine and nursing to respond likewise to change has probably brought these two disciplines nearer the position of PAM's, improving the potential for successful wider implementation of the model.

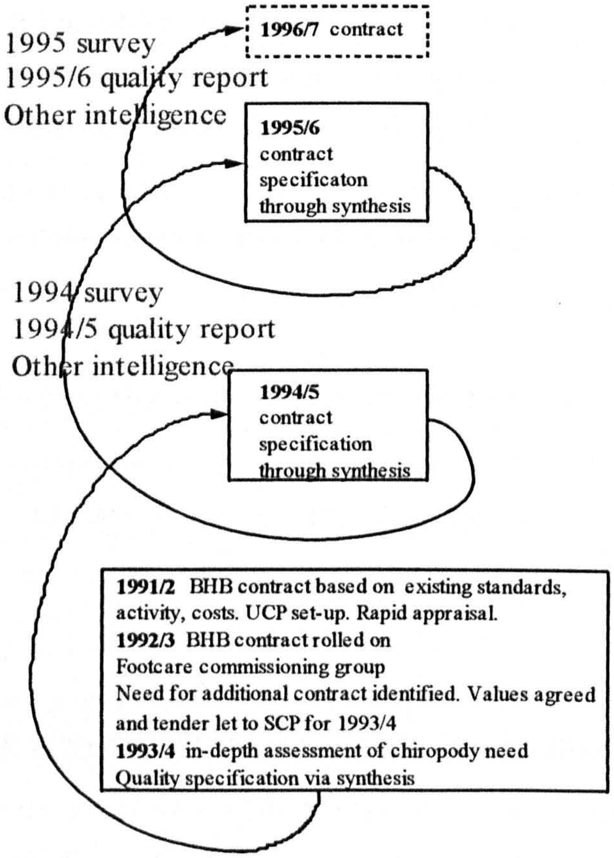
From the viewpoint of the local influences, the two Chiropody services in the pilot study were biased in respect of the emphasis placed on contestability within the commissioning approach used and therefore probably more susceptible to a positive response to change than others not subjected to this influence.

7.2 Components of the Quality Synthesis Model

The quality synthesis model developed in Chapter 5 to meet the objectives of the two questions consisted of a number of components which worked in a cyclical mode to theoretically deliver CQI:

- **Quantitative data and qualitative information** on stakeholders' needs.
- **Collaboration of stakeholders** to convert needs into specifications.
- **Quasi-quantitative methods** to establish a baseline of satisfaction with the specification.
- **Participant involvement** to improve quality continuously.
- **Quasi-quantitative methods** to establish change in satisfaction with the specification.
- **A cyclical process** which would start the process over again.

The identified need was footcare for older people (see section 2.9, Chapter 2). The quantitative and qualitative approaches were combined in an action research approach and were used to specify, review and improve quality within the commissioning cycle. This process is shown in graphic form in Fig. 7.1.



UCP, Unified Commissioning Project; SCP, Sclare Chiropody Partnership; BHB, Barking, Havering and Brentwood NHS Trust.

Fig. 7.1 Quality synthesis action research cycle in service specification.

7.3 Implementation and evaluation of the Quality Synthesis Model

7.3.1 Quantitative data and qualitative information on stakeholder needs

The Unified Commissioning Project (UCP) (see section 2.9, Chapter 2) required a service quickly to meet the need identified for more chiropody for people over 75 in certain wards in the south-west of the district. This was in addition to that currently provided by the Barking, Havering and Brentwood NHS Trust (BHB). A Footcare Commissioning Group was set up to implement the project. .

Noting the need for clarity and agreement over quality issues, and vision and values between stakeholders for successful change (see Chapter 3), a meeting was held in 1992 between the joint purchasers and GP representatives, current and potential providers, patient representative (Community Health Council), and the Society of Chiropodists (the Society). The outcome of the day was the development of four projects which would establish a shared baseline (Table. 7.1).

Adaptation of national standards of practice to local needs which was published (see Appendix 8) and made available to all GPs and other interested parties and submitted to, and accepted by, the NHS Executive as an example of good practice in the first A–Z of quality publication (NHSME, 1993).

Advice to purchasers on the issues they should be aware of was developed between the purchasers and providers in the absence of information from the Society (see Appendix 9).

Practice accreditation which was to be developed by the Society so that a requirement for practices tendering in the future could be evidence of organisational standards acceptable to the Society.

Independent clinical peer review which was to be developed for use by the purchasers, contracted providers and Society so that clinical standards could be assured on request by knowledgeable peers (see Appendix 10).

Table 7.1 Four projects from the chiropody stakeholder meeting

An outline specification for the additional service for those aged over 75 was developed collaboratively, resulting in the Sclare Chiropody Partnership (SCP), a private State Registered provider, being awarded the contract for 1993–4 on the basis of best value for money.

The two chiropody providers to Barking and Havering therefore had different contracts, one based on comprehensive historic *demand* and one on contemporary *need* for those aged over 75 in defined areas. The ultimate objective was to move towards a single best practice specification for district-wide comprehensive footcare provision.

7.3.2 Collaboration of stakeholders to convert needs into specifications

It has been established (see Chapter 3) that sustained quality improvement requires cultural change, and the adapted Clarke principles of change model (see Fig. 3.1), was introduced by the author to, and accepted by, the group as a framework for activity. The following reflect the process of the use of the framework.

Understand the organisations

To identify the existing culture, local purchaser and provider positions at the start of the project were self-audited. The results identified both to be at the most basic summary position on Crosby's Quality Management Maturity Grid (Table 7.2) which had the opportunity to move to the right as the responses to change management become more positive (see Chapter 3).

Measurement categories	Stage 1: uncertainty	Stage 2: awakening	Stage 3: enlightenment	Stage 4: wisdom	Stage 5: certainty
Summation of quality posture	"We don't know why we have problems with quality"	"Is it absolutely necessary to always have problems with quality"	"Through management commitment and quality improvement we are identifying and resolving our problems"	"Defect prevention is a routine part of our operation"	"We know why we do not have problems with quality"

Table 7.2 Section of Crosby's Quality Management Maturity Grid. (Source: Crosby, 1980)

Appreciate the reasons for change, know the process, establish communication

To address the deficit in knowledge about general quality issues, a local rolling programme for quality awareness was developed for staff at all levels, including the Health Authority, Trust Boards and clinical staff, after consultancy with the TQM Centre at Anglia Polytechnic University. The programmes included presentations by this author and others on quality theory, and group work with feedback on quality improvement of a topic of universal interest---the internal postal system. Analysis of participant evaluation sheets indicated that this was successful. For users, Public meetings were organised by the Foot Care Commissioning Group to explain the NHS changes and invite comments on chiropody.

The success markers set by the Unified Commissioning Group (UCP) were recorded simply as health gain, satisfaction and effectiveness. The expectations and satisfaction measures of the three main participants were investigated in depth, using public health data, community consultation, views of referrers and service review of both providers (Cahill et al., 1994) (see Appendix 12). This complemented the Rapid Appraisal (see section 2.8, Chapter 2) by probing stakeholders' needs in a specific service. Health gain was determined by patients and chiropodists in the exploratory survey (Appendix 13) as pain relief, mobility and comfortable shoe wearing; satisfaction was with various aspects of the service identified by stakeholders; and clinical effectiveness would be assessed by peer review.

The development of the Quality Synthesis Model (Fig. 7.2) (see section 6.7, Chapter 6) had involved some participants who also had an interest in the chiropody contract. To ensure that all chiropody stakeholder participants were at the same level of understanding, a revision seminar on the model was undertaken by the author, with a hands-on training session for software confidence and back up technical support. The allocation of provider time for such activities had been a contract requirement.

Purchasers, providers and user representatives then put into action the Quality Synthesis Model (Fig 6.3) for the 1994/5 quality specification through consideration of the relevant quality intelligence; synthesis of the resulting objectives into the service specification; with quantitative and qualitative reporting requirements. Core standards were based on Patient Charter requirements; Care Group standards were based on professional requirements and those expected by older people (see section 5.3, Chapter 5).

The contract would be measured by quantitative data on activity and cost; and quasi-experimental and qualitative information on perceived health gain and satisfaction.

An example of the resulting standard is provided in Fig 7.2 (the full process is documented in Addendum 1).

Standard 3: the provider will develop an information sheet to include all basic criteria on access to, content of and outcome of treatment and measure its effectiveness.
Target: all essential information needed by applicants
Measure and report: quarterly progress, with pilot by December 1994

Plan	Do	Check	Act

Exception report attached [✓ yes]/no
Additional comments
1st quarter:
2nd quarter:
3rd quarter:
4th quarter:

Fig 7.2 Documented quality standard through Quality Synthesis Model

7.3.3 Quasi-experimental and qualitative methods to establish a baseline of satisfaction with the 1994/5 specification

With reference to the quasi-experimental and qualitative methods of research design (see section 2.7, Chapter 2), survey and telephone interview were the options chosen to ascertain satisfaction. An exploratory survey was undertaken in 1992 to establish feasibility (see Appendix 13), and after amendment of the tool, the full survey was implemented in 1994 and repeated in 1995. The full detail is provided in Appendix 14. The following highlight the contribution of the survey and interview to the implementation of the model.

Method

The aim of the first full survey in 1994 was to establish a baseline of expectations, facts, perceptions and satisfaction with the chiropody services. The results would contribute to the 1995–6 contract specification.

The population and sample

The population consisted of all the current users of Barking and Havering NHS-funded chiropody provision for those aged 75 and over (see section 2.9.5a and Table 2.4).

In the 1992 pilot study, overall satisfaction with the service was reported by 69% of the sample. This result was used to calculate 95% confidence intervals on the basis of which a sample size of not less than 750 was considered to provide sufficient accuracy for the main study. The number of chiropody patients in each locality for each provider was identified, and 10% of each locality taken as the sample (with a larger percentage in smaller localities).

Response rate

Questionnaires were sent to 782 patients and, after one reminder, there was a response rate of 82% (641). The response rate by the key variables of age, gender, locality and provider are provided in Table 7.3.

Follow-up interview

Willing respondents were randomly contacted for the semi-structured telephone interview.

Analysis

The data on characteristics (age, gender, locality and provider) and variables of related interest (categorised under health gain and satisfaction) were cross-tabulated using the Statistical Package for Social Sciences (SPSS). Chi-squared tests were calculated to determine the probability of an observed association between two variables occurring by chance.

As age is likely to affect both response rate and views, it was considered against the locality and provider variables to establish predisposing influences in responses. This analysis is used to explain the calculations used throughout the survey. In this example, there was a significant association between age group and provider (p = 0.00919), those being treated by SCP being significantly older than those with the BHB (Fig. 7.3). For example, 40.7% (207) of the BHB patients were in the younger 75–79 age group compared with only 26.3% (35) for SCP.

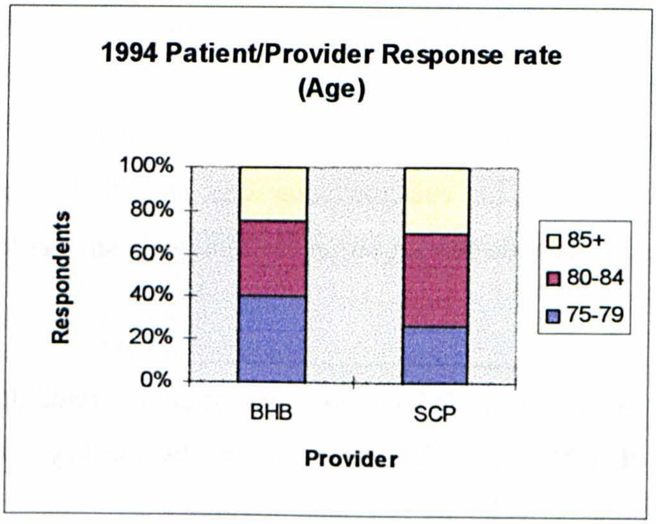


Fig 7.3 1994 response rate analysed by age of respondent

L	**Age**						**Gender**				**BHB**		**SCP**		**Total**	
	1994	**1995**	**1994**	**1995**	**1994**	**1995**	**1994**	**1995**	**1994**	**1995**	**1994**	**1995**	**1994**	**1995**	**1994**	**1995**
	75–79	**75–79**	**80–84**	**80–84**	**85+**	**85+**	M	M	F	F	▨	▨	▨	▨	▨	▨
1	29	24	34	26	28	23	15	11	76	62	91	73			91/107	73
2	42	37	13	9	8	4	22	20	41	30	63	50			63/78	50
3	24	23	27	27	29	19	18	12	62	57	80	69			80/89	69
4	21	16	19	14	20	11	17	13	43	28	60	41			60/68	41
5	37	31	43	27	26	16	25	19	81	55	58	49	48	**25**	106/125	74
6	48	51	42	43	32	23	44	42	78	75	74	57	48	**60**	122/164	117
7	41	42	55	51	23	29	41	39	78	83	82	64	37	**58**	119/151	122
Total	**242/282 (85.8%)**	**224/300 (74.6%)**	**233/276 (84.4%)**	**197/280 (70.3%)**	**166/215 (77.2%)**	**125/202 61.8%)**	**182/215 (84.6%)**	**156/226 (69%)**	**459/567 (80.9%)**	**390/556 (70.1%)**	**508/589 (86.2%)**	**403/577 (69.8%)**	**133/193 (68.9%)**	**143/205 (69.7%)**	**641/782 81.9%**	**546/782 69.8%**

Table 7.3 1994 and 1995 response rates by key variables of age, gender locality and provider

There was a significant association between age and locality of respondents (p = 0.00021) (Fig. 7.4). Particularly striking is locality 2 which had 66.7% (42) of its respondents in the 75–79 age group, compared with the next highest of 39.3% (48) in locality 6.

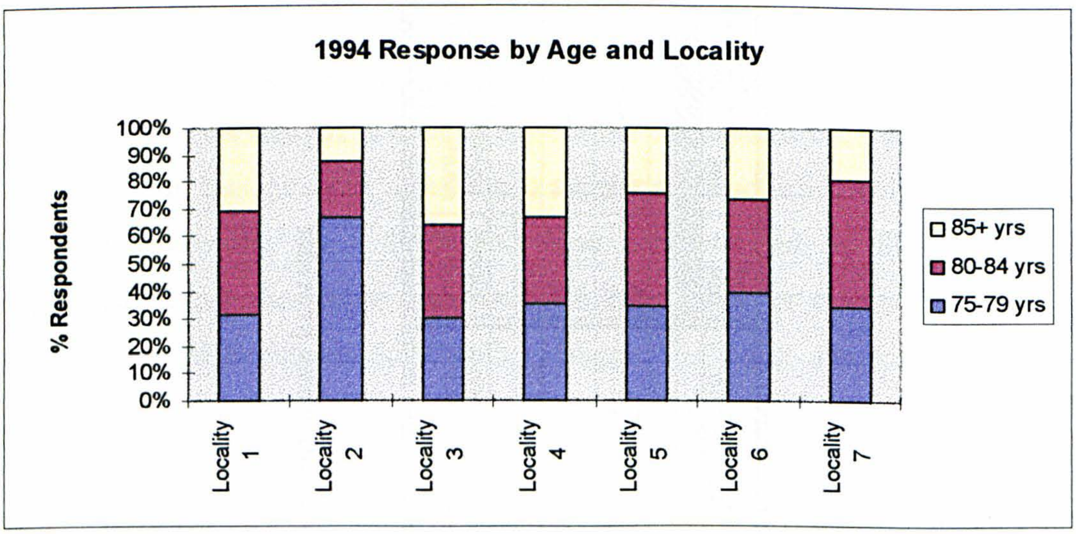


Fig 7.4 1994 response rate analysed by age and locality of respondents

The key findings from the 1994 survey and follow-up interview of users were as follows.

General findings

- Of the 782 patients surveyed there was a valid response of 76.4% (598).
- Of these, 16.2% (97) needed help to complete the questionnaire, with more help needed with increasing age.
- General information on health services and specific information on chiropody was felt to be important. More was wanted of the latter, particularly instructions for self-care of the feet in written and diagrammatic format available from the chiropodist or library.
- There was a visible connection between expectation and experience (see Appendices 15–19).

There was a significant association at the $p < 0.05$ level for the following findings.

Age related findings 1994

Expectation and experience of domiciliary care increased with age

If only those respondents who stated a definite preference were compared, there was a highly significant association between age and venue (P = 0.00000). For example, 9.1% (17) of those aged between 75 – 79 years expected to have treatment at home compared with 14.1% (23) of those aged 80-84 and 32% (33) of those aged 85 and over. A significant result on this variable was found in 1995 and the two results are compared in Fig, 7.5.

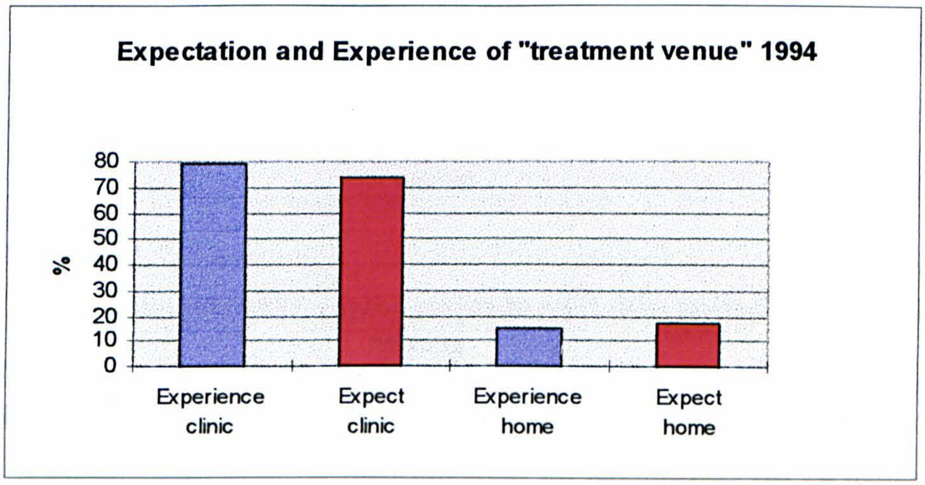


Fig. 7.5 Expectation and experience of treatment venue 1994

These findings emphasise the importance of clear information which is recognised as consistent with practice.

Gender related findings 1994

When only those who answered were considered and those who were dissatisfied and very dissatisfied were aggregated, there was a significant association between satisfaction with type of chiropody received and gender (p = 0.03413) (Fig. 7.6), for example, 43.6% (68) of male patients were satisfied compared with 53.6% (206) of female patients.

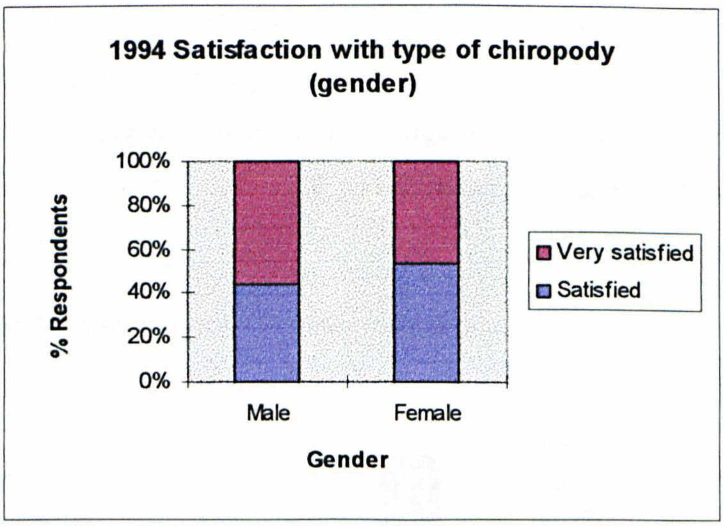


Fig 7.6 Satisfaction with type of chiropody by 1994 respondents analysed by gender

Frequency of treatment was expected to be regular by female patients and decided by the chiropodist for male patients

If only those who provided a definite answer to the question were considered, there was a significant association between gender and expected frequency of treatment (p = 0.00007) (Fig. 7.7), for example, 22.7% (34) male patients expected a regular number of weeks compared with 34.5% (138) of the female patients; in addition, 58.7% (88) of the male patients expected frequency set by the chiropodist compared with 36.8% (147) of the female patients.

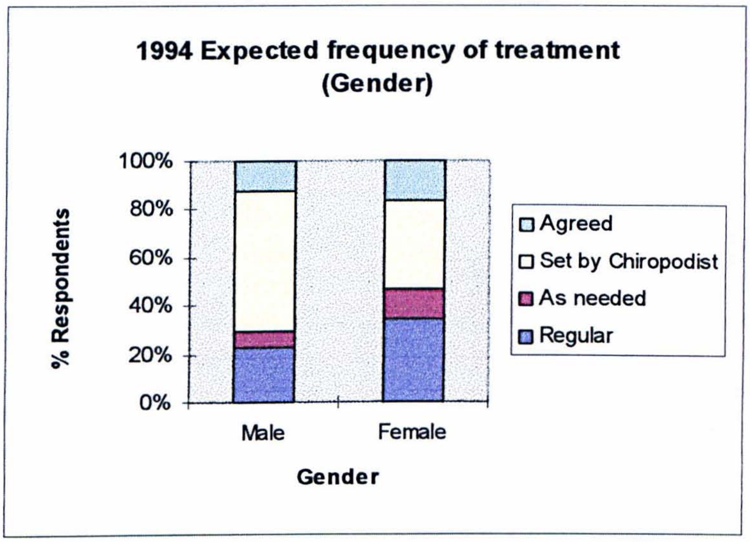


Fig. 7.7 Expected frequency of treatment by 1994 respondents by gender

Female patients were mostly registered for 6+ years and male patients for 1-2 years.

When only those responding to the question were considered, there was a significant association between gender and length of time as a patient (p = 0.00001) (Fig. 7.8), for example, attendance of male patients peaked at 1–2 years, being indicated by 33.1% (51), compared with only 21.9% (84) of women. Conversely, attendance of female patients peaked at 6+ years, being indicated by 46% (176) compared with 22.7% (35) for men.

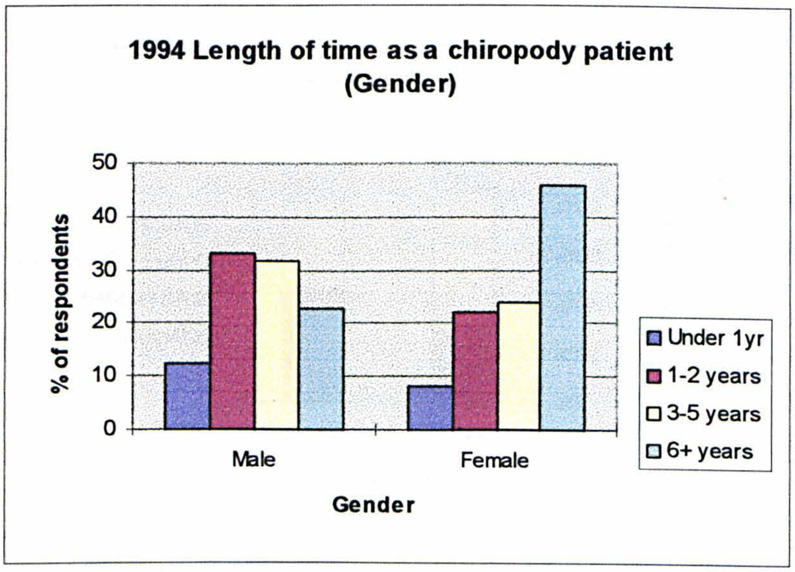


Fig. 7.8 Length of time as a chiropody patient by 1994 respondents analysed by gender

The longer duration and regular frequency of treatment for female patients, with which they were satisfied, may reflect their greater need, expectation and confidence in getting their health needs met. Only peer review could confirm the validity for longer duration and regular frequency of treatment.

Locality related findings 1994

Locality 2 had the youngest patients (Table 7.4) who found making follow-up appointments easiest.

1994

If only those who responded were considered, there was a significant association between actual ease of making follow-up appointments and locality ($p = 0.00576$) (Fig. 7.9). For example, the experience of making a follow-up appointment was felt to be very easy in locality 2 for 56% (28) compared with the next highest of 50% (47) in locality 6.

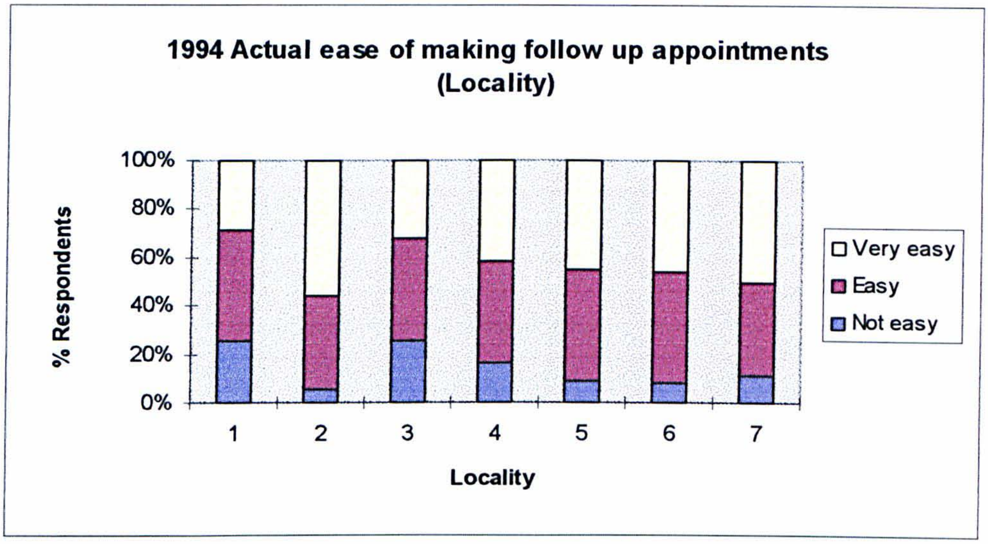


Fig. 7.9 Actual ease of making follow up appointments by 1994 respondents analysed by locality

Locality 2 were most deferent to the decisions of the chiropodist

When only those who provided a definite answer were considered, there was a positive association between the actual method of deciding the next treatment and locality (*p* = 0.00215) (Fig. 7.10), for example, only 4.3% (3) of patients in locality 1 actually agreed their treatment date compared with the highest of 17.5% (10) in locality 2.

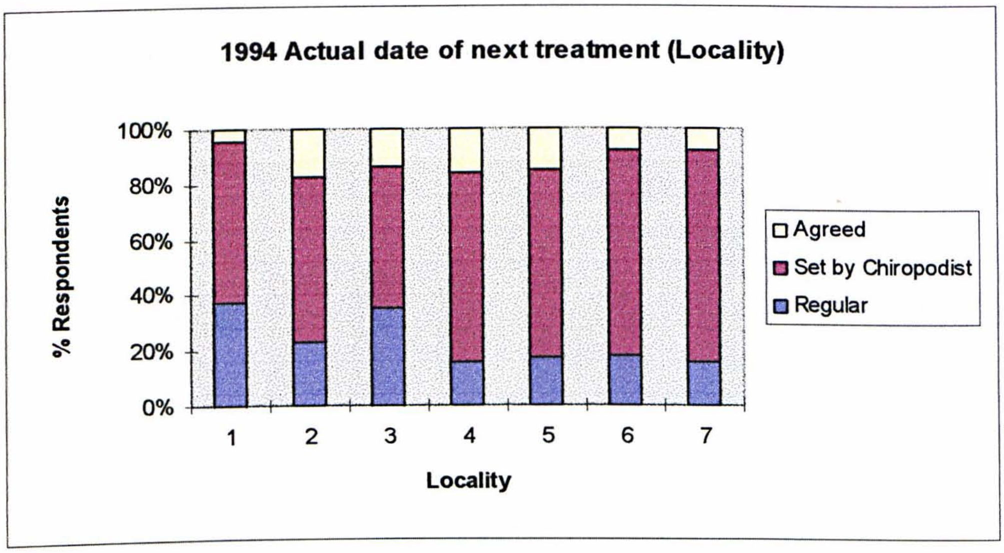


Fig 7.10 Actual date of next treatment by 1994 respondents analysed by locality

Locality 6 patients were most satisfied with making follow-up appointments

If only those responding were considered, and those who were very dissatisfied and dissatisfied were aggregated, there was a significant association between satisfaction with the arrangements for making follow-up appointments and locality (*p* = 0.00027) (Fig. 7.11), for example, in locality 1 where only 14.6% (12) were very satisfied compared with 44.9% (48) in locality 6.

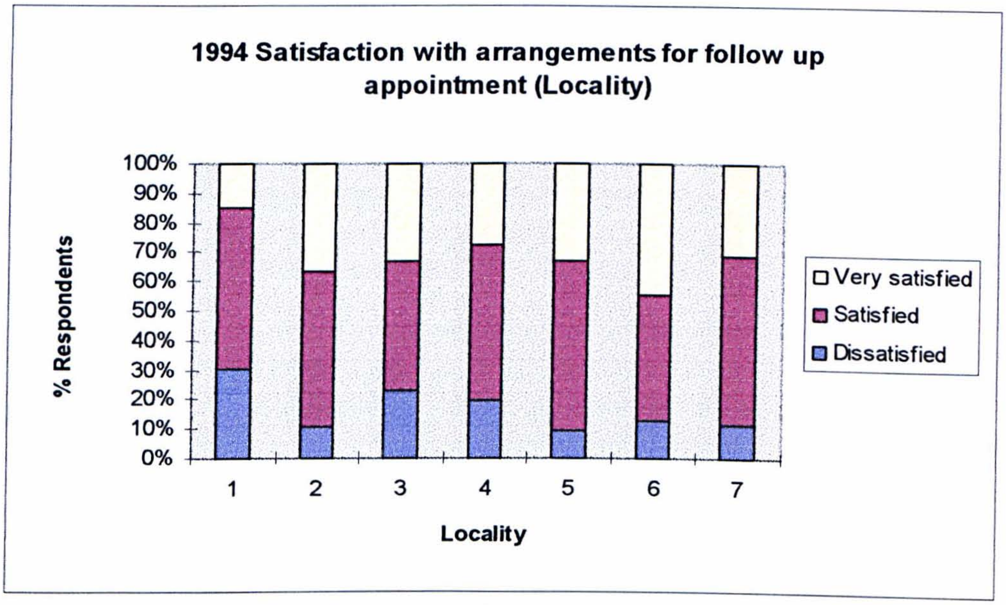


Fig 7.11 Satisfaction with arrangements for follow-up appointment by 1994 respondents analysed by locality

Locality 5, 6 and 7 patients sought and received domiciliary treatment

If only those respondents who stated a definite preference were compared, there was a highly significant association between locality and venue (p = 0.00000) (Fig. 7.12). Particularly notable was the expectation of home treatment in locality 5 (=36.3% or 33), locality 6 (27.5% or 28) and locality 7 (26.5% or 26), compared with the next highest of 10.2% (5) in locality 4. Localities 5, 6 and 7 correspond to those covered by the SCP.

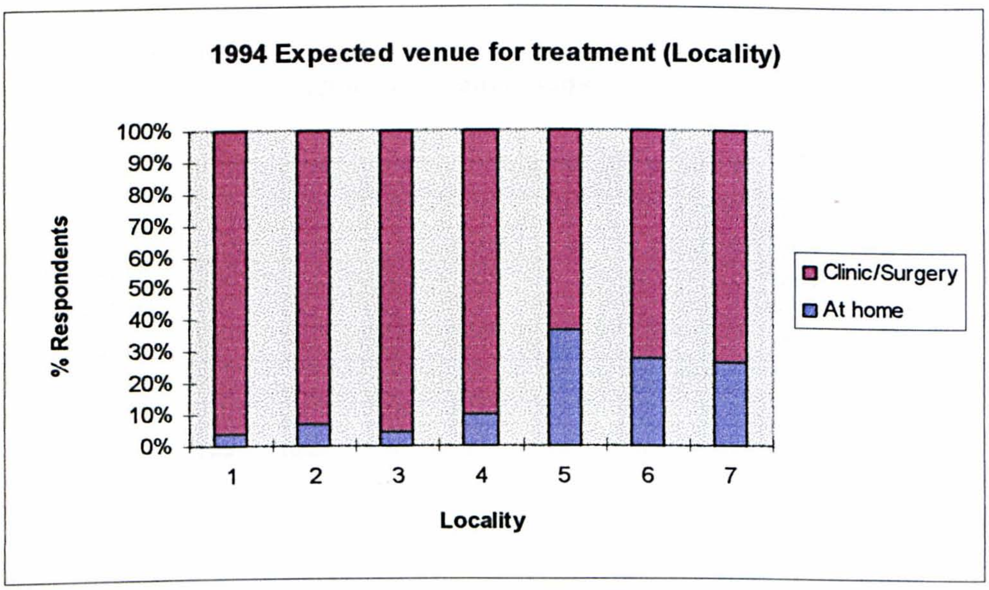


Fig 7.12 Expected venue for treatment by 1994 respondents analysed by locality

If only those respondents who indicated that they usually had their treatment at home or at the clinic/surgery were compared, there was a highly significant association between locality and usual venue for treatment (p = 0.00000) (Fig. 7.13), for example, home-based treatment occurred for 32.6% (30) in locality 5, for 24.8% (26) in locality 6 and for 19.4% (19) in locality 7, compared with the next highest of 8.6% (5) in locality 2. Localities 5, 6 and 7 correspond with those covered by the SCP and it is noted below (Fig 7.17) that there was a significant association (P=0.00000) between provider and venue. SCP also had the older patient profile and it was noted above (Fig 7.5) that there was a significant association between age and venue (P=0.0000). The result could be influenced by age and provider variables.

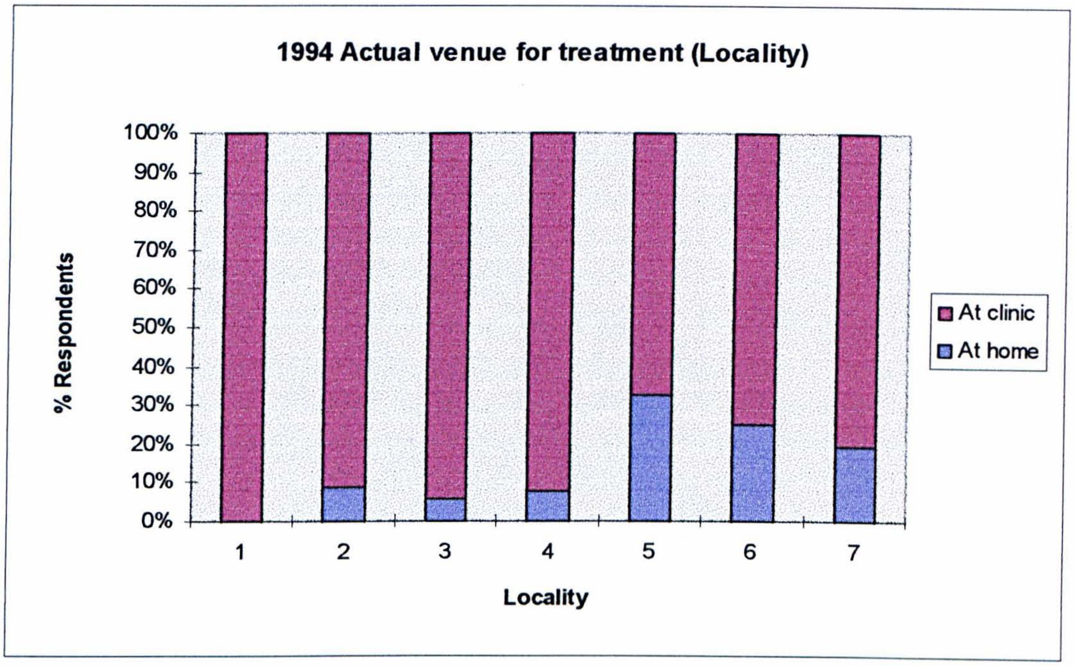


Fig 7.13 Actual venue for treatment by 1994 respondents analysed by locality

Patients in localities 1-3 had regular appointments and patients in localities 4-7 had them set by the chiropodist

When only those who provided a definite answer were considered, there was a positive association between the actual method of deciding the next treatment and locality (p = 0.00215) (Fig. 7.14), for example, only 4.3% (3) of patients in locality 1 actually agreed their treatment date compared with the highest of 17.5% (10) in locality 2.

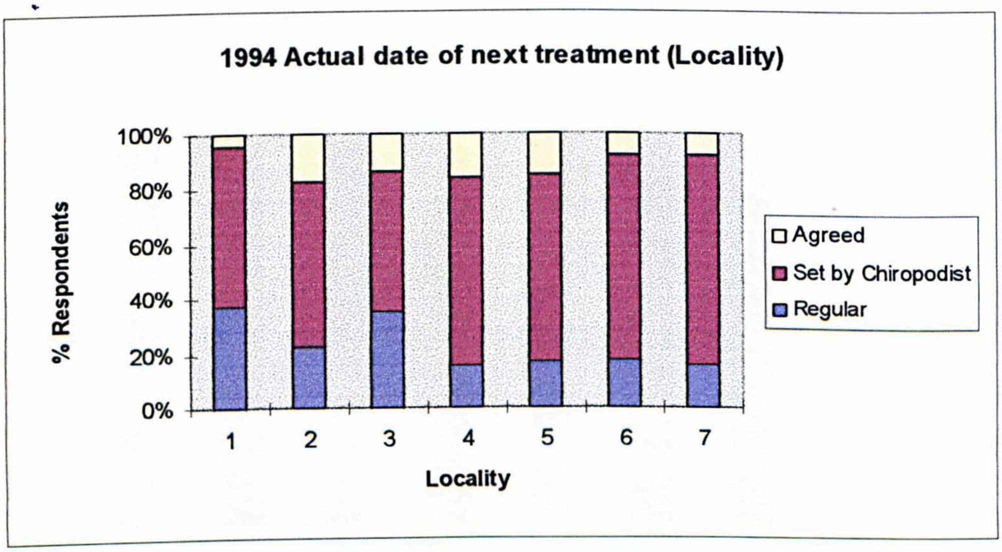


Fig 7.14 Actual date of next treatment by 1994 respondents analysed by locality

Patients in localities 1-4 had mostly been registered for 6+ years compared with less for localities 5, 6 and 7

When only those responding were considered, there was a significant association between length of time as a patient and locality (p = 0.00515) (Fig. 7.15). Of particular interest is the grouping of localities 1–4 and 5–7 where, for example, 51.9% (42) of patients in locality 1 had been patients for 6+ years, compared with the lowest of 26% (27) in locality 6. This grouping may reflect the fact that the SCP, which covers the latter group, were only contracted to provide a service from 1991.

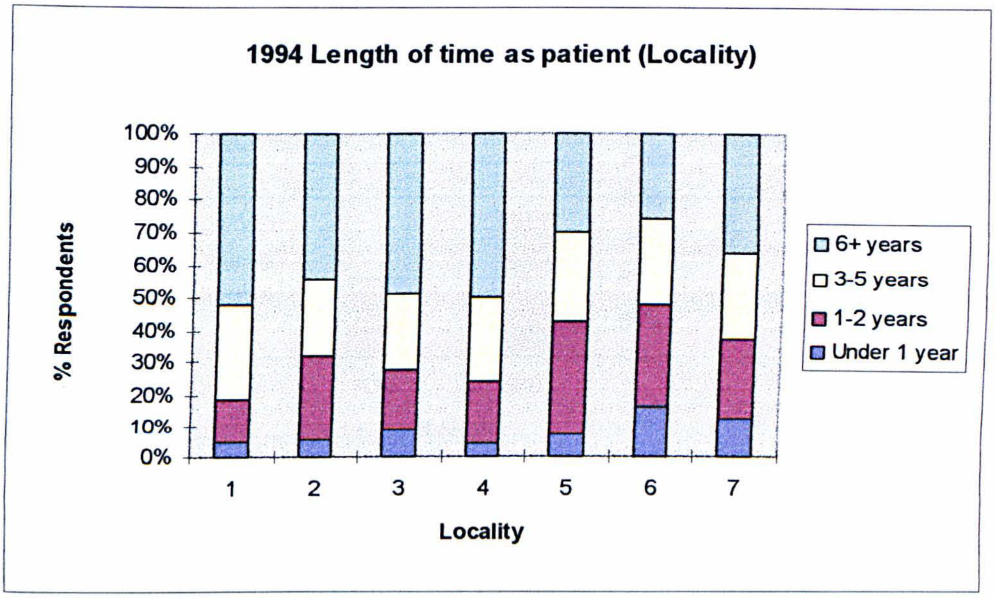


Fig. 7.15 Length of time as a chiropody patient by 1994 respondents analysed by locality

Provider related findings 1994

SCP patients were older (Table 3) and found making the first and follow-up appointments easiest.

If only those respondents who answered the question were considered, there was a high level of ease of making the first appointment. There was a significant association between provider and actual ease of making the first appointment (*p* = 0.00004) (Fig. 7.16). For example 26.4% (34) of the BHB patients found it very easy compared with 59.4% (38) the SCP patients.

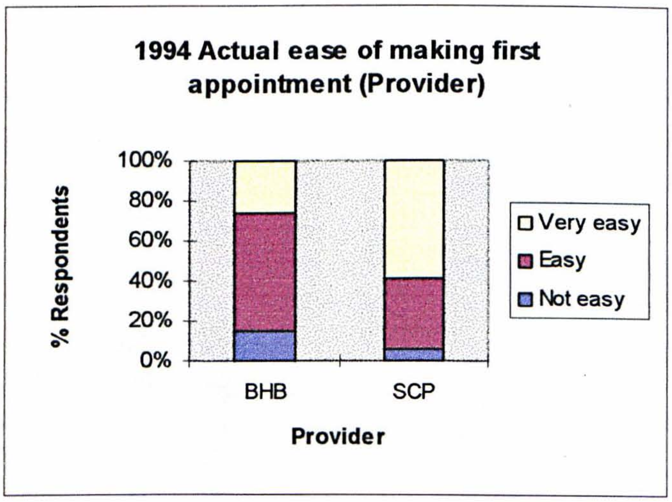


Fig. 7.16 Actual ease of making first appointment by 1994 respondents analysed by provider

Regarding follow-up appointments, if only those who responded to this question were considered, there was a significant association between provider and actual ease of making appointments (p = 0.00023). For instance, 38.6% (154) of the BHB patients found it very easy compared with 60.2% (62) of the SCP ones. This is compared later with 1995 data where it was also significant (Fig 7.25).

SCP patients were most satisfied with the follow-up appointment arrangements

If only those responding were considered, and very dissatisfied and dissatisfied were aggregated, there was a highly significant association between satisfaction with the arrangements for making follow-up appointments and provider (p = 0.00000), for example, 26.6% (119) of the BHB patients were very satisfied compared with 53% (61) of the SCP patients. A significant result on this variable was found in 1995 and the two results are compared in Fig. 7.26.

SCP patients were most satisfied with service organisation

When those answering the question were considered and disorganised and very disorganised were aggregated, there was a significant association between view of chiropody organisation and provider (p = 0.00019), for example, 49.1% (55) of the SCP patients felt that their service was very organised compared with 29.3% (129) of the BHB patients. A significant result on this variable was also found in 1995 and the two results are compared in Fig 7.31.

SCP patients were most satisfied overall

If only those who responded were considered and those who were dissatisfied and very dissatisfied were aggregated, there was a significant association between overall experience of NHS chiropody and provider (p = 0.02298), for example, 42.2% (188) of the BHB patients were satisfied compared with 55.2% (58) of the SCP patients. A significant result on this variable was also found in 1995 and the two results are compared in Fig 7.27.

BHB patients expected and received treatment at the clinic

If only those respondents who stated a definite preference were considered, there was a highly significant association between provider and venue (p = 0.00000) (Fig. 7.17), with 6.3% (27) of the BHB patients expecting treatment at home compared with 68.8% (75) for the SCP patients (Fig. A14.8). It was noted earlier that analysis of responses had found that the SCP patients were older which equates with dependence.

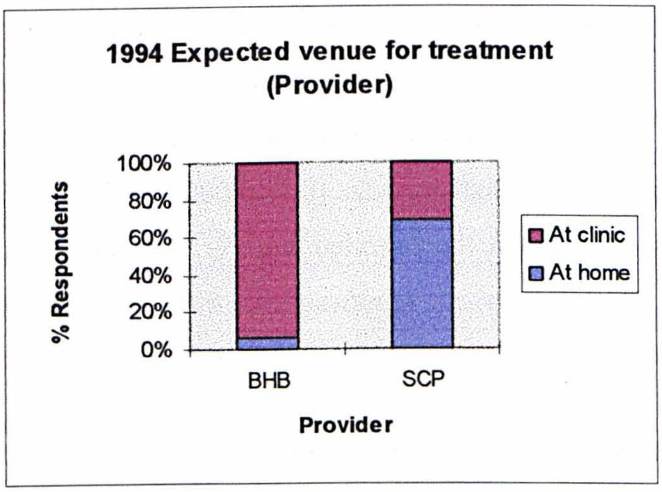


Fig 7.17 Expected venue for treatment for 1994 respondents analysed by provider

Explanation of the 1994 survey findings

Overall, there was a high level of satisfaction with both services, with the different contract requirements making some contribution to the differences between providers. For example, the service provided by the SCP was new, targeted at the older age groups who may have greater need for domiciliary care, and had restricted alternative arrangements (a single clinic and no dedicated ambulance). The locality differences are also largely provider related, which in turn are a reflection of the different contracts. Further investigation into any unique circumstances within locality 2 was requested of the provider in view of the findings on age (Table 7.5) and deference (Fig 7.10) and was reported in 1995 (see below).

In 1994, each respondent was asked to name a particular area of concern or positive comment. There was a lot of praise for the service, mainly about staff attitude (humanity), promptness of appointment and actual treatment. Concerns were about clinical and administrative processes.

A summary report on the 1994 survey (see Appendix 20) was sent to providers, commissioners and the 258 patients in the survey sample requesting it. The report noted recommendations for the following improvements to the services.

criteria to be established
clarity on chiropody and personal care to be established
appointment system to be reviewed
user information to be developed
clinic selection by balanced choice.

Quality reports 1994–5

Providers recorded progress each quarter on the quality specification in the format requested, Fig 7.18 provides an example. When collated these formed a comprehensive report (Addendum 1).

<table>
<tr><td colspan="4">Standard 3: the provider will develop an information sheet to include all basic criteria on access to, content of and outcome of treatment and measure its effectiveness.
Target: all essential information needed by applicants
Measure and report: quarterly progress, with pilot by December 1994</td></tr>
<tr><td>Plan</td><td>Do</td><td>Check</td><td>Act</td></tr>
<tr><td>Q1</td><td>Q2, Q3</td><td>Q4</td><td>Q4</td></tr>
<tr><td colspan="4">Exception report attached [✓ yes]/no
Additional comments
1st quarter:
2nd quarter: staff involved in planning form.
3rd quarter: draft ready, collaborating with HA
4th quarter: leaflet printed, HA funded, in use.
Annual report submitted</td></tr>
</table>

Fig. 7.18 Documented quarterly progress on a standard

Independent clinical peer review (ICPR), 1994

After the initial stakeholder meeting which identified ICPR as a project (see Table. 7.1), a paper was put to the Footcare Commissioning Group by this author in 1993, indicating that assurance of clinical standards required external peer review to ensure independence and facilitate benchmarking against national best practice.

The process of developing such a review for chiropody services follows, which this author believes has wider applicability. The stakeholders were identified and an exploratory seminar was held with the patients' representative (Age Concern and Community Health Council), the chiropody providers (BHB, SCP), their professional body the Society of Chiropodists and Podiatrists (the Society), and the joint purchasers (BHHA and FHSA). A formal contract was subsequently made with The Society for the review which includes record audit, confirmatory visits, verbal feedback and a written report (Appendix 10). The report was shared with the Contract review Team responsible for chiropody services. The recommendations, as part of many sources of intelligence on quality, were considered for inclusion in the quality specification for 1995-6 to ensure continuous improvement..

A follow-up meeting of the stakeholders took place to review the initiative. It was felt to be non-threatening by the providers because they were involved from the start and there had been no complaints from service users. Now that the process had been designed, the overall timescale from decision to approach the professional body to receipt of the final report could be reduced to four months. The conclusion of all stakeholders was that the initiative delivered what had been intended---a review by peers against local requirements with recommendations for continuous improvement.

1994–5: chiropody contract review

Evaluation of the 1994–5 chiropody contract indicated that there had been success against the UCP markers of health gain (pain relief, mobility and comfortable shoe wearing) satisfaction (with various aspects of the service) and effectiveness (by peer review) :

- The improvement hoped for was recorded by 82.4% of users.
- There was 88.6% satisfaction by users.
- Treatment was appropriate (ICPR assessor's report).

7.3.4 Participant involvement to continuously improve quality: contract specification for 1995–6

Where appropriate, all completed standards were transferred into the providers' internal quality system for ongoing audit, with the incomplete contributing to the next synthesis along with changing statutory requirements, new evidence and reports from 1994/5 (see Addendum note 2). The Quality Synthesis Model was used again to prioritise, document, ensure continuous improvement and record progress (see Addendum Note 3). All final standards were included in the sample frame each quarter, whereby the evidence supporting the report was reviewed by the purchaser against the agreed criteria.

During this contract period, particular emphasis was placed on eligibility of the BHB service users as many who were aged over 75 had been long-term patients, entering through the different criteria of the time. The initiative was funded through an additional 2.5 Whole Time Equivalent (WTE) chiropodists for one year by the Health Authority to undertake the extra work. All first contacts in the year (estimated to be 12,500) were to be treated as new patients, with full assessment and a plan for an *episode* of care where appropriate. The results would inform future Commissioning Intentions, required by the Department of Health to indicate plans and stimulate local discussion. The purchaser also offered to fund and contribute to a change management programme for chiropodists, to assist them in dealing with disappointed users who might feel that they were not receiving what they had assumed as entitlement. This was undertaken using an external facilitator who used group work and role play to help the chiropodists understand how stakeholder expectations were formed; develop appropriate responses; and plan a preventive strategy.

Quality reports 1995–6

Providers again reported quarterly progress on the quality specifications in the format requested (see Addendum Note 3). Conversion of the progress data into graphic format enabled comparison between providers with benchmarking of best practice. It also identified problem areas, such as delay in progress, which could be investigated to assist the provider in identifying the cause and to suggest solutions. An example is shown in Fig. 7.19, in which SCP failed to move beyond planning for tiered care and the flow of progress by the BHB was stalled in the third quarter. These delays could trigger purchaser and provider attention and appropriate action.

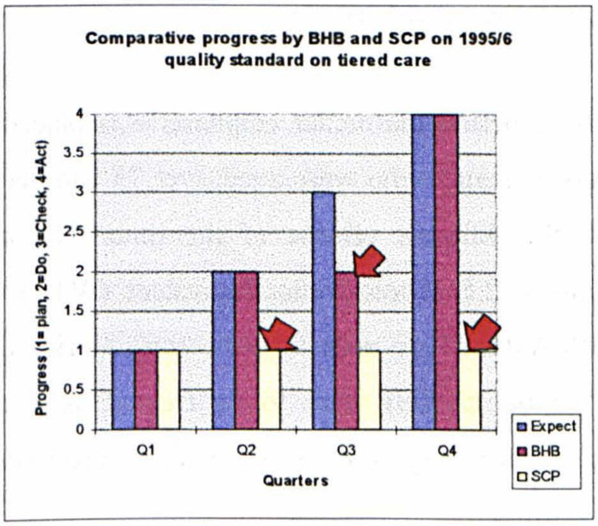


Fig. 7.19 Comparative data from BHB and SCP 1995–6 quality standard on tiered provision (BHB Standard 9, SCP Standard 5)

Another example was the result of combined standards 3, 4 and 5:

- **Standard 3:** policy for died/discharged
- **Standard 4:** criteria
- **Standard 5**: information to patients including possibility of clinic choice.

This resulted in the production of a comprehensive, appropriate service leaflet, agreed by the stakeholders, piloted on users, and funded by the purchaser (see Appendix 21).

7.3.5 Quasi-quantitative methods to establish change in satisfaction with the 1995/6 specification

As with the 1994 survey, satisfaction with a number of issues identified through assessment of need and other intelligence was undertaken. The same sample was used, with replacements recruited to replace those who had died. The 1995 data was subsequently compared with that of 1994 to establish changes in response. After one reminder, there was a response rate of 69.8% (546).

As for the 1994 survey, age was considered against the locality and provider characteristics. There was a significant association between age and locality of respondents ($p = 0.00218$) (Fig. 7.20). Again locality 2 is striking, with 75.5% (37) of its respondents in the 75–79 age group, compared with the next highest of 44.4% (48) in locality 6.

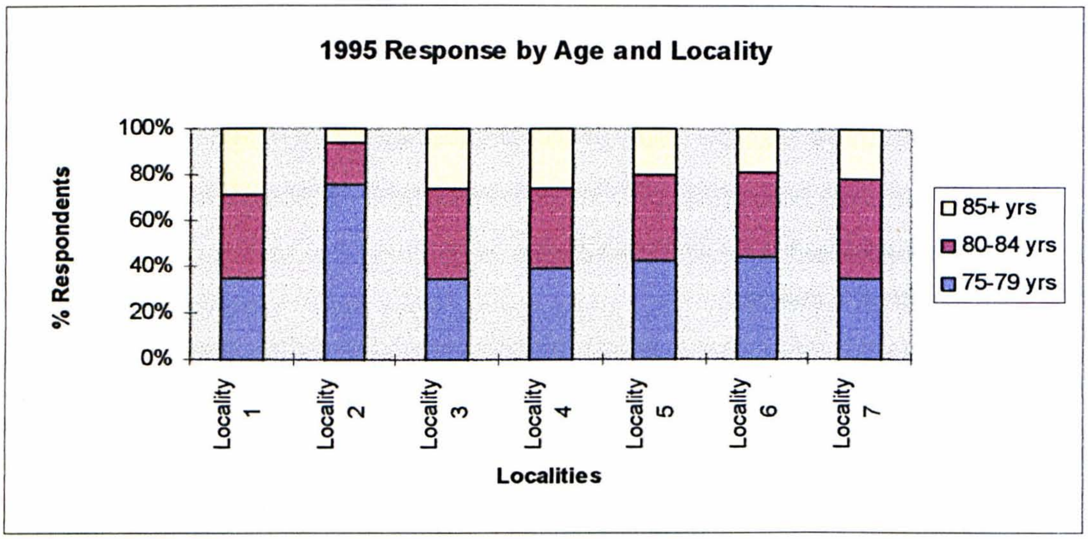


Fig. 7.20 Response by age and locality of respondent (1995)

The key findings from the 1995 user survey and interviews were as follows:

General findings

- Of the 782 patients surveyed there was a valid response rate of 65.2% (510).
- Of these, 14.7% (75) needed help to complete the questionnaire; more were with SCP.
- Both providers had made progress on a number of issues since 1994.
- General information on health services and specific information on chiropody continued to be important. The latter was, was found to be useful, was even more likely to be obtained from chiropodists, and more was wanted. Advice on implements was particularly sought. Criteria for all stages of care were sought.
- Reduction in the footcare problem was mainly sought, although need for advice increased and 79.8% felt that the need was met.
- BHB patients had most suggestions for dealing with wasted appointments proposing more information, improved venues/transport; reminders and improved cancellation facilities, and stronger penalties for culprits, particularly default charges, treatment delay or discharge.
- BHB patients were more likely to volunteer additional comments, be willing to be interviewed and seek a report.
- The appointment system continued to be of considerable concern.

- Links of expectation, perception and satisfaction were again not dissimilar, but were moving together towards agreed best practice (see Appendices 15–19) so, for example, t less people had an expectation that making an appointment would be difficult.

There were significant associations at the $p < 0.05$ level for the following findings.

Age related findings 1995

If only those respondents who stated a definite preference were compared, there was a highly significant association between age and venue (P = 0.00000) for example, 9.1% (17) of those aged 75–79 years expected to have treatment at home compared with 14.1% (23) of those aged 80–84 and 32.4% (33) of those aged 85 and over. This is compared with the significant finding from 1994 (Fig 7.21).

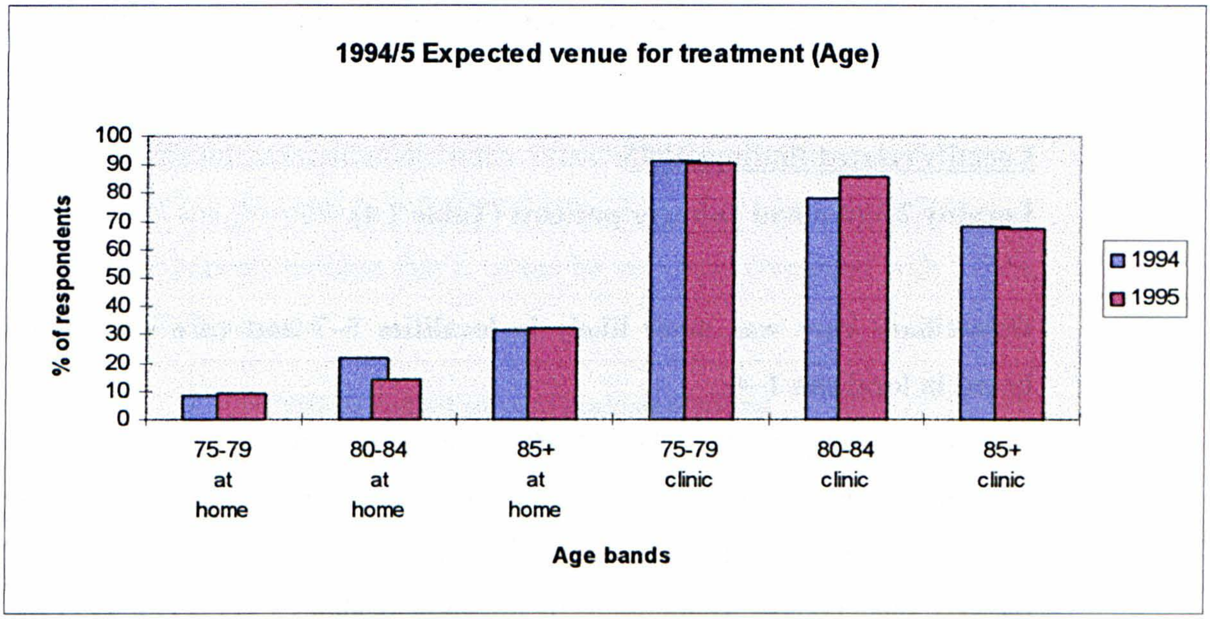


Fig. 7.21 Comparison of expected venue for treatment of 1994 and 1995 respondents analysed by age

If only those respondents who indicated where they had their treatment were considered, there was a highly significant association between age and venue (p = 0.00000), for example, 8.8 % (17) of those aged 75-79 had their treatment at home compared with 13.9% (23) of those aged 80–84 and 31.1% (32) of those aged 85+. This is compared with the significant finding from 1994 (Fig 7.22).

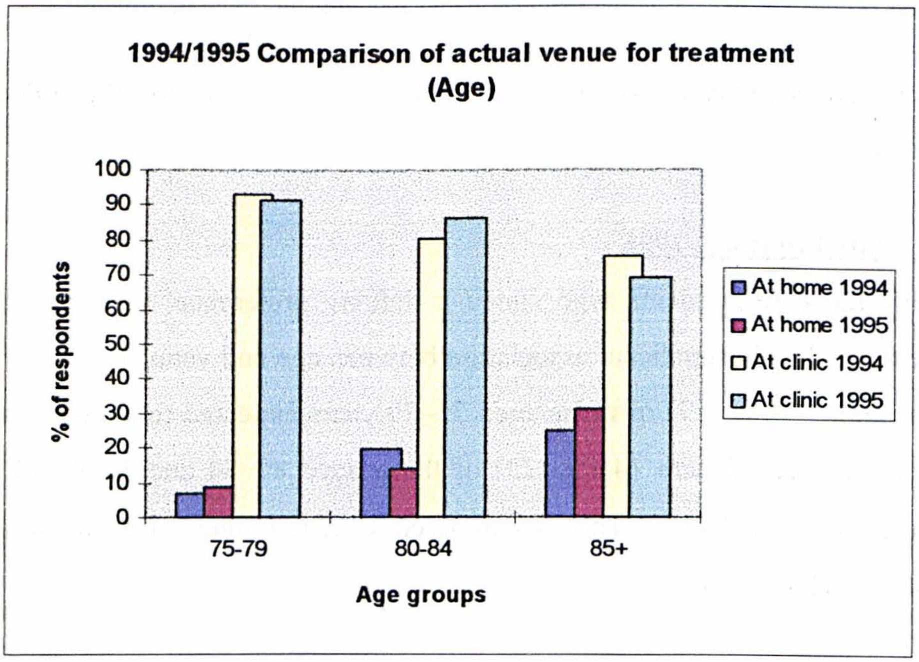


Fig 7.22 Comparison of actual venue for treatment by 1994 and 1995 respondents analysed by age

Locality related findings 1995

Locality 2 again had younger patients (Table 7.4).

Domiciliary care was more likely in localities 5–7 and care was clinic-based in localities 1–4.

If only those respondents who indicated where they had their treatment were compared, there was a highly significant association between locality and venue (*p* = 0.00000) (Fig. 7.23). This should be interpreted with caution because of the very small number having home treatment in localities 1 (1), 2 (2), 3 (2) and 4 (1), which correspond to the localities solely covered by the BHB. Domiciliary care was provided to 26.2% (16) in locality 5 and 25.5% (25) in locality 6 as well as (24.8% (25) in locality 7 which correspond to SCP areas.

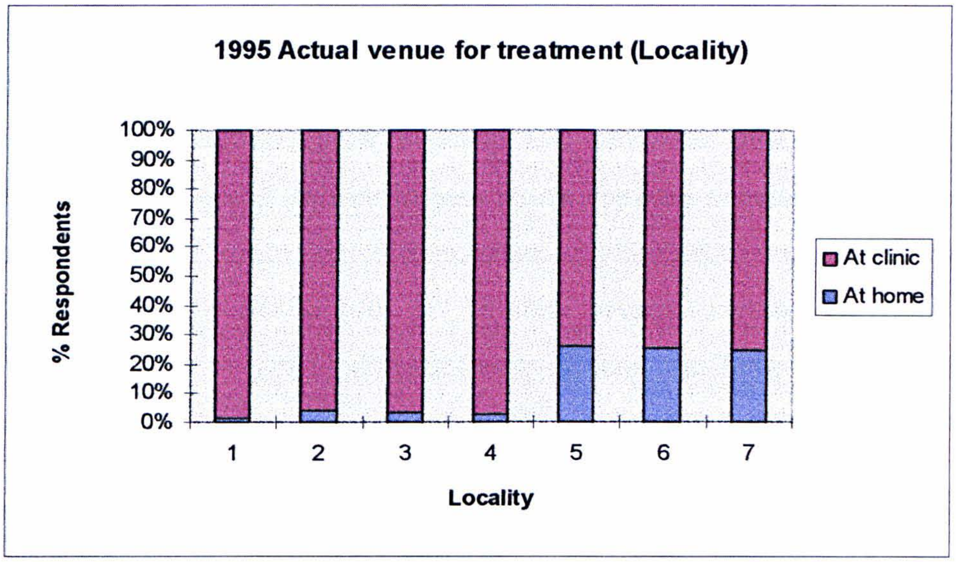


Fig 7.23 Actual venue for treatment by 1995 respondents analysed by locality

Provider related findings 1995

Those treated by the SCP expected making follow-up appointments to be easiest.

After deletion of data from those who did not know and did not reply, there was a significant association between expected ease of making a follow-up appointment and provider (*p* = 0.00034) (Fig. 7.24). For example 33.7% (112) of the BHB patients thought that it would be very easy compared with 53.6% (59) of the SCP patients.

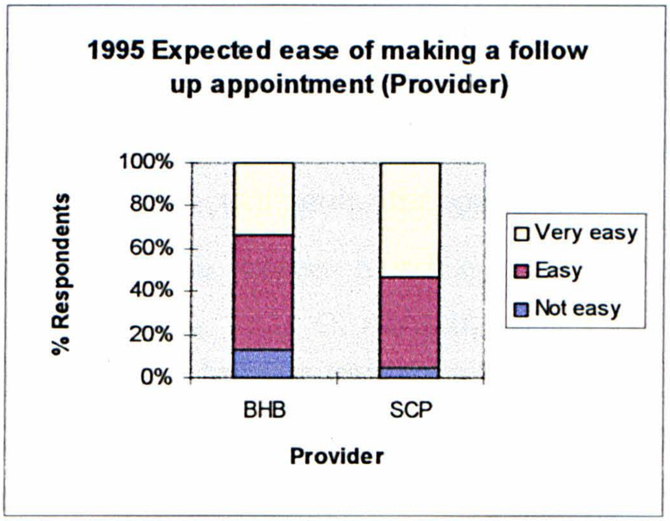


Fig. 7.24 Expected ease of making a follow-up appointment by 1995 respondents analysed by provider

Those treated by the SCP found making follow up appointments easiest

If only those who answered this question were considered, there was a significant association between actual ease of making follow-up appointments and provider (*p* = 0.00000) For instance, 34.9% (113) of the BHB patients found it very easy compared with 57.1% (60) of the SCP patients. This compared with significant findings from 1994 (Fig. 7.25).

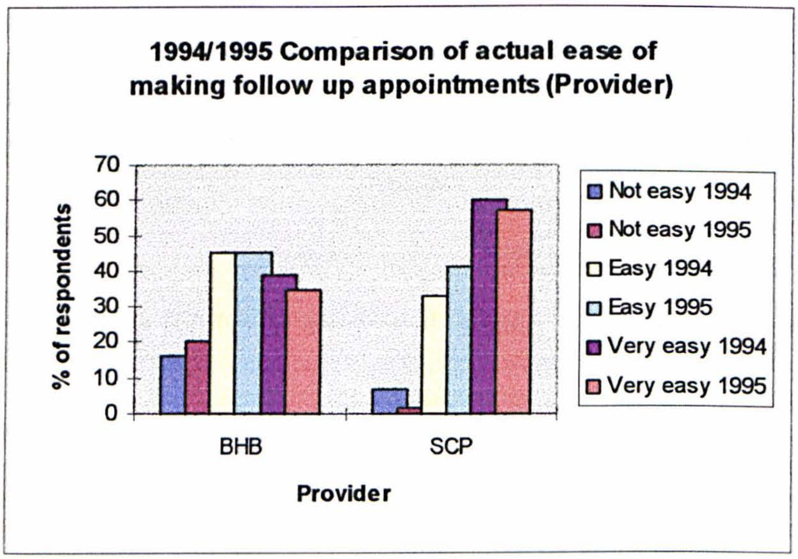


Fig. 7.25 Comparison of actual ease of making first appointments between 1994 and 1995 respondents analysed by provider

Comparison over the two years indicates that SCP have improved on "not easy" where BHB has worsened, and on "easy" where BHB has remained static. Both have lost ground on a "very easy" experience of making follow-up appointments, probably in line with rising user expectations not matched by provider improvement.

Those treated by the SCP were most satisfied with the arrangements for making follow up appointments.

When only those who responded were considered and those who were very dissatisfied and dissatisfied were aggregated, there was a significant association between satisfaction with the arrangements for making follow-up appointments and provider ($p = 0.00001$) (Fig. 7.26), for example, 34.8% (117) of the BHB patients were very satisfied compared with 57% (65) of the SCP patients.

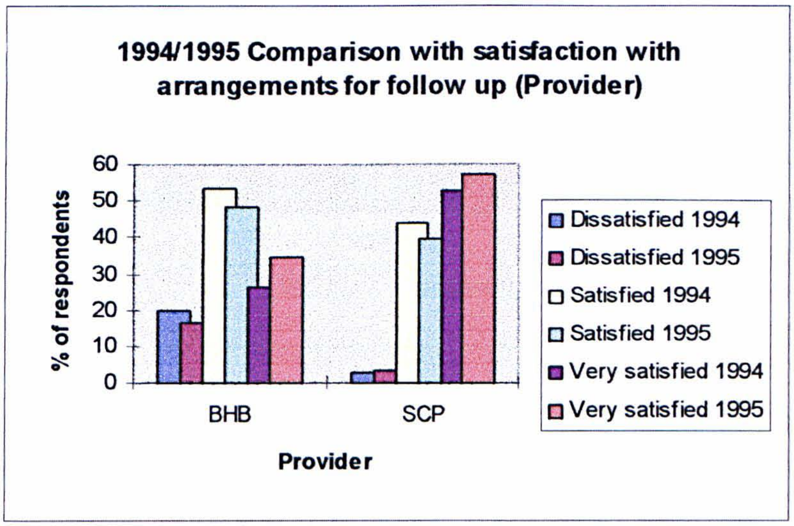


Fig 7.26 Comparison of satisfaction with arrangements for follow-up appointments by 1994 and 1995 respondents analysed by provider

Comparison over the two years indicates that both the BHB and the SCP have made some progress on high satisfaction, but mainly at the expense of "satisfaction", although the BHB have also made some impact on "dissatisfaction".

SCP patients were most satisfied with their overall experience of the service.

When only those responding were considered, and those indicating that their experience was unsatisfactory or very unsatisfactory were aggregated, there was a significant association between overall experience of chiropody and provider ($p = 0.01255$) (Fig. 7.27). Of the BHB patients 49.1% (158) were very satisfied and 62.6% (72) of the SCP patients. This was slightly lower than the 69% overall satisfaction with the SCP service in the 1992 pilot survey.

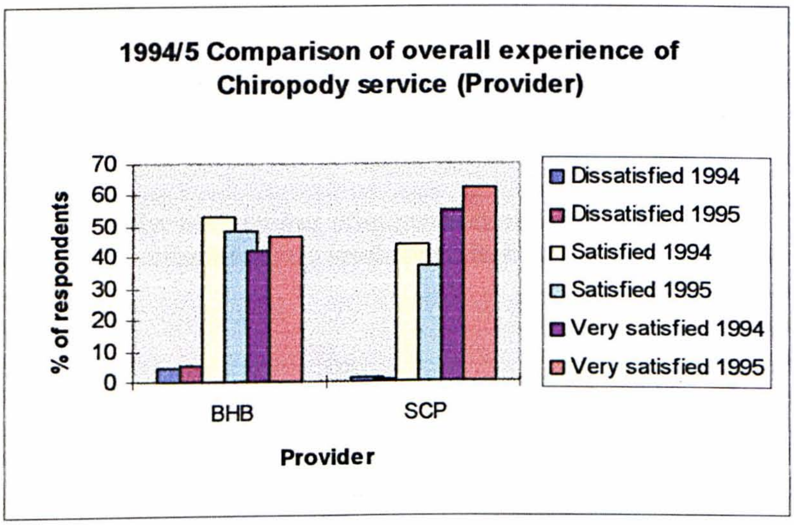


Fig. 7.27 Comparison of overall experience of chiropody service by 1994 and 1995 respondents analysed by provider

Comment on the 1995 findings

Overall satisfaction was high and increasing. More information was needed on what criteria patients use to make their scores, and the issue was included in the 1994 and 1995 interview schedules. In 1995 each respondent was again asked to name a particular area of concern and the overall concern was the appointment system.

Provider comparison on 1994 and 1995 surveys

Significant issues were compared between 1994 and 1995 to show the changes that were occurring. Comparison on arrangements for follow-up showed both providers making progress (Fig. 7.28).

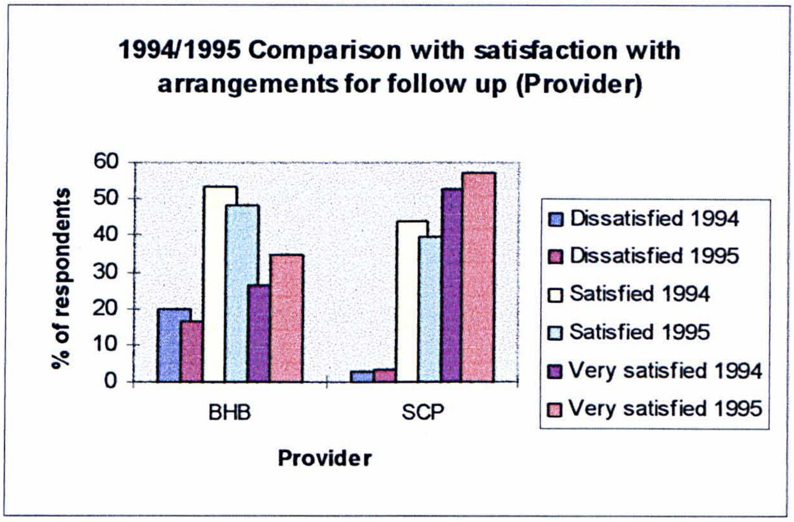


Fig 7.28 Comparison between 1994 and 1995 survey results on satisfaction on arrangements for follow-up appointments compared between providers

Comparison on venue for treatment showed that more SCP patients expected and experienced a clinic venue for treatment. The latter is compared with 1994, indicating the change in practice of SCP in response to contract requirements to increase clinic-based and decrease home-based care (Fig. 7.29).

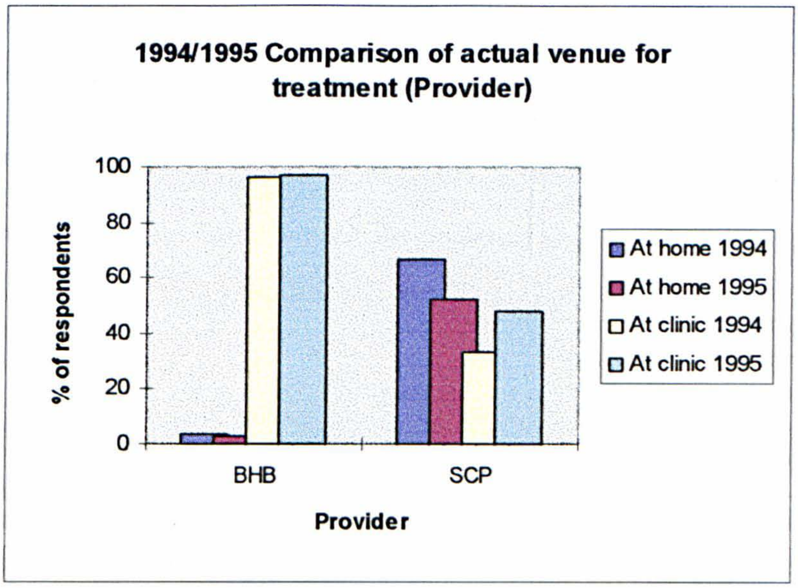


Fig. 7.29 Comparison between 1994 and 1995 survey results on actual venue for treatment and compared between providers

Comparison of view of Chiropody organisation showed that SCP patients were most satisfied with service organisation. SCP had made particular progress since 1994; BHB had remained constant (Fig. 7.30).

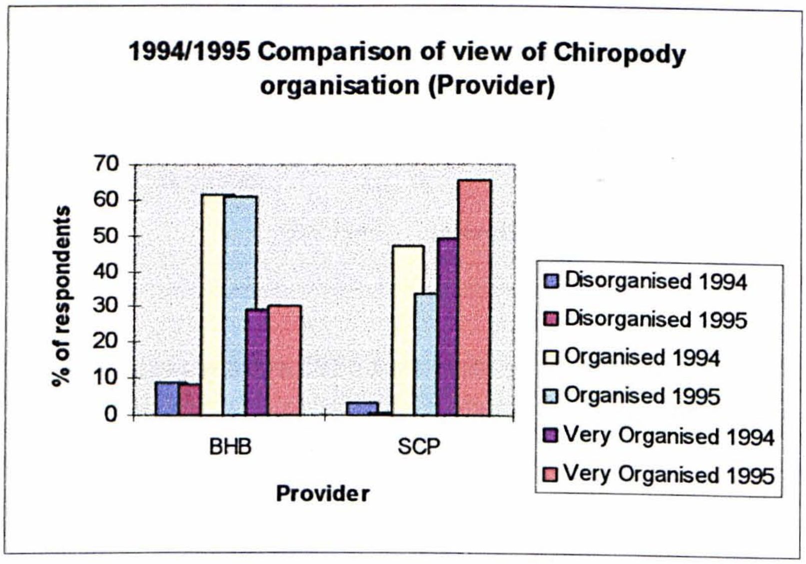


Fig 7.30 Comparison between 1994 and 1995 survey results on view of chiropody organisation compared by provider

Trends between 1994 and 1995

The trends between 1994 and 1995 were that usefulness of footcare information had increased and its provision by the chiropodist had also increased. There was: increased satisfaction with arrangements for follow-up appointments; increased expectation of domiciliary care; satisfaction with arranged venue; increased satisfaction with clinic facilities.

Locality 2

The chiropody service in locality 2 continued to have younger patients with similar requirements to those in 1994, although inconsistent with the locality demography. The result of the internal investigation into differences in the locality revealed that it was *the only locality without administrative help*. The potential to probe this issue further was noted for inclusion in 1996/7 quality synthesis process. In the meantime it was hypothesised that lack of administrative help would leave the chiropodist little time to search out patients not on the list (making the age profile younger) and who would make appointments directly (chiropodist defined and probably accepted by patients more deferent to a professional). This lack of administrative help had been unknown to the author and indicated the potential of the model to indicate unexplained variation for investigation.

The views of new patients in 1995 were analysed by frequency only, due to the small numbers. It was felt that their views would provide information on how the service was now perceived by new entrants. These are fully described in Appendix 24, and key issues of note are as follows

- Those who had been discharged were satisfied with the arrangements
- More new patients were seeking advice
- They were more likely to expect and receive clinic treatment

There remained the perception that chiropody was for life which they felt they were receiving and were satisfied with.

A summary report on the 1995 survey (see Appendix 22) was sent to providers, commissioners and the 157 patients requesting it. The report noted recommendations for the following improvements to the services:

- **Information**: comprehensive single leaflet.
- **Failed appointments by patients**: publish policy.
- **Failed appointments by chiropodists**: monitor.
- **Appointment system**: improve.
- **Personal footcare plan**: agree at first appointment.
- **Nail cutting**: develop a plan.
- **Staff and facilities**: review.

There was no response on the content.

Evaluation of the content indicated that there had been success against the markers of health gain, satisfaction and effectiveness:

- Improvement hoped for was recorded by 79.8% of users
- There was overall satisfaction by 85.7% of users
- Treatment was appropriate (by internal audit)

Where appropriate all completed standards were transferred into the providers internal quality system for ongoing audit, those uncompleted being carried forward for synthesis for 1996–7.

7.3.6 A Single comprehensive service based on best practice: 1996 –7 specification

A briefing paper written for the Management Team by the Footcare Commissioning Group, in readiness for statutory 1996–7 Commissioning Intentions, indicated that the two services would be in a position to compete for a single specification. This was based on: the results from the patient reassessment programme; input by an external independent chiropody consultant; the views of interested GP fundholders; and clear specifications with milestones and measures. It was recommended that the successful process of synthesising issues from a wide range of intelligence for baseline requirements should continue.

Service specification 1996–7

The core, care group and service-specific specifications were updated in line with changing statutory requirements, new evidence, reports from 1995–6 and specific issues highlighted for investigation with each provider (see Addendum Note 4). A nail-cutting service was a particular issue for consideration, having been identified as a need by the comprehensive patient reassessment initiative.

Nail-cutting service

The local community consultation and national Feet First report (NHS Executive, 1994) had reached the same conclusions and recommended the need for commissioners to think in terms of three levels of service:

- basic footcare
- specialist footcare (chiropody)
- operative intervention (surgical podiatry).

Subsequent national joint work between Age Concern England (as proxy for the voluntary sector) and the Society of Chiropodists and Podiatrists produced guidelines for volunteer nail-cutting services (Society of Chiropodists, 1995). The Footcare Commissioning Team pursued the initiative (see Appendix 23). On the strength of the rationale, a bid to the Health Authority for additional funding to commission such a service was successful. This offered the potential for the divergent stakeholders' needs of patients (for nail cutting), providers (for retention of complex procedures) and purchasers (for cost-effectiveness of total spend) to be met to mutual satisfaction by innovative provision. These social, scientific and business focussed needs reflect those identified in the preparatory literature search. The goal for this initiative was agreed with both providers (Fig 7.31).

Standard 5 (SCP)/9 (BHB): Tiered provision **Objective/goal:** Joint working e.g. AC/SC and P Nail Cutting initiative **Measure and report:** As requested			
Plan	**Do**	**Check**	**Act**
E Q1	**E Q2**	**E Q3**	**E Q4**
Exception report attached yes/no **Additional comments** **1st quarter:** **2nd quarter:** **3rd quarter:** **4th quarter:**			

Fig 7.31 Goals set for both providers on joint working for tiered provision

The progress made by BHB and SCP on the same standard of tiered provision is documented in Addendum 3, and conversion of the progress data into graphic format enabled comparison between providers with benchmarking of best practice. It also identified problem areas, such as delay in progress, which could be investigated to assist the provider in identifying the cause and to suggest solutions. The example was shown in Fig. 7.19 above.

7.4 Evaluation

The preparatory work (see Chapter 5) established that the quality synthesis model should be evaluated in the following ways:

1. **That the model to establish and respond to patient, purchaser and provider expectations meet the operational criteria expected by purchasers and providers.**

2. **That the model provide a cyclical process compatible with and enhancing commissioning.**

From the point of view of validity of the research process, it was also necessary to ensure:

3. **That the model was valid, reliable and repeatable.**

It was also necessary to ensure that:

4. **The process could result in stakeholder culture change towards continuous improvement of agreed quality.**

5. **The model avoided the sins and diseases of public sector management through:**
    - costs of quality assessed
    - internal and external customers and their needs identified
    - protection provided for minority group interests
    - customer driven measures of quality used.

The following addresses each of these issues in turn.

7.4.1 That the model to establish patient, purchaser and provider expectations meet the operational criteria expected by purchasers and providers

The issues raised in the literature reviews regarding quality management and implementation are considered against the results of the project as described to date (Table 7.4).

Issues from the literature	**Findings from the project**
Comprehensive in coverage	Coverage of all aspects of a service was achieved through the resume'
Dynamic	Changing expectation were identified through the annual cycle as well as in year through focused sampling
Visible	The process is overt and facilitates ownership by participants
Encompass the expectations of all stakeholder	Core, care group and service-specific expectations of all stakeholders can be captured through the synthesis process
Satisfy the expectations of all stakeholders	Once expectations are identified, satisfaction can be explored
Include goals of equity, health gain	Equity and effectiveness are service criteria
Use the information to progress commissioning	The cyclical nature of the work informed subsequent commissioning (e.g. nail cutting initiative)

Implementation should ensure	**Experience from the project**
Top commitment	Top commitment was established through Health Authority sponsorship and top provider support
Education and development of stakeholders	Education and development needs of commissioners and providers were identified through organisational analysis and met through formal training; those of patients and carers were identified through assessment of need and appropriately met
Collaboration and development of congruent values	The development of shared standards early in the project
Cost-effectiveness	Positive initial cost analysis of the project. Effectiveness through stakeholder satisfaction. Cost-effective provision proposals

Table 7.4 Progress on key points from the literature on quality in healthcare

Comparison with the concerns that had been raised over the original method of assuring progress on the quality specification were considered by the purchasers and main providers during a reflective seminar. The results indicate that the model resolved those concerns (Table 7.5).

Original concerns	Achievements
Costly	Efficient
Top-down	Top-down and bottom-fed
Superficial	Comprehensive and probing
Not comparable	Comparable between quarters and providers
Unclear achievement	Clear achievement
Subjective	Objective
Slow in process	Timely
Static	Dynamic
Restricted access	Authority-wide access

Table 7.5 Comparison between original quality monitoring concerns and achievements using the quality synthesis model

7.4.2 That the process could be integral to and enhance the commissioning process

The process fitted well within the commissioning framework. Cost-effectiveness, health gain and satisfaction had been the service outcome measures of effectiveness of the model. The nail-cutting bid was a particular example of how a robust approach can maximise success.

7.4.3 That the model was valid, reliable and repeatable

In line with established best practice, the design met the requirements of validity (measures reflect the concepts studied) and reliable (the measures and tools were appropriate) (Bryman, 1995). As an action research approach is used to facilitate change in unique situations, repeatability (repeat beyond the research location with the same results) is not an objective. However, implementation of the model with other unidisciplinary and multidisciplinary groups is essential for wider application. The profession of chiropody is therefore reviewed against the key issues for professional status (Chapter 1) to consider any which may have influenced the result and might affect the application of the model in different circumstances (Table 7.6).

Key issues of clinical professionalism	**Professionalism issues in Chiropody**
Specialised skill and expert knowledge	Yes and expanding
Control over entry and qualification	Predominantly peer regulation.
Intellectual and practical training	Practical predominates, academic base developing.
High degree of autonomy and responsibility	Yes and mutual diagnostic relationship with medicine
A trusting relationship with client	Yes
Collective responsibility	Partial
A code of ethics	Yes
Self regulation	Predominantly peer regulation.
Collegiate organisation	No
Meet contemporary needs	Yes
Scientific approach	Improving
Inclusive	No—title not limited.

Table 7.6 Review of Chiropody against the key issues for professions

This picture can be said in general to reflect the aspiring professions allied to medicine and nursing. A key difference with nursing would be the more powerful position of the nursing professional bodies. The review of the services against its peers would indicate that success of implementation of the Quality Synthesis Model in the local chiropody services was biased in respect of the sophisticated rather than routine contestability current in the NHS services used in this project. In comparison with some other chiropody services, the project services were more advanced than some and behind in others in their skill repertoire.

The successful implementation of the Quality Synthesis Model in services with a medical component would differ in the reduced threat of domination, although the new culture of clinical governance provides for powerful lay accountability; and that the lower level "medical skills" are opportunities for cost effective aspirants. The use of the model in multidisciplinary situations would greatly enhance its value and such subsequent exploratory use has been productive.

The tension for professional staff will continue to be that between employer, profession and increasingly users (Johnson, 1972). It is suggested that the Quality Synthesis Model, proven to reduce such tensions in chiropody, provides the opportunity for similar change for other professions through the opportunity of stakeholder contact, evidence based debate, defence of peer authority and overt and agreed measures of progress. The action research approach ensures appropriate implementation of the acquired knowledge and encouragement for continuous improvement---the most effective combination (Effective Healthcare, 1999).

7.4.4 That the process could result in stakeholder culture change towards total quality

The strategies that had been pursued since the initial analysis of the two organisations were considered by the contract team. The review showed that the original areas of concern had been addressed, although there was still room for improvement:

- quality issues were clearer
- the evolving collaborative approach by chiropody staff reflected positively on enhanced change management skills (for example Table 7.1)
- paperless communication channels were very innovative in the NHS at the time (see Chapter 6, section 6.7.3)
- user participation was established.

The factors highlighted in the review of organisational change were compared with the statements on the Crosby Quality Management Maturity Grid. By comparison with the summary statements on the original culture (see Table. 6.4), this could be interpreted as having moved to a more proactive stance on quality (Table 7.7).

Measurement categories	**Stage 1: uncertainty**	**Stage 2: awakening**	**Stage 3: enlightenment**	**Stage 4: wisdom**	**Stage 5: certainty**
Summation of quality posture	"We don't know why we have problems with quality"	"Is it absolutely necessary to always have problems with quality"	"Through management commitment and quality improvement we are identifying and resolving our problems"	"Defective prevention is a routine part of our operation"	"We know why we do not have problems with quality"

Table 7.7 Organisation progress on the Crosby Quality Management Maturity Grid. (Source: Crosby, 1980)

To investigate another dimension of commissioning, a review of purchaser/provider relationships was undertaken. The model for this review was the pilot of a tool developed jointly by a Health Authority and Trust (Leader et al., 1995), in which both parties independently answer a number of questions, compare scores with each other, and discuss and agree a final score. This enables collaboration and focus on issues for improvement. The score is compared with the maximum given in the model to obtain a final position. The recent development of the relationship model precluded its use as a comparative pre-test tool. Patient representatives were not included in this review process, which compared the situation with that in 1993, but in retrospect they could have been.

The BHHA and BHB representatives who took part in the pilot study achieved a 67% score against the maximum, which both parties felt to be a fair reflection. The relevant statement from the tool for this score was as follows:

> "Evidence of effective efforts in many categories and outstanding in some. A good preventative based process. Many areas lack maturity. Further deployment and results needed to show continuity."

Overall, it can be deduced that progress had been made on organisational change, with opportunity for further improvement. The triangulation of independent sources of evidence through quantitative and qualitative data from the patient survey, together with other quantitative and qualitative data from the purchaser/provider relationship review, points to a common conclusion that progress had been made towards meeting stakeholders' needs. In the view of Hart and Bond (1995), this strengthens confidence in the inference, in this case that there had been progress in stakeholders' culture change towards total quality.

The sustainability of change has already been noted as necessary to ensure reinforcement of the change. Unfortunately, sponsor commitment to the author's post ceased at the end of the 95/96 contract year when the government required cuts in management costs and quality became the operational responsibility of individuals. The consequence was that although staff had been trained in all aspects of the work and had participated in the development of the Quality Synthesis Model, the duration of the project (2 years), well below the 5-10 years noted by Peters and Waterman (1991) and others as necessary for sustaining a change; demoralisation with the effect of parallel management cuts in provider services; and the loss of a comprehensive strategic vision for the service all combined to reduce commitment to the project. The apparent absence of an officer responsible for leading the work resulted in a gradual return by providers to their traditional service-led approach, culminating in a return to waiting lists and complaints.

7.4.5 That the model avoided the sins and diseases of public sector management

The four issues identified by Milakovich (1991) above were used to evaluate the model further.

Outline cost of the model

The calculation of the total costs of quality include the following:

- negative costs (complaints, negligence claims, lost reputation)
- positive cost of appraisal and assurance
- positive cost of preventing poor quality (planning, education, market research and analysis).

In a non-quality organisation, quality costs are 20% of income related to sales (Crosby, 1980) (see Fig. 4.4). This can only loosely be compared with the contracted cost of a public service which is subsidised to varying amounts by the government. Of the quality costs, however determined, around 75% will be negative issues, 5% on prevention and 20% on appraisal (Anderson and Daigh, 1991). The aim is to reduce the negative costs of quality by increasing preventive costs and minimising appraisal costs.

Now that the quality synthesis model is established, the positive cost of preventing poor quality by planning, education, market research and analysis through continued application of the model can be calculated as a percentage of the contract price (Table 7.8). This assumes that the geographical distance between purchaser and provider is close; that a mature relationship exists between stakeholders; that the institution has an adaptive, bottom up, culture; that the professions involved are developing; and that computer hardware is available. Undertaking the preparatory work of managing change in an environment new to the model or facilitating staff to achieve the receptive culture of "active professional development" would incur additional set up costs.

Purchaser	**Activity**	**Provider**
1	Collect intelligence over year	1
1	Jointly prioritise and develop issues	1
-	Internalise with senior staff	4
1	Finalise standards	1
4 X 0.25	Additional quarterly monitoring	4 X 1
2	Computer programming	–
6 days	**Total**	**11 days**

Table 7.8 Calculations for the costs of quality

The total chiropody contract value, including staff, clinical equipment, training, travel and assets of the combined services, was estimated at £1 million. Inclusive average senior staff costs were calculated at £100 per day and the total senior staff input was calculated as 6 days for purchasers and 11 days for providers. No charge had been made by Age Concern or the CHC for their input, but it should be anticipated that such participants could charge in the future in the light of the commercial environment affecting all sectors.

The cost of the annual process (£1,700) was calculated as 0.2% of the contract value. Additional appraisal costs were the "Happy Feet" survey (approximately £2,000) and independent clinical peer review (total costs shared by purchaser and providers of approximately £6,000). Neither the survey nor the review need necessarily be undertaken annually, but when included would increase the cost to 1% of the contract price. By increasing the quality input into planning (preventive costs), the need for appraisal and assurance (appraisal costs) could feasibly be reduced.

Unfortunately, data on the negative costs as a sole consequence of chiropody was not available and provides a topic for future research. The major clinical risk in chiropody is gangrene and amputation of the lower limb from lack of, or inadequate, intervention. Medium clinical risk, but major social effect, is the resulting loss of mobility. Both of these chiropody risk areas are difficult to separate from other influences.

Internal and external customers and their needs should be identified

Stakeholders' participation in assessment of need was an integral part of the process.

Protection should be provided for minority group interests

Assessment of need enabled the most vulnerable to be identified and their needs met through a proactive rather than a reactive approach. For example, the person with diabetes, who has dementia, lives in a tower block and who might in the past have only been eventually referred to chiropody by a concerned visitor, could now be identified at an earlier stage for proactive preventive work. The information on population need, the clear criteria for access, the activity goals to be achieved and audit processes gave the incentive to seek out need rather than react to demand.

Customer-driven measures of quality should be use

The research methods used enabled users to identify their expectations and perceptions of service quality; they could feed back to providers for response and had the ability, through repeat surveys, to state their concurrent expectations and perceptions.

These findings resulted from implementation of the model in a chiropody service, and consideration was given to factors which might affect its wider implementation. Chiropody is categorised as a Profession Allied to Medicine (PAM) and defined as a semi-profession. At the time of the research, the author placed the PAMs as more advanced in responsiveness to healthcare change than medicine and nursing due to demand, autonomy, quality assurance and familiarity with customer responsiveness through experience in the private sector. Chiropody was placed in the middle of the group, traditional organisational culture being balanced by extensive experience in the private sector.

The greater encouragement of medicine and nursing to respond likewise to change has probably brought them nearer to the PAM position, improving the potential for successful wider implementation of the model.

7.5 Conclusion

Evaluation of the effectiveness of the Quality Synthesis Model to deliver continuous quality improvement of stakeholders expectation has been reviewed in this chapter.

The findings from the implementation of the project of particular note were that for:

Management of change - the best practice markers noted from the literature for improving the likelihood of successful change were conducive culture, communication, commitment and measures of progress provided a valuable framework. The autonomy of professional clinical staff could prove a stumbling block unless active professional development was in existence. Implementation of the model in an unresponsive culture would need to be preceded by work to facilitate professional development.

Change management in the NHS was known to be a particular challenge and preparatory work had included a retrospective review of implementation of the 1990 reforms to ascertain markers to assist in the project. These markers of the need for clarity and agreement over quality issues, vision and values; a strategic approach; and capacity and empowerment to respond were incorporated at various stages during implementation and provided valuable reference points.

Evaluation was based on a number of different approaches ensuring that the model:

Met the operational criteria expected by purchasers and providers
Comparison with the concerns that had been raised over the original method of assuring progress on the quality specifications were reversed, in particular the model was comprehensive, dynamic and visible. The ability of the Quality Synthesis Model to indicate unexplained variation for investigation was an unexpected bonus.

Provided a cyclical process compatible with and enhancing commissioning

The model was compatible with the cyclical commissioning process; incorporated a variety of quantitative and qualitative measures of contract outcome as appropriate. A particular success was the acceptance by the HA of ensuing data as credible, facilitating a previously unsuccessful bid for service enhancement.

Was viable, reliable and repeatable

In line with established best practice, the design met the requirements of validity (measures reflect the concept studies) and reliability (the measures and tools were appropriate) (Bryman, 1995). Reliability is not a goal with action research, as by definition, circumstances will be unique. The use of the principles of the model elsewhere, generalisability, is of more importance and wide applicability is indicated so long as there is a culture of active pursuit of professional development by participants.

Could result in stakeholder culture change towards total quality

The use of the Crosby tool for quality management maturity and Leader tool for purchaser/provider relationships showed that cultural change occurred slowly but positively. Of equal value was the discovery of such measures and their positive reception by purchaser and providers. The opportunity to include users was missed, but has been noted for future reference.

Avoided the sins and diseases of public sector management.

Four further issues were used to evaluate the model to ascertain the risk of public sector programme failure:

Outline cost of the model: the positive cost was calculated as 0.2% to 1% of contract price depending on the components used and the stage of cultural development of the targets. Due to the lack of information available, the negative costs were not investigated.

Internal and external customers and their needs should be identified: Stakeholders' participation in assessment of need was an integral part of the process.

Protection should be provided for minority groups: assessment of need enabled the most vulnerable to be identified and their needs met through a pro-active rather than re-active approach.

Customer driven measures of quality should be used: users were encouraged to identify their expectations and perceptions of service quality

On the basis of the foregoing, it is the view of this author that implementation and evaluation of the model has been able to answer the research questions:

- Can an effective CQI model for healthcare be identified, or developed, and evaluated which incorporates Juran's approach and the needs of local key stakeholders?
- Can local organisational change within the NHS be improved by learning from the lessons of change theory and national implementation of the reforms?

It is also the view of this author, that the hypothesis:

". . . by incorporating user, provider and purchaser expectations, health needs assessment can be converted into a best quality service specification."

has been answered in the research situation.

Coinciding with completion of the project, Langlands (1997), Chief Executive of the NHS, stated that:

> "The best leaders in the NHS have also developed the power of synthesis and are good at telling stories. They can take the complex problems which rain down from the centre, deal with the internal cost and service pressure in their part of the service, and take on board the needs and demands of their local community. They engage their staff, set a clear direction of travel for their health organisation, find ways of involving people delivering it, and they can explain it all to the public in a straightforward way."

The five-year development and implementation of the synthesis approach had unknowingly, but gratifyingly, been in line with the highest national thinking.

Addendum 1

Service Specific quality requirements for 1994/5

1994–5 BHB

Standard 1: to provide an estimate of the likely Chiropody provision based on public information and applied to local population and then target information needs
Target: (not defined)

Measure and report: quality progress report on plan of action
Full review in annual report

Plan	Do	Check	Act
Q1, Q2	Q3	Q4	Q4

Exception report attached [✓ yes]/no
Additional comments
1st quarter:
2nd quarter: sources still being identified
3rd quarter: sources identified, preparing local report, acquiring national data for comparison
4th quarter: report and annual report submitted.

Standard 2: the provider will review a sample of clients receiving just footcare, identify common factors especially contact with formal carers and suggest an action plan.
Target: sample of clients receiving just footcare
Measure and report: evidence of a system to analyse and quarterly progress on implementation and action plan. Full review in annual report

Plan	Do	Check	Act
Q 1	Q2, Q3	Q4	Q4

Exception report attached [✓ yes]/no
Additional comments
1st quarter:
2nd quarter: sample defined, questionnaire prepared
3rd quarter: consultation on draft questionnaire, provisional date Feb 95

4th quarter: report and annual report submitted

Standard 3: the provider will develop an information sheet to include all basic criteria on access to, content of and outcome of treatment and measure its effectiveness.
Target: all essential information needed by applicants
Measure and report: quarterly progress, with pilot by December 1994

Plan	Do	Check	Act
Q1	Q2, Q3	Q4	Q4

Exception report attached [✓ yes]/no
Additional comments
1st quarter:
2nd quarter: staff involved in planning form.
3rd quarter: draft ready, collaborating with HA
4th quarter: leaflet printed, HA funded, in use. Annual report submitted

Service Specific Quality Standards 1994/5 SCP

Standard 1: an analysis of the cause of inappropriate referrals will be undertaken by the provider and an appropriate action plan implemented.

Target: all inappropriate referrals

Measure and report: quarterly progress report on implementation of system. Full review in annual report.

Plan	Do	Check	Act
Q1	Q2	Q3	Q4

Exception report attached yes/no
Additional comments
1st quarter: planning the project
2nd quarter: project being implemented
3rd quarter: review of inappropriate referrals
4th quarter: new policy in place. Report submitted.

Standard 2: the provider will review a sample of clients receiving just footcare, identify common factors especially contact with formal carers and suggest an action plan.
Target: sample of clients receiving just footcare
Measure and report: Evidence of a system to analyse and quarterly progress report on implementation and action plan. Full review in annual report

Plan	Do	Check	Act
Q1	Q2	Q3	Q4

Exception report attached yes/no
Additional comments
1st quarter: planning the project
2nd quarter: sampling undertaken
3rd quarter: common criteria identified

4th quarter: working with HA on nail-cutting project

Standard 3: the provider needs to establish protocols for treatment venues, and review its implementation
Target: all new referrals and sample of current clients
Measure and report: quarterly progress in developing and implementing a protocol. Full review in annual report

Plan	Do	Check	Act
Q1	Q2	Q3	Q4

Exception report attached yes/no
Additional comments
1st quarter: planning project
2nd quarter: researching protocols
3rd quarter: testing proposed protocols.
4th quarter: policy in place

Addendum 2

Issues for consideration along with other quality intelligence for 1995/6 contract

A. Developing service policies and procedures

- **Record-keeping policy** to be developed, including legibility, comprehensive details and removal of deceased patients from the caseload.
- **Provider benchmarking** procedures for appointments (including guidelines for treatment times) , venue and frequency. Agree and publish criteria.
- **Collaborative treatment planning**, including frequency, venue and anticipated duration of episode to be developed with written record for patient, chiropodist and referrer.
- **DNA policy** to be clarified and published considering patients' suggestions of improved organisation, service information, cancellation facility and note made of vulnerable for reminder.
- **A patient-information strategy** is required to include:
  - safety, lotions and purchase of implements for self-care
  - written information with diagrams and demonstration
  - sources of information – chiropodist and library
  - criteria for venue, frequency and transport
  - appointment procedure
  - information on delays
  - clinic address and phone number
  - gloves policy

B. Monitoring

- **Provider self-audit** across service and comparison of localities to improve equity of:
  - – **clinic sites** (what, where, parking, public transport)
  - – **facilities** (clean, chairs, privacy
  - – **customer care issues** (humane staff attitude, time for a "chat" welcome)
  - – **clinical practice** (speed, gloves policy).
- **A comprehensive reassessment** of all patients is required to ensure that treatment plans are appropriate.

C. Planning

- **Review of chiropody transport service** is required, including clarification and publication of criteria, identification of anticipated changes in demand with suggestions for development.
- **Nail cutting project**: contribute to purchasers' discussions for a supplementary service not requiring continuous professional chiropody input.
- **Foot health education/self-carer training**: provider proposals for commissioning intention bids

Addendum 3

Service Specific Quality Standards 1995/6

BHB 1995–6

Standard 1: review of service against national standards of practice
Objective/goal: report on audit framework 1st Q, progress and results during year
Measure and report: audit framework 1st quarter: quarterly progress, annual report

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1, Q2	Q3	Q4	Q4

Exception report attached yes/no
Additional comments
1st quarter:
2nd quarter: discussions with QA manager
3rd quarter: developing tool, audit Q4
4th quarter: audited, developing standards. Annual report submitted

Standard 2: documentation audit

Objective/goal: records support decisions. Sample notes of all staff in year

Measure and report: quarterly progress annual report

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1	Q2	Q3,	Q4

Exception report attached yes/no
Additional comments
1st quarter
2nd quarter: discussions with HA. Audit Q3

3rd quarter: discussions with HA. Audit Q4
4th quarter: audited. Record form revision. Annual report submitted.

Standard 3: policy for died/discharged
Objective/goal: policy for inactive records/caseload, and audited
Measure and report: 1st quarter

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1	Q2, Q3, Q4		

Exception report attached yes/no
Additional comments
1st quarter:
2nd quarter: policy being developed
3rd quarter: policy to be agreed. Audit Q4
4th quarter: delay due to computerisation Annual report submitted.

Standard 4: Criteria
Objective/goal: draft by end of April 95. Pilot then publish
Measure and report: April 95

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1	Q2, Q3	Q4	

Exception report attached yes/no
Additional comments
1st quarter:
2nd quarter: under discussion with HA
3rd quarter: under discussion with HA

4th quarter: pilot yet to be evaluated Annual report submitted.

Standard 5: information to patients including possibility of clinic choice
Objective/goal: pilot draft by end of April 95. Final version in year
Measure and report: annual report

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1	Q2	Q3	Q3

Exception report attached yes/no
Additional comments
1st quarter:
2nd quarter: leaflet developed for patient information
3rd quarter: leaflet produced
4th quarter: clinic leaflet being designed. All patients have choice of clinic. Annual report submitted.

Standard 6: user involvement in new treatment plans
Objective/goal: document users involvement

Measure and report: quarterly progress, Annual report

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1	Q2	Q3	Q4

Exception report attached yes/no
Additional comments
1st quarter:
2nd quarter: new treatment plan in operation
3rd quarter: plan in operation. Audit Q4
4th quarter: user required to sign plan. Annual report submitted.

Standard 7: personal care information documented to support treatment
Objective/goal: plan a comprehensive pack: and have completed **one** topic by end of year
Measure and report: quarterly progress Annual report

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1	Q2	Q3	Q4

Exception report attached yes/no
Additional comments
1st quarter:
2nd quarter: Developing comprehensive package
3rd quarter: Pack developed. Audit Q4

4th quarter: Clinical leaflets being designed Annual report submitted

Standard 8: Appointment system

Objective/goal: Report by December 1995. Pilot January 1996

Measure and report: quarterly progress Annual report including results of pilot

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1	Q2, Q3	Q4	

Exception report attached yes/no
Additional comments
1st quarter:
2nd quarter: IT system in. Reviewing initial data
3rd quarter: software problems causing delay
4th quarter: considering systems nationwide. Annual report submitted

Standard 9: tiered provision
Objective/goal: joint working, e.g. AC/SC and P nail-cutting initiative

Measure and report: as requested

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1	Q2, Q3	Q4	Q4

Exception report attached yes/no
Additional comments
1st quarter:
2nd quarter: under discussion with HA
3rd quarter: under discussion with HA
4th quarter: nail-cutting service planned. Annual report submitted.

Standard 10: skill mix review
Objective/goal: method to ensure skill levels continually reviewed in response to changing demands
Measure and report: quarterly progress. Annual report

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1	Q2	Q3	

Exception report attached yes/no
Additional comments
1st quarter:
2nd quarter: discussing with QA manager
3rd quarter: method set. Audit Q4
4th quarter: monthly review instituted. Annual report submitted.

Standard 11: clinic facilities
Objective/goal: audit against user/professional criteria
Measure and report: quarterly progress. Annual report

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1, Q2, Q3, Q4			

Exception report attached yes/no
Additional comments
1st quarter:
2nd quarter: audit planned for Q4
3rd quarter: audit planned for Q4
4th quarter: audit criteria being developed. Annual report submitted.

Standard 12: site review
Objective/goal: comprehensive audit report

Measure and report: quarterly progress. Annual report

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1, Q2, Q3, Q4			

Exception report attached yes/no
Additional comments
1st quarter:
2nd quarter: audit planned for Q4
3rd quarter:
4th quarter: audit to now include mobile clinic. Annual report submitted.

Standard 13: Strategy for education/research
Objective/goal: report on progress
Measure and report: quarterly progress
Annual report

Plan	Do	Check	Act
E Q1	**E Q2**	**E Q3**	**E Q4**
Q1	**Q2, Q3, Q4**		

Exception report attached yes/no
Additional comments
1st quarter:
2nd quarter: manager compiling strategy
3rd quarter: manager compiling strategy
4th quarter: Strategy being developed within Trust policy. Annual report submitted.

SCP 1995/6

Standard: review of service against national standards of practice
Objective/goal: report on audit framework 1st Q, progress and results during year
Measure and report: audit framework
1st quarter
Quarterly progress
Annual report

Plan	Do	Check	Act
E Q1	**E Q2**	**E Q3**	**E Q4**
Q1, Q2	**Q3**	**Q4**	

Exception report attached yes/no
Additional comments
1st quarter: discussions with HA
2nd quarter: planning the project
3rd quarter: developing audit tool
4th quarter: pilot tool

Standard: documentation audit

Objective/goal: Records support decisions. Sample notes of all staff in year

Measure and report: quarterly progress
Annual report

Plan	Do	Check	Act
E Q1	**E Q2**	**E Q3**	**E Q4**
Q1, Q2	**Q3**	**Q4**	

Exception report attached yes/no
Additional comments
1st quarter: discussion with HA
2nd quarter: discussion with HA
3rd quarter: audit tool finalised
4th quarter: audit undertaken

Standard 3: policy for died/discharged
Objective/goal: policy for inactive records/caseload, and audited
Measure and report: 1st quarter

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1	Q2	Q3	Q4

Exception report attached yes/no
Additional comments
1st quarter: planning project
2nd quarter: draft policy developed
3rd quarter: draft policy tested
4th quarter: policy in place

Standard 4: criteria
Objective/goal: draft by end of April 95

Measure and report: pilot then publish

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1	Q2	Q3	Q4

Exception report attached yes/no
Additional comments
1st quarter: discussion with HA
2nd quarter: discussion with HA
3rd quarter: discussion with HA
4th quarter: criteria agreed

Standard 5: Tiered provision
Objective/goal: Joint working e.g. AC/SC and P Nail Cutting initiative
Measure and report: As requested

Plan	Do	Check	Act
E Q1	E Q2	E Q3	E Q4
Q1, Q2, Q3, Q4			

Exception report attached yes/no
Additional comments
1st quarter:
2nd quarter: under discussion with HA
3rd quarter: under discussion with HA
4th quarter: nail-cutting service planned. Report submitted.

Addendum 4

1995: issues for consideration along with other quality intelligence for 1996–7 contract

A. Developing service policies and procedures

- **Appointment system** to be reviewed and improved.
- **Review all criteria developed in 1995/6** to ensure ongoing suitability.
- **Continue to review DNA policy** and reconsider patient suggestion of reminder system, especially for vulnerable, identify and publicise the size of problem.
- **Benchmark across services** procedures for appointments; venue, and frequency to improve quality and consistency.
- **Patient information strategy** should continue to be implemented. Attention should be paid particularly to first appointment, re-accessing after discharge and scope of chiropody. Providers should actively ensure that patients have the information that they need about the service and care of their feet, including access to implements. Information on self-care should be made widely available

B. Monitoring

- **Provider self-audit** across services and comparison of localities to improve equity, consistency and quality and contribute to service plans especially continued differences in locality 2:
    - **clinic facilities** (time keeping, in turn, attitude, taxi call facility, clean, tidy, equipment, chairs, toilets, refreshments, privacy, machine repairs, refreshments)
    - **organisation** (record policy especially deceased, consistency chiropodist, time keeping, cover, competence, advice, notice of appointments, appointment time in consideration of bus pass rules, appointments to time at clinic and domiciliary, sufficient notice of appointments, frequency, speed, cancellation policy, attitude,

assistance, lost cards, distant sites, physical help, booking system, time for a chat, humane attitude, know who is next, DNAs, phone answer policy and standard, cancellation by chiropodist)

– **site review**: consider clinics at clubs

– **clinical care**: peer review of quality of treatment, treatment plans, speed of treatment.

- **All issues within patient leaflet.**

C. Planning

- **Review service provided to residential homes**
- **Nail-cutting service** to supplement chiropody for those not needing continuous professional chiropody should continue to be considered by purchasers.
- **Purchaser plans** for chiropody provision should be clarified, documented and consistently repeated.

Chapter 8

Reflections, conclusions and recommendations

8.1 Introduction

This project evolved when the 1990 NHS Reforms required health service commissioners to ensure quality management systems were in place. A review of health and health care, change management and quality theories was undertaken. This identified that health services are unique cultures, largely due to the political power of doctors and strong support for the public service, requiring an equally unique model for successful change. Also that participation by stakeholders was potentially the key to success in local quality management in the NHS. Finally that quality is a complex and personal concept with satisfaction determined by individuals as the gap between their expectation and perception.

The philosophy of Total Quality Management (TQM) might have provided the solution to the need for quality management, but national implementation was not successful and the focus on management, implicit within the title, was viewed with suspicion by autonomous clinicians. Similar principles under the refreshed title of Continuous Quality Improvement offered promise. In particular the approach by Juran appeared appropriate. Juran acknowledged the heterogeneous needs of customers in the service sector and also the need to embed some activities in standards that can be assured to allow a platform for continuous improvement.

The objective of identifying, synthesising and continuously meeting the rising expectations of the three key stakeholders in public healthcare---users, providers and managers---through participation was the main concept explored by the researcher.

In the absence of an existing tool appropriate to the NHS culture, the Quality Synthesis Model was developed by the author, building on the work of hitherto separate but complementary approaches to capture and develop existing knowledge. The model, which incorporated stakeholders' needs into prioritised standards or goals with paperless reporting, was piloted and subsequently implemented in a chiropody service. The methodology for evaluation used both quantitative and qualitative methods. These methods were combined in an action research approach to maximise stakeholder commitment to change.

The results showed that the model provides a cost-effective approach to quality management for continuous improvement, offering the potential for mutual satisfaction to all parties concerned. It was concluded that the model was valid, reliable and repeatable. The model is not however generalisable without modifications due to the need to manage change in unique situations.

The position of chiropody in the hierarchy of health professions was reviewed to consider any issues which may influence application in different circumstances. It was established that chiropody is a semi-profession along with other professions allied to medicine and nursing. Historically these professions emerged to support medicine; did not meet the established criteria for full professional recognition; were predominantly female; provided mainly technical services and were without the all important collegiate structure to pursue their claim. Nursing has directly challenged medicine to rectify its subordinate state, but has failed in its endeavour through lack of achievement on monopoly, autonomy, peer supervision and a scientific as opposed to sociological knowledge base (Abbott and Meerabeau, 1998).

The professions allied to medicine have made further progress on their separation from medicine, autonomy, peer supervision and scientific knowledge base. Their titles are not limited and so they have failed to achieve monopoly. Like nursing, they remain subservient in the all important eyes of the public and also lack the collegiate structure to pursue their claim. Within the allied professions, chiropody is, in different settings, one of the most traditional, autonomous and progressive professions.

It was concluded that implementation of quality improvement in chiropody was likely to be challenging and largely reliant on the balance at the time between tradition and progress. The sample service was biased in respect of the sophisticated rather than routine contestability current in the services used in this project. It was also noted that implementation in multidisciplinary services including a medical component might risk traditional resistance but that clinical governance and the threat of cost effective aspirant professions would probably act as a counter balance.

Throughout the period of the research project the same reflective questions repeatedly surfaced. These are answered below together with a reflection on methodology; lessons for the future; suggestions for further research; and future prospects for quality in healthcare.

8.2 The aim of the study

The aim of the study was to develop an appropriate conceptual framework to implement and evaluate quality management in a pilot service which provided chiropody.

8.3 The objective of the study

The objective of the study was to answer two questions which emerged from the preparatory research:

- **Can an effective CQI model for healthcare be identified, or developed, and evaluated which incorporates Juran's approach and the needs of local key stakeholders?**
- **Can local organisational change within the NHS be improved by learning from the lessons of change theory and national implementation of the 1990 reforms?**

The hypothesis, based on existing theories, was that:

> **". . . by incorporating user, provider and purchaser expectations, health needs assessment can be converted into a best quality service specification."**

8.4 Reflection and conclusions

The principal reflective questions, which repeatedly surfaced and were pursued through the literature review, were as follows:

- What is quality ?
- What is quality in healthcare and public healthcare?
- Why did overt quality come later to the NHS than other organisations?
- Why was a quality management model suitable for healthcare not found to exist?
- Why was there such an emphasis on sensitive development and implementation of the model?
- How could the success of the model be measured?

The literature search which sought to answer these questions included: management and sociological change theory; quality theory in manufacturing, service and public service industries; and health, healthcare and the NHS. The answers to the reflective questions demonstrate the frontiers of knowledge highlighted and exposed through the research. Opportunities for further research which evolved are identified. The following proposes answers to each of the questions posed.

8.4.i What is quality?

The qualities of a product or service were identified as its attributes or characteristics, which may or may not satisfy the needs of an individual. Satisfaction was determined as the gap between expectation and the *perception* of the product or service by the evaluator(s). It remains unclear how needs are determined by individuals, expectations formed, choices made on solutions, perceptions formed on the responses and judgements calculated on the process and outcome. It is known that these processes are frequently subconscious and may be based in part on issues not directly related to the stated need to be satisfied. It is a human characteristic that once satisfied, another need will generally emerge.

A quality product or service is one that meets the needs of the individual who makes the judgement, which may be the customer, supplier or producer. Where there are multiple, often divergent, interests in the same product or service, it was realised that the needs of all stakeholders must be met for total satisfaction. This would require education, synthesis and specification. It was revealed that needs change as a result of various influences, as do expectation and perception, creating a dynamic situation. This is a particular concern in human services because not only do expectation and perception change, but also the need and type of response *during* the service changes as a result of the service provided.

The qualities expected of products, services and public services were found to differ, but the user of each has generic requirements on which those of cohorts and groups of users are superimposed. Maslow (1943) and Kano et al. (1984) agree that a hierarchy of needs exists, with basic needs always having to be met at any level of satisfaction. The most common failure in providing satisfaction is when exciting supplier responses, based on *supplier* quality expectations, exclude the basic needs of users.

Despite a fifty year history of overt interest in quality, the preparatory literature search for this project highlighted that the process of satisfaction remains surprisingly unclear. A better understanding of the process in this area will provide a platform for more complex areas, for example, public healthcare.

The answer to the question posed is that quality is a complex and personal concept of the ability of a product or service to meet identified need.

8.4.ii What is quality in healthcare and public healthcare?

Quality in healthcare was found to be based on the needs of key stakeholders—users, providers and managers. This research probed further and identified that for users, their needs include generic, cohort and user group characteristics of personal interest; for providers it will be rooted in professional and service values for groups of individuals; and for managers it will be cost-effectiveness, cost containment, equity and health gain of the population for whom they have responsibility.

These needs are potentially contradictory: for example users seek proven effectiveness, although their heterogeneous needs require responsive variation in provision; providers deliver variation in practice, based on autonomy in the absence of evidence rather than through guidelines that could ensure consistency in comparable situations; individual user needs may be compromised by those of the wider community; and user values will be expanded by the rules of equity that replace the power of direct payment in welfare, while provider values of altruism and autonomy are constrained by contained resources. It appeared to the author that these concepts epitomised the conflict of satisfaction in healthcare, particularly at the key interface between user and provider.

This project has been innovative in beginning to identify key healthcare stakeholders and their needs. Not only is there a greater range of stakeholders whose needs require consideration, but more probing of their health and social needs is required to maximise the appropriateness of response.

The answer to the question posed is that quality in healthcare is a complex and personal concept of the ability of a service to meet needs identified by stakeholders.

8.4.iii Why did overt quality come later to the NHS than to other organisations?

Power in public healthcare has been exercised through an agreement between the medical profession and the state to control demand to the supply available (Salter, 1998). Although autonomy in the absence, or rejection, of evidence remained a threat to cost containment of such organisations (Zola and Miller, 1973), managers found it useful to obscure rationing and maintain user deference (Harrison and Pollitt, 1995). Such power was used by providers to protect the status quo and resist change.

Pressure to change eventually came from a number of sources, for example: managers are under pressure from the government to improve cost-effectiveness; providers are being pressed by users to provide more responsive services; users experience better quality in other services and now expect it of all services that they use irrespective of service status; younger cohorts of users are more educated, confident and assertive in obtaining what they view as their right; the new phenomenon of a pro-active aged population of users with little to lose by expressing their concerns; media interest in both success and scandal; and new entrants to the supply of healthcare are providing cost effective competition to traditional practice and practitioners.

The tension for professional staff will continue to be that between employer, profession, the courts (Edwards, 1999) and increasingly users (Johnson, 1977). It is anticipated that *lay* managers, now also accountable for clinical governance (Department of Health, 1998), will limit their personal exposure by taking stricter control over clinical practice (Edwards, 1999). The risk is that continued conformance to standards could restrict necessary autonomy and also fail to capture the enthusiasm of professionals to improve their practice continuously. A greater understanding of how quality improvement can be implemented to enhance provider autonomy and at the same time assure quality, could be the key to quality in healthcare. The new concept of clinical governance may provide the solution.

Despite the growing awareness of the possibility and potential for change, the lack of guidance, investment, capacity and above all a compatible model to emulate which would incorporate stakeholders' needs, has resulted in the NHS being slow to join the quality movement.

It is suggested that the Quality Synthesis Model, proven successful in the pilot stage in chiropody, provides a vehicle for similar change in other professions, and ultimately groups of professions and organisations, through the opportunity of stakeholder contact, evidence based debate, challenge to peer authority and overt and agreed progress. The action research approach ensures appropriate implementation of the acquired knowledge and encouragement for continuous improvement---the most effective combination (Effective Healthcare, 1999).

The answer to the question posed is that quality came late to the NHS due to the political convenience of medical power, the historic need for provider autonomy and the encouraged existence of user deference.

8.4.iv Why did a quality management system not exist that was suitable for healthcare?

Quality management incorporates a number of approaches, including quality control, assurance and continuous improvement. These are said to be "total quality management" when within a corporate philosophy. It was found that over the last fifty years various attempts had been made to measure quality. Conformance to manufacturer-defined specification was through quality control (QC), and confirmation that processes were followed during production was through quality assurance (QA); now continuous quality improvement (CQI) is being pursued to respond to continuously changing needs.

The competitive drive in manufacturing industry has been the focus for quality management, only recently moving to service industries with public sector services virtually untouched. The traditional approaches of control and assurance confirm conformance against static requirements. This is rejected by autonomous health professionals dealing with heterogeneous patients and using practice which largely lacks evidence.

Attempts to implement manufacturing industry models of quality control and assurance into the unique culture of healthcare consequently failed. This was mainly the result of lack of understanding by sponsors and agents of the philosophy needed, the principles of successful change management, the capacity of the organisation to respond, and the duration of enthusiasm needed for consolidation. Initiatives were consequently short-lived and cynicism consequently developed among providers about "quality" and "management".

Healthcare cannot be assured, it can only be protected by standards and enhanced through continuous quality improvement. The latter not only facilitates autonomous practice but encourages refinement of such practice against guidelines to allow for necessary variation while ensuring consistency of response in similar situations. In theory, this approach would solve the problem of unacceptable variation of, but allow the continuation of, autonomous practice. It would also require development of and adherence to guidelines. Of the traditional quality gurus, Juran is unique in promoting CQI supported by QA and QC rather than the manufacturing-based QA supported by QC. The work of Juran (1988) is based on the formation of a framework of assessment of need and process design, quality control through specification, measures and monitoring, and quality improvement by systematic project selection.

Herzlinger (1997), writing recently in the context the USA, has stated that, if it had been easy for healthcare to have followed other sectors in their pursuance of quality management, it would have been done. The lack of an available system therefore appeared universal

The answer to the question posed is that the absence of a quality management system was the result of service complexity, user heterogeneity and provider autonomy.

8.4.v Why was the style of local development and implementation of the model so important?

The review of change management theory indicated conducive culture, commitment, communication and progress measurement to be the generic requirements for success. The additional needs of the unique culture of the NHS were unknown but once identified, should facilitate smoother implementation of the required local initiatives, consequently reducing the time needed to deal with resistance, false starts and blind alleys.

Using an adaptation by this author of the change management model by Clarke (1994) (see Fig. 3.1, Chapter 3), an analysis of the implementation of the 1990 NHS reforms was undertaken. The emerging lessons for successful change in the NHS were: the need for clarity and agreement over quality issues, vision and values; a strategic approach; and the capacity and empowerment to respond. Values, particularly strongly held ones in healthcare, are the most difficult personal characteristic to change but provide the strongest support when congruent. A participative style of development and implementation facilitate closeness of values and acceptance of change.

The generic values of healthcare stakeholders have begun to be examined in this project from the literature available. More qualitative research is needed to confirm their continued existence during change and to examine the possibly differing values that exist within cohorts, care groups and specialties, and why and how they have developed. The options for, and effects of, congruence between stakeholders in these different circumstances can then be established to maximise effect.

In an attempt to incorporate all the components identified for successful quality management in healthcare, the simple yet effective Quality Synthesis Model (Fig 7.2, Chapter 7) was developed by this author as a key innovation for wider implementation.

The model incorporates intelligence from a number of sources, synthesising them by stakeholder participation into core, care group or service standards (or goals). These standards or goals form the agreed specification which is monitored. The results are feed back into the system to join new information for progression towards quality improvement in the next round.

Within this concept a Quality Pathway Matrix (see Fig. 6.3, Chapter 6) was developed for local identification of service-specific issues, guided by the hitherto independent but complementary work of Ovretveit (1994b), Donabedian (1988, 1989) and Maxwell (1992). In this matrix the hypothetical patient can be tracked through the system by the provider, each step being objectively checked against stakeholders' views and the relevant quality dimensions. Scores in the matrix identify priority topics for action within a comprehensive framework. Resulting standards are therefore *evidence* based, *owned* by the provider and address *priority* need. In the absence of a recognised weighting system, each concern recorded was given equal weight and this is an issue for future research.

The answer to the question posed is that clarity and agreement over quality issues, vision and values; a strategic approach; and the capacity and empowerment to respond were needed for successful NHS change.

8.4.vi How would success of the model be measured?

Chiropody for those aged 75 and over was chosen by the commissioner of the research to test the model following an assessment of unmet population health need. The markers of success of the model which evolved from the preparatory research were:

- operational criteria to be met
- a cyclical process compatible with commissioning
- valid, reliable and transferable methodology
- stakeholder culture change towards continuous improvement
- avoidance of the sins of public sector management by:
    - assessment of costs of quality
    - identification of customers needs
    - protection for minority group interests
    - customer-driven measures of quality.

The measures of quality specific to chiropody were determined by the commissioners simply as health gain, satisfaction and effectiveness. Health gain was subsequently determined by patients and chiropodists in the exploratory survey (Appendix 13) as pain relief, mobility and comfortable shoe wearing; satisfaction was with various aspects of the service identified by stakeholders; and clinical effectiveness would be assessed by peer review.

The answer to the question posed is that the model could be evaluated through quantitative and qualitative measures of change in stakeholders experience against the success markers identified in the preparatory research.

8.5 Methodology for evaluation

The objective of the research was behaviour change by stakeholders in unique settings. This resulted in quantitative and qualitative paradigms being explored. A solely quantitative approach was rejected on the basis of the need in the study for empowered change in behaviour. Quasi-experimental methods could be used to obtain data through structured surveys and interviews. This would provide information on expectations, perceptions and satisfaction to compare with baseline need. Apart from quantitative characteristics to establish baseline need, other data from structured questions would be subjective and therefore towards the qualitative end of the research continuum. Although a case-study approach was required, it would need to be extended beyond the traditional empirical approach to incorporate reflection and change. Qualitative probing of issues through interview would enable understanding of the reported view.

The objectives of the research question indicated to this author that a model was required that would provide:

- **Quantitative data and qualitative information** on stakeholder needs.
- **Collaboration of stakeholders** to convert needs into specifications.
- **Quasi-quantitative methods** to establish a baseline of satisfaction with the specification.
- **Participant involvement** to improve quality continuously.
- **Quasi-quantitative methods** to establish change in satisfaction with the specification.
- **A cyclical process** which would start the process over again.

Action research offered a framework whereby a combination of methods could meet the practical need and uphold research principles. The method would therefore be predominantly at the qualitative end of quasi-experimental methods; would carry the risk of high internal but low external validity; but could be transferable in *principle* if not in outcome to other situations.

8.5.i Action research approach

Constraints on action research have been categorised as appropriateness, validity and repeatability, scope, conflict, resource, balance and commitment. Each of these were reviewed in the light of the research with the following conclusions:

Appropriateness: the approach was acceptable to stakeholders because it was participatory with measurable outcomes.

Validity and repeatability: in action research this relates to power levels within the group and in this case power was perceived by stakeholders to be balanced.

Scope: the scope was clearly defined by geography, service, provider and user group

Conflict: the relationship between the participants who represented the key stakeholders throughout the project was predominantly positive and issues were openly raised and sensitively addressed.

Resources: the project was adequately funded by the Health Authority through part of the researcher's post, IT investment, the workload of colleagues, and inclusion in the contract requirement of providers.

Balance: in the author's opinion this project provided an effective balance between action and research which was essential to meet sponsor expectations of evidence-based work, together with providers' and users' expectations of practical action.

Commitment: the fact that the approach would incorporate the views of all stakeholders, as opposed to top-down approaches being used elsewhere in the NHS, particularly gained provider support. Unfortunately, sponsor commitment ceased when the government required cuts in management costs three years into the project, the researcher's post being lost. The consequence of this reduced commitment was a gradual return by providers to their traditional service-led approach, culminating within eighteen months to a return to waiting lists and complaints. The established need for 5-10 years consolidation to establish new practices was not achieved. Although the NHS is within a political time table risking continuity of any policy, the principle of quality improvement has been a consistent feature of both conservative and labour governments. The theme then was consistent, the potential failing is in the spirit of both the intention and implementation, with reduction in government funding and local concern at exposure through probing.

8.5.ii Data collection

Obtaining the sample was problematic because records were manual and documentation was poor. Providers should have removed records of deceased patients from their list, but such systems were inadequate. Some deceased patients were consequently included in the sample, causing offence to the bereaved.

This biological fact of the age of the survey population was a serious consideration due to the likelihood of physical impairment compromising completion of the survey questionnaire and mental impairment compromising understanding as well as completion of the tool.

In anticipation of potential problems of sample response, there was a focus on communication with respondents and their carers. In the event such problems were minimal.

—Quantitative method

In most cases data could only be obtained from manual records. The post code was the most common omission, often through inability of the patient to provide it, compounded by the absence of a system at the provider end to supply it, although available on the software market.

—Quasi-experimental method

The survey tool included questions seeking interpretative responses on the baseline issues. The sample was selected avoiding bias, and the survey questions were based on literature searches and participant suggestion to avoid researcher domination.

Further work was undertaken on change in purchaser and provider culture using models from the literature and piloting a tool developed for such occasions. This proved to be effective.

---Qualitative method

Neither of the survey approaches described are regarded as purely qualitative. The public meetings, as part of the consultation exercise on the Chiropody Strategy, provided qualitative information and the topics were included in the survey. An opportunity was lost in capturing the qualitative information voluntarily provided to day centre staff by service users following their receipt of the questionnaire.

8.5.iii Results of the pilot project

The implementation of the Quality Synthesis Model enabled participating stakeholders to identify statutory, professional, health and personal needs. The sharing of knowledge and mutual education resulted in agreement over standards/goals to be met and their priority order. The results of the methods used to gauge baseline health gain, satisfaction and effectiveness in the first pilot year informed the subsequent contracting process by contributing to the synthesis process and facilitating continuous quality improvement.

8.5.iv Validity, reliability and repeatability of the method

In the author's view the methods used meet the requirements of face validity, internal validity, reliability and repeatability. The methods do not meet the external validity requirement of generalisability. This lack of generalisability is an accepted feature of action research as it does ensure that, even when the method is "taken off the shelf", implementation will be participatory, issues appropriate, more likely to be owned, and consequently successful.

The key here is the difference between repeatability and generalisation. The *method* has now been repeated in a number of different situations. These include user group specialties (for example, learning disabilities) and specialist services (for example, physiotherapy, occupational therapy). The conclusions reached from each of these settings are not generalisable because they are, by their very nature, bespoke and related to the specific issues, and the environment and chemistry of the groups involved.

—Bias of pilot service

The position of the pilot service, chiropody, within the hierarchy of professions was reviewed to consider any issues which may have influenced the result and might affect the application of the model in different circumstances. Chiropody was found to be one of the most autonomous, traditional and progressive of the secondary professions and therefore powerful enough in its own right to resist change. Success in chiropody therefore offered hope for its implementation in other secondary professions. Potential bias was found to focus on the sophisticated rather than routine contestability of the local NHS services used in this project.

Within medicine, the power hierarchy depends on how acute and dependent on medical skill the patients' condition is likely to be. On this basis, specialties such as learning disabilities would have less power to resist change than surgery.

8.5.v Reflection on methodology

Overall, the methodology was deemed appropriate and implemented effectively. Response rates to the postal survey were above the norm in quantity, and wholly acceptable in content. The telephone interviews were particularly well received. The key points of concern are that:

- ◊ More robust systems are needed to prevent the records of deceased patients being included in a survey sample.
- ◊ Provider units need to be aware of simple IT tools and use them where appropriate, for example post coding.
- ◊ An opportunity to capture qualitative information from users at day centres could have been used by a more holistic view of the process.

8.6 Rolling out the Quality Synthesis Model---a vision for Quality Improvement for total health.

The Quality Synthesis model has been shown by this project to be a cost effective and acceptable approach to participative quality improvement in chiropody. It appears in principle to be suitable for wider healthcare use and to be particularly suited to the development of Primary Care Groups (PCGs) and Primary Care Trusts (PCTs). In this environment stakeholders are in close proximity, the culture is yet to consolidate, quality improvement is high on the performance agenda and the mix of off-the-shelf and personalisation reduces delay and enhances ownership. PCG/PCT contact with Local Government staff widens the accepted concept of total health and its promotion.

For successful implementation, a process is suggested which would follow contact being made with a Quality Synthesis Model (QSM) facilitator along the lines of

- Personal introduction of model to key stakeholders (standard half day presentation)
- Self Assessment of quality management maturity (based on Crosby Matrix)
- Self assessment of IT capacity (if paperless approach to be used)
- Base line expectation/perception gap analysis (stakeholder survey---QSM or in house)
- Quality development if necessary to improve maturity (QSM facilitator)
- Implementation in a pilot service (early win and confirmation of maturity)

- Repeat base line expectation/perception gap analysis (stakeholder survey)
- Planned roll out to adjacent services towards total coverage (acceptable speed)
- Maintenance of model through trained in house/QSM facilitator.

This model would be low in overt cost to the organisation with a number of tasks being in house if required. An umbrella group of QSM facilitators would maintain standards and facilitate the spread of good practice. The ideal would be a facilitator per NHS Region, a higher ratio speeding up the process towards total NHS CQI.

8.7 Literature enhancement through the research

It was noted in Chapter 2 that the literature search revealed a gap in that available on managing change for quality improvement in public healthcare. Through this research, the established literature has been enhanced by:

- Collation of comparative issues on markets in private and public healthcare (see Table. 1.3).
- depiction of the flow of need based on Bradshaw's and Kano's models (see Fig. 4.1)
- combination of Bradshaw's and Kano's models of need and experience (see Table. 4.2)
- constructing a model for costs of quality (see Table 4.4)
- collating the views of numerous authors on service characteristics (see Table 4.5)
- enhancing the established characteristics of public services (Chapter 4)
- noting the importance of *increased variation* in healthcare and the need for consistency of delivery in comparative situations (Chapter 4)
- the addition of "ignorance" to Drucker's sins of public services (Chapter 4)
- enhancement of the meanings of quality of Pfeffer and Coote to include an inclusive view (Chapter 4)
- identification of the basic, expressed and unexpected needs of the three key stakeholders (Chapter 5)
- consideration of examples of cohort and care group variations (Chapter 5)
- notification of the upcoming influence of the health activist (Chapter 5)
- documentation of the professional values of clinical practitioners (see Table 5.1).

- consideration of the implications of different interface needs for patient focused care (see Table 5.2)
- demonstration of continuous comprehensive improvement as an answer to quality management in healthcare (see Fig. 5.3).
- collation of the principles and problems in action research (see Table A 5.1)
- conception of the Quality Synthesis Model (see Fig. 6.3)
- combination of models to form the quality pathway matrix (see Fig. 6.4)
- development of BAHCHART paperless quality reporting system (see section 6.7.3).
- implementation of change using general guidelines and experience from the NHS (Chapter 7)
- creating a national approach to independent clinical peer review (see Appendix 10)
- successfully using survey and telephone interview methodology with older people (Chapter 7)
- developing an innovative contract for a nail-cutting service (see Appendix 23)
- developing a commissioning project evaluation schedule based on stakeholders' expectations, culture change and effectiveness (see section 7.4).

8. 8 Lessons for the future

Maturity of need assessment

To date, comprehensive quality has been rhetoric rather than reality in the NHS. Quality standards have generally been superficial, satisfying the non-technical expectations of users. The requirements of the Patients' Charter are prime examples of superficial quality where length of wait, rather than effectiveness of intervention at the end of the wait, has been regularly measured. The published results form bald national league tables without differentiation between *what* was waiting and *why*. It is anticipated that a range of forces will change this approach in the future, not least of which will be the more informed service user.

Resources

Resources will continue to be under pressure from increasing demand and static, if not decreasing, supply. This results from the change in the dependency ratio and social expectations. There will be increasing audit of value for money spent and focus on the negative costs of quality. This will produce high-value, short-term gains. There will be management disappointment that such gains are not repeatable.

There has been little consideration of costs in the NHS beyond inputs. Health economists have been used to comparing costs and benefits of specific high-profile treatments in often unique situations. Little has been replicated. The more routine and relatively simple costs of process failure, prevention and appraisal are virtually non-existent, and are certainly not routine. Approaches that will help staff to understand the relevance, calculate the costs and take the necessary action should be beneficial.

Equity and priority

When pressed, the public support issues temporarily affecting the majority of "us", rather than peripheral problems permanently affecting the majority of "them" (Carpenter, 1994). Anecdotal evidence shows that the same individual supports equity to some extent when receiving public services, but sees only ***their*** episode of care in the private sector. Experience indicates that user altruism is reducing. There is concern that a special health tax, largely expected and welcomed by users (Pollard and Raymond, 1999), could strengthen this non-collective stance, risking the wider benefits of a welfare system (Editorial, 1997a).

Legislation in 1998

In 1998, legislation introduced the concept of the Primary Care Group. This will bring the interface between planner/provider Primary Care Group managers closer to users and their perceptions through reduction in geographical distance and potential increase in user influence. Clinical governance is a component of the legislation and includes evidence of internal mechanisms for quality improvement. The Quality Synthesis Model meets that requirement.

Responsibilities of stakeholders

The NHS of the future will be increasingly based on efficiency, effectiveness, accountability and partnerships for survival. The different roles and responsibilities that stakeholders will be required to take for organisational success are suggested by Herzlinger (1997) as:

- **providers** should be customer-focused, have effective systems, capitalise on the potential of IT for measurement and comparison, and provide services that are focused, efficient and ethical
- **purchasers** should welcome innovation, and empower and audit their providers
- **patients** should be informed, assertive, promote their own health – and be good customers (courteous and prompt).

Probably the most encouraging addition here is the need for patients to be informed and equal partners as their contribution to the new healthcare culture. There remains much work to be done to realise the totality of this vision.

This project has shown that patients, providers and purchasers generally have some distance to cover to meet Herzlinger's aspiration, but that with commitment and resource it can be done. The methods effectively used in this project now need to be considered outside of the privilege of a research environment.

Healthcare activist

In a few instances, a glimpse of the future healthcare activist is being seen and heard (Herzlinger, 1997). In this author's view, the potential size of this group of newly/early retired users, who have much to give and little to lose, is an influence *seriously* underestimated by the service, which, having lost the opportunity for efficient proactive partnership, will ultimately respond in a costly reactive way. Further investigation is a particularly exciting greenfield opportunity, especially appealing to the voluntary sector

The preparatory literature search for this project identified the healthcare activist as an emerging and unknown quantity. Such individuals were not encountered during the project which focussed on an older age group, but theoretically have the potential for considerable influence through ability and availability. How these individuals are identified and their contribution constructively used will provide a productive opportunity for the proactive.

8.9 Suggestions for future research

In addition to answering the original research questions, this work has identified a number of areas for further research:

⇒ An understanding of how needs are determined by individuals, expectations formed, choices made on solutions, perceptions formed on the responses, and judgements calculated on the process and outcome to provide satisfaction.

⇒ Expansion of this research to gain an even greater understanding of the differing needs of healthcare stakeholders and effective processes to achieve mutual satisfaction.

⇒ More evidence is needed to guide autonomous practice and a greater understanding of how it can be progressed by CQI.

⇒ A greater understanding of the influence on quality management of the updated diseases of performance and sins of public sector management.

⇒ A deeper understanding of the values held by public healthcare stakeholders and the options for, and effects of, their congruence.

⇒ A weighting system is needed to enable objective prioritisation of quality issues in healthcare

⇒ A greater understanding of the cost of quality and its implications for all stakeholders in public healthcare.

⇒ A better understanding of the encouragement and effect of stakeholder responsibility

⇒ Investigation into the attributes, expectations and contribution of the healthcare activist.

8.10 Future prospects for quality in healthcare

The 1998 NHS reforms clearly promote quality: with the National Institute of Clinical Effectiveness to develop guidelines; the Commission for Health

Improvement to monitor implementation; and with local responsibility for clinical governance. Quality in healthcare is firmly on the agenda. The political objective is however unclear, as is whether the trend will be QA for political protection, CQI for professional development and user advantage or a combination of the two.

Surveys in 1997 and 1999 by the Social Market Foundation identified that the public is well aware of the gap between demand and supply in healthcare, and are willing to contribute to the resources needed so long as the destination of the tax can be guaranteed (Pollard and Raymond, 1999). The interest that the public will have in the use of a clear hypothecated tax may either act as the stimulus for greater improvement, or break the now fragile spirit of staff confused by the objectives and exhausted by the incessant organisational changes and service demands.

8.11 Conclusion

The fundamental conclusion of this thesis is that in the NHS local quality management through commissioning is viable so long as a systematic, participatory and cost-effective approach is pursued. The inclusive Quality Synthesis Model, which incorporates quality improvement and accepts autonomy is offered as a structured yet flexible tool for wider implementation.

For implementation to be effective in complex environments such as the NHS, the approach must be one of quality improvement, based on appropriate standards where they exist; the duration should be sufficient to establish the new behaviour; there needs to be the specific requirements for successful change in the NHS of clarity and agreement, a strategic approach and the capacity and empowerment to respond in addition to the generic requirements of a conducive culture, commitment, communication and progress measurement; and evaluation should be comprehensive and encompass both quantitative and qualitative measures of change in stakeholders experience.

The most likely barrier is the consequence of the service being within direct political control, the timetable for which compromises the need for consistency of vision to ensure change is established. For self protection, governments pursue quality control which limits provider autonomy and dampens enthusiasm while at the same time provides managers and public with assurance of some activities. Although basic needs are what matter to human beings, these do not excite providers, the public at large or the media and so alternative goals are set and pursued, resulting in superficial excitement, but lack of fundamental satisfaction.

An educated public can challenge these barriers through the democratic process. Such activity is beginning to emerge and may do more to change the direction of healthcare than any other. Quality theory is poorly developed in the service sector and this work will contribute to further understanding and subsequent informed change towards greater satisfaction of all stakeholders.

Glossary

Choice: A decision made after the comparison of need with the available solutions.

Common cause: a cause of variation inherent in the process as it was originally set up.

Continuous quality improvement (CQI)--- a corporate vision in which every member pursues quality continually.

Costs of quality: the combination of costs of ensuring conformance to requirements, together with failure costs; sometimes shown as costs of prevention, inspection, internal failure and external failure.

Customer: Anyone who receives the output of work---internal or external.

Qualities: Attributes or characteristics.

Quality: Conformance to the agreed requirements of the customer.

Quality Assurance: All the planned and systematic actions necessary to provide adequate confidence to management and customers that a product or service will satisfy given requirements for quality.

Quality Control: The operational techniques and activities that sustain the product or service quality to specified requirements.

Quality management: Incorporation of a number of approaches, including quality control, assurance and continuous improvement to identify and meet the needs of customers.

Quality system: The organisational structure, responsibilities, procedures, processes and resources for implementing quality management.

Satisfaction: The gap between expectation and perception.

Special cause: Any departure or variation from the plan which was not accounted for in the process when it was set up.

Stakeholders: Those who have an interest in the organisation.

Total quality management (TQM)---a philosophy in which every member pursues quality in every action.

(Sources include PIKE, J., BARNES, R. (1996) *TQM in Action*. (London: Chapman & Hall))

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Appendices

Appendix 1

The challenges to UK healthcare on the horizon

Demographic	An ageing population with a 25.5% increase in those aged over 85 by 2001 (Zimmern, 1995); fewer school leavers with wide career choices; nuclear family mobility with consequent reduced community commitment. Dependency ratio mismatch on the horizon (Lilley, 1995); retirement overseas by the most robust, independent and sociable (Spinney, 1997)
Epidemiological	Delayed disability with increased life expectancy (Fitzpatrick and Dunnell, 1993); predominantly joint and other chronic diseases affecting function (CHMU, 1992)
Technological	Medical developments extending care to vulnerable groups (Ranade, 1994); ethical issues such as in reproductive technology (Meerabeau, 1995); cost and lack of evaluation concerns (Stocking, 1992); basic needs remain unmet (Stocking, 1993); engineering technology has facilitated physical independence and home working provides opportunities for parallel "home care" (Toffler and Toffler, 1995); IT developments enabling health information, clinical consultation and some services (such as shopping) "on line"
Economic	Cost of NHS is around 7% of GDP, half that of the USA and below most of Europe with similar results (Zimmern, 1995); mainly tax funded and one of the most efficient services in the world due to capitation, salaried staff and GP filter to secondary care. Explosion of state-funded continuing care a major concern
Expectations	Implicit quality struggling with rising public expectations; individual experience being compared with growing contact with private sector healthcare and more sophisticated patients. A belief in the right of citizens to the best available healthcare (AQH, 1994)

Table A1.1 The challenges to UK healthcare on the horizon

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Appendix 2

The history of healthcare in the UK

The development of UK Healthcare to the 1946 NHS Act

Healthcare in the UK evolved from agrarian self-sufficient community provision; it developed into a market and was paid for by voluntary insurance and charitable help for the poor. Services became professionalised in the industrial era; state provision and regulation developed where they were deemed essential for community well-being. Private general medical practice (GP) emerged in the nineteenth century (OHE, 1974). State-insured GP care for workers began in 1911; other users paid directly or by subscription – a visit costing a day's wage for an average working man; hospitals were voluntary (for acute conditions – supported and cherished by the surrounding community) and infirmaries (for chronic conditions – attached to the dreaded workhouse for the poor), where use resulted in disenfranchisement. Hospital medical care was provided free by specialists, raising their profile and attracting referrals to their main private work.

The development of the 1946 NHS Act

The 1946 NHS Act, brought GPs, voluntary hospitals and infirmaries into one central government service, leaving social and community care under local government. The Act clarified the territory between the two groups of doctors (domestic, general and primary care versus hospital, specialist and technical), leading to a perceived status difference by both practitioners (OHE, 1974) and the public.

By 2000, on a typical day almost a million people visit their family doctor, 130,000 visit their dentist, 1.5 million prescriptions are dispensed, 2,000 babies are delivered, 130,000 patients are treated in outpatient clinics and district nurses will make 100,000 visits (Department of Health, 2000). All this is achieved within a cost of around 6% of Gross Domestic Product (GDP); the

NHS has comparable results with, and is the second cheapest within, Europe and the costs are half those in the USA.

Through its bi-party development, both the Conservative and Labour parties felt that they had a stake in the service and, during office, each tackled what they felt to be the crucial issues of the time. This was generally regarded as tinkering with the system for fear of electoral reaction by the public.

Timmins (1995) classified the post-war decades of the NHS as expansion (1950 to the 1970s) (Table A2.1) and uncertainty (the 1980s and 1990s) (Table A2.2).

1972 Seebohm Report	Separation of Local Authority "health services" and "social services" and development of health centres for GPs and their primary care teams
1973 National Health Service Reorganisation Act (implemented in 1974)	Consensus management; co-terminosity with local government and transfer of their healthcare staff to the NHS (such as district nurses and chiropodists). Community Health Councils introduced as the patients "watch dog" In reality consensus was so difficult to achieve that the status quo was retained (Ham, 1985; Ranade, 1994), and Community Health Councils had little power with which to make an impact
1976 Royal Commission	Requested after unprecedented unrest within the NHS. Among other concerns, the report defined the quality expectations of the service as: – inputs: such as staffing (it was assumed that more was better) – outcome: health improved (little evidence so audit of professional practice) – process: what ought to happen (based on providers' values) (Klein, 1982)
1976 Resource Allocation Working Party (RAWP) report	Plans to improve regional resources up to those of the best based on size of population and standardised mortality rate (SMR)

Table A2.1 Key NHS Policies 1950–70: the decades of expansion

By the 1980s the Welfare State was having to cope with changing demands. Legislation attempted to address these issues (Table. A2.2) culminating in the introduction of general management in 1983 to progress the service from administration, but the power of medical autonomy remained.

1982 Community Care: Agenda for Action (Chairman, Sir Roy Griffiths)	Re-provision of long-stay hospital patients to more homely surroundings following public concern.
1983 NHS Management Inquiry (The Griffiths Report)	General managers were to be appointed from internal and external applicants to address the lack of basic measurement, customer focus and direction, delays and ineffectiveness. Introduction of quality management initiatives.
Performance Indicators (1983)	Indicators for inputs (staff) and processes (length of stay), but few for outcomes. Original intention of a management tool became a central control mechanism.

Table. A2.2 Key NHS Policies 1980s: the decade of uncertainty

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Appendix 3

The 1990 NHS Reforms: Working for patients

This part of the reform consisted of:

- **Devolution** of responsibility through the hierarchy, with hiving off to trading agencies unless retention was the most cost-effective solution.
- **Management** reformed by reduced size of regional, district and FHSA boards, and appointment of executive and non-executive directors. There would be an NHS Policy Board for strategy and NHS Management Executive (later NHS Executive) for implementation.
- **Capitation** would be phased in, with which Health Authorities would fund services within and outside the District for their patients, with a special fund available for "extra contractual referrals" to meet unexpected, rare or highly specialised services not contracted for.
- **Self-governing Trusts** would be developed from Acute and Community Directly Managed Units meeting the necessary criteria, would take on greater responsibility for their own affairs and would raise income from purchasers – Health Authorities, GP fundholders and private patients – with funding linked to agreed activity
- **GP fundholders** would be developed from general practices meeting the necessary criteria, receiving a budget from Health Authorities for the purchase of a specified range of services. They were to remain the gate-keepers to NHS services. Health Authorities would consult with GPs on commissioning plans.
- **Purchasers** would evolve from Health Authorities and FHSAs which would work more closely together, with responsibility for assessment of health and quality needs of their population, ensuring comprehensiveness, innovation and quality, and transforming the quality, cost and volume requirements into contract specifications for tenders.
- **Medical audit** would be conditional for Trust status, and GPs would be accountable to the FHSA for their audit progress. Doctors alone would be reimbursed for their time

Appendix 4

Tools for quality

Seven original tools for quality

Cause effect or "fish bone": identifies potential causes of a given problem and their interrelationships (Sallis and Hingley, 1992)

Check sheets: data collection for objective measurement of change (Bendell and Merry, 1992)

Stratification: classification and separation of data for further analysis (Bendell and Merry, 1992)

Histogram: graphic display of check sheet data in adjacent bars (Bendell and Merry, 1992)

Pareto: sequential data display by frequency (Bendell and Merry, 1992).Commonly 80% of problems come from 20% of the processes (Sallis and Hingley, 1992)

Scatter diagrams: diagrammatic display of relationship between cause and effect (Bendell and Merry, 1992)

Control charts: display of data showing variation against acceptable limits after elimination of special cause using Statistical Process Control, the statistical calculation of control (Bendell and Merry, 1992)

New tools of quality

Relations diagram: refined cause/effect analysis for complex interrelationships (Bendell and Merry, 1992)

Affinity: cause/effect issues grouped for local action (Bendell and Merry, 1992)

Tree diagram: project planning by asking "HOW" (Bendell and Merry, 1992)

Matrix diagram: relationship implications between two characteristics (Bendell and Merry, 1992)

Matrix data analysis: Adds weighting to complex matrix relationships (Bendell and Merry, 1992)

Process decision progress chart (PDPC): tree diagram with anticipation of problems at each decision (Bendell and Merry, 1992)

Arrow diagrams: flow chart of tasks (Bendell and Merry, 1992)

Examples of Management tools appropriate for quality

Failure modes and effects analysis (FMEA) probes PDPC and prioritises and costs risks (Bendell and Merry, 1992)

Quality function deployment (QFD): customer wishes are checked at each stage of system design (Bendell and Merry, 1992)

Taguchi method: any variation from specification is regarded as a loss and requires investigation back to basic design (Bendell and Merry, 1992)

Departmental purpose analysis (DPA): the objectives of all departments are in line with objectives (Bendell and Merry, 1992)

Business re-engineering: outcome led forward and backward process mapping (Joss and Kogan, 1995)

Diagonal ranking (whereby an individual can indicate their preferences on an infinite number of paired issues, the aggregated scores of all participants forming the final decision) (Turril, 1986)

Delphi technique: whereby surveyed experts put topics in priority order, repeated for the top priority until the required length of list is achieved (French, 1988)

Examples of social science tools appropriate for quality

Surveys: statistical analysis of questionnaires developed through sound methodology (McIver, 1991)

Critical incident technique: why certain opinions held (Cole, 1994)

Interviews: face to face or phone, based on sound methodology (Lofland, 1984)

Table A4.1 Tools for quality

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Appendix 5 Action Research

Action research facilitates change that can occur with minimum conflict through the voluntary involvement of different stakeholders in the change process based on research. The integral continuous feedback loop in action research goes beyond investigation to action and reflection, reducing the traditional separation between research and practice.

Types of action research

Hart and Bond (1995) describe four types of action research as experimental, organisational, professionalising and empowering (Table A5.1)

Constraints to action research

Inevitably there are constraints to action research which are as follows:

Appropriate

The approach used must be appropriate to the subjects. For example, an "empowering" approach requires autonomous practitioners with the power to implement the resulting action. This is a particularly difficult concept in a multidisciplinary setting where participants are at different levels of autonomy (Meyer and Bateup, 1997). The approach must also be acceptable to research sponsors, who may need educating on the alternatives to a traditional positivist approach (Meyer and Bateup, 1997).

Validity, reliability and repeatability

There are two different audiences in action research – internal and external. The internal audience (participants) must recognise the information on which they base their change, which collaboration throughout the process should have ensured (Titchen, 1995). Bias of the researcher should, on the one hand, be avoided (Bryman, 1995), but, on the other, it will be difficult to act dispassionately as a change facilitator if personal values are at odds with the principles being addressed (Titchen, 1995). A particular problem is noted where

Action research type	**Experimental**	**Organisational**	**Professionalising**	**Empowering**
Criteria **1. Educative base**	Re-education	Re-education/training.	Reflective practice	Consciousness-raising
	Enhancing social science/administrative control and social change towards consensus.	Enhancing managerial control and organisational change towards consensus	Enhancing professional control and individuals ability to control work situation	Enhancing user-control and shifting balance of power; structural change towards pluralism.
	Inferring relationship between behaviour and output; identifying causal factors in group dynamics.	Overcoming resistance to change/restructuring balance of power between managers and workers	Empowing professional groups; advocacy on behalf of patients/clients	Empowering oppressed groups
	Social scientific bias/researcher focused.	Managerial bias/client focused	Practitioner focused	User/practitioner focused
2. Individuals in groups	Closed group, controlled, selection made by researcher for purposes of measurement/inferring relationship between cause and effect.	Work groups and/or mixed groups of managers and workers	Professional(s) and/or (interdisciplinary) professional groups/negotiated team boundaries	Fluid groupings, self selecting or natural boundary or open/closed by negotiation
	Fixed membership	Selected membership	Shifting membership	Fluid membership
3. Problem focus	Problem emerges from the interaction of social science theory and social problems.	Problem defined by most powerful group; some negotiation with workers	Problem defined by professional group; some negotiation with users	Emerging and negotiated definition of problem by less powerful group(s)
	Problem relevant for social science/ management interest	Problem relevant for management/social science interest	Problem emerges from professional practice/experience	Problem emerges from members' practice/experience
	Success defined in terms of social science	Success defined by sponsors	Contested, professionally determined definitions of success	Competing definitions of success accepted and expected.

Action research type	**Experimental**	**Organisational**	**Professionalising**	**Empowering**
4. Change intervention	Social science, experimental intervention to test theory and/or generate theory.	Top down, directed change towards predetermined aims	Professionally led, pre-defined, process led	Bottom, undetermined, process-led.
	Problem to be solved in terms of research aims	Problem to be solved in terms of management aims	Problem to be resolved in the interests of research-based practice and professionalisation	Problem to be explored as part of process of change, developing an understanding of meanings of issues in terms of problem and solution.
5. Improvement and involvement	Towards controlled outcome and consensual definition of improvement.	Towards tangible outcome and consensual definition of improvement	Towards improvement in practice defined by professionals and on behalf of others	Towards negotiated outcomes and pluralist definitions of improvement: account taken of vested interests.
6. Cyclic process	Research components dominate	Action and research components in tension; action domination	Research and action components in tension; research dominated	Action components dominate.
	Identifies causal process that can be generalised	Identifies causal processes that are specific to problem context and/or can be generalised.	Identifies causal processes that are specific to problem and/or can be generalised	Change course of events; recognition of multiple influences upon change.
	Time limited, task focused	Discrete cycle, rationalist, sequential.	Spiral of cycles, opportunistic, dynamic	Open ended, process driven
7. Research relationship, degree of collaboration	Experimenter/respondent	Consultant/researcher, respondent/participants	Practitioner or researcher/collaborators	Practitioner researcher/co-researchers/co-change agents
	Outside researcher as expert/research funding	Client pays an outside consultant—"they who pay the piper call the tune"	Outside resources and/or internally generated	Outside resources and/or internally generated
	Differentiated roles	Differentiated roles	Merged roles	Shared roles

Table A5.1 Action research criteria and typology. (Source: Hart and Bond, 1995)

the facilitator has an incentive for particular results, through either the project brief or academic achievement (Breakwell and Millward, 1995).

For the external audience (interested non-participants), the context should be recognisable (Titchen, 1995), the data reliable and the integrity of the researcher above doubt. The nature of action research results in innovative approaches, and so methods must be fully described to audiences. It should then be possible to transfer the *principles* to similar environments, although the process and results will inevitably be different as a result of the unique circumstances of each enquiry. A major problem with qualitative research, and particularly action research, is this lack of opportunity for generalisation (Heller, 1986).

Scope

The level of action research can be at almost any scale, from single groups, whole organisations to across organisations. Hart and Bond (1995) note the opportunity that exists for the collaboration of clients, users and managers for achieving shared goals. This is particularly appropriate in health and social care settings, where the objective is research-based improvement in established process and practice.

Conflict

The participatory nature of action research relies on a positive chemistry between participants which cannot be guaranteed, although agreed values can provide a working relationship (Rapoport, 1970). Issues that may contribute to difficulties include the following:

- **Topics** influenced by funding, politics and personal interests of sponsors (Heller, 1986), rather than issues seen as a priority by the participants.
- **Exposure** of problems to colleagues within the group may be difficult for some individuals (Rapoport, 1970), risking investigation bias. From the view of local management, exposure of failure may compromise continued employment.

- **Different problems** to the one(s) anticipated may be identified by research into the situation (Rapoport, 1970), testing the resolve of the group, skills of the facilitator and support of the sponsor.
- **Wider implications** may be exposed which may compromise commitment to change by participating individuals and sponsoring organisation (Rapoport, 1970), for political and financial reasons.
- **Political sensitivity** may require reporting on the work in an appropriate way (Lees, 1975), compromising the principles of the researcher.

Resource

Resource constraints include time, physical space, communication and funds. Although the researcher may be funded, other participants may be required to contribute over and above their primary roles. A particular concern is the ability of the researcher and sponsors to sustain the action until the change is embedded in the culture of the organisation (Street, 1995), commonly five to ten years.

The principles and problems of action research

Action research is based on the principles outlined in Table A5.2 each of which has accompanying issues to be considered.

Principles	Problems
1. Practical Arises from practical day-to-day questions initiated from outside of the group concerned (Altricher et al., 1993)	Unclear origin of the topic and expected response sought may be inappropriate (Hart and Bond, 1995)
2. Reflective Participants seek to clarify the question, assumptions and interpretations (Winter, 1989)	Reflection may not yet be standard practice (Myer and Bateup, 1997) and may result in *"unacceptable"* answers
3. Potential The topic has potential for change (Winter, 1989) and is compatible with and enhances organisational values (Altricher et al., 1993)	Potential and values must be clarified and accepted by those involved (Hart and Bond, 1995)
4. Involvement Carried out by those directly concerned (Altricher et al., 1993); participants suggest changes and an action strategy (Altricher et al., 1993)	The formation, power and patronage may need clarification and power can be threatening to managers. (Hart and Bond, 1995)
5. Focused The process is problem-focused, context-specific, future-oriented (Hart and Bond, 1995) and achievable (Altricher et al., 1993)	The current problem and future vision may be unclear
6. Collaboration There is collaboration, not synthesis, on the direction of change based on evidence to maximise support (Winter, 1989).	Direction may be unclear, evidence unavailable and time at a premium Collaboration may not achieve a result
7. Intervention Involves a change intervention (Hart and Bond 1995)	Requires agreement and perhaps resource for the intervention
8. Cyclical Cyclical, educative process of change in which research, action and evaluation are interlinked, with duration essential for reinforcement (Hart and Bond, 1995)	Collaboration may override research (Hart and Bond, 1995); qualitative research may be discredited by positivists (Altricher et al., 1993); the system and vested interests may override the proposed change (McNiff, 1994); the direction of change may be unpredictable (McNiff, 1994); and the process is time-consuming (Altricher et al., 1993)
9. Outcome Measurable outcomes at any stage in the process (Hart and Bond, 1995); results may indicate review of the original theory (Winter, 1989); the result will be unique, the process may be transferable (Robson, 1997)	Could be manipulation for research or management agenda, subtle and unnoticed, unsustainable or not transferable.

Table A5.2 The principles and problems of action research

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Appendix 6
Quality Pathway Matrix working sheet

	Selection Referral process S/P/O △	**Entry** Clients first request S/P/O △	**1st contact** Service response S/P/O △	**Assessment** Agreed contract S/P/O △	**Intervention** Meeting client needs S/P/O △	**Review** Re-assess needs S/P/O △	**Closure** Evaluation, preparation S/P/O △	**Follow-up** Audit S/P/O △	**Development** *e.g. Reprovision* △
Effective Optimising prognosis									
Acceptable Consumer view									
Efficient Lowest unit cost									
Accessible Overcoming boundaries									
Equitable Fair between patients or communities									
Relevant Benefit individual/ population									

Table. A6.1 Quality Pathway Matrix worksheet

Appendix 7
Complaints reporting format

BHB Community Health Care NHS Trust main areas of complaints – one per new case (a)

Directorates	**Older people**	**Disabilities**	**Mental H**	**C & Child H**
	(incl. chiropody)	(incl. DSC occupational therapy, physiotherapy, speech therapy	(incl. clinical psychology), child and adolescent drug advisory	(incl. district nursing health visitors, health, promotion, alcohol advice, transport, community paediatrics, clinics, continence, dentistry)

Quarters	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	**Cum tot**
1. Explain/risk/consent																	
2. Records																	
3. Research																	
4. Pt Charter Info																	
7. Privacy/dignity/cul/rel																	
7.1 Mixed sex wards																	
7.2 Ethnic monitoring																	
8. Info' minorities																	
10.1 30 min OPD wait																	
10.2 DN convenient																	
10.3. DN urgent 4 hrs																	
10.4. DN-non-urgent 2 days																	
10.5 DN convenient appt																	
10.6 DNA																	
12. Wait 1st OPD																	
15 Transport home 45 min																	
17. Named nurse																	
18. Discharge																	
19. Staff I/D																	
20. Signs/enquiry																	
21.1 Policies/procedures																	
23.5 GP info' change																	
23.6 GP info' admit																	
23.7 GP info' death																	
23.8 2nd opinion																	
26. Prompt & courteous																	
26.2 Disabled access																	
26.3 Child facilities																	
26.4 Clean/warm/safe																	
26.5 Personal consult																	
26.6 Portering																	
26.7 Safe equipment																	
27 Food																	
OTHER																	

Totals (a)																	

Table A7.1 Complaints reporting format

Appendix 8
Adaptation of National Standards of Practice

Guidelines On Standards Of Chiropody/Podiatry For Barking, Havering And Dagenham

Society of Chiropodists

September 1992

Barking & Havering
Family Health Services Authority
St George's Hospital, Suttons Lane
Hornchurch, Essex RM12 6SD

Barking, Havering and Brentwood
Health Authority
Harold Wood Hospital, Gubbins Lane
Harold Wood, Romford, Essex RM3 0BE

Contents

Introduction

Chiropody/Podiatry is a health care profession whose members provide a fully comprehensive service for conditions of the foot and lower limb. The scope of the profession can be summed up as "relief of pain caused by deformities and dysfunctions, curative footcare, preventive services, and the recognition and treatment of foot problems resulting from pathologies such as ulcerative conditions and diabetes."

A chiropodist's assessment of a patient should take account of the patient's culture, psychological state and social position. The knowledge and skills required to make diagnoses are gained through the 3-year pre-registration course, and developed through constant post-graduate study and widening experience.

The Society of Chiropodists is the professional body recognised by the Health Department for UK State Registered Chiropodists. The Society is an autonomous body which sets and maintains educational and professional standards and enforces its own Code of Ethics for members. **State Registered Chiropodists are independent practitioners who, whilst recognising the need to communicate and co-operate with other disciplines in the management of patients, take full responsibility for independent professional practice.**

Barking, Havering and Brentwood District Health Authority and Barking and Havering Family Health Services Authority gratefully acknowledge the help of the Society of Chiropodists, the Barking, Havering and Brentwood District Chiropodist and the B.L. Sclaire partnership in developing these local guidelines.

Background

The requirements of NHS contracts for formal systems of quality assurance and the growing demands for accreditation of health care services have made it imperative that the chiropody profession should set out what it believes to be the essential standards of practice.

Barking, Havering and Brentwood District Health Authority and Barking and Havering Family Health Services Authority will only employ State Registered Chiropodists to deliver their service.

Communication And Teamwork

Communication is an element of every patient and professional encounter and facilitates the provision of effective and appropriate care.

Standard 1 The patient is acknowledged and respected as an individual, in accordance with the Patients Charter.

Criteria

1.1 The patient is addressed by the name of his/her choice.

1.2 The patient's consent to treatment is obtained (Standards 12 and 13).

1.3 The patient is given the chiropodist's undivided attention wherever possible.

1.4 The chiropodist is courteous and considerate at all times.

1.5 The chiropodist respects and responds to cultural differences.

1.6 The chiropodist responds to language and communication difficulties.

Standard 2 The patient is provided with relevant written and verbal information.

Criteria

2.1 During the initial contact the chiropodist explains his/her role in the management of the patient's problem.

2.2 The chiropodist uses discretion in the discussion of the diagnosis with the patient.

2.3 Treatment goals are agreed between the patient and the chiropodist.

2.4 The patient receives, where appropriate, written information including:

- Appointment system
- Transport
- Home compliance programme
- Treatment plan
- Time and venue for treatment

2.5 All written information is clear, concise and in lay terms.

Standard 3 Communication with informal carers, when involvement in the patient's management is considered appropriate, should respect the wishes of both patient and carer, and only take place when agreed by the patient.

Criteria

3.1 Contact is made with the carer at the earliest opportunity.

3.2 The carer's role in the care plan is explained and agreement sought.

3.3 Meetings, visits and treatment sessions are arranged to suit carers, where possible.

3.4 Relevant written information is provided to informal carers, with patient's permission.

3.5 The chiropodist is courteous and considerate to carers.

3.6 The chiropodist respects and responds to cultural differences.

3.7 The chiropodist responds to language and communication difficulties appropriately.

Standard 4 Communication with other chiropodists should ensure continuity of effective patient care and facilitate the use of available clinical expertise.

Criteria

4.1 There is a system for referral to other clinical specialists.

4.2 There is a procedure for the transfer of patients.

4.3 Treatment records are usable by all disciplines (see Standard 7) and a list of abbreviations should be available to all providers as well as purchasers.

4.4 Relevant information is fed back promptly and clearly to the referrer and GP, unless requested not to do so by the patient.

4.5 Records should remain the property of the purchaser at the conclusion of treatment.

Standard 5 Chiropodists, where appropriate, should be members of the multi-disciplinary team caring for the patient. All chiropodists should be made aware of other members of the team.

Criteria

5.1 Relevant information is communicated promptly and clearly within the team.

5.2 Relevant information is sought promptly within the team.

5.3 There is a system for written communications with other members of the care team.

5.4 Operational policies exist for the following:

- ☐ Cross referral to other professions in the team
- ☐ Discharge
- ☐ Transfer of patients

5.5 There is evidence of participation in, where applicable:

- ☐ Case conferences
- ☐ Ward rounds
- ☐ Individual patient programming meetings.

5.6 The chiropody goals comply with the team goals.

Standard 6 Communication links should exist between staff, the manager of the service and the organisation, to optimise the quality of patient care provided.

Criteria

6.1 There is evidence that the chiropody manager ensures the provision of the following:

- ☐ A job description for each staff member
- ☐ A formal appraisal system by a chiropodist
- ☐ An annual report to include waiting times for chiropody, and peer review programme
- ☐ Regular staff meetings
- ☐ An organisation chart

6.2 All relevant policies and procedures of the organisation are available to staff.

6.3 The chiropody manager attends head of department meetings.

6.4 There is evidence of links with the Society of Chiropodists.

Documentation

Chiropody documentation should be clear and accurate to facilitate optimum patient care and to satisfy legal requirements. Our local objective is to achieve uniformity of record cards across providers.

Standard 7 Clear, accurate and up-to-date records are maintained.

Criteria
7.1 Writing is legible.
7.2 Writing is in permanent ink.
7.3 All entries are recorded at the time of treatment.
7.4 Corrections to the record are initialled and dated.
7.5 A clear and logical format is used.
7.6 Judgmental statements of a personal nature are not made.
7.7 All entries are dated and initialled.
7.8 All attendances are dated and initialled.

Standard 8 Records describe all elements of the care episode.

Criteria
8.1 Patient details are recorded.
8.2 Subjective information is documented (but see 7.6).
8.3 Findings of objective examinations are documented.
8.4 A problem list is drawn up.
8.5 Timed goals are identified and agreed with the patient.
8.6 A treatment plan is recorded.
8.7 Progress notes are recorded.
8.8 A goal-related discharge summary is recorded.

Standard 9 Records are retained in accordance with existing policies and current legislation.

Criteria
9.1 Records are retained for a minimum of 8 years after the conclusion of treatment and will remain the property of the purchasing authority.

9.2 Patient records are stored accurately and securely.

9.3 Computerised chiropody records are registered under the Data Protection Act 1984.

9.4 Records are released with the patient's permission.

9.5 Patients must be made aware of their rights under the local and national Patients Charter to see their records.

Assessment

Assessment is a continuous process by which the acquisition of relevant, quantitative and other data results in the formulation of treatment plans relating to goals which have been actively set with the patient.

Standard 10 The initial assessment process provides sufficient information to formulate a problem list using a clinical reasoning process.

Criteria 10.1 There is written evidence of a database consisting of:

- A clinical examination of the patient
- Pertinent information gathered from the patient
- Information gathered from other relevant sources eg treatment received elsewhere.

Standard 11 There is written evidence of agreed problem-orientated goals and related treatment plans. These are to be discussed with the patient and their expectations for treatment fully explored.

Criteria 11.1 Achievable timed goals are set jointly.

11.2 The treatment plan is identified and patient's agreement sought.

11.3 The treatment plan is carried out.

11.4 The outcome of each intervention is evaluated at an appropriate time.

11.5 Goals are reviewed and altered as necessary.

Informed consent is the voluntary and revocable agreement of a competent individual to participate in a therapeutic or research procedure, based on an adequate understanding of its nature, purpose and implications.

Standard 12 Patients, wherever possible, will be given information about the chiropody procedures proposed.

Criteria

12.1 The patient is informed of the findings of the assessment.

12.2 The preferred approaches, including any significant side effects, are discussed with the patient.

12.3 The patient is given the opportunity to ask questions.

12.4 The patient is given the opportunity to decline particular modalities during the treatment plan.

12.5 The patient is given the opportunity to discontinue treatment.

12.6 Patients wishing to discharge themselves would need to sign a statement disclaiming the responsibility of chiropodists and the purchasing authority.

Standard 13 For patients who may not be competent to give an informed consent, that is, unconscious people, children, people with mental health problems, and elderly confused people, consent should be obtained, wherever possible, from parents, guardians, carers or others designated to act on the patient's behalf.

Criteria

13.1 Before seeking consent from another source, the chiropodist must satisfy him/herself that the patient is not competent.

13.2 The chiropodist ascertains which agency or person is acting on the patient's behalf.

13.3 The patient's agent is given all relevant information, and given the opportunity to decline the chiropodial intervention.

Standard 14 Touching, even therapeutic touching, without the consent of the patient comes within the scope of the criminal offences of assault and battery.

Criteria

14.1 The chiropodist obtains the implied consent of the patient prior to touching the patient during any part of the therapeutic process.

14.2 Nail surgery will require written consent.

14.3 All chiropodists must be cleared under the Children's Act.

Environment, Health And Safety

The chiropody service shall have sufficient space, facilities and equipment to meet its professional and managerial needs and to ensure that staff and patients are provided with a safe environment.

Standard 15 Any designated chiropody area should be accessible to staff and patients.

Criteria

15.1 Chiropody departments/treatment areas are clearly signposted.

15.2 There is clear signposting of specific areas within a department.

15.3 Access is suitable for all users including those in wheelchairs.

15.4 Wheelchairs are available to transfer patients within departments/treatment areas.

15.5 There is parking for disabled people close to the entrance to a department.

Standard 16 Designated chiropody departments should provide comfortable reception and waiting facilities.

Criteria

16.1 A reception area is clearly signposted.

16.2 The reception/waiting areas do not disadvantage wheelchair users.

16.3 Appropriate and comfortable seating is provided.

16.4 Toilet facilities are provided for able and disabled people.

16.5 There is access to a telephone.

16.6 Reading material for adults and children is available.

16.7 Health promotion literature is displayed.

Standard 17 Treatment areas should offer privacy, security and comfort.

Criteria

17.1 Curtaining/screening is provided to ensure visual privacy for patients to meet Health and Safety requirements.

17.2 There is a room for individual examinations or for interviews of a particularly personal nature.

17.3 Staff have access to an office/area where confidential telephone conversations can be made.

17.4 Work areas are kept tidy.

17.5 Clothes hooks are provided in each treatment cubicle.

17.6 Secure facilities are available for patients' property if required.

17.7 Treatment areas are of the appropriate size for the activities carried out.

Standard 18 Sufficient appropriate equipment, commensurate with modern practice, should be available to ensure effective patient care.

Criteria

18.1 Each work area carries a range of modern chiropodial equipment, as recommended by the Society of Chiropodists.

18.2 Each work area has sufficient equipment for its workload.

18.3 Equipment is serviced and maintained on a regular planned basis.

18.4 There is a procedure for the urgent repair of equipment.

18.5 Equipment is kept clean.

18.6 There is a policy for the planned replacement of equipment.

18.7 There are facilities for the safe storage of equipment and materials.

Standard 19 Chiropody staff should be provided with appropriate facilities, where possible.

Criteria

19.1 Staff have a separate rest area.

19.2 Staff have changing accommodation.

19.3 Staff have a personal locker for valuables.

Standard 20 Chiropody areas should comply with the Health and Safety at Work etc Act, health and safety regulations and **relevant local policies** on health and safety.

Criteria

20.1 Staff are aware of their responsibilities as employees under the Health and Safety at Work etc. Act.

20.2 The department is cleaned in accordance with local policies.

20.3 Treatment couches are cleaned as necessary.

20.4 Hand washing facilities are available.

20.5 The department is at the regulation temperature.

20.6 The department is at the regulation humidity.

20.7 The department is adequately lit.

20.8 The department is adequately ventilated with special facilities for particular equipment.

20.9 The department has non-slip flooring.

20.10 An annual health and safety audit is carried out.

20.11 Local policies and procedures on health and safety issues are available, to include:

☐ Fire
☐ Disposal of clinical and non-clinical waste
☐ Spillage
☐ Resuscitation
☐ First Aid
☐ Control of infection.

20.12 Notices of hazards to patients are prominently displayed.

20.13 There is an emergency-call system in the department.

20.14 The department is provided with fire-fighting, first aid and resuscitation equipment.

20.15 Fire exits are clearly marked and kept free of obstruction.

20.16 Staff receive health and safety training, including:

- ☐ Fire procedures
- ☐ Resuscitation
- ☐ Lifting and moving patients/equipment.

20.17 Heads of department receive and act, where necessary, on Department of Health Safety Bulletins.

Quality Assurance

A quality assurance programme provides a systematic method of evaluating the quality and appropriateness of chiropody services and offers a means of correcting identified weaknesses.

Standard 21 There is evidence of a programme designed to review annually the appropriateness and equity of service provision.

Criteria

21.1 There is monitoring of access to chiropody services.

21.2 There is a programme for assessing the availability of chiropody services.

21.3 There is monitoring of the range of chiropody services provided.

21.4 There is a system of monitoring consumer satisfaction with the service.

21.5 There is a complaints procedure.

21.6 There is a policy to facilitate an appropriate response to adverse comments and complaints.

Standard 22 There is evidence of a systematic review of the quality of chiropody practice.

Criteria

22.1 Written standards of practice are available in every department.

22.2 Written standards are available for the documentation system, which is in use.

22.3 Audits are held at specified intervals to monitor the following:

- Patient assessment
- Problem Identification
- Goal setting
- Treatment programme
- Evaluation of outcomes
- Documentation

22.4 There is a peer review of the clinical decision-making process.

Standard 23 The responsibility for quality assurance is clearly defined.

Criteria

23.1 There are written specifications of the roles of managers, chiropodists and support workers in the quality assurance programme.

23.2 Responsibility for the reporting of results of quality assurance activities is clearly defined.

Standard 24 The findings and recommendations from quality assurance activities are documented and reported to management at specified times and simultaneously fed back to all grades of staff, together with the appropriate plan of action.

Criteria

24.1 There is an organisation policy with regard to the reporting of quality assurance data.

24.2 Written evidence of recommendations for action required to resolve identified weaknesses in the service is held at department level.

24.3 This information is accessible to all grades of staff.

Standard 25 Information from quality assurance activities is used in planning future developments in the service.

Criteria

25.1 An annual report from each provider identifies appropriate changes which have been made due to the results of quality assurance activities.

25.2 There are written reports on all quality assurance activities which have been conducted, highlighting the findings and recommendations.

Standard 26 There is a policy for the evaluation of the quality assurance programme.

Criteria

26.1 The effectiveness of the programme is assessed at least annually.

26.2 All aspects of the programme are reviewed.

26.3 All grades of staff are involved in the evaluation.

26.4 The policy is in accordance with the organisational policy of the organisation.

Appendix 9
Advice to Purchasers

BHB
COMMUNITY HEALTH CARE

The Society of Chiropodists

Sclare Chiropody Partnership

PURCHASING CHIROPODY SERVICES

The NHS Reforms have enabled Chiropody to be purchased through a number of routes (Health Authority, General Practitioners, Local Authority and Private Health Sector), and the following advises purchasers on the criteria, requirements, standards and evaluation procedures in use by State Registered Chiropodists.

Medical conditions such as diabetes put the feet at risk if not treated competently. Foot and nail deformities increase with age, and people with disabilities, and older people may have physical or mental problems which prevent them taking general care of their feet. The provision of care for foot problems not requiring professional skills such as simple pedicure, including care of the nails, is normally undertaken by responsible relatives or carers. Chiropody is a scarce resource and should be limited to assessment of clients felt to be at risk, and treatment of medical / chiropodial conditions in conjunction with client's personal care arrangements.

The State Registered Chiropodist has successfully completed a diploma / degree in Podiatric Sciences which enables him/her to work independently, perform specialised assessment of the lower limb, make their own diagnosis and take full responsibility for the treatment and management of their own patients.

The Chiropodist is a specialist member of the medical team who provides a fully comprehensive foot service for conditions affecting the lower limb, including prescription and provision of orthosis and appliances (to compensate for structural imbalance which affect the functioning of the feet and legs), and relief of pain caused by deformities and dysfunction. Appropriate post - graduate training enables curative footcare by the use of invasive surgery under local anaesthetic.

Referral

Where a medical or chiropodial need is felt to exist, clients can refer themselves or be referred by an advocate or health professional for Chiropody assessment regardless of age. The Chiropodist feeds back the outcome of the assessment to the GP and other referrer where relevant.

Assessment

All new patients will be assessed by the Chiropodist, and a treatment plan explained and agreed with the client which will include Chiropody intervention where necessary and delegation of appropriate tasks to the client, carer or Foot Care Assistant with periodic review by the Chiropodist. This package of care aims to meet foot health goals, rather than palliative care at unquestioned regularity. Case mix severity determines case load to honour the legal requirement of the provision of a "full duty of care".

Frequency of treatment as determined by the Chiropodist is commensurate with medical / chiropodial need and varies accordingly. Caseload planning should allow for staff continuity, patient communication and emergency referrals. Onward referral to medical or other facilities is undertaken as necessary.

Treatment

The Chiropodist uses a separate set of pre - autoclaved instruments for each treatment and requires access to an accessible clinic with adjustable height chair, angled examination light, trolley, autoclave, clinical waste and sharps disposal and hand washing facilities. The treatment includes all dressings and medicaments necessary , and advice available in response to requests by the patient on the purchase of additional items which may be available in the clinic.

Venue

Where a need for treatment is identified, the venue will depend on the patient's medical condition, physical and mental ability & social circumstances. The clinic carries more specialised equipment and less risk of infection; home treatment takes double the time of the Chiropodist due to travel and limited facilities; mobile clinics or transport combine equipment and accessibility but may be unreliable due to vehicle or driver failure. For cost effectiveness all patients would attend the surgery but where this is not possible transport advice or provision may be offered or a domiciliary visit may need to be considered, the simple criteria being whether the patient is:-

Unable to leave home due to illness of self or dependent
Unable to get into car or taxi
Isolated by lack of public / clinic transport

The building where the treatments are carried out must be fully insured including public liability cover.

Standards

State Registered Chiropodists work to the Statement of Conduct laid down by the Chiropodists Board of the Council for the Professions Supplementary to Medicine under the 1960 Act. A code of ethics has been produced by the Society of Chiropodists together with Guidelines on Standards of Chiropody/Podiatry Practice which covers organisational, clinical and personal skills.

Monitoring

Practice Accreditation may be pursued via Kings Fund Organisational Audit and/or British Standard 5750. Arrangements should be made to facilitate and co-ordinate peer review among providers of NHS chiropodial care, with the aim of maintaining an equal provision of high quality care. Independent peer assessment of clinical standards is welcomed. Client satisfaction is sought via qualitative surveys. Outcome measures are audited by comparison with the treatment plan which emphasises health gain. The service annual report will include the results of monitoring systems.

Statutory & Other Requirements

State Registration is required for NHS employment.
Statutory requirements under the Health & Safety Act 1974 and associated regulations.
Fire Regulations and instruction.
COSHH
Disposal of waste.
Local disciplinary procedure.

The State Registered Chiropodist follows the agreed local grievance procedure Insurance is provided by membership of The Society of Chiropodists (to £1,000,000 in any 1 year for Professional Indemnity, Product Liability & Public Liability) or individual policy.

This paper was initiated by BHB District Chiropody Service and The Sclaire Chiropody Partnership, 535 Rainham Rd Sth, Dagenham, Essex RM10 7XJ Tel: 081 595 9111 in conjunction with The Society of Chiropodists, 53, Welbeck St, London W1M 7HE Tel : 071 486 3381.

April 1993

Appendix 10
Independent clinical peer review

Identifying stakeholder expectations and ensuring that non-clinical components are met can be a lay activity of audit against documented standards – generally considered to be a first-level review. Judgements on clinical standards require review by peers who are able to appreciate the professional decisions made. Roberts (1987) feels that this gives the best assessment of quality and describes the characteristics of peer review as:

- conducted by clinicians knowledgeable in the practice being reviewed
- characterised by an objective analysis of the clinical facts of a case(s)
- focused on evaluating the quality of care
- protected from unwarranted legal intrusion and resource control objectives
- removed from decisions concerning corrective action.

Authorities will need to commission an independent, credible and experienced practitioner to undertake the peer review. Although peer review is well established elsewhere (El-Din, 1991), the experience in the UK appears to have been limited. The process of developing such a review for chiropody services follows, which the author believes` has wide applicability.

Chiropody provision for the local population had well-established plural provision, partnership sourcing and quality assurance. A natural progression was to the next level of external peer review. The requirement for providers to participate was included in the 1994–5 service specification, resources were identified and a co-ordinator named. The scope of the review reflected the chiropody service contract. The stakeholders, necessary for successful implementation of any initiative, were identified and an exploratory seminar was held with the patients' representative (Age Concern), the chiropody providers (BHB, SCP), their professional body the Society of Chiropodists and Podiatrists (the Society), and the joint purchasers (BHHA and FHSA). A formal contract was subsequently made with The Society for the review.

The review

Preparation

The work of one month was identified for the sample. This comprised about 1,000 treatment episodes undertaken by the two providers. The patients' details were recorded on prepared sheets accommodating variables for age, locality and level of expertise provided. From this initial sample, the assessors selected 200 individual patient records by stratified sampling, and a sub sample of 40 patients. The latter were contacted by the purchaser with the aim of making an appointment for an assessor to visit the patient at home. These were known as confirmatory assessments, the purpose being to compare records with the evidence of treatment. For this to be feasible, as short a time as possible between treatment and visit was necessary – creating logistical pressure. During this period, the accommodation arrangements for the assessors were made – note being made of the need for the availability of working space, and accessibility of power for their PCs with spreadsheet and word-processing facilities, which later proved essential.

Record audit

Stage 1 consisted of a card audit of the 200 records. A flexible two-stage audit tool was designed to cope with the various record-keeping systems used by the two providers, against which the records were evaluated using 30 individual criteria. The assessors undertook a self-validation exercise to ensure consistency.

The collection of the selected records took place just before the three-day visit of the assessors. The chiropody services were provided from a number of locations, with the clinical records kept on site. A photocopy of key information for patients known to be re-attending during the review period was retained by the clinics. The facility to obtain notes for emergency treatment was also seen as essential. On completion of the review, the notes were duly returned to their clinic of origin. In total the record audit took the assessors approximately 50 person hours, an average of 15 minutes per record.

Visits

Two-thirds of the sub sample of 40 patients replied favourably to the purchaser's request for a visit. The confirmatory visits were undertaken in the patient's home to facilitate the assessment (availability of prescribed drugs, carers, environment, etc.). The commissioning authorities provided the driver/escorts for the assessors and preparatory route planning proved essential to make best use of the time. The use of drivers who were involved in commissioning the service, but had no previous experience of the clinical interface issues, was an added bonus through their education. All visitors were provided with official identification and patients had written confirmation of the visit. All the patients were ready, and welcomed the visits. No chiropody treatment took place at the assessment, but the identification of need for intervention could be reported to the relevant provider who had agreed to provide treatment as a priority – there was one such occurrence. The number of visits per assessor was determined using a typical local domiciliary workload, and proved to be a useful "rule of thumb" measure in planning the day.

This second part of the review process provided the assessors with the opportunity of correlating the patient's personal and medical details with those noted on the record card. It is generally accepted that, although it cannot guarantee the quality of clinical care, competent record-keeping is a good measure of the provider's ability to sustain a quality clinical service (Brooks and Pitt, 1990)..

Verbal feedback

A presentation by the assessors to representatives of the Authorities, Society, providers and users was held on the third day. It was considered timely and valuable, and it maintained the necessary confidentiality. The timeliness was particularly valued by the recipients of the review.

Written feedback

The draft written report was received by the purchaser within four weeks for correction of factual errors, checked by relevant parties, and returned. The final bound document was received two weeks later. It had been agreed that the findings of the exploratory review would be kept confidential but the following was agreed as a statement of findings.

> "The Society of Chiropodists and Podiatrists applauded the initiative to carry out the review
>
> There was evidence of an enthusiastic approach of both Providers to adopt the core guidelines produced by the professional body
> There was evidence of a modification of working practices with regard to record keeping (from the agreed date)
> Use of a unified record system was strongly recommended irrespective of provider
> Further development of the Providers assessment and documentation protocols was encouraged to enable a tiered level of provision of service to be implemented effectively particularly in the light of the recent 'Feet First' publication by the Department of Health
>
> Encouragement of the maintenance of the initiatives that have been demonstrated in the sample that we have seen was recommended."

Table A10.1 Extract from the ICPR assessor's report

Action on the report

The report was shared with the Contract Review Team responsible for chiropody services. The recommendations, as one of many sources of intelligence on quality, were considered for inclusion in the quality specification for 1995–6 to ensure continuous improvement. Contract specifications subsequently included the requirement for providers to participate in such reviews on request.

Action on the initiative

A follow-up meeting of the stakeholders took place to review the initiative. The purchaser considering a similar approach with other disciplines. The Society will progress its plans for refinement of its response. The initiative was felt to be non-threatening by the providers because they were involved from the start and there had been no complaints from service users. The overall timescale from decision to approach the professional body to receipt of the final report could be reduced to four months. A summary of the ICPR process appears in Table A10.2.

Reason for review identified (e.g. concern, assurance, quality goals)
Resources identified (personnel, finance, time)
Partnership through presentation of idea to Provider, and User representative
Professional body contacted with details of scope, contract etc
Planning (accommodation, notes, interviews)
Visit: three-day review (notes audit, interviews, feedback)
Report: draft and final
Action on recommendations
Monitoring of progress in achievement
Decision on need to repeat review, etc.

Table A10.2 The ICPR process

Conclusion

The initiative delivered what was intended – a review by peers against local requirements with recommendations for continuous improvement. The key features of note were:

1. The sensitivity of exposing clinical practice to peers was balanced by the partnership approach and potential benefits to the service.
2. The selection of an appropriate organisation, trained assessors and tool was essential.
3. Appropriate and consistent record systems are essential for legal as well as audit processes.
4. Confirmation of the written word by patient assessment was valuable.
5. The minimum of disruption to hard pressed services must be considered.
6. The cost of the exercise in all resources should not be underestimated.

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Appendix 11

Stakeholders expectations of chiropody

Patients' expectations: treatment	
Footcare (nail cutting)	Expected by 40% of users (Jay, 1987), integral to treatment and maximises satisfaction (Griffiths and Tomlinson, 1993)
Life-long	Expected by 51% of users (Jay, 1987)
Treatment	When needed, competent skill, continuity of staff and autonomy of patient (Hares et al., 1992)
Advice	Expected by 32% of users (Jay, 1987); more likely to be followed in leaflet form with verbal back up (Hares et al., 1992)
Patients' expectations: outcome	
Improved mobility	Scanty evidence (Hughes, 1983; EARHA, 1992) but parallel trend between decreasing outdoor mobility and inability to cut toenails with ageing (OPCS, 1986); patients place a higher value on the effect of chiropody on mobility than chiropodists (Cartwright and Henderson, 1986)
Shoe wearing	85% of older people wear unsuitable shoes (Kemp and Winkler, 1983) and chiropody treatment will need to be complemented by appropriate footwear, the patient retaining choice which if compromising treatment may necessitate discharge
Comfort	81% of users in a survey by Jay (1987) sought comfort, and Jay suggests that the possibility of cure is underestimated and requires education
Patients' expectations: non-clinical	
Social	Considerable social component – delivered by physical contact, face to face at a comfortable (leg length) social distance. Domiciliary care may have an even greater social value
Other	Generic and cohort needs; external and internal accessibility (Simpson and Kontos, 1992); helpfulness, consideration, kept informed and consulted (McDonald, 1986)
Patient satisfaction	
The most liked service after the GP (EARHA, 1992), 84% were satisfied at surgery, 94% satisfied at home, particularly with attitude; greatest dissatisfaction with frequency and access (Salvage et al., 1988). Chiropody is also the service that older people are most likely to complain about (EARHA, 1992), perhaps due to visibility and previous personal experiences of the task. The main problems appear to be frequency (Cartwright and Henderson, 1986; Salvage et al., 1988), wait for appointments (Salvage et al., 1988) and the appointment system (Brennen et al., 1991)	
Expectations of professionals	
Hares et al. (1992) showed that clinical staff, including chiropodists, treating diabetic patients expected to provide written information and empathy, accepted that patients would have to wait and used the medical model based on clinical priority. These are inconsistent with patients' expectations revealed in the same study (above), with treatment when needed, competent skill, continuity of staff and autonomy of patient expected (Hares et al., 1992)	
Expectations of purchasers	
Purchasers seek cost-effectiveness, foot health promotion, equitable access for assessment, clear criteria, early referral, priority for greatest need; prevention of costly problems leading to limb loss should make chiropody a purchaser priority (Beaver, 1994)	

Table A11.1 Expectations and satisfaction of chiropody service stakeholders

References

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Appendix 12

Summary of needs assessment report on chiropody services in Barking and Havering.

Footcare need for older people in Barking and Havering

The footcare commissioning group requested an assessment of local footcare need and provision which was undertaken by three members of the group (Cahill et al., 1994).

Demography and epidemiology

The number of people aged over 65 in Barking and Havering is approximately 61,700, and the commissioning team used an intermediate estimate of need (50%) to identify that approximately 30,800 people may require foot health services. Service users were recorded by age band unless they had other medical needs. From the service records, 9,141 older people were known to be NHS users, with poor data on those with disabilities and feet at risk (Table A12.1).

Target group	Population	Need	Met need
Elderly	61,700	30,800	9,141
Disabled	16,200	11,300	Unknown
At risk	11,200	Unknown	5,059

Table A12.1 Older chiropody users in Barking and Havering

It was difficult to quantify levels of need due to lack of research on the chiropody needs of various target groups in the population. It also highlights the difficulty in obtaining information on current levels of service provision.

However, despite these caveats it is clear that there was a large amount of unmet need for foot health services in the District.

Community consultation

The discrepancy between professional, user and purchaser views is likely to lead to dissatisfaction unless the identified gap can be narrowed. To address these issues, the commissioning team undertook community consultation in each locality with open audiences that included users, potential users, formal and informal carers, and providers. The venues were geographically and physically accessible, advertising was wide, and the numbers attending each meeting varied from three to 35 representing a cross-section of the community.

The meetings started with a brief presentation outlining the NHS reforms, the history of the chiropody service in the District and how future services were being considered. Those present were then asked to give their opinions. The following were the key issues: insufficient service and a need for nail cutting; confusing appointment system and inadequate frequency; insufficient transport and inaccessible clinics; and lack of information. There was satisfaction with the limited service available.

Current NHS Footcare Services in Barking and Havering

A review of the structure and process of both providers was undertaken. This indicated that, jointly, provision was 25% below the national recommendation on staffing levels (28 WTE (all grades) for 370,000 compared to a recommended 37); in addition, there was open referral, comprehensive assessment but independent goal setting. Discharge was rare, resulting in decreasing frequency of treatment to cope with the increasing caseload, Professional Standards of Practice were selectively implemented, training of carers had been poorly taken up and there was a lack of comprehensive information for users.

The service blueprint was established (Fig. A12.1), indicating a lack of transparency of the appointment and assessment stages.

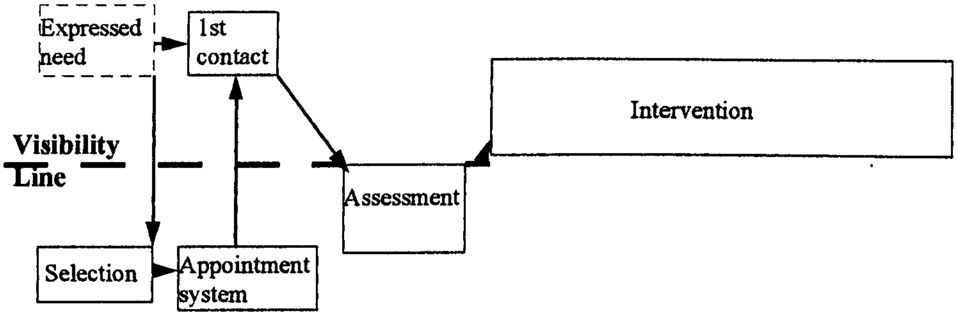

Fig. A12.1 Chiropody service blueprint

Monitoring of cost-effectiveness through HA contracting

The most apparent result of the contract review was: the variation in frequency of treatment between the two providers; the mutual lack of data on case mix and outcome; and the mutual lack of criteria for access, acceptance and discharge. The reluctance of informal and formal carers to take on uncomplicated footcare after appropriate instruction was a key factor to be addressed.

GP fundholding

In Barking and Havering at the time, there were 11 fundholding practices and a multifund, which together covered 51% of the district population. BHB was the main provider with one non-registered chiropodist working to one fundholder. A comprehensive Health Authority survey of all GPs included a question on chiropody requested by the team, which showed that GPs also had concerns on length of wait for assessment and frequency of treatment.

Service review

BHB (Barking, Havering and Brentwood Community Healthcare Trust)

The BHB service employed 16.9 WTE chiropodists, 5.6 footcare assistants and 2.6 clerical/administrative staff, and one dedicated ambulance driver to provide chiropody services to the 20,000 people on its books. The clinical services included assessment, advice and treatment, nail surgery, orthotics and cryosurgery.

There were 10 clinics offering chiropody services across the District. A domiciliary service operated across the district for housebound patients and during 1993–4 there were approximately 1,300 housebound service users. Referral was open. Urgent cases were seen at the first available appointment with the remaining non-urgent cases allocated to a waiting list. Waiting times could fluctuate between referral and assessment, with the target for the first assessment being within six weeks.

Completed referral forms were logged centrally before being sent on to the patients' nearest and/or appropriate local clinic for an appointment to be made. Follow-up appointments were requested by the patient and details sent to the patients home.

Transport

This could be provided by a dedicated transport facility if a patient was immobile but could mean an additional wait for treatment.

Assessment

This was carried out by a State-Registered chiropodist before a treatment plan was decided. This plan needs to balance the need of the individual with the contracted service prioritisation criteria

Health promotion and self-care training

These were included in the initial assessment, as well as: participation in National Footcare Week; provision of a resource centre with displays of shoes and implements; and talks to groups of retired people and old people's clubs. Target training of health professionals, such as health visitors and district nurses, had received a poor take-up for such reasons as not having enough time, access to the correct equipment or not considering nail cutting to be part of their work.

Staff development

There was a budget set aside for staff training and personal development. Footcare assistants underwent in-house training whereas professional staff were trained externally. Regular staff meetings were also held to inform, update and feedback.

Professional expectations

In line with most professionals, chiropodists wanted to provide high-quality, skilled footcare to meet client need effectively without straining resources.

Patients' and carers' expectations

There was a strong local public belief of entitlement to NHS chiropody services upon reaching retirement age, and that chiropody and all aspects of footcare should be for life. This was reflected by both formal and informal carers, some of whom found having to care for others people's feet offensive.

SCP (Sclare Chiropody Partnership)

The SCP had two chiropodists providing a service for 1,200 NHS patients and one WTE receptionist for the NHS and private service. Referrals were open, with the first appointment made within one week of referral for a treatment date within six weeks. Subsequent appointments were booked at the time of the appointment, with receptionist telephone reminders just before the appointment to those deemed most likely to forget. A more limited range of treatments was provided. There was one clinic within the District, although the practice had surgeries elsewhere. A domiciliary service operated. No transport was provided, but the service had produced an advice sheet on how users could obtain free or reduced rate transport from other services (e.g. public transport, Dial a ride, taxi card) and provided a cab call service at the end of treatment. The surgery was accessible for those with disabilities and wheelchairs.

Assessment

This was carried out by a State-Registered Chiropodist, before a treatment plan was decided. The contract was fee for service by application to a contracted case load limit, and consideration of population priorities was not an issue.

Health promotion and self-care training

Courses for informal carers were advertised via the local newspaper and voluntary organisation newsletters in addition to targeting residential homes and home care. Interest in the courses was minimal because people reported that they were unwilling to cut other people's nails or did not want the responsibility if things went wrong.

Staff development

There was no formal training programme for staff who were all self-employed. There were no footcare assistants. Regular staff meetings were held to inform, update and feed back.

Professional expectations

In line with most professionals, chiropodists wanted to provide high-quality, skilled footcare to meet client need effectively with due regard to profit.

Patients' and carers' expectations

Assumed entitlement to NHS chiropody services for life upon reaching retirement age was also found, and could be indulged in a fee-for-service contract.

Comparison

Although the services of the two providers cannot be compared directly, given the number of clients and contract details, there have been substantial gains through contestability. These include reducing the waiting times to six weeks, less complaints and an impetus to provide services more competitively across both services, tentatively commencing with administrative (SCP) and assistant (BHB) skill mix. There have also been disadvantages in having two different styles of contract.

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Appendix 13

The 1992 exploratory "Happy Feet" Survey

The Unified Commissioning Project (UCP) chiropody contract for people aged over 75 was commissioned to supplement the District-wide contract in three localities. A requirement to monitor user satisfaction was included in the specification. The difficulties of surveying older people were well recognised, such as fear of service withdrawal, appearing ungrateful, compromising possible future need, low expectation and lack of information (Vetter, 1995). A questionnaire was designed, including topics noted from the literature and other sources to be of importance to users, providers and purchasers. The instrument was piloted and received approval from the District Ethics Committee. It was sent to all 332 new referrals in the first three months of the UCP contract with the Sclare Chiropody Partnership (SCP) with an explanatory letter and request for help from carers where appropriate. After one reminder, the response rate was 78% (259), with a mortality rate in line with the age of the sample. Respondents were compared with non-respondents and found more likely to be younger, referred by self or GP, to have chronic painful problems and be seen at the surgery. This indicated that those who were more assertive, active and in pain were more likely to respond, but it is not clear if this could bias the response because assertiveness may be tempered by gratefulness.

The most disappointing response was from a residential home where, by admission criteria, residents were dependent on help that would probably include completion of such a form. Staff understandably gave the survey a low priority within their work load, eventually filling in one form to cover 20 patients, therefore excluding the opinions of individual patients. This response was excluded from the analysis.

The remaining responses were analysed against the patient characteristics of age, gender, locality and provider which had been noted as influential in the preparatory research, for example:

- **Age**: older people have needs and expectations in line with their age cohort. Age bands of 75–79, 80–84, 85+ were used.
- **Gender**: men make less demands, have similar health need and are more likely to have a spouse. Their silent presence within the population required identification for service planning.
- **Locality**: there were socioeconomic and demographic differences between localities. These needed to be tested against equity of provision.
- **Provider**: the history, contracts and subsequent marketing by the two providers differed. The consequences needed to be understood.

The results of the analysis were as follows.

1. Living arrangements

Of patients responding, 52.1% (134) lived alone, 7.8% (20) lived with someone aged under 65, and 40.1% (103)% with someone aged over 65. Two patients did not complete this question.

2. Previous footcare

This question is used to explain the calculations used throughout the survey. The data on variables of related interest was cross-tabulated using the Statistical Package for Social Sciences (SPSS). Chi-squared tests were calculated to determine the probability of an observed association between two variables occurring by chance. Those showing a significant association, $p < 0.05$, were investigated further. Expected frequencies of less than 5 in any cell in the contingency table used for the calculation invalidates the test. Where appropriate, observations were aggregated and the data recalculated. Where chi-squared was significant and above the critical value for the presenting degrees of freedom at the 95% confidence level, the result was accepted as a positive association between the two variables and not the result of chance.

When only those who responded are considered and those for whom treatment was not discernible in the notes are excluded: 37.6% (91) of respondents had previously ensured care of their feet by self-care, 19% (46) through a friend or nurse, 20.2% (49) by free NHS chiropody and 10.7% (26) by private chiropody, with a mix of care making up the remaining 12.4% (39) (Table A13.1). There was a significant association between previous care and current treatment ($p = 0.00117$). For example, of those receiving continuous treatment (usually provided for conditions requiring a skilled professional or trained competent carer), only 8.7% (9) had previously used a friend/nurse compared with 26.8% (37) for those now needing periodic care (maintenance usually by self or carer). This indicated that chiropody was being accessed by those whose needs had exceeded self-care.

Count Row (%) Column (%) Total (%)	**Continuous treatment**	**Periodic maintenance**	**Row total**
Self	42 46.2 40.4 17.4	49 53.8 35.5 20.2	91 37.6
Friend	9 19.6 8.7 3.7	37 80.4 26.8 15.3	46 19.0
NHS	28 57.1 26.9 11.6	21 42.9 15.2 8.7	49 20.2
Private	15 57.7 14.4 6.2	11 42.3 8.0 4.5	26 10.7
Mix	10 33.3 9.6 4.1	20 66.7 14.5 8.3	30 12.4
Column total	104 43.0	138 57.0	242 100.0

Table A13.1 Comparison between previous and current treatment

3. Goals

Those not answering this question and those whose notes did not include relevant data are excluded from the analysis. Of the remaining respondents, the best agreement between the goal of treatment for the same patient as seen by the chiropodist and patient was on pain relief sought by 39.5% (96) of patients, and recorded in 18.1% (44) of chiropody records; 13.6% of patients had a mobility goal which coincided with that of the chiropodist and 3.7% a shoe-wearing goal (Table A13.2).

Chiropodist's goals	**Patient**	**Goals**		
	Pain	**Shoes**	**Walk**	**Total**
Pain	44 18.1%	15 6.2%	31 12.8%	**90** **37%**
Shoes	23 9.5%	9 3.7%	41 16.9%	**73** **30%**
Walk	29 11.9%	18 7.4%	33 13.6%	**80** **32.9%**
Total	**96** **39.5%**	**42** **17.3%**	**105** **43.2%**	**243** **100%**

Table A13.2. Comparison of goals set independently by chiropodist and patient

4. Improvement hoped for

Of the patients, 98% (253) felt that, overall, they had the improvements that they had hoped for.

5. Overall satisfaction

Of the 259 respondents, 69% (180) reported overall satisfaction.

Findings related to the survey methodology with older people

- Patients aged 75+ responded well to an appropriately planned and worded survey.
- Access to patients in residential/nursing homes needs to be reconsidered.
- Carers were asked to assist, and did so, as the need arose.
- The time between collection of names and issue of questionnaire should be minimise to avoid distress to the newly bereaved.

The positive response resulted in the conclusion that a postal survey of this population was feasible so long as the caveats were noted.

Reference

VETTER, N. (1995) *The Hospital: From Centre of Excellence to Community Support.* (London: Chapman & Hall).

Appendix 14
The 1994 and 1995 Happy Feet Surveys

Summary

As part of the Barking and Havering NHS contract for development and evaluation of chiropody, satisfaction surveys were required. Satisfaction was defined as the difference between expectation and perception. The title "Happy Feet" was chosen to stimulate interest. Following a pilot, two successive surveys were administered to 782 chiropody users aged 75 and over with 76.4% and 65.2% response rates. Analysis by the user characteristics of age, gender, locality and provider contributed to the quality intelligence for collaborative goal and standard setting for continuous service improvement. A graphic summary indicates the success of the initiative (see Appendices 15–19), and issues for action are summarised below. A summary of the results of each survey was fed back to the providers, interested participants and commissioners. The survey method of identifying satisfaction of older people was found to be a valuable source of quality intelligence.

The surveys

Surveys were required in 1994 and 1995 covering both local NHS chiropody providers, Sclare Chiropody Partnership (SCP) and Barking, Havering and Brentwood Community Health Care Trust (BHB). The purpose was to establish the baseline and ascertain progress on various aspects of the services that were being changed in response to need. The preparatory research had identified the important relationship between expectation and perception on measurement of satisfaction, and these three aspects were used where appropriate for each topic that had been identified as being important to users, providers and purchasers. The characteristics of age, gender, locality and provider used in the 1992 pilot were used again, to which was added a new user category of those patients who were "new in 1995" and who would have been assessed after the changes made in response to the first substantive (1994) survey.

The sample frame

The population consisted of all the current users of Barking and Havering NHS-funded Chiropody provision for those aged 75 and over. The take up of Chiropody in each of the localities combining current BHB and SCP patients aged 75 and over was noted as equitable with demographic and epidemiological need, with greater provision amongst older populations in the more deprived localities of 6 and 7 (Table A14.1).

L	Total pop'n	Men	Women	75+	85+	Total 75+	Chiropody	% Chiropody
1	69,760	33,743 (48%)	36,017 (52%)	3,530 (5%)	1,003 (1%)	4533	1068	23.5
2	47, 927	22,962 (47%)	24, 965 (53%)	2,702 (6%)	541 (1%)	3243	769	23.7
3	56, 635	27, 566 (48%)	29, 069 (52%)	2,772 (5%)	841 (1%)	3613	890	24.6
4	55,170	26,893 (49%)	28,277 (51%)	2,351 (4%)	482 (1%)	2833	676	23.86
5	30, 100	14,388 (48%)	15, 427 (52%)	1,350 (4%)	369 (1%)	1719	425	24.72
6	52, 503	25,053 (48%)	27, 450 (52%)	3,266 (6%)	822 (2%)	4088	1259	30.79
7	61, 340	29,490 (48%)	31,850 (52%)	3,779 (6%)	934 (2%)	4713	1521	32.27

Table A14.1 Locality age and gender profile (percentage of total population in brackets)

In the 1992 pilot study, overall satisfaction with the service was reported by 69% of the sample. This result was used as the basis for calculating the 95% confidence intervals to determine the most appropriate sample size for the main surveys (Table A14.2).

Possible sample	Indicator ± SE x 1.96	Range ± 69% at 95% confidence interval
500	69 ± 2.07 x (1.96) = 4.06	64.94D73.06%
750	69 ± 1.69 x (1.96) = 3.31	65.69D72.31%
1000	69 ± 1.46 x (1.96) = 2.86	66.14D71.88%

Table A14.2 95% confidence intervals on sample size for 69% indicator

On the basis of these results a sample size of not less than 750 was considered to provide sufficient accuracy for the main study with due regard to the resource and time available.

The number of chiropody patients in each locality for each provider was identified, and 10% of each taken as the sample. Where the number of patients in a locality for a service was small, a higher percentage was taken (Table A14.3).

Locality	Number over 75	10% sample	Comments
1	1068 BHB	107	
2	796 BHB	78	
3	890 BHB	89	
4	676 BHB	68	
5	322 BHB + 103 SCP	64 BHB (20% sample) + 61 SCP (60% sample) = 125	Small locality
6	892 BHB + 367 SCP	90 BHB + 74 SCP (20%) = 164	Greatest need
7	939 BHB + 582 SCP	93 BHB + 58 SCP = 151	Greatest need
Totals	6, 556	782	

Table A14.3 Sample of chiropody patients by locality and provider

Each person in the 1994 and 1995 samples was provided with the following, examples of which are attached:

- **A letter** explaining the background, importance of contribution, help with completion available from Barking and Dagenham Old People's Welfare and arrangements for return of questionnaire.
- **A letter** to anyone who might be asked by the individual to provide help in filling in the form to ensure they would enable the user to understand and respond to the question themselves in an unbiased way.
- **A questionnaire.**
- **A stamped addressed envelope.**

While the patient sample details were being obtained, a pilot of the questionnaire was undertaken on 30 patients, with a 93% response rate. Two questions were found to be ambiguous and changed, and the request for participation in a possible interview was so overwhelmingly accepted that it was changed to ensure that respondents understood that only a small number of interviews would be taking place, and selected volunteers would be contacted to make the necessary arrangements.

The final questionnaire was submitted to the BHB Community Healthcare NHS Trust Medical Ethics Committee for approval, which was granted.

Sample method

BHB Community Healthcare Chiropody (BHB)

The BHB data base for chiropody was only partially installed at the time of the survey. Hard records of basic patient data, routinely collected at a clinic attendance within the last three months, were made available, from which cases were randomly selected. Each address drawn from the record was manually matched with the post code/locality list until the number was reached that made up the locality sample size. The age band and gender content of the samples were therefore random. If more than one name selected proved to be from the same institution (for example, residential or nursing home), only the first name selected was included to prevent excessive pressure on staff noted as a problem in the pilot survey (see Appendix 13). Subsequent "residents" from the same institution, drawn from the files, were replaced by the next name drawn from that locality. The final sample composition is shown in Tables A14.4 and 14.5

L	Age						Gender				BHB		SCP		Total	
	1994	1995	1994	1995	1994	1995	1994	1995	1994	1995	1994	1995	1994	1995	1994	1995
	75-79	75-79	80-84	80-84	85+	85+	M	M	F	F	▨	▨	▨	▨	▨	▨
1	33	32	39	34	35	36	17	18	90	84	107	102			107	102
2	51	52	15	15	12	9	25	24	53	52	78	76			78	76
3	28	28	30	32	31	29	19	18	70	71	89	89			89	89
4	23	24	23	22	22	18	22	19	46	45	68	64			68	64
5	38	38	49	43	38	24	31	28	94	77	64	63	61	42	125	105
6	59	67	58	60	47	42	53	61	111	108	90	86	74	83	164	169
7	50	59	62	74	39	44	48	58	103	119	93	97	58	80	151	177
Total	282/782 (36.1%)	300/782 (38.4%)	276/782 (35.3%)	280/782 (35.9%)	215/782 (27.5%)	202/782 (25.8%)	215/782 (27.5%)	226/782 (28.9%)	567/782 (72.5%)	556/782 (71.1%)	589/782 (75.3%)	577/782 (73.8%)	193/782 (24.7%)	205/782 (26.2%)	782	782

Table A14.4. 1994 and 1995 Sample frame by key variables of age, gender, locality and provider

L	Age						Gender				BHB		SCP		Total	
	1994	1995	1994	1995	1994	1995	1994	1995	1994	1995	1994	1995	1994	1995	1994	1995
	75-79	75-79	80-84	80-84	85+	85+	M	M	F	F	▨	▨	▨	▨	▨	▨
1	29	24	34	26	28	23	15	11	76	62	91	73			91/107	73
2	42	37	13	9	8	4	22	20	41	30	63	50			63/78	50
3	24	23	27	27	29	19	18	12	62	57	80	69			80/89	69
4	21	16	19	14	20	11	17	13	43	28	60	41			60/68	41
5	37	31	43	27	26	16	25	19	81	55	58	49	48	25	106/125	74
6	48	51	42	43	32	23	44	42	78	75	74	57	48	60	122/164	117
7	41	42	55	51	23	29	41	39	78	83	82	64	37	58	119/151	122
Total	242/282 (85.8%)	224/300 (74.6%)	233/276 (84.4%)	197/280 (70.3%)	166/215 (77.2%)	125/202 61.8%)	182/215 (84.6%)	156/226 (69%)	459/567 (80.9%)	390/556 (70.1%)	508/589 (86.2%)	403/577 (69.8%)	133/193 (68.9%)	143/205 (69.7%)	641/782 81.9%	546/782 69.8%

Table A14.5. 1994 and 1995 response rates by key variables of age, gender locality and provider

Sclare Chiropody Partnership

For the SCP sample, a print-out was provided of the current 1,163 NHS patients after known deaths/discharges/moves had been removed. Incomplete post codes on records of 112 patients were excluded. The resulting list was manually matched with the District's post code/locality list. When all were allocated, the number required for the sample were selected systematically. The age band and gender content of the samples was therefore random. As with the BHB list, if more than one name proved to be from the same institution, only the first selected was included, and subsequent ones replaced with the next from that locality. The final sample composition is shown in Tables A14.4 and 14.5

Follow-up interview

The preparatory research had identified the value of probing key issues by interview to understand why such an opinion was held (Cole, 1994). Other researchers had shown that, so long as the methodology was sound and circumstantial differences taken into account, face-to-face and telephone interviews provide equivalent response (Loffland and Loffland, 1984; Frey, 1989) and are particularly advantageous for use with older people (Ormond, 1993). Such issues were identified for further investigation from the survey and developed into a semi-structured interview schedule (attached) where question numbers follow those of the original questionnaire for ease of cross-reference.

A survey question asked respondents whether they were willing to be interviewed and 193 (32.3%) indicated that they would, and 146 provided comprehensive contact details including telephone number. Potential interviewees were categorised into localities and age groups.

As a result of the wide availability of telephones among older people, and the efficiency of their use for interviewing (Frey, 1989), an initial approach was made to two people in each of the three age bands in a single locality. One of each pair was interviewed face to face and one by telephone, both interviews being tape-recorded with the agreement of the patient. The transcriber of the tapes reported no discernible difference between the two styles. This supports the work of Frey (1989) who indicated that there is minimum loss of data quality between face-to-face and telephone interviewing. Consequently, in the remaining six localities, respondents in each of the three age bands who had given a phone number were serially contacted to seek their agreement to take part in a phone interview which would be recorded. A date and time were agreed with the first respondent in each age group in each locality giving a positive response. A letter confirming the arrangements was sent, again stating the intention of recording the interview to assist with note-taking and that the recording would then be destroyed.

This process resulted in interview data being obtained from 21 (87.5%) out of a possible 24 patients (the three pilot face-to-face and three telephone interviews within one locality were included; one patient refused when telephoned and two did not answer the telephone at the prearranged time). At the recommendation of Frey (1989), each interview began with a "warm-up", including introduction, confirmation of patient details, ability to hear the interviewer, convenience of the activity at this time, explanation about the process, assurance on confidentiality, further agreement to tape recording and comfort for the 15 minutes' duration. After affirmative responses to these questions, the interview began.

A similar process was followed in 1995, approaching three people in each locality. Of the 21 respondents identified, all were interviewed.

Analysis of the 1994 and 1995 surveys

Those assisting patients with day-to-day tasks were asked to indicate if the patient was unable to provide answers to the questions, for instance as a result of cognitive impairment, and return the form to ensure that only users' views were captured. These responses were deleted from the full analysis. Those able to respond but unable to complete the form could be helped by their carer so long as the *patients'* view was indicated. All valid responses were considered against the key characteristics of age, gender, locality and provider, and were analysed as before with the following results.

Question 31 (1994), Question 32 (1995): "Unable to provide information"

1994

Of the 641 forms received, 6.7 % (43) were reported by their carer as unable to answer the questions, with inability increasing with age. The full analysis is therefore based on 598 (76.4%) valid responses (Table A 14.5).

1995

Of the 546 forms received, 6.6% (36) were reported by their carer as unable to answer the questions, with inability increasing with age. The full analysis is therefore based on 510 (65.2%) valid responses (Table A 14.5).

Comparative analysis of the 1994, 1995 and New 1995 samples follows.

Questions 1–3 were about information on health services in general, and chiropody in particular.

Question 1: "How important is it to you to have information about health services you receive?"

Importance of information (%)	**1994**	**1995**	**New 1995**
Not important	1.5% (9)	1.4% (7)	1.4% (1)
Fairly important	7.5% (45)	5.7% (29)	4.3% (3)
Important	26.6% (159)	28% (143)	23.2% (16)
Very important	59.4% (355)	52.4% (267)	55.1% (38)
Not answered	5% (30)	12.5% (64)	15.9% (11)
Total	**100% (598)**	**100% (510)**	**100% (69)**

Table A14.6 Frequency data on importance of information about health services for 1994, 1995 and new 1995 respondents

Overall

The importance of information remains high. When tested against the key variables there were no significant findings in 1994 or 1995.

Question 2: "Where have you got most information about chiropody from?"

Respondents could indicate any of the sources of information, giving multiple responses.

Source of information (%)	1994 (598)	1995 (510)	New 1995 (69)
Friend	31.8% (190)	12.9% (66)	26.1% (18)
Doctor	12.2% (73)	4.7% (24)	7.2% (5)
Nurse	5.9% (35)	5.7% (29)	15.9% (11)
Chiropodist	35.5% (212)	57.6% (294)	24.6% (17)
Heard from other	13.4% (80)	6.3% (32)	14.5% (10)
Leaflet	5.4% (32)	2.9% (15)	4.3% (3)
Newspaper	3.8% (23)	2.5% (13)	11.6% (8)
Magazine	2.3% (14)	1.4% (7)	2.9% (2)
Radio/TV	1% (6)	1% (5)	2.9% (2)
Read in other sources	5.9% (35)	2.4% (12)	4.3% (3)

Table A14.7 Frequency data on source of chiropody information for 1994, 1995 and new 1995 respondents

Overall

The sources of information reflect the marketing strategy at the time, resulting in the variations between sources over time, but the importance of non-professional sources should not be overlooked.

Question 3: "How useful is the information you have on chiropody?"

Use of information	1994	1995	New 1995
Very little	6.9% (41)	3.9% (20)	2.9% (2)
Little	5.4% (32)	5.3% (27)	5.8% (4)
Useful	42% (251)	38.2% (195)	31.9% (22)
Very useful	39.6% (237)	39.6% (202)	43.5% (30)
Not answered	6.2% (37)	12.9 % (66)	15.9% (11)
Total	100% 598	100% 510	100% 69

Table A14.8 Frequency data on usefulness of chiropody information by 1994, 1995 and new 1995 respondents

Overall

The usefulness of information had increased. When tested against the key variables there were no significant findings in 1994 or 1995 but, in the light of purchaser and provider interest in promoting health education, the issue was investigated at interview with the result that, in 1994, patients wanted:

- To know what it is safe to do; what lotions to use; where to obtain implements.
- Written information with diagrams and demonstration.
- To obtain information from the chiropodist or library.

In 1995, interviewees reported that generally information was not provided, but was wanted. Where it had been available, it was found to be helpful. Respondents felt that if they did ask it would be willingly provided. There were several requests again for information on what implements to get, and where.

Questions 4–6 sought information on expectation, perception and satisfaction with making the first chiropody appointment and was only relevant for first-time respondents.

Question 4: "How easy did you expect it to be to make your first appointment?"

Expected ease	**1994**	**New 1995**
Not easy	9.9% (59)	14.5% (10)
Easy	19.4% (116)	26.1% (18)
Very easy	8.4% (50)	11.6% (8)
Not answered	62.4% (373)	47.8% (33)
Total	**100% 598**	**100% 69**

Table A14. 9. Frequency data on expected ease of making first appointment by 1994 and new 1995 respondents

Overall

The high non-response rate to this set of questions was probably due to the fact that the "first appointment" may have been made by a representative of the user and/or some time, even years, beforehand, and the process was not remembered. Slightly more of the 'new 95' group answered the question, probably related to the experience being more recent. The pessimism was similar to that of established users.

When tested against the key variables there were no significant findings in 1994.

Question 5: "How easy was it for you/your carer to make your first appointment?"

Experience	1994	New 1995
Not easy	3.8% (23)	2.9% (2)
Easy	16.4% (98)	24.6% (17)
Very easy	12% (72)	21.7% (15)
Don't know	3% (18)	2.9 % (2)
Not answered	64.7% (387)	47.9 % (33)
Total	100% 598	100% 69

Table A14.10. Frequency data on actual ease of making first appointment by 1994 and new 1995 respondents

Overall, experience of making the first appointment had improved. When tested against the key variables the following were significant :

1994

Provider: if only those respondents who answered the question were considered, there was a high level of ease of making the first appointment. There was a significant association between provider and actual ease of making the first appointment (p = 0.00004) (Fig. A14.1). For example 26.4% (34) of the BHB patients found it very easy compared with 59.4% (38) the SCP patients.

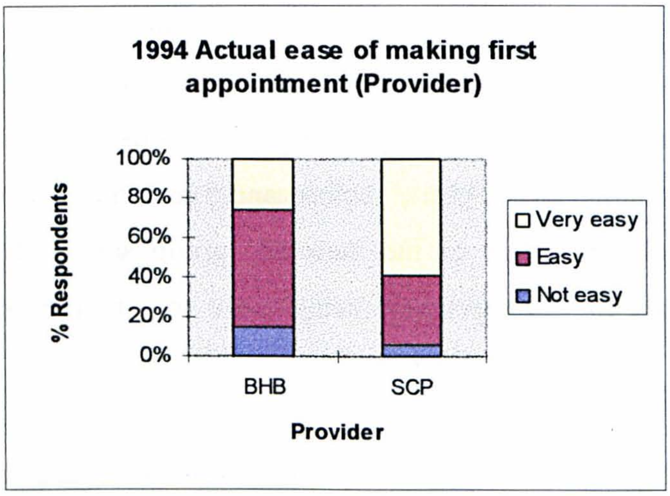

Fig. A14.1. Actual ease of making first appointment by 1994 respondents analysed by provider

Question 6: "How satisfied are you with the arrangements for making the first appointment?"

Satisfaction	1994	New 1995
Very dissatisfied	0.7% (4)	0
Dissatisfied	2% (12)	1.4% (1)
Satisfied	18.2% (109)	23.2% (16)
Very satisfied	17.1% (102)	29% (20)
Not answered	62% (371)	46.4% (32)
Total	**100% 598**	**100% 69**

Table A14.11 Frequency data on satisfaction with arrangements for making the first appointment by 1994 and new 1995 respondents

Overall there had been a marked improvement with arrangements for making the first appointment. When tested against the key variables there were no significant findings in 1994.

A graphic summary of responses to Questions 4–6 (see Appendix 15) indicates that expectation, experience and satisfaction with making the first appointment had improved, although there was also an increase in expectation of difficulty which requires attention. The issue is investigated further in the interview schedule (see below).

Questions 7–9 sought information on ease of making follow-up appointments

Question 7: "How easy did you expect it to be to make a follow-up appointment?"

Expected ease	**1994**	**1995**	**1995 new**
Not easy	15.2% (91)	9.4% (48)	5.8% (4)
Easy	49.2% (294)	43.7% (223)	40.6% (28)
Very easy	27.4% (164)	33.5% (171)	39.1% (27)
Don't know	0	4.1% (21)	4.3% (3)
Not answered	8.2% (49)	9.2% (47)	10.1% (7)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.12 Frequency data on expected ease of making a follow-up appointment by 1994, 1995 and new 1995 respondents

Overall

Optimism about making follow-up appointments had increased. When tested against the key variables there were no significant findings in 1994 but the following was significant in 1995 :

Provider: after deletion of those who did not know and did not reply, there was a significant association between expected ease of making a follow-up appointment and provider (p = 0.00034) (Fig. A14.2). For example. 33.7% (112) of the BHB patients thought that it would be very easy compared with 53.6% (59) of the SCP patients.

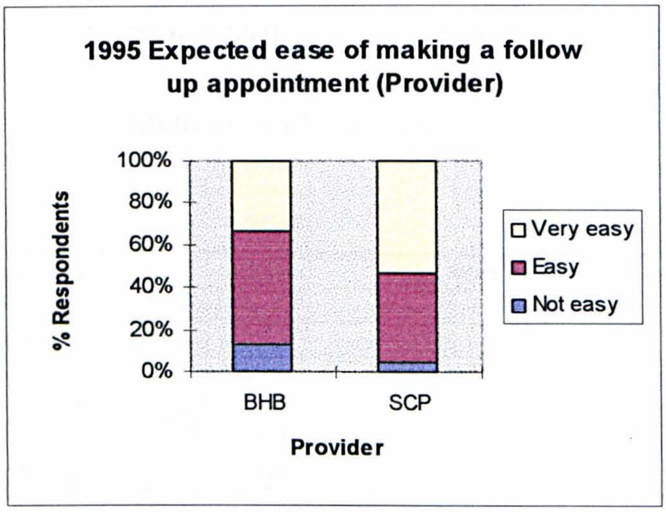

Fig. A14.2 Expected ease of making a follow-up appointment by 1995 respondents analysed by provider

Question 8: "How easy is it for you or your carer to make follow-up appointments?"

Ease of follow-up	1994	1995	New 1995
Not easy	11.9% (71)	13.1% (67)	2.9% (2)
Easy	36% (215)	37.1% (189)	31.9% (22)
Very easy	36.1% (216)	33.9% (173)	42% (29)
Don't know	3.7% (22)	1.8% (9)	4.3% (3)
Not answered	12.4% (74)	14.1% (72)	18.8% (13)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.13 Frequency data on experience of ease of making follow-up appointments by 1994, 1995 and new 1995 respondents

Overall

Patients were satisfied with the ease of making follow-up appointments. When tested against the key variables the following were significant :

1994

Locality: if only those who responded were considered, there was a significant association between actual ease of making follow-up appointments and locality

($p = 0.00576$) (Fig. A14.3). For example, the experience of making a follow-up appointment was felt to be very easy in locality 2 for 56% (28) compared with the next highest of 50% (47) in locality 6.

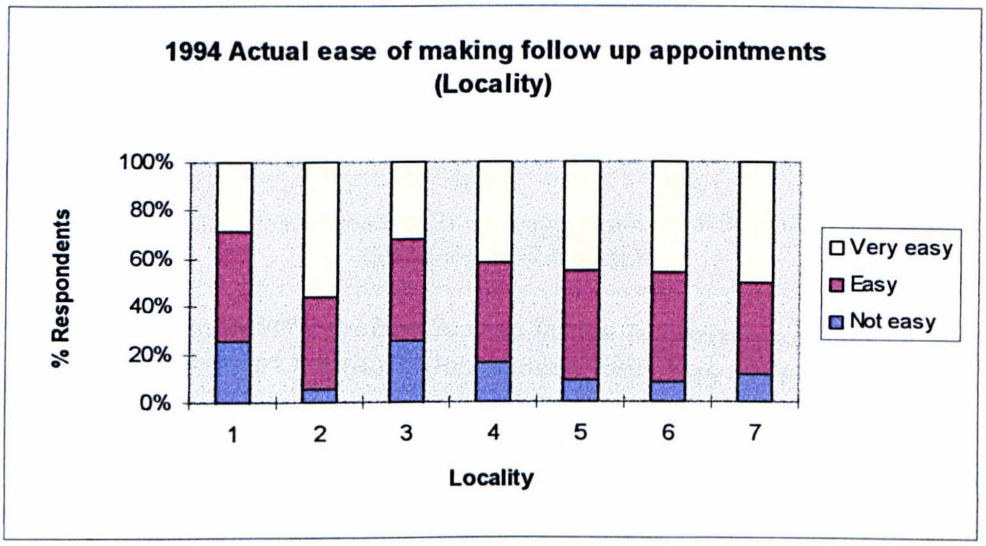

Fig. A14.3 Actual ease of making follow up appointments by 1994 respondents analysed by locality

Provider: if only those who responded to this question were considered, there was a significant association between provider and actual ease of making appointments ($p = 0.00023$) (Fig. A14.4). For instance, 38.6% (154) of the BHB patients found it very easy compared with 60.2% (62) of the SCP ones.

1995

Provider: if only those who answered this question were considered, there was a significant association between actual ease of making follow-up appointments and provider ($p = 0.00000$) (Fig. A14.4). For instance, 34.9% (113) of the BHB patients found it very easy compared with 57.1% (60) of the SCP patients.

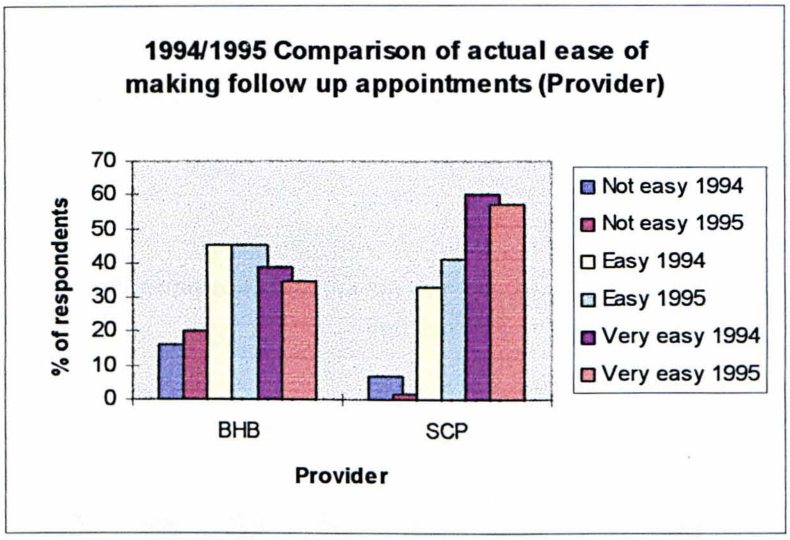

Fig. A14.4 Comparison of actual ease of making first appointments between 1994 and 1995 respondents analysed by provider

Comparison over the two years indicates that SCP have improved on "not easy" where BHB has worsened, and on "easy" where BHB has remained static. Both have lost ground on a "very easy" experience of making follow-up appointments.

Question 9: "How satisfied are you with the arrangements for making follow up appointments?"

Satisfaction	1994	1995	New 1995
Very dissatisfied	3.3% (20)	2.9% (15)	4.3% (3)
Dissatisfied	12% (72)	8.8% (45)	4.3% (3)
Satisfied	48.5% (290)	40.8% (208)	26.1% (18)
Very satisfied	30.1% (180)	35.7% (182)	49.3% (34)
Not answered	6% (36)	11.8% (60)	15.9% (11)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.14 Frequency data on satisfaction with arrangements for making follow-up appointments by 1994, 1995 and new 1995 respondents

Overall

Satisfaction overall is high, when tested against the key variables the following were significant:

1994

Locality: if only those responding were considered, and those who were very dissatisfied and dissatisfied were aggregated, there was a significant association between satisfaction with the arrangements for making follow-up appointments and locality ($p = 0.00027$) (Fig. A14.5), for example, in locality 1 where only 14.6% (12) were very satisfied compared with 44.9% (48) in locality 6.

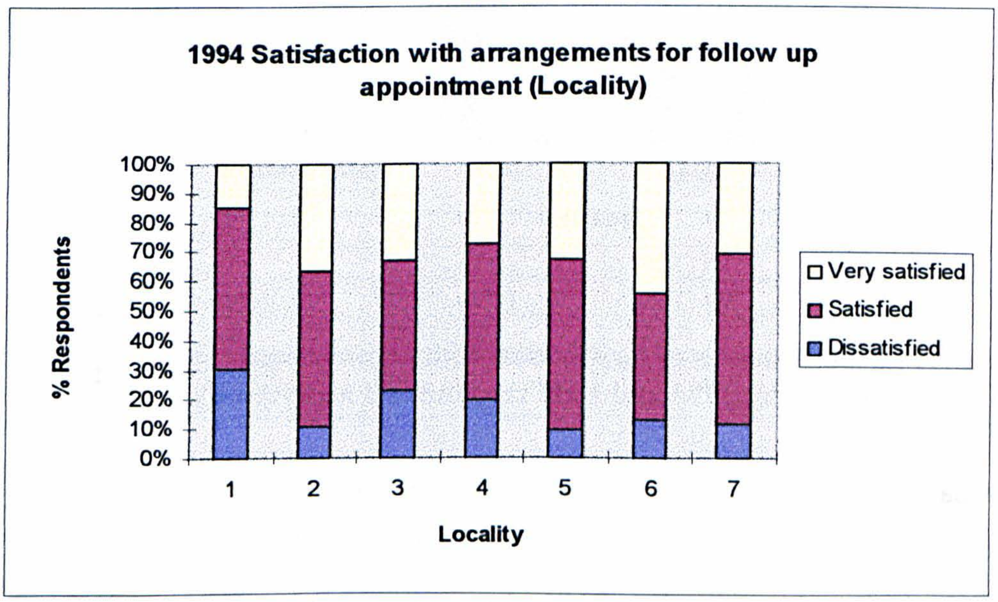

Fig A14.5 Satisfaction with arrangements for follow-up appointment by 1994 respondents analysed by locality

Provider: if only those responding were considered, and very dissatisfied and dissatisfied were aggregated, there was a significant association between satisfaction with the arrangements for making follow-up appointments and provider ($p = 0.00000$) (Fig. A14.6), for example, 26.6% (119) of the BHB patients were very satisfied compared with 53% (61) of the SCP patients.

1995

Provider: when only those who responded were considered and those who were very dissatisfied and dissatisfied were aggregated, there was a significant association between satisfaction with the arrangements for making follow-up appointments and provider (*p* = 0.00001) (Fig. A14.6), for example, 34.8% (117) of the BHB patients were very satisfied compared with 57% (65) of the SCP patients.

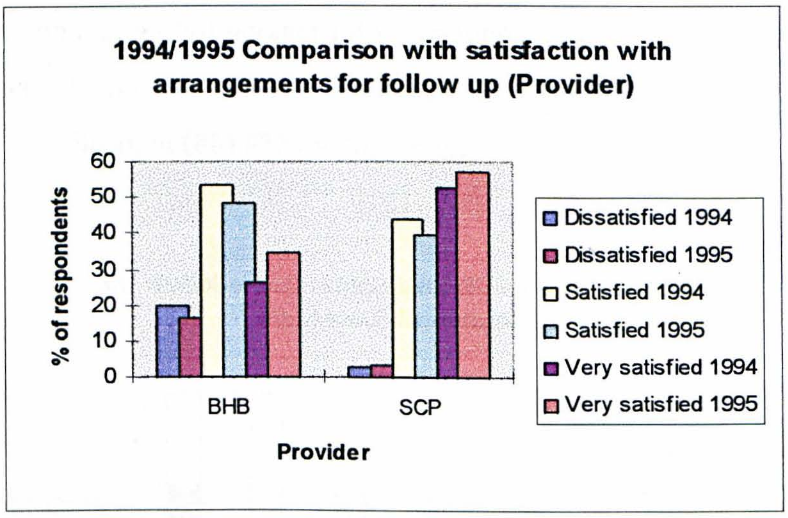

Fig A14.6 Comparison of satisfaction with arrangements for follow-up appointments by 1994 and 1995 respondents analysed by provider

Comparison over the two years indicates that both the BHB and the SCP have made some progress on high satisfaction, but mainly at the expense of "satisfaction", although the BHB have also made some impact on "dissatisfaction".

A graphic summary of responses to Questions 7–9 (see Appendix 16) indicates that expectation, experience and satisfaction are becoming more positive at the extremes; those in the neutral group make up a large proportion and more work is required to identify their expectations and perceptions in order to facilitate their feelings of satisfaction.

The issue was investigated through the follow-up interview seeking suggestions for improving the appointment system

In 1994, there was a strong preference for making the appointment at the time of the treatment; there was anxiety that, by leaving their card for the chiropodist to send out nearer the time, they might get forgotten. Patients had no idea how long they would wait and were concerned that the date might not be convenient. There were also comments that times of domiciliary visits should be acceptable to older people (i.e. after 10 am). In 1995 there were no particular suggestions.

Questions 10–12 sought information on how the venue for treatment was selected.

Question 10: "Where did you expect to have your treatment?"

Expected venue	**1994**	**1995**	**New 1995**
At home	17.1% (102)	14.3% (73)	39.1% (27)
Clinic/surgery	73.4% (439)	74.3% (379)	47.8% (33)
Where best	2.8% (17)	1.6% (8)	1.4% (1)
No preference	1.3% (8)	0.8% (4)	0
Not answered	5.4% (32)	9% (46)	11.6% (8)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.15 Frequency data on expected venue for treatment by 1994, 1995 and new 1995 respondents

Overall

The expectation of domiciliary care had increased, when tested against the key variables.

1994

Age: if only those respondents who stated a definite preference were compared, there was a significant association between age and venue for treatment ($p = 0.00000$) (see Fig. A14.9 later), for example, 8.7% (19) of those aged 75–79 years expected treatment at home compared with 22.1% (44) of those aged 80–84 and 31.5% (39) of those aged 85 and over.

Locality: if only those respondents who stated a definite preference were compared, there was a significant association between locality and venue ($p =$

0.00000) (Fig. A14.7). Particularly notable was the expectation of home treatment in locality 5 (=36.3% or 33), locality 6 (27.5% or 28) and locality 7 (26.5% or 26), compared with the next highest of 10.2% (5) in locality 4. Localities 5, 6 and 7 correspond to those covered by the SCP.

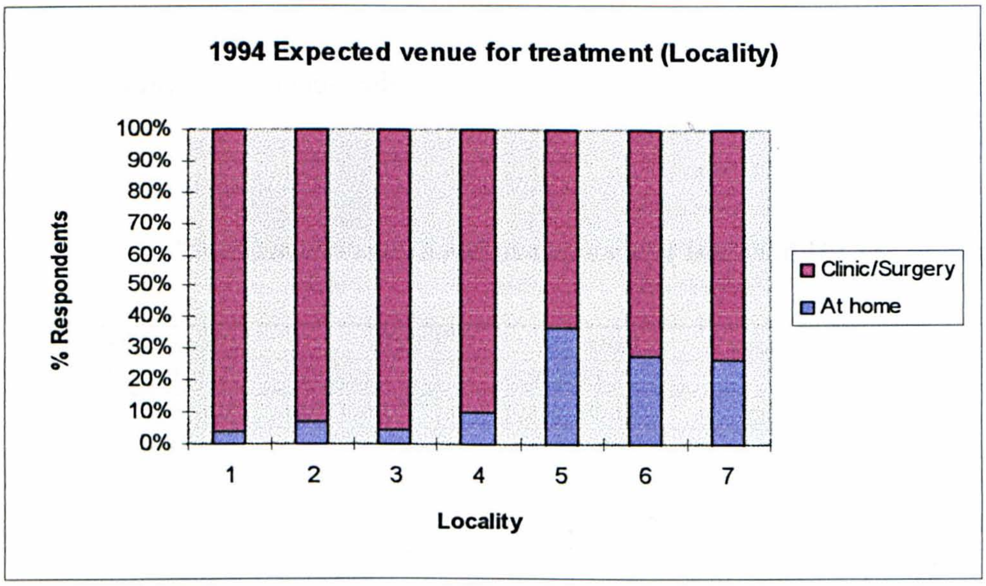

Fig A14.7 Expected venue for treatment by 1994 respondents analysed by locality

Provider: if only those respondents who stated a definite preference were considered, there was a significant association between provider and venue (p = 0.00000) (Fig. A14.8), with 6.3% (27) of the BHB patients expecting treatment at home compared with 68.8% (75) for the SCP patients (Fig. A14.8). It was noted earlier that analysis of responses had found that the SCP patients were older which equates with dependence.

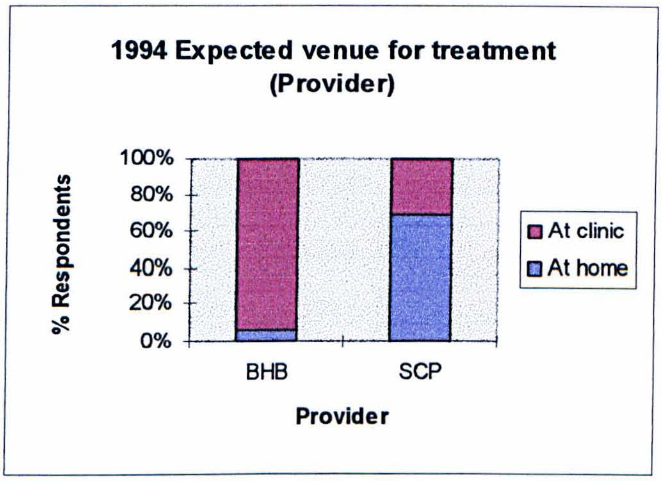

Fig A14.8 Expected venue for treatment for 1994 respondents analysed by provider

Age: if only those respondents who stated a definite preference were compared, there was a significant association between age and venue (P = 0.00000) (Fig A14.9), for example, 9.1% (17) of those aged 75–79 years expected to have treatment at home compared with 14.1% (23) of those aged 80–84 and 32.4% (33) of those aged 85 and over.

Provider: if only those respondents who stated a preference were considered, there was a significant association between provider and expected venue for treatment (p = 0.00000) (Fig. A14.10), for example, only 3.6% (12) of the BHB patients expected treatment at home compared with 53.5% (61) of the SCP patients.

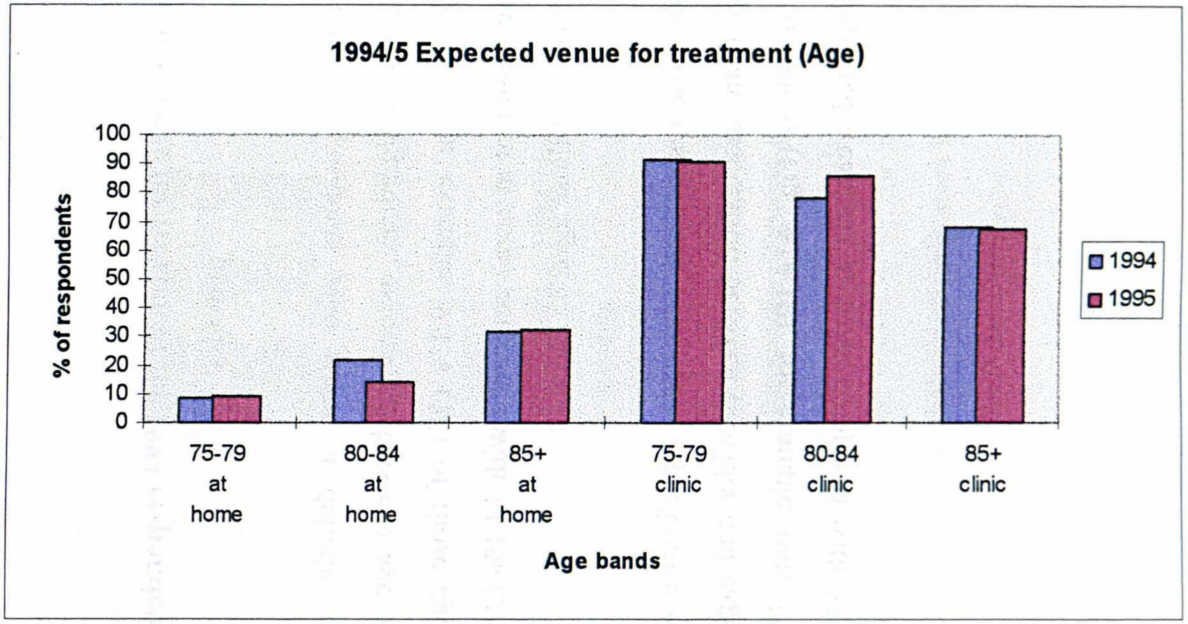

Fig. A14.9 Comparison of expected venue for treatment of 1994 and 1995 respondents analysed by age

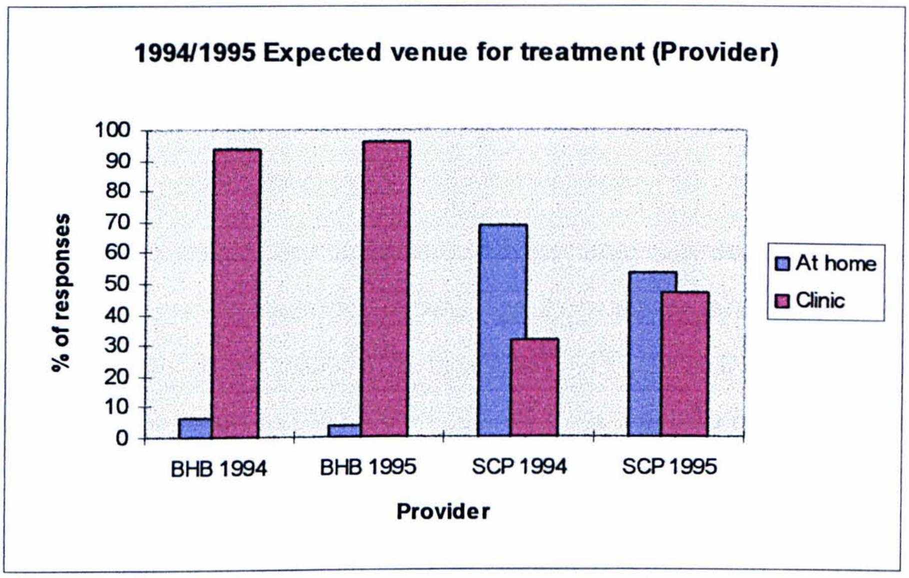

Fig. A14.10 Comparison of expected venue for treatment by 1994 and 1995 respondents analysed by provider

Comment

The difference in expectation of venue can be ascribed to provider effect and has been modified during the period by increased purchaser pressure for clinic-based treatment where possible.

Question 11: "Where do you usually have your treatment ?"

Usual venue	**1994**	**1995**	**new 1995**
At home	14.7% (88)	14.1% (72)	37.7% (26)
Clinic/surgery	78.9% (472)	76.5% (390)	50.7% (35)
Where best	0.7% (4)	0.6% (3)	1.4% (1)
Varies	0.8% (5)	0	0
Not answered	4.8% (29)	8.8% (45)	10.1% (7)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.16 Frequency data for usual venue for treatment by 1994, 1995 and new 1995 respondents

Overall

Home-based care has increased with the new 1995 patients.

When tested against the key variables the following were significant:

1994

Age: if only those who indicated home or clinic venue were compared, there was a significant association between age and actual venue for treatment (p = 0.00001) (see Fig. A14.12 later). The likelihood of treatment at home increased with age, being 7.1% (16) of those aged 75–79, 19.4% (40) of those aged 80–84 and 24.8% (32) of those aged 85+.

Locality: if only those respondents who indicated that they usually had their treatment at home or at the clinic/surgery were compared, there was a significant association between locality and usual venue for treatment (p = 0.00000) (Fig. A14.11), for example, home-based treatment occurred for 32.6% (30) in locality 5, 24.8% (26) in locality 6 and 19.4% (19) in locality 7, compared with the next highest of 8.6% (5) in locality 2. Localities 5, 6 and 7 correspond with those covered by the SCP; the result could be the result of provider or age variables.

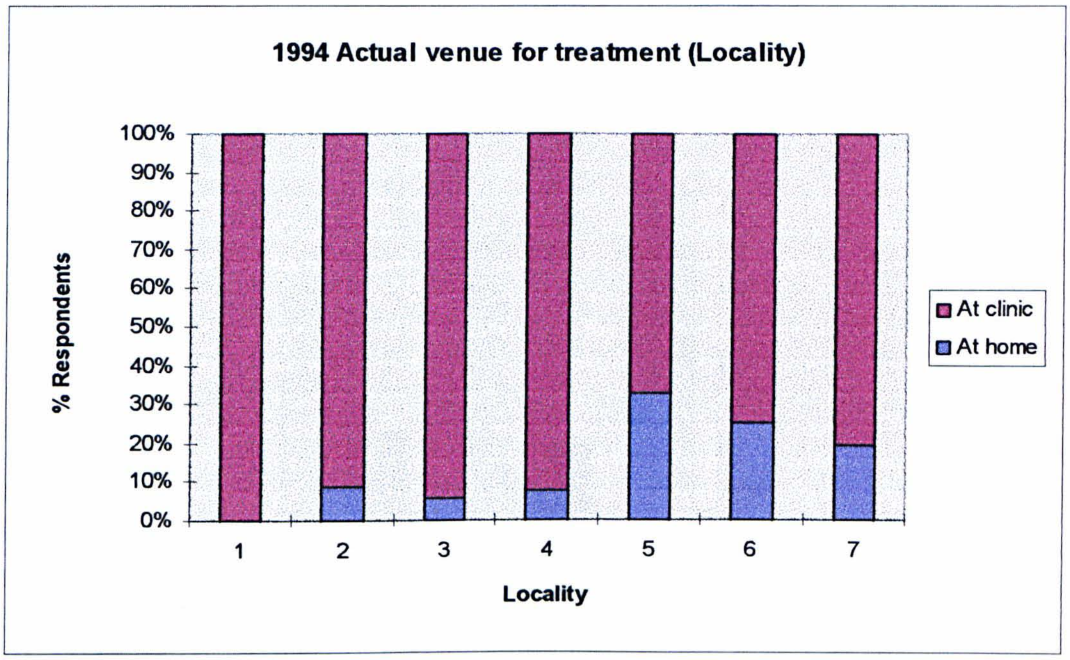

Fig A14.11 Actual venue for treatment by 1994 respondents analysed by locality

Provider: if only those respondents who indicated that they usually had their treatment at home or at the clinic/surgery were considered, there was a particularly significant association between provider and usual venue for treatment (p = 0.00000) (Fig. A14.14 later), for example, 3.7% (17) of the BHB patients had their treatment at home compared with 67% (71) of the SCP patients. It was noted in the analysis of respondents that SCP patients were older, which increases the likelihood of dependence.

1995

Age: if only those respondents who indicated where they had their treatment were considered, there was a significant association between age and venue (p = 0.00000) (Fig. A14.12), for example, 8.8 % (17) of those aged 75-79 had their treatment at home compared with 13.9% (23) of those aged 80–84 and 31.1% (32) of those aged 85+.

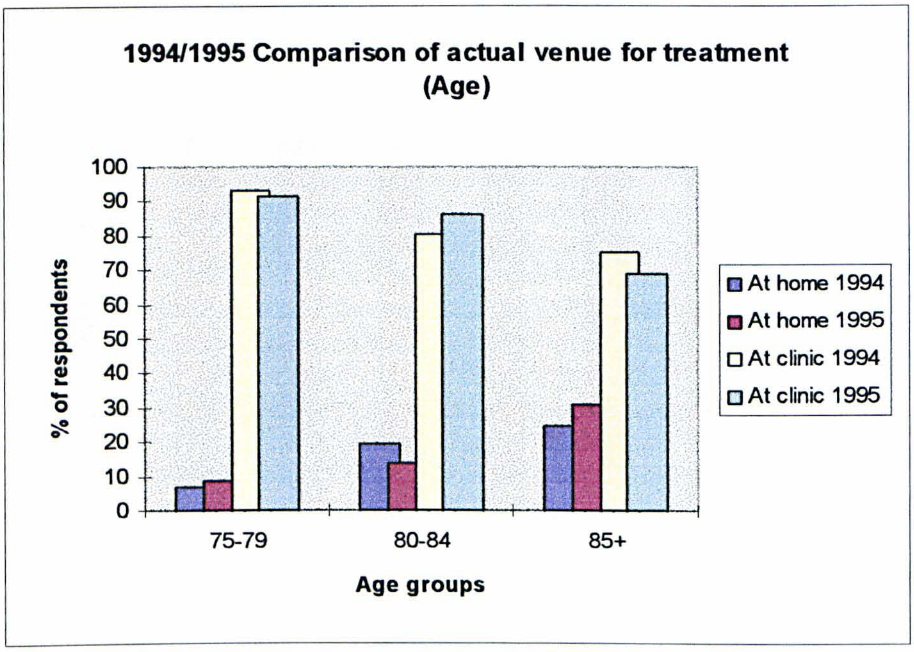

Fig A14.12 Comparison of actual venue for treatment by 1994 and 1995 respondents analysed by age

Locality: if only those respondents who indicated where they had their treatment were compared, there was a significant association between locality and venue (p = 0.00000) (Fig. A14.13). This should be interpreted with caution because of the very small number having home treatment in localities 1 (1), 2 (2), 3 (2) and 4 (1), which correspond to the localities solely covered by the BHB. Domiciliary care was provided to 26.2% (16) in locality 5 and 25.5% (25) in locality 6 as well as (24.8% (25) in locality 7 which correspond to SCP areas.

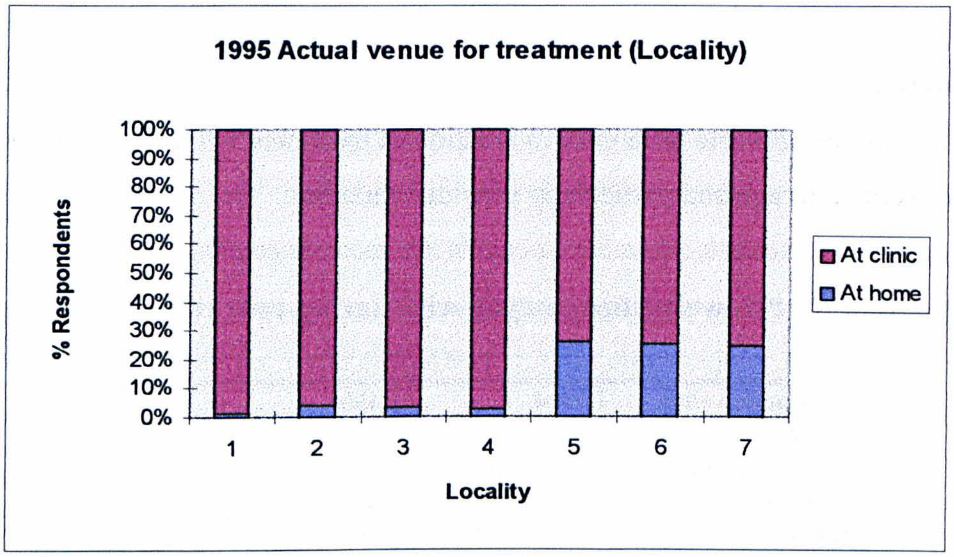

Fig A14.13 Actual venue for treatment by 1995 respondents analysed by locality

Provider: if only those respondents who indicated where they had their treatment were considered, there is a particularly significant association between provider and venue for treatment ($p = 0.00000$) (Fig. A14.14), for instance, 97.1% (333) of the BHB patients and 47.9% (57) of the SCP patients have treatment at the surgery.

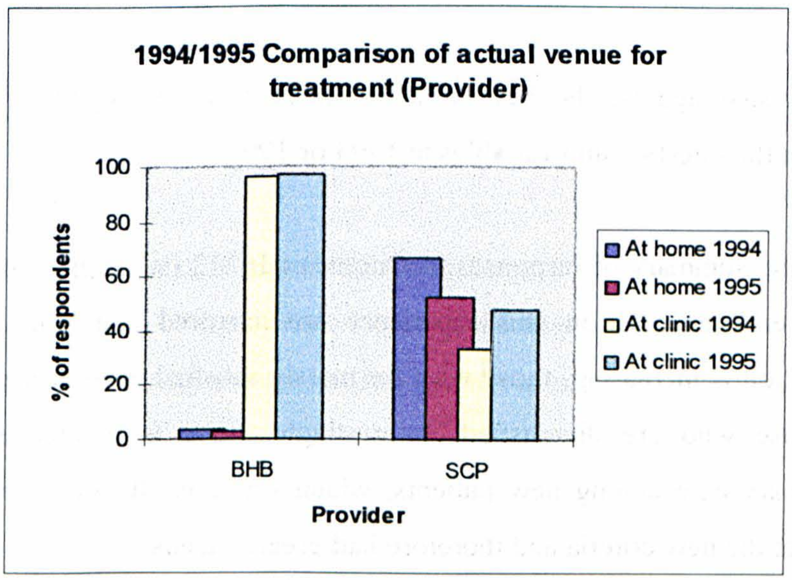

Fig A14.14 Comparison of actual venue for treatment by 1994 and 1995 respondents analysed by provider

Overall

There is considerable difference in location of treatment within localities which can be ascribed to age and particularly provider variables.

Question 12: "How satisfied are you with having your treatment there?"

Satisfaction with venue	**1994**	**1995**	**New 1995**
Very dissatisfied	1.8% (11)	2.5% (13)	4.3% (3)
Dissatisfied	2.7% (16)	2.2% (11)	1.4% (1)
Satisfied	46% (275)	36.5% (186)	24.6% (17)
Very satisfied	44.5% (266)	49.8% (254)	59.4% (41)
Not answered	5% (30)	9% (46)	10.1% (7)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.17 Frequency data on satisfaction with venue for treatment by 1994, 1995 and new 1995 respondents

Overall

Satisfaction was high with the treatment venue arrangements.

When tested against the key variables, there were no significant associations between the question and variables in 1994 or 1995

A graphic summary of responses to Questions 10–12 (see Appendix 17) indicates that overall expectation and experience are mirrored and that, although high satisfaction is increasing, those who are merely satisfied have decreased, although not those who are dissatisfied. Interestingly, there is greater expectation of domiciliary care among new patients, which was met. It could be assumed that they met the new criteria and therefore had greater needs.

The issues were further investigated in the 1994 interview schedule where it was felt that home visits should be available for the housebound, those in poor health and those unable to travel. Regarding clinics, there was a lack of information on what was available and where; parking was reported as reserved for staff or disabled; and public transport near the clinic as well as the patient's own home was an important consideration. The BHB Chiropody Ambulance was appreciated and further such facilities were wanted. There was a suggestion that a more flexible service could provide more domiciliary visits in winter, but it was appreciated that this would be difficult to administer.

Question 13: "If you currently have treatment at a chiropody clinic or surgery, what is your general view of the facilities?"

View of facilities	**1994**	**1995**	**new 1995**
Very poor	0.2% (1)	0	0
Poor	2% (12)	1% (5)	0
Good	39.8% (238)	32.5% (166)	18.8% (13)
Very good	42.1% (252)	46.7% (238)	37.7% (26)
Not answered	15.9% (95)	19.8% (101)	43.5% (30)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.18 Frequency data on view of clinic facilities by 1994, 1995 and new 1995 respondents

Overall

There is a high level of satisfaction with clinic/surgery facilities by those who have their treatment there. When tested against the key variables, there were no significant associations between the question and variables in 1994 or 1995.

Comment

The actual facilities on which users measure their satisfaction is unclear and the issue was consequently included in the interview schedule. In 1994, respondents appreciated the warm welcome, cleanliness, positive attitude of staff, comfortable chairs, information about delays and efficient treatment. Concerns were voiced about the lack of privacy at some clinics for removal/reapplication of stockings, and the suggestion that at least a screen be provided. There were specific comments about recent increases in speed of treatment, gloves not being used and poorer attitude from staff. The lack of parking for patients was commented on.

In 1995, respondents appreciated good time-keeping, treatments not being rushed and people "keeping their turn". There were a number of compliments about attitude of both chiropodists and receptionists, and particularly the help provided by the latter, for example, in ordering cabs. The clinic facilities (clean, tidy, equipment, chairs and toilets) were appreciated, especially in the refurbished BHB clinics. There were fewer negative responses, but these focused on:

- appointment system and infrequency of treatment
- inconsistency of chiropodist and quality of treatment
- lack of physical help for those with disabilities who make it to clinics
- knowing turn in mixed waiting areas, especially when blind.
- facilities: privacy (named clinic), delay in machine repairs, lack of refreshments.

Questions 14, 15 and 16 refer to expectations, experience and satisfaction with the type of chiropody treatment received.

Question 14: "Which of the following do you expect to have as part of chiropody treatment?"

Respondents could indicate any of the options providing multiple answers.

Type of chiropody expected	1994	1995	New 1995
Chiropody for life	74.7% (447)	76.3% (389)	69.6% (48)
Assessment and plan	15.2% (91)	12% (61)	15.9% (11)
Shown self-care	7.5% (45)	6.1% (31)	10.1% (7)
Discharge discussed	1.8% (11)	2.7% (14)	5.8% (4)

Table A14.19 Frequency data on expectation of type of treatment by 1994, 1995 and new 1995 respondents

Overall

Expectation of chiropody for life remained high, but expectation of self-care advice was increasing, as was discussion about discharge.

Question 15: "What type of chiropody do you have?"

Respondents could indicate any of the options provided.

Type of chiropody received	1994	1995	New 1995
Chiropody for life	68.1% (407)	65.1% (332)	55.1% (38)
Assessment and plan	15.9% (95)	11.4% (58)	17.4% (12)
Shown self-care	5% (30)	4.3% (22)	4.3% (3)
Discharge discussed	0.5% (3)	0	0

Table A14.20 Frequency data on type of treatment received by 1994, 1995 and new 1995 respondents

Overall

The experience was decreasingly about "chiropody for life", but there was no clear trend as to what was replacing it. Discussion about discharge was virtually denied, even though 36 patients in 1995 answered a later question (number 32) about their discharge arrangements.

Question 16:"How satisfied are you with the type of chiropody you receive?"

Satisfaction with type of treatment	**1994**	**1995**	**New 1995**
Very dissatisfied	1.5% (9)	1.8% (9)	1.4% (1)
Dissatisfied	2% (12)	1.4% (7)	0
Satisfied	45.8% (274)	37.3% (190)	24.6% (17)
Very satisfied	44.5% (266)	48.4% (247)	62.3% (43)
Not answered	6.2% (37)	11.2% (57)	11.6% (8)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.21 Frequency data on satisfaction with type of treatment received by 1994, 1995 and new 1995 respondents

Overall

The high level of satisfaction is encouraging, but must be balanced against the gratitude often displayed by such a very vulnerable group, and the fact that expectations are continually increasing.

When tested against the key variables there was a significant association with the following:-

1994

Gender: when only those who answered were considered and those who were dissatisfied and very dissatisfied were aggregated, there is a significant association between satisfaction with type of chiropody received and gender (p = 0.03413) (Fig. A14.15), for example, 43.6% (68) of male patients were satisfied compared with 53.6% (206) of female patients.

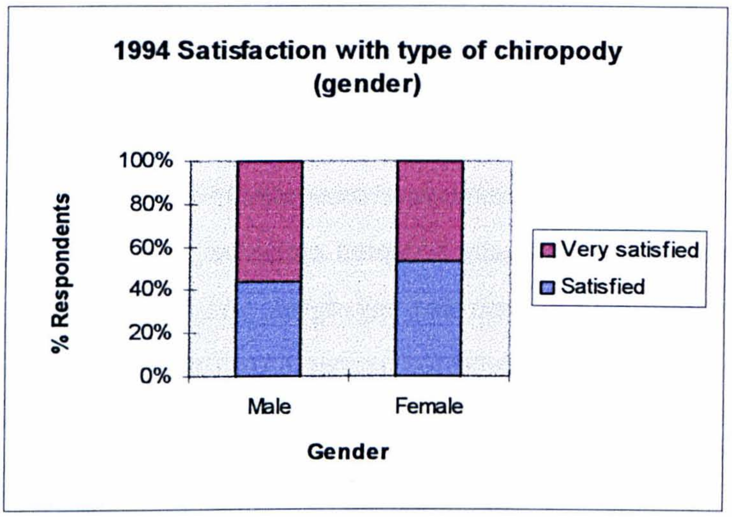

Fig A14.15 Satisfaction with type of chiropody by 1994 respondents analysed by gender

Frequency tables for type of chiropody indicate that most respondents felt they were getting chiropody for life, which may reflect in their satisfaction (Table A14.22).

Type of treatment	Men	Women	Total
Chiropody for life	103 (59.9%)	304 (71.4%)	407
Assessment and plan	39 (22.7%)	56 (13.1%)	95
Shown self care	9 (5.2%)	21 (4.9%)	30
Discharge discussed	1 (0.6%)	2 (0.5%)	3

Table A14.22 Frequency data on expectation of type of treatment by gender of 1994 respondents

There were no significant associations in 1995.

A graphic summary of responses to Questions 14–16 (see Appendix 17) shows that expectation and experience of treatment are closely mirrored. There is a gradual move away from "chiropody for life" to an assessment and treatment plan.

Comment

There remained a high expectation and experience of "chiropody for life". More information was needed from users on what they viewed as "Chiropody for life" and was included in the interview schedule. In 1994 "chiropody for life" was reported not to be a generally accepted comment. Some felt that they deserved it, some that these days no one had any rights, and some that everything was taken for granted. In 1995, few reported having heard this statement. Most felt that there were no "entitlements" these days, that chiropody should be for need and that need did increase with age.

The issue of "discharge" was included in the 1995 interview and most felt that, *if* the problems could be cured, discharge would be accepted, but that it was unlikely *in their case*; nails still needed to be cut and they couldn't reach them. There were also concerns about re-accessing the service after discharge if their needs changed.

Questions 17 and 18 were about self-care of the feet.

Question 17: "If the plan for your foot care does include care of your feet by you/your carer between treatments, how satisfied are you with the information you were given on how to do it?"

Satisfaction with information on self-care	**1994**	**1995**	**New 1995**
Very dissatisfied	3.2% (19)	1% (5)	1.4% (1)
Dissatisfied	4.3% (26)	3.5% (18)	1.4% (1)
Satisfied	36.1% (216)	31.2% (159)	26.1% (18)
Very satisfied	11.2% (67)	17.1% (87)	21.7% (15)
Not answered	45.2% (270)	47.3% (241)	49.3% (34)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.23 Frequency data on satisfaction with information on self care by 1994, 1995 and new 1995 respondents

Overall

Only those with self-care in their programme were asked to respond. Satisfaction with self-care information had remained high and increased in strength. When tested against the key variables there were no significant findings in 1994 or 1995.

Question 18: "How strongly do you feel about older people/their carers looking after basic foot care needs when they are able to?"

Views on self care	**1994**	**1995**	**New 1995**
Strongly disagree	10.7% (64)	8% (41)	8.7% (6)
Disagree	22.7% (136)	20.6% (105)	13% (9)
Agree	35.3% (211)	32% (163)	37.7% (26)
Strongly agree	10% (60)	13.1% (67)	21.7% (15)
Not answered	21.2% (127)	26.3% (134)	18.8% (13)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.24 Frequency data on views on self care by 1994, 1995 and new 1995 respondents

Overall

The high non-response rate can be partly explained by the low expectation and low experience of self-care as part of chiropody treatment. The increase in acceptance of self-care when able was encouraging. When tested against the key variables, there were no significant findings in 1994 or 1995.

In view of the interest of the purchaser in facilitating self-care, the issue was included in the 1995 interview schedule, revealing several requests for information, which were not felt to be forthcoming from the chiropodist without being requested. A number felt that the service was just for nail cutting and did not include advice.

Questions 19 and 20 were about the goals for chiropody treatment.

Question 19: "What results do you hope for from the treatment?"

Respondents could select more than one answer providing multiple responses.

Results hoped for	**1994**	**1995**	**New 1995**
Cure	11.2% (67)	12.9% (66)	11.6% (8)
Reduce problem	65.9% (394)	56.1% (286)	49.3% (34)
Advice	11.9% (71)	12% (61)	18.8% (13)
Not sure	6.4% (38)	5.7% (29)	5.8% (4)

Table A14.25 Frequency data on results hoped for from treatment by 1994, 1995 and new 1995 respondents

As the answers to this question were not mutually exclusive, chi-squared analysis has not been carried out on this data. It is also not known whether these goals match those of the provider.

Overall

The main change over time is the increased expectation of advice and decreased expectation of cure. A small number remain unsure about what the goal of their treatment was.

Question 20: "Do you feel that chiropody is giving the results you hoped for?"

Results hoped for	**1994**	**1995**	**New 1995**
Yes	82.4% (493)	79.8% (407)	88.4% (61)
No	4.3% (26)	2.5% (13)	0
Don't know	5.9% (35)	4.9% (25)	1.4% (1)
Not answered	7.4% (44)	12.7% (65)	10.1% (7)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.26 Frequency data on satisfaction with results of treatment hoped for by 1994, 1995 and new 1995 respondents

Overall

Satisfaction with the outcome of treatment was consistently high. When tested against the key variables there were no significant differences in 1994 or 1995.

Questions 21–23 were about the frequency of treatment.

Question 21: "How frequently do you expect to get your treatment?"

Frequency expected	**1994**	**All 1995**	**New only 1995**
Regular	28.8% (172)	30.6% (156)	21.7% (15)
As needed	10% (60)	7.1% (36)	5.8% (4)
Set by Chiropodist	39.3% (235)	34.9% (178)	39.1% (27)
Agreed with Chiropodist	13.9% (83)	16.3% (83)	23.2% (16)
Don't know	1% (6)	0.8% (4)	1.4% (1)
Not answered	7% (42)	10.4% (53)	8.7% (6)
Total	**100% 598**	**100% 510**	**100%**

Table A14.27 Frequency data on expected frequency of treatment by 1994, 1995 and new 1995 respondents

Overall

There had been a decrease in expectation of regularity and increase in collaborative plans, but a low expectation of frequency based on need. Expectation that frequency was set by the chiropodist remained consistently high.

When tested against the key variables, there was a statistically significant association between the question and the following variables :-

1994

Gender: if only those who provided a definite answer to the question were considered, there was a significant association between gender and expected frequency of treatment ($p = 0.00007$) (Fig. A14.16), for example, 22.7% (34) male patients expected a regular number of weeks compared with 34.5% (138) of the female patients; in addition, 58.7% (88) of the male patients expected frequency set by the chiropodist compared with 36.8% (147) of the female patients.

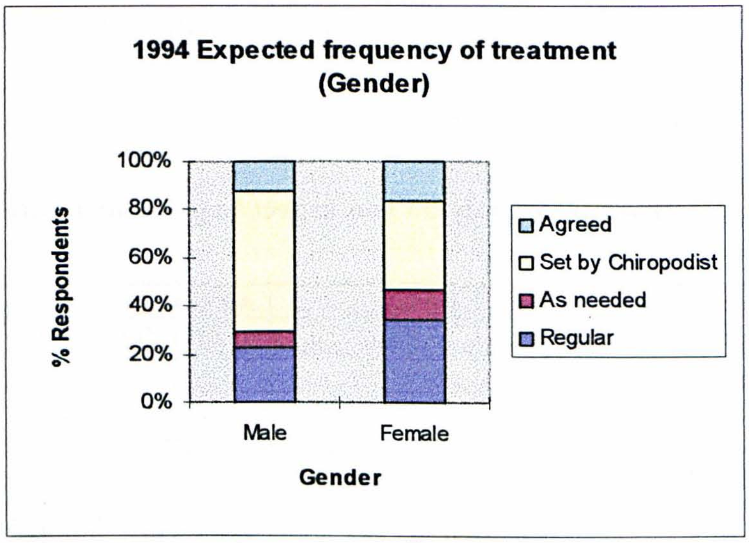

Fig. A14.16 Expected frequency of treatment by 1994 respondents by gender

Locality: if only those who provided a definite answer to the question were considered, there was a significant association between locality and expected frequency of treatment ($p = 0.02144$) (Fig. A14.17). A particularly striking difference is that 54.5% (30) of patients in locality 2 expected the date to be set by the chiropodist, compared with the lowest of 25.5% (13) in locality 4.

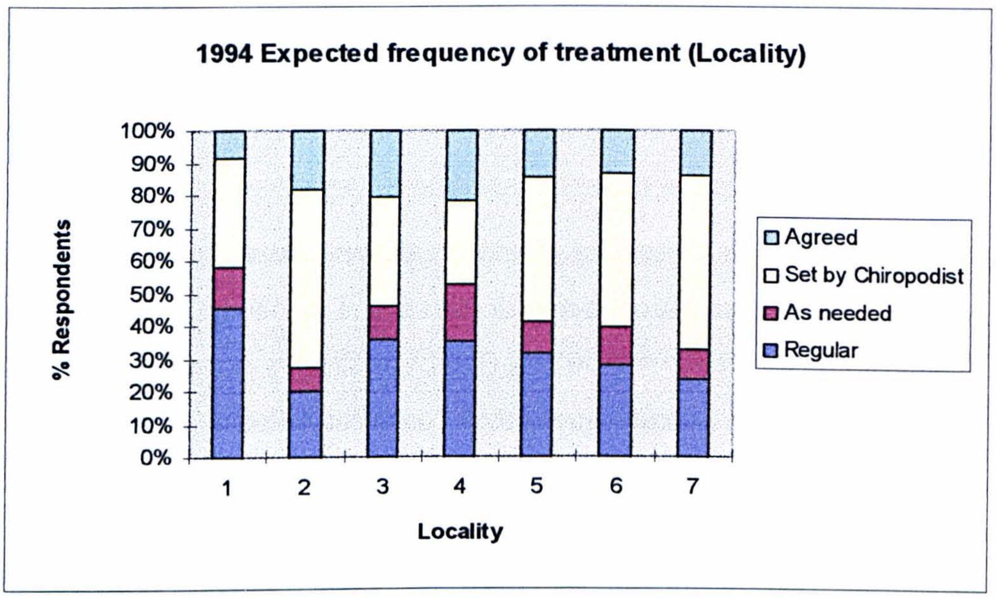

Fig A14.17 Expected frequency of treatment by 1994 respondents analysed by locality

1995

There were no significant findings.

Question 22: "How is the date of your follow up treatment decided?"

Date decided	**1994**	**1995**	**New 1995**
Regular	19.1% (114)	20.6% (105)	20.3% (14)
As needed	3.5% (21)	4.1% (21)	2.9% (2)
By Chiropodist	56.5% (338)	52% (265)	47.8% (33)
Agreed with Chiropodist	9.5% (57)	10.6% (54)	11.6% (8)
Don't know	3.5% (21)	2.4% (12)	2.9% (2)
Not answered	7.9% (47)	10.4% (53)	14.5% (10)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.28 Frequency data on method for deciding date of follow-up treatment by 1994, 1995 and new 1995 respondents

Overall

Despite changes in expectation, there has been little change in the experience of patients over time, except a decrease in the date set solely by the chiropodist and increase in agreement with the chiropodist. When tested against the key variables there was a significant association with the following:-

1994

Locality: when only those who provided a definite answer were considered, there was a positive association between the actual method of deciding the next treatment and locality ($p = 0.00215$) (Fig. A14.18), for example, only 4.3% (3) of patients in locality 1 actually agreed their treatment date compared with the highest of 17.5% (10) in locality 2.

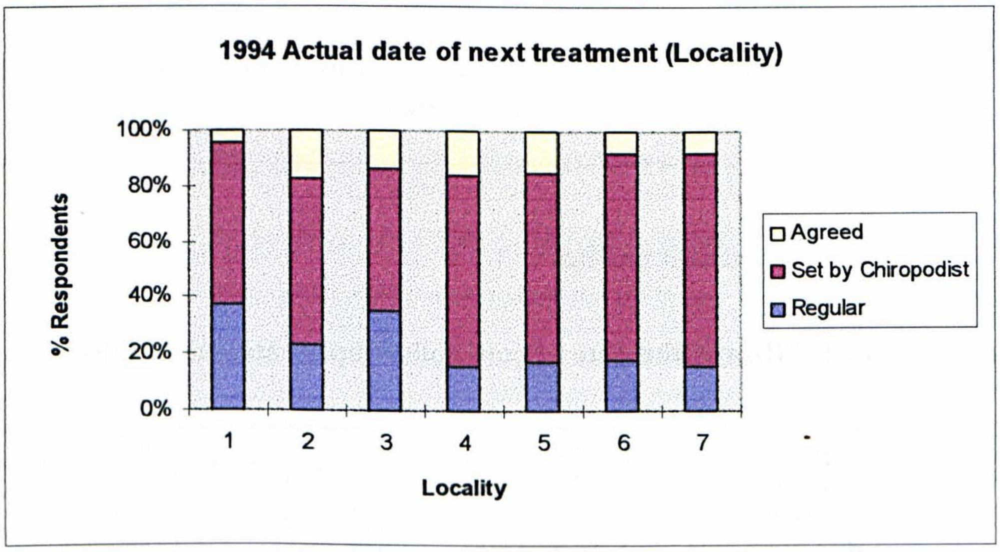

Fig A14.18 Actual date of next treatment by 1994 respondents analysed by locality

1995

Locality: if only those who provided a definite answer were considered, there was a significant association between how the date of the next treatment was decided and locality ($p = 0.00176$) (Fig. A14.19), for example, only 5% (3) of patients in locality 1 actually agreed their treatment plan compared with the highest of 25% (13) in locality 3.

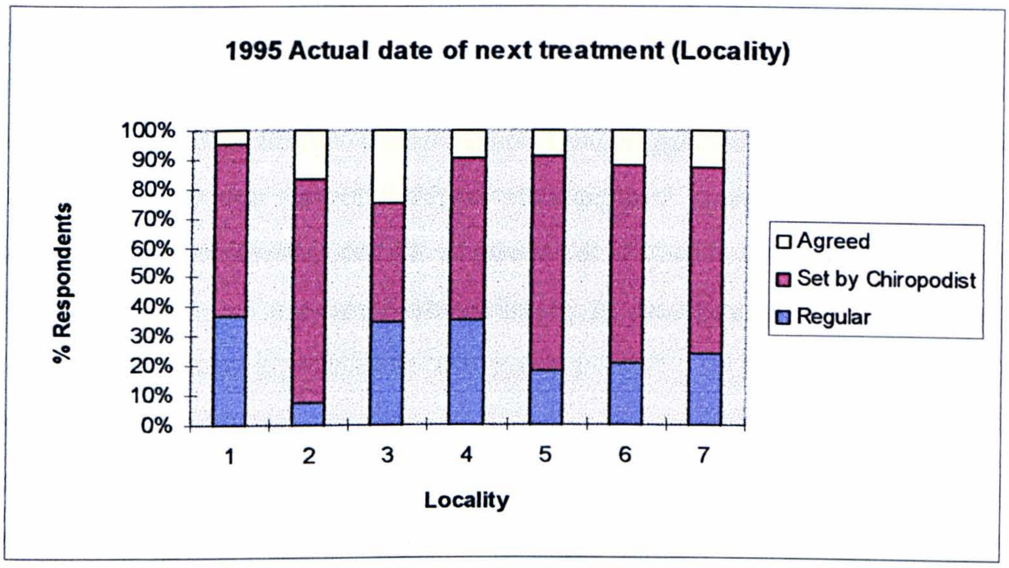

Fig. A14.19 Actual date of next treatment by 1995 respondents analysed by locality

Question 23: "How satisfied are you with the arrangements for your follow-up treatments?"

Satisfaction with follow up arrangements	1994	1995	New 1995
Very dissatisfied	4.5% (27)	2.4% (12)	1.4% (1)
Dissatisfied	12.4% (74)	9.8% (50)	5.8% (4)
Satisfied	50.8% (304)	46.1% (235)	36.2% (25)
Very satisfied	24.6% (147)	31.8% (162)	44.9% (31)
Not answered	7.7% (46)	10% (51)	11.6% (8)
Total	100% 598	100% 510	100% 69

Table A14.29 Frequency data on satisfaction with arrangements for follow-up treatment by 1994, 1995 and new 1995 respondents

Overall

There was a high level of satisfaction which had increased in strength over time, when tested against the key variables.

1994

Provider: when only those who responded were considered and dissatisfied and very dissatisfied were aggregated, there was a significant association between satisfaction with making arrangements for the follow-up appointment and provider (p = 0.00000) (Fig. A14.20), for example, 43.2% (48) of the SCP patients were very satisfied compared with 22.4% of the BHB patients.

1995

Provider: when only those who responded were considered and dissatisfied and very dissatisfied were aggregated, there was a significant association between satisfaction with making arrangements for the follow-up appointment and provider (p = 0.00000) (Fig. A14.20), for example, 53.3% (64) of the SCP patients were very satisfied compared with 28.9% (98) of the BHB patients.

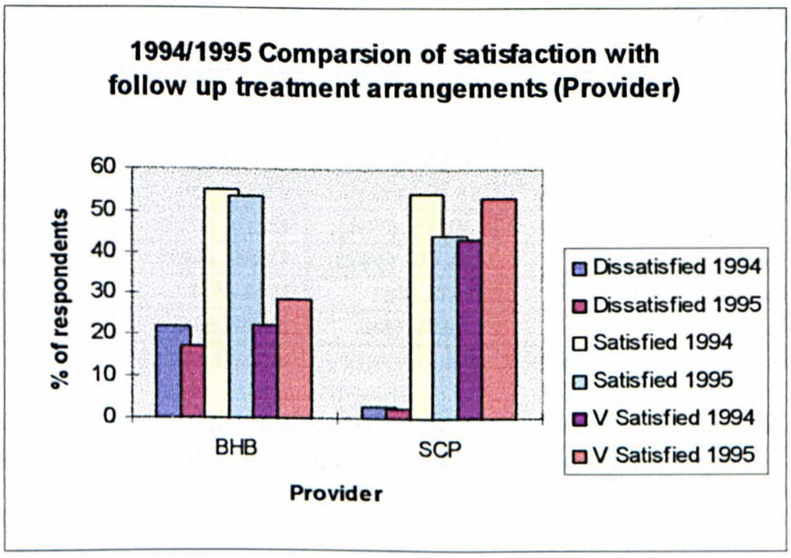

Fig A14.20 Comparison of satisfaction with follow up treatment by 1994 and 1995 respondents analysed by provider

A graphic summary of responses to Questions 21–23 (see Appendix 18) shows an increase in expected agreement, but the expectation and especially the experience that the chiropodist will set the frequency of treatment remain high.

The issue was investigated further in the 1994 interview schedule and most felt that the frequency of treatment was decided by the chiropodist. The facility to telephone beforehand if problems arose was appreciated, although few had used it, being willing to struggle on; those that had were generally informed that there were no staff available, but emergency requests were dealt with within three or four days. It was suggested that, if frequency was increased, the need to telephone would be reduced. Some patients reported that information was being given by the chiropodist, mostly about lotions, hygiene and nail care, to enable self-care between treatments. Demonstration and information on availability of implements were requested.

Questions 24-29 were about users view of the chiropody service in general.

Question 24: "In your view, how does the organisation of the Chiropody service appear?"

View of organisation	**1994**	**1995**	**New 1995**
Very disorganised	1.2% (7)	1.4% (7)	1.4% (1)
Disorganised	6.2% (37)	4.3% (22)	1.4% (1)
Organised	54.3% (325)	48.2% (246)	36.2% (25)
Very organised	30.8% (184)	35.1% (179)	47.8% (33)
Not answered	7.5% (45)	11% (56)	13% (9)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.30 Frequency data on view of organisation of service by 1994, 1995 and new 1995 respondents

Overall

There was consistently high satisfaction which had increased in strength.

When tested against the key variables there was a significant association with the following :-

1994

Locality: when only those responding to the question were considered and disorganised and very disorganised were aggregated, there was a significant association between view of chiropody organisation and locality (p = 0.02975) (Fig. A14.21), for example, 72.2% (48) of the patients in locality 3 felt the service was organised compared with 47.9% (46) in locality 5.

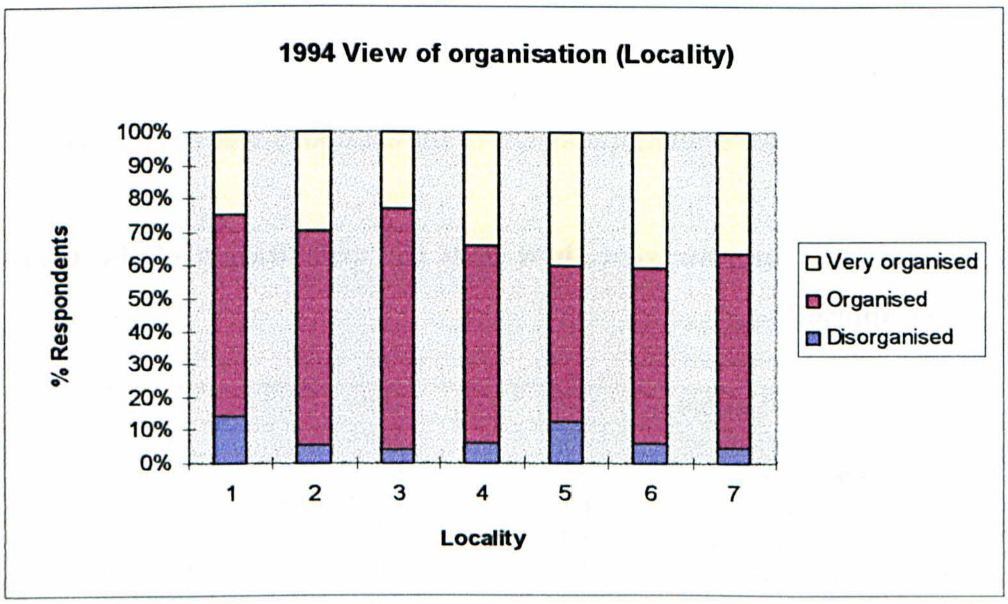

Fig. A14.21 View of organisation by 1994 respondents analysed by locality

Provider: when those answering the question were considered and disorganised and very disorganised were aggregated, there was a significant association between view of chiropody organisation and provider ($p = 0.00019$) (Fig. A14.22), for example, 49.1% (55) of the SCP patients felt that their service was very organised compared with 29.3% (129) of the BHB patients.

1995

Provider: if only those who answered the question were considered, and disorganised and very disorganised responses were aggregated, there was a significant association between view of organisation of the service and provider ($p = 0.00000$) (Fig. A14.22), for example, 65.5% (76) of SCP patients felt their service to be very organised compared with 30.5% (103) for BHB.

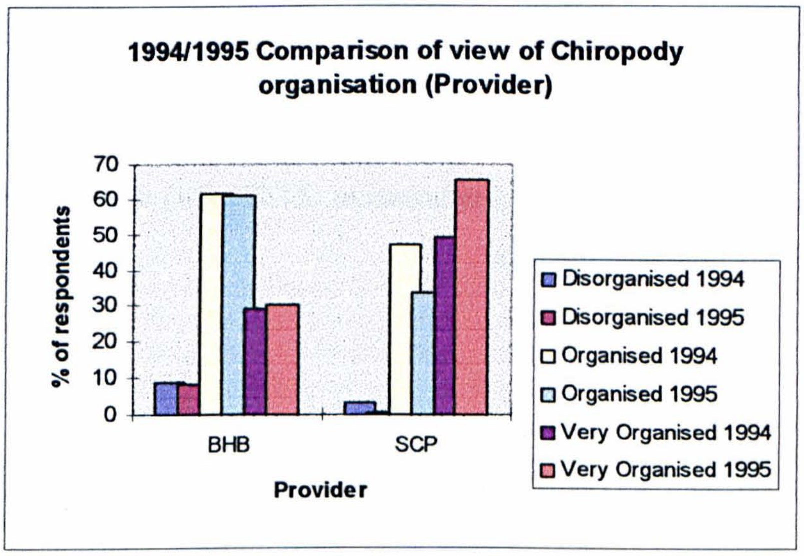

Fig A14.22 Comparison of view on organisation of chiropody by 1994 and 1995 respondents analysed by provider

By comparing the two surveys, it can be seen that patients view BHB as maintaining its position, with SCP further improving its level of organisation.

The issue was further investigated in the 1994 and 1995 interview schedules. In 1994, the appointment system gave most concern. In 1995, most patients were very complimentary about the services. They particularly valued time-keeping, cover arrangements, clinical skills, advice, home visits to day and time, professionalism, sufficient notice of appointment, frequency, no rush and advice of cancellations. The end of the treatment re-booking system was appreciated. There were few complaints. The appointment system was a major concern. Other issues were inconsistency of staff, carelessness, rushed treatments, lack of patience, lost cards, missed appointments, distant sites and lack of physical help.

Question 25: "Have you any suggestions which would reduce the number of people who fail to turn up for their chiropody appointments"

This was an open question.

1994

In total, 18.4% (110) provided information: 24.4% (94) of the BHB patients and 18.6% (16) of the SCP patients.

1995

Of patients 21.6% (110) had suggestions for DNA: 31.9% (92) of the BHB patients and 20.5% (18) of the SCP patients. Only 2.9% (2) of the new 1995 patients had suggestions.

Analysis of text

The main points are noted in Table A14.31. Most respondents took a serious view of other people's lack of consideration at missing appointments, and generally felt that, if their foot problem was bad enough, they would not forget. They also appreciated the consequence on all patients for the wasted treatment time.

Respondents explained that older people may not know from day to day how they are going to feel, and incidents such as oversleeping, a fall, missing the bus, personal transport failure or generally feeling unwell can cause problems. Some are not on the telephone, and may not have a carer who can make timely contact with the service. There were also compliments for the service, both for chiropodists and receptionists. In addition there was a comment about chiropodist failures to attend.

1994	1995
To make it easier to attend	**To make it easier to attend**
Transport should be more widely available, and those using it checked to see if they really need it Information on other transport facilities should be made more widely available, e.g. Taxicard, Dial-a-ride More home visits should be made available	Provide transport Appointment time within Bus Pass rules Clinics at Old People's Clubs
To make it easier to cancel	**To make it easier to cancel**
The clinic number should be printed on the appointment card A free phone number should be provided for cancellations only	Patients could leave SAE for reminder Send /phone call reminder – patient pays Freephone for cancellations Answer the phone Pre-paid card to send in Make sure patient has the clinic number Improve communication
To prevent failure to attend	**To prevent failure to attend**
When the appointment is made, remind patient to put it on their calendar Provide a card to return to clinic if cannot attend Remind patient to let know 2–3 days or at least 24 hours ahead if can't come Send out a reminder/phone a few days ahead Make it clear that after 1, 2 or 3 failures, will be discharged and will need to find another chiropodist	Improve frequency – would not forget/go elsewhere. Clarify policy - notice time, reasons, consequences, etc. Advertise the number failing Carer/relative responsible Improve booking system (while at clinic favoured)
To deal with failures to attend	**To deal with failures to attend**
Find out why, reassess need, MSW to visit persistent failures Those who are genuinely ill, disabled should not be penalised Suggested penalties were financial, or no appointment until next due But it was pointed out by respondents that any resulting increase in foot problems only made for more work for the chiropodist	Discharge: after 1, 2 or 3 failures Charge: £1, or more if transport wasted Delay next appointment Chiropodist to keep record and investigate

Table A14.31 Suggestions to reduce the number of failed appointments by 1994 and 1995 respondents

Question 26: "How long have you been a patient with the free NHS Chiropody service for your current footcare problem?"

Duration as patient	1994
Under 1 year	8.4% (50)
1-2 years	22.6% (135)
3-5 years	23.6% (141)
6+ years	35.3% (211)
Not answered	10.2% (61)
Total	100% 598

Table A14.32 Frequency data on length of time as NHS patient by 1994 respondents

This question was only asked in 1994. When tested against the key variables there was a significant association with the following:-

1994

Gender: when only those responding to the question were considered, there was a significant association between gender and length of time as a patient (p = 0.00001) (Fig. A14.23), for example, attendance of male patient peaked at 1–2 years, being indicated by 33.1% (51), compared with only 21.9% (84) of women. Conversely, attendance of female patients peaked at 6+ years, being indicated by 46% (176) compared with 22.7% (35) for men.

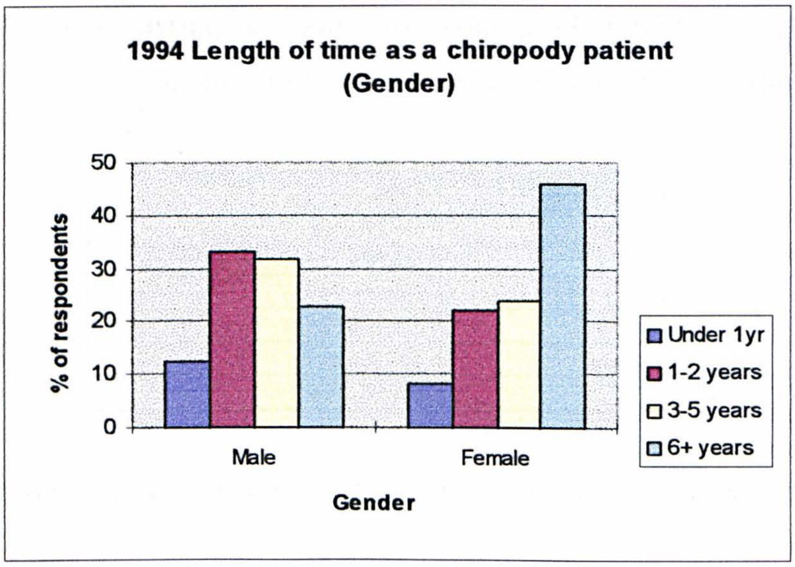

Fig. A14.23 Length of time as a chiropody patient by 1994 respondents analysed by gender

Locality: when only those responding were considered, there was a significant association between length of time as a patient and locality ($p = 0.00515$) (Fig. A14.24). Of particular interest is the grouping of localities 1–4 and 5–7 where, for example, 51.9% (42) of patients in locality 1 had been patients for 6+ years, compared with the lowest of 26% (27) in locality 6. This grouping may reflect the fact that the SCP, which covers the latter group, were only contracted to provide a service from 1991.

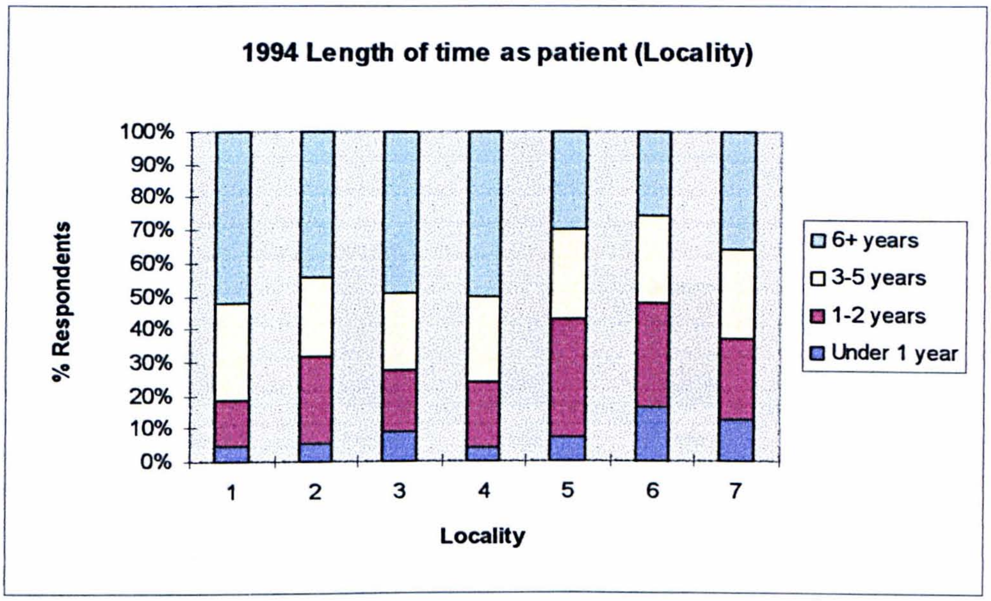

Fig. A14.24 Length of time as a chiropody patient by 1994 respondents analysed by locality

Provider: when only those who responded to the question were considered, there was a significant association between length of time as a patient and provider (p = 0.00000) (Fig. A14.25), for example, 44.9% (196) of the BHB patients reported 6+ years of affiliation, compared with 15% (15) of the SCP patients. This bears out the contract commencement date. Although the BHB patients showed an increase in affiliation over the years, the SCP patients had 48% (48) of their patients attending from one to two years, compared with 19.9% (87) for the BHB. This probably reflects the snap shot in which most patients who commenced with the contract are now in their second year, and some would graduate to the adjacent group as time passes.

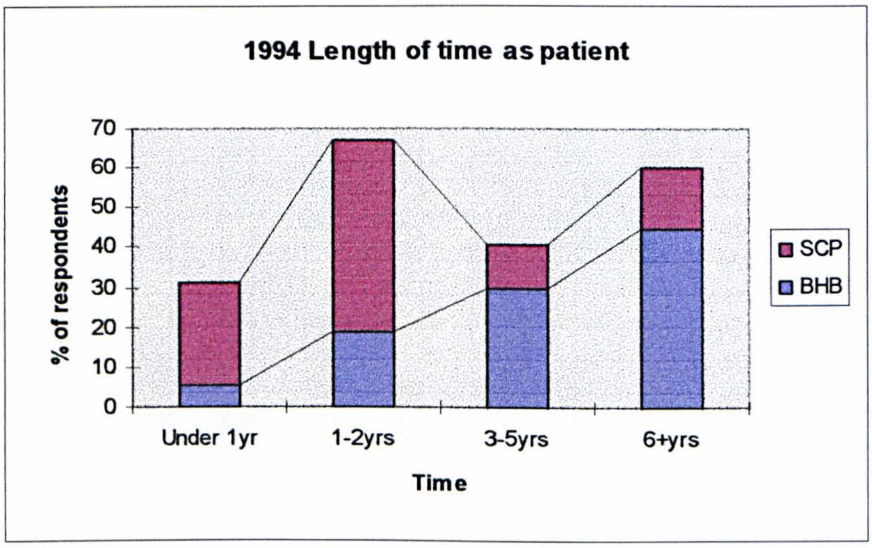

Fig. A14.25 Length of time as a chiropody patient by 1994 respondents analysed by provider

Comment

The gender and locality scores are in keeping with need. The BHB patients show that a snap shot of the caseload indicates a relationship between number of patients and length of contact with the service. This is consistent with the patients' expectation of life-long treatment and limits the number of patients who can access assessment. the SCP had only been under contract for two years, and those indicating three or more years' contact either were mistaken as to their provider or had transferred between providers or between private and NHS facilities. It has been noted that calculating the "exact" number of years was a concern to some patients and was raised by them with BDOPWC.

Question 27: "How satisfied are you with the attitude of the chiropodist(s) whom you see?"

Satisfaction with attitude	**1994**	**1995**	**New 1995**
Very dissatisfied	0.8% (5)	0.8% (4)	1.4% (1)
Dissatisfied	1.3% (8)	1.6% (8)	0
Satisfied	38.1% (228)	33.9% (173)	24.6% (17)
Very satisfied	52.2% (312)	52.2% (266)	56.5% (39)
Not answered	7.5% (45)	11.6% (59)	17.4 % (12)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.33 Frequency data on satisfaction with attitude of chiropodist by 1994, 1995 and new 1995 respondents

Overall

Satisfaction with attitude remained consistently high. The low response from new patients was of interest, unless it was felt that an opinion could not be formed from a new encounter.

When tested against the key variables there were no significant findings in 1994 or 1995.

The issue was included in the 1995 interview schedule revealing that the main measure of satisfaction with attitude was making the time to "have a chat" and humanity. There were few responses to comments on measures of poor attitude, but an offhand attitude and lack of time for "a chat" were the most common.

Comment

Despite the high level of satisfaction, which risks complacency, differences exist between localities and providers from which much can be learnt. The fact that the 1992 survey indicated that 50% of respondents lived alone and 40% with someone aged over 65 may account for the importance placed on the "social" aspects of the service.

Question 28: "Overall, how satisfactory has your experience of the NHS chiropody service been?"

Overall satisfaction	1994	1995	New 1995
Very unsatisfactory	0.7% (4)	1.2% (6)	1.4% (1)
Unsatisfactory	2.8% (17)	2.4% (12)	1.4% (1)
Satisfactory	47.5% (284)	40.6% (207)	34.8% (24)
Very satisfactory	41.1% (246)	45.1% (230)	46.4% (32)
Not answered	7.9% (47)	10.8% (55)	15.9% (11)
Total	**100% 598**	**100% 510**	**100% 69**

Table A14.34 Frequency data on overall satisfaction with chiropody by 1994, 1995 and new 1995 respondents

Overall

Satisfaction overall was consistently high, but appeared fragile in that "satisfactory" has decreased more than "very satisfactory" had increased. When tested against the key variables there was a significant association with the following:-

1994

Provider: if only those who responded were considered and those who were dissatisfied and very dissatisfied were aggregated, there was a significant association between overall experience of NHS chiropody and provider (p = 0.02298) (Fig. A14.26), for example, 42.2% (188) of the BHB patients were satisfied compared with 55.2% (58) of the SCP patients.

1995

Provider: when only those responding were considered, and those indicating that their experience was unsatisfactory or very unsatisfactory were aggregated, there was a significant association between overall experience of chiropody and provider ($p = 0.01255$) (Fig. A14.26). Of the BHB patients 49.1% (158) were very satisfied and 62.6% (72) of the SCP patients. This was slightly lower than the 69% overall satisfaction with the SCP service in the 1992 pilot survey.

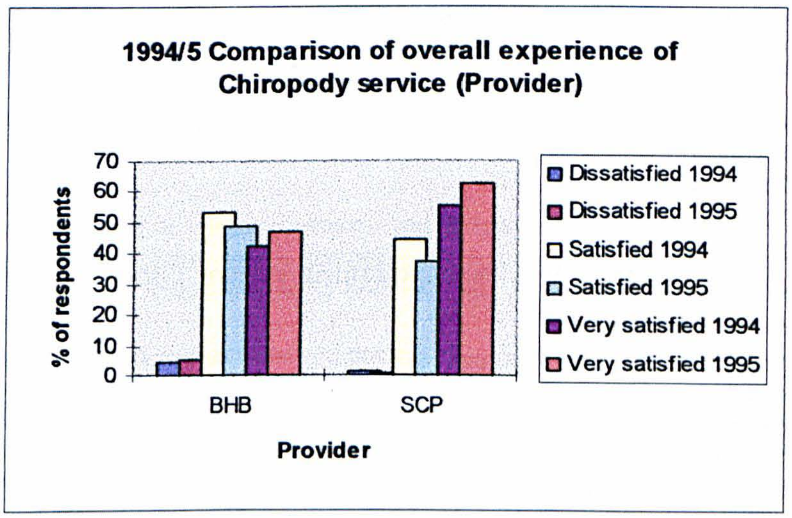

Fig. A14.26 Comparison of overall experience of chiropody service by 1994 and 1995 respondents analysed by provider

Comment

Overall satisfaction was high and increasing. More information was needed on what criteria patients use to make their scores, and the issue was included in the 1994 and 1995 interview schedules. In 1994, each respondent was asked to name a particular area of concern, the topics emerged as follows:

- lack of privacy
- times of home visits
- lack of help to get in and out of taxi at clinic end of journey
- frequency
- altered dates
- delays/short treatment due to late arrival of patient
- chiropodists not turning up for domiciliary visits
- accessibility of clinics
- appointment system – at least an idea of when an appointment is likely to be or advise patients of a delay
- not wearing gloves.

To end the interview on a positive note, the final question was about areas of satisfaction and raised the following comments:

- staff attitude
- treatment
- free service.

In 1995 the worst aspect was the appointment system. Other concerns were:

- cover for absenteeism
- pain during and after treatment
- actual treatment
- distant sites (a named clinic)
- frequency
- lack of information
- cancellations
- criteria for the service
- concerns for future.

There was a lot of praise for the service, mainly about staff attitude (humanity), promptness of appointment and actual treatment. One woman commented that, to her, the knowledge that the service was *there* was important.

The penultimate question was open.

Question 29: "Have you any other comments to make about the Chiropody Service?"

1994

Of patients 151 (25.3%) indicated that they had further comments to make: 33.9% (137) of the BHB patients responded and 14.7% (14) of the SCP patients.

In addition to a number of positive comments about the service, care given and attitude of the staff, the following issues were emphasised:

- Treatments should be longer, consistent, and include finger nails.
- There was considerable concern that frequency should be reduced.
- The appointment system should be reviewed and consideration given to convenience of dates to user.
- The current system wastes money on postage.
- Refreshments at the clinic would be appreciated.
- The number of home visits should be increased, and clinics sited more conveniently.
- Cancellations by the service were unacceptable.
- Information on items, aids, self care and general foot care should be available.
- Particular mention was made of demonstrations by chiropodists visiting day centres, lunch clubs, Carers Association, etc. on "How to care for your feet", with demonstration and leaflet with follow-up to see if successful, with follow up sessions to make sure people confident.

1995

Of patients 25.7% (131) volunteered comments: 36.3% (109) of the BHB patients responded and 21.4% (22) of the SCP patients.

In addition to a number of very positive comments about the service, care given and attitude of the staff, the following issues were emphasised:

- Appointment system strongly disliked.
- Inconsistency of chiropodist, cancellations, variable quality, rushed appointment and lack of service in residential homes.
- Time between treatment too long.
- Use of first class mail wasteful.
- Nail cutting (hands and feet) requested.
- Clarification of criteria for transport, domiciliary visits and emergency appointments.

Question 30 asked whether respondents needed help to complete the questionnaire.

1994

Of respondents 16.2% (97) indicated that they did need help which increased with age (Fig. A14.27): 18.8% (72) of the BHB patients and 30.5% (25) of the SCP patients needed help, reflecting the older age group registered with the latter.

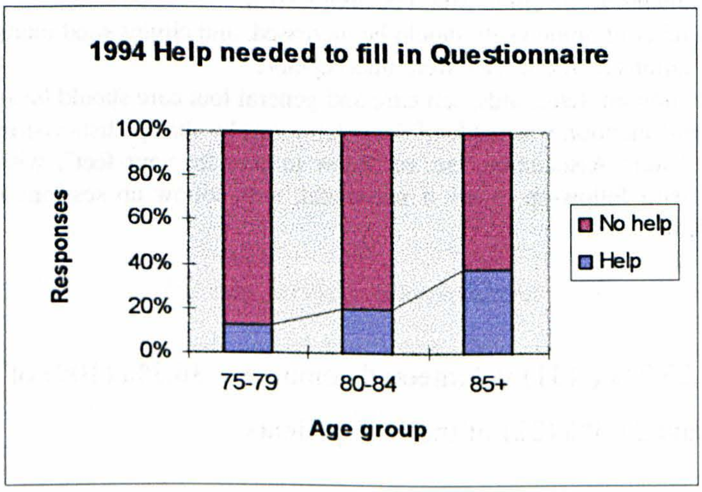

Fig. A14.27 Help needed to fill in questionnaire by 1994 respondents analysed by age group

1995

Of respondents 14.7 % (75) indicated that they needed help to fill in the questionnaire which increased with age (Fig. A14.28): 13.6% (52) of the BHB patients and 17.6% (23) of the SCP patients needed help, again reflecting the older age group registered with the latter.

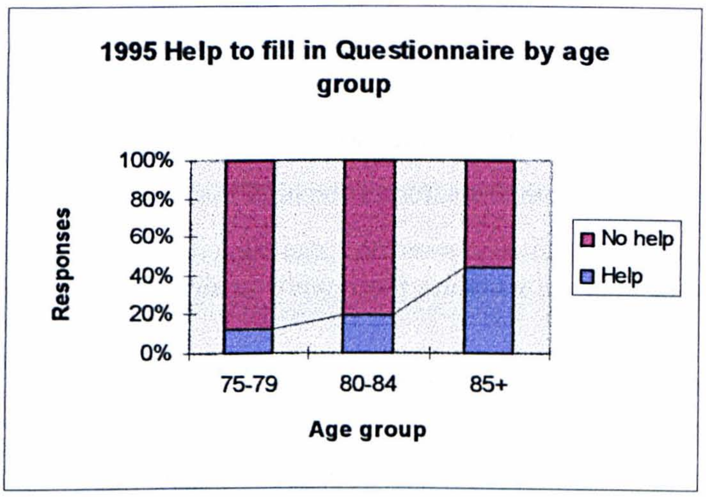

Fig A14.28 Help needed to fill in questionnaire by 1995 respondents analysed by age group

Question 32: Discharge (1995 only)

This question was added in the 1995 survey to ascertain the success of the discharge policy. Only those of the sample who had been discharged were asked to complete it, and 36 did so (despite none confessing to having discussed discharge at Question 15 in 1995).

	1995	New 1995
Very dissatisfied	0.6% (3)	2.9% (2)
Dissatisfied	0.2% (1)	0
Satisfied	3.3% (17)	5.8% (4)
Very satisfied	2.9% (15)	5.8% (4)
Not answered	92.9% (474)	85.5% (59)
Total	**100% 510**	**100% 69**

Table A14.35 Frequency data on satisfaction with discharge policy by 1995 and new 1995 respondents

Overall

The slight but non-significant increase in satisfaction surrounding discharge is particularly important when related to the high expectation of "chiropody for life".

When tested against the variables there were no significant differences.

The open part of the question received eight responses:

- Unclear whether discharged or not – last appointment two years ago (1).
- Unclear whether able to access service again once agreed to discharge (2).
- Pleased with the total service (5).

Question 32 (1994)/Question 33 (1995) Interview

Finally, respondents were asked if they would be willing to take part in a short follow-up interview.

1994	1995	New 1995
32.3% (193)	25.7% (131)	40.6% (28)

Table A14.36 Frequency data on 1994, 1995 and new 1995 respondents willingness to take part in interview

1994

Of the patients, 32.3% (193) were willing to be interviewed. By gender, 34.7% (67) of male patients and 65.3% (165) of female patients were willing; by provider 33.3% (159) of the BHB patients and 28.1% (34) of the SCP patients were willing; and by age group willingness decreased with age.

1995

Of the patients, 25.7% (131) were willing to be interviewed. By gender, 28.9% (43) of male patients and 24.4% (88) of female were willing; by provider 26.3% (100) of the BHB and 23.8% (31) of the SCP patients were willing; and by age group willingness decreased with age. There was a large fall in the number of female patients willing to be interviewed from 65.3% to 24.4% for which no reason could be found.

Question 33 (1994), Question 34 (1995) Report

All respondents were asked if they would like a summary of the report as a token of thanks for their help.

1994	1995	New 1995
43.1 (258)	30.8 (157)	18.8 (13)

Table A14.37 Frequency data on interest in receiving a report on the survey by 1994, 1995 and new 1995 respondents

1994

Of the patients, 43.1% (258) requested a report. By gender 41.9% (72) of male and 43.7% (186) of female patients requested a report; by provider 45.3% (216) of the BHB and 34.7% (42) of the SCP patients; and by age group, interest in receiving a report decreased with age.

A summary report on the 1994 survey was sent to the 258 patients requesting it (see Appendix 20). There was no response on the content, but an enquiry for an additional copy was received and sent by return.

1995

Of the patients, 30.8% (157) requested a report. By gender 25.5% (38) of male and 33% (119) of female patients requested a report; by provider 32.9% (125) of the BHB and 24.6% (32) of the SCP patients requested a report; and by age group interest in receiving a report decreased with age. A summary report on the 1995 survey was sent to the 157 patients requesting it (see Appendix 22). There was no response on the content.

Reflection on the methodology for 1994 and 1995 surveys

- Patients aged 75+ responded well to an appropriately planned and worded survey.
- Carers were asked to assist, and did so, as the need arose.
- The time between collection of names and issue of questionnaire should be minimised to avoid distress to the newly bereaved.
- There should be co-ordination of surveys especially to vulnerable care groups.

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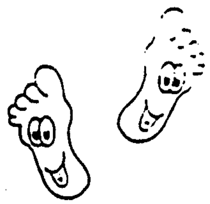


Unified Commissioning Project

Happy Feet Survey

August 1994

Your local Health Authorities have arranged the provision of NHS Chiropody which you have used this year. We now need your views to help us plan the Chiropody service for next year. Would you please help us by completing the attached form and returning it in the envelope by August 31st ?

Should you need any help to read or complete the form, you may ask club staff, a friend or other visitor but preferably **not** your Chiropodist. If you need further assistance to complete the form, please contact Barking & Havering Old Peoples Welfare Committee, who have agreed to help, on 081 252 8009.

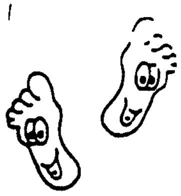
Please read the questions and write your answers as appropriate. The information will be kept on computer, and kept confidential.

Thank you

Mandy Squires
Quality Assurance Officer

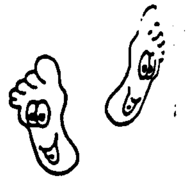
Barking
& Havering
Family Health Services Authority

BARKING HAVERING
HEALTH AUTHORITY



Unified Commissioning Project

Happy Feet Survey



August 1994

To those assisting patients with the Happy Feet Survey.

The NHS Reforms have enabled Health Authorities to undertake health needs assessment of their local population, and commission services accordingly. Our assessment identified Chiropody as an essential service, and also identified the standards of service that users expected. I am now seeking the views of clients over 75 years of age on their satisfaction with the standards of the NHS Chiropody service they have used during the last year. As older people are more likely to have problems completing a questionnaire, I have prepared these notes for those who have offered to help them.

It is important that I get patients views, not influenced by yourself in the way the questions are read or answered. Please read the information to the client so that they understand the purpose of the form; who is asking for the information; what it will be used for; and that all information will be kept confidential by the researcher. Each question should be read as written, and repeated if necessary. Please provide the clients response where indicated. If through incapacity, the client is unable to provide any information, please return the form indicating at Question 31 that it cannot be completed.

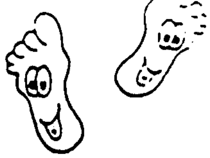
On completion of the task, please return the form to me in the envelope provided, no later than August 31st.

Thank you for your help.

Mandy Squires
Quality Assurance Officer.

Barking
& Havering
Family Health Services Authority

BARKING HAVERING
HEALTH AUTHORITY



August 1994

Code_______________

Happy Feet Survey

Thank you for taking part in this survey which only refers to the free NHS Chiropody you receive which is organised from Victoria Hospital,

Firstly I would like to ask your views about information on health services in general.

1. How important is it to you to have information about health services you receive? (Tick ONE box)

Not important	Fairly Important	Important	Very important
☐	☐	☐	☐
1.1	1.2	1.3	1.4

2. Where have you got the most information about Chiropody from ? (Tick ANY boxes which apply)

	Friend	Doctor	Nurse	Chiropodist	Other
Heard from	☐	☐	☐	☐	☐
	A2.1	A2.2	A2.3	A2.4	A2.5

	Leaflet	Newspaper	Magazine	Radio/TV	Other
Read in	☐	☐	☐	☐	☐
	A2.6	A2.7	A2.8	A2.9	A2.10

3. How useful is the information you have on Chiropody? (Tick ONE box)

Very little use	Little use	Useful	Very useful
☐	☐	☐	☐
3.1	3.2	3.3	3.4

****

The next 3 questions are only for those patients who **started their current Chiropody treatment within the last 12 months.**Other patients should go to question 7.

I would like to ask you about making your first appointment.

4. How easy did you expect it to be to make your first appointment ? (Tick ONE box)

Not easy	Easy	Very easy
☐	☐	☐
4.1	4.2	4.3

5. How easy was it for you or your carer to make the first appointment? (Tick ONE box)

Not easy	Easy	Very easy	Don't Know
☐	☐	☐	☐
5.1	5.2	5.3	5.4

6. How satisfied are you with the arrangements for making the first appointment? (Tick ONE box)

Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
☐	☐	☐	☐
6.1	6.2	6.3	6.4

Next I would like to ask <u>all</u> patients about their follow up Chiropody appointments.

7. How easy did you <u>expect</u> it be to make a follow up appointment ? (Tick <u>ONE</u> box)

Not easy	Easy	Very easy
☐	☐	☐
7.1	7.2	7.3

8. How easy <u>is it</u> for you or your carer to make a follow up appointment? (Tick <u>ONE</u> box)

Not easy	Easy	Very easy	Dont Know
☐	☐	☐	☐
8.1	8.2	8.3	8.4

9. How <u>satisfied</u> are you with the arrangements for making a follow up appointment? (Tick <u>ONE</u> box)

Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
☐	☐	☐	☐
9.1	9.2	9.3	9.4

* * *

Next I would like to ask you about where you have your treatment.

10. Where did you <u>expect</u> to have your treatment ? (Tick <u>ONE</u> box)

At home	At a clinic/surgery	Where best for the treatment	No preference
☐	☐	☐	☐
10.1	10.2	10.3	10.4

11. Where do you usually <u>have</u> treatment ? (Tick <u>ONE</u> box)

At home	At a clinic/surgery	Where best for the treatment	Varies
☐	☐	☐	☐
11.1	11.2	11.3	11.4

12 . How <u>satisfied</u> are you with having treatment there ? (Tick <u>ONE</u> box)

Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
☐	☐	☐	☐
12.1	12.2	12.3	12.4

13. If you <u>currently</u> have treatment at a <u>Chiropody Clinic or Surgery</u>,what is your general view of the facilities ? (Tick <u>ONE</u> box if appropriate)

Very poor	Poor	Good	Very good
☐	☐	☐	☐
13.1	13.2	13.3	13.4

The next set of questions refer to the Chiropody treatment you receive.

14. Which of the following would you expect to have as part of Chiropody treatment ? (Tick ANY boxes which apply).

"Chiropody for life"	**A foot assessment followed by a plan for treatment**	**To be shown how care for your own feet`**	**To eventually be discharged**
☐	☐	☐	☐
14.1	14.2	14.3	14.4

15. What type of Chiropody do you have ? (Tick ANY boxes that apply)

"Chiropody for life"	**A foot assessment followed by a plan for treatment**	**To be shown how to care for your own feet`**	**Eventual discharge has been discussed.**
☐	☐	☐	☐
15.1	15.2	15.3	15.4

16. How satisfied are you with the type of Chiropody you receive ? (Tick ONE box)

Very dissatisfied	**Dissatisfied**	**Satisfied**	**Very satisfied**
☐	☐	☐	☐
16.1	16.2	16.3	16.4

17. If the plan for your footcare does include care of your feet by you/your carer between treatments, how satisfied are you with the information you were given on how to do it ? (Tick ONE box)

Very dissatisfied	**Dissatisfied**	**Satisfied**	**Very satisfied**
☐	☐	☐	☐
17.1	17.2	17.3	17.4

18. How strongly do you feel about older people/their carers looking after basic foot care needs when they are able to ? (Tick ONE box).

Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
☐	☐	☐	☐
18.1	18.2	18.3	18.4

19.What results do you hope for from the treatment ? (Tick ANY boxes which apply).

Cure	**Reduce Problem**	**Advice**	**Not sure**
☐	☐	☐	☐
19.1	19.2	19..3	19.4

20. Do you feel that Chiropody is giving the results you hoped for ? (Tick ONE box)

Yes	**No**	**Don't Know**
☐	☐	☐
20.1	20.2	20.3

21. How frequently do you <u>expect</u> to get your treatment ? (Tick <u>ONE</u> box).

Regular number of weeks	As needed by patient	Set by Chiropodist	Agreed between Chiropodist & Patient	Don't know
☐	☐	☐	☐	☐
21.1	21.2	21.3	21.4	21.5

22. How is the <u>date</u> of your next follow up treatment decided ? (Tick <u>ONE</u> box)

Regular number of weeks	As needed by patients	Set by Chiropodist	Agreed between Chiropodist & Patient	Don't know
☐	☐	☐	☐	☐
22.1	22.2	22.3	22.4	22.5

23. How <u>satisfied</u> are you with this arrangement for your follow up treatment ?
(Tick <u>ONE</u> box)

Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
☐	☐	☐	☐
23.1	23.2	23.3	23.4

* * *

Next I would like to ask you about the Chiropody service in general.

24. In your view, how does the organisation of the Chiropody service appear ?
(Tick <u>ONE</u> box)

Very disorganised	Disorganised	Organised	Very organised
☐	☐	☐	☐
24.1	24.2	24.3	24.4

25. Have you any suggestions which would reduce the number of people who fail to turn up for their Chiropody appointments ? (Tick <u>ONE</u> box)

Yes	No
☐	☐
25.1	25.2

If yes, please provide details below

....

....

....

....

26. How long have you been a patient with the free NHS Chiropody service for your <u>current</u> footcare problem (Tick <u>ONE</u> box)

Under one year	1 - 2 Years	3-5 years	6+ years
☐	☐	☐	☐
26.1	26.2	26.3	26.4

27. How satisfied are you with the attitude of the Chiropodist(s) you see ?
(Tick <u>ONE</u> box)

Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
☐	☐	☐	☐
27.1	27.2	27.3	27.4

28. <u>Overall</u>, how satisfactory has your experience of the NHS Chiropody Service been ?
(Tick <u>ONE</u> box)

Very unsatisfactory	Unsatisfactory	Satisfactory	Very satisfactory
☐	☐	☐	☐
28.1	28.2	28.3	28.4

29. Have you any other comments to make about the Chiropody Service?

Yes	No
☐	☐
29.1	29.2

If you answered yes, please provide details

....

....

....

30. Please indicate if you required help to complete this questionnaire. This will help me in planning future surveys. (Tick <u>ONE</u> box)

Yes	No
☐	☐
30.1	30.2

****

31. If the user of the Chiropody service was unable to provide any information, would the carer please indicate and return the form

User unable to complete
☐
31.1

Thank you for completing this questionnaire. I shall also be undertaking a <u>small</u> number of interviews to hear more about the issues that have been raised. If you would be willing to be interviewed by me, please tick the box and be sure to give your name and address below and a telephone number if you have one. If you are selected, I will arrange a time convenient to you for the interview later in the year, and will carry an identification card with me.

(Please tick the box **and give address below**)

Willing to be interviewed

Please indicate if you would like a summary of the final report which will be available in early 1995 and give your details below.

(please tick box)

Would like report

Name..

Address..

....

....

....

Tel..

<u>or</u> if you wish to remain anonymous, please contact me separately requesting the report.

Mrs A Squires, QA Officer, The Grange, Gubbins Lane, Romford, Essex RM3 ODD

Happy Feet Telephone Interview 1994 **Code** ____________

Name ____________ **Phone number** ____________ **Date** ____________

TAPE NUMBER	SIDE

Name p3
Q 13

Is that Mr/S ? [____] This is Mrs Squires from the Health Authority. You agreed to take part in an interview about Chiropody to help us improve the service you receive. Is it convenient for you to talk now ? [____] Before we start, can I make sure you can hear me clearly [____] .

Firstly I would like to explain how the interview will take place. I am going to ask you some general questions about the Chiropody service you receive. I would just like you to give me your opinions. If you would like me to repeat any question, please just ask me. The interview will also be confidential and no one else will be told the comments you make.

With your agreement I would like to tape record the interview to help me make notes. Are you happy for me to do that, the recording will be destroyed afterwards [____]

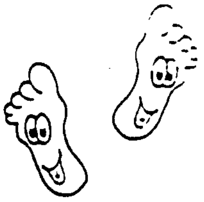
The interview will take about 15 minutes, and I would just like to make sure you are quite comfortable before we start [____].

	Q2/3 General health Information **The first question is about general information on the care of your feet.**	
2/3 A	People have told us that information about foot care is important to them. Could you tell me what sort of information you would like to have about the care of your feet?	
2/3 B	How would you expect to get hold of such information ?	
	Q 4-9. **The next question is about making Chiropody appointments.**	
4-9A	Some people have said they find it difficult to make Chiropody appointments. Do you have any suggestions that would make the situation easier ?	
	Q 10/11/12 Venue **The next question is about where Chiropody treatment takes place.**	
10/11/12 A	How do you decide where to have your treatment	
10/11/12 B	*? probe*	
	Q13 Facilities (check if they go or not) **The next question is about the facilities at the clinic you attend.**	
13 A	**What sort of things do you particularly like about the clinic?**	
13 B	*? probe—could you tell me more about that*	

13 C	**What sort of things do you particularly dislike about the clinic ?**	
13 D	***? probe—could you tell me more about that***	
13 E	**How could this be improved ?**	
	Q 14/15/16 Chiropody treatment **The next question is about Chiropody treatment.**	
14/15/16/A	Some people have told us that as pensioners they feel they have a right to chiropody for the rest of their lives, irrespective of whether they need it---how do you feel that they form this view ?	
14/15/16/B	*? probe*	
	21/22/23 Frequency **The next question is about how often patients get their treatment.**	
21/22/23/ A	How is the date of your next treatment decided ?	
21/22/23 B	In your opinion do patients have enough information about how to care for their own feet between appointments?	
21/22/23 C	*If yes---go to next question.* *If no*---what sort of information would be of help to them?	
	24 Organisation **The next question is about the overall organisation of the Chiropody service**	
24 A	Some people feel the service is well organised----what sort of things would give you that impression	
24 B	Some people feel the service is disorganised---what sort of things would give you that impression.	
	The last question I would like to ask you is about what you feel are the worst and best parts of the Chiropody service.	
28A	Firstly can you describe what you feel are the worst aspects---	
28B	What suggestions would you make for improving them ?	
28C	And secondly can you describe what you feel are the best aspects of the service?	

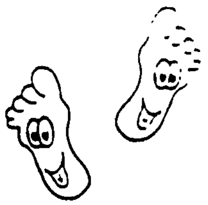
Before I end the interview Mr/Mrs/Miss________________ can I thank you for agreeing to take part. I will be sending you a short report on my research in due course. Thank you very much again. Good Bye.

Thesis/Phone doc. 15/11/94



Unified Commissioning Project

Happy Feet Survey II



August 1995

You took part in a survey last year about the NHS Chiropody service your local Health Authorities have arranged. From the results, a number of changes have been made. We now need your views again so that we can see the effect of these changes, and to help us plan the Chiropody service for next year. Would you please help us by completing the attached form and returning it in the enclosed pre-paid envelope by August 31st ? If you do not wish to take part in this survey it will not affect your future healthcare provision.

Should you need any help to read or complete the form, you may ask club staff, a friend or other visitor but preferably **not** your Chiropodist. If you need further assistance to complete the form, please contact Barking & Havering Old Peoples Welfare Committee, who have agreed to help, on 0181 252 8009.

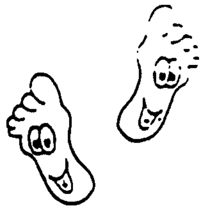
Please read the questions and write your answers as appropriate. The information will be kept on computer, and kept confidential. A summary of the results of the survey will be sent on request.

Thank you

Mandy Squires, Quality Assurance Officer

Barking
& Havering
Family Health Services Authority

BARKING HAVERING
HEALTH AUTHORITY



Unified Commissioning Project

Happy Feet Survey II

August 1995

<u>To those assisting patients with the Happy Feet Survey II.</u>

The NHS Reforms have enabled Health Authorities to undertake health needs assessment of their local population, and commission services accordingly. Our assessment identified Chiropody as an essential service, and also identified the standards of service that users expected. An initial survey of users views was undertaken in 1994, from which various changes were made. I am now seeking the views of the same group of clients on their satisfaction with the standards of the NHS Chiropody service they have used during the last year. As older people are more likely to have problems completing a questionnaire, I have prepared these notes for those who have offered to help them.

It is important that I get patients views, not influenced by yourself in the way the questions are read or answered. Please read the information to the client so that they understand the purpose of the form; who is asking for the information; what it will be used for; that all information will be kept confidential by the researcher; and that not wishing to take part will not affect the right to Chiropody treatment. Each question should be read as written, and repeated if necessary. Please provide the clients response where indicated. If through incapacity, the client is unable to provide any information, please return the form indicating at the start (Question 31) that it cannot be completed.

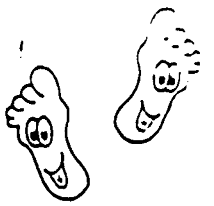
On completion of the task, please return the form to me in the pre-paid envelope provided, no later than August 31st.

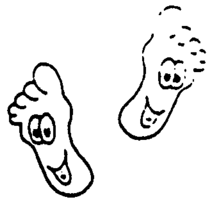
Thank you for your help.

Mandy Squires
Quality Assurance Officer.

Barking
& Havering
Family Health Services Authority

BARKING HAVERING
HEALTH AUTHORITY
Health for Life





Returned____________ August 1995 Code____________

Happy Feet Survey II

Thank you for taking part in this follow up survey which only refers to free NHS Chiropody, which is organised from the Victoria Centre/Sclaire Chiropody Practice, in the last year.

31. If the user of the Chiropody service is unable to provide any information, would the carer please indicate and return the uncompleted form

User unable to complete ☐ 31.1

****

32. If you have now been discharged from Chiropody, please indicate how satisfied you are with the discharge arrangements. (Tick ONE box)

Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
☐	☐	☐	☐
32.1	32.2	32.3	32.4

Please add any additional comments about the discharge, and then return the form WITHOUT answering any more questions.

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

****

All other patients should go to page 2.

This survey is about the Chiropody service you have received **in the last 12 months.**

Firstly I would like to ask your views about information on health services in general.

1. How important do you now feel it is to have information about health services you receive? (Tick <u>ONE</u> box)

Not important	Fairly Important	Important	Very important
☐	☐	☐	☐
1.1	1.2	1.3	1.4

2. Where have you got the <u>most</u> information about <u>Chiropody</u> from in the last year ?
(Tick <u>ANY</u> boxes which apply)

	Friend	Doctor	Nurse	Chiropodist	Other
Heard from	☐	☐	☐	☐	☐
	A2.1	A2.2	A2.3	A2.4	A2.5

	Leaflet	Newspaper	Magazine	Radio/TV	Other
Read in	☐	☐	☐	☐	☐
	A2.6	A2.7	A2.8	A2.9	A2.10

3. How useful is this information you now have on Chiropody? (Tick <u>ONE</u> box)

Very little use	Little use	Useful	Very useful
☐	☐	☐	☐
3.1	3.2	3.3	3.4

****

Questions 4-6 about first appointment are ONLY for patients who have started their Chiropody treatment SINCE August 1994. All other patients please go to Question 7.

4. How easy did you <u>expect</u> it to be to make your <u>first</u> appointment ? (Tick ONE box).

Not easy	Easy	Very easy
☐	☐	☐
4.1	4.2	4.3

5. How easy <u>was it</u> for you or your carer to make the first appointment ?
(Tick ONE box).

Not easy	Easy	Very Easy	Don't know
☐	☐	☐	☐
5.1	5.2	5.3	5.4

6. How satisfied <u>are you</u> with the arrangements for making the first appointment ?
(Tick ONE box)

Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
☐	☐	☐	☐
6.1	6.2	6.3	6.4

Next I would like to ask you about your follow up Chiropody appointments.

7. How easy did you expect it to be to make a follow up appointment this year ?

Not easy	Easy	Very easy	Don't Know
☐	☐	☐	☐
7.1	7.2	7.3	7.4

8. How easy has it been for you or your carer to make a follow up appointment in the last year ? (Tick ONE box)

Not easy	Easy	Very easy	Don't Know
☐	☐	☐	☐
8.1	8.2	8.3	8.4

9. How satisfied have you been with the arrangements for making a follow up appointment in the last year? (Tick ONE box)

Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
☐	☐	☐	☐
9.1	9.2	9.3	9.4

****

Next I would like to ask you about where you have your treatment.

10. Where did you expect to have your treatment during this last year? (Tick ONE box)

At home	At a clinic/surgery	Where best for the treatment	No preference
☐	☐	☐	☐
10.1	10.2	10.3	10.4

11. Where have you usually had treatment in the last year ? (Tick ONE box)

At home	At a clinic/surgery	Where best for the treatment	Varies
☐	☐	☐	☐
11.1	11.2	11.3	11.4

12 . How satisfied are you with having treatment there ? (Tick ONE box)

Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
☐	☐	☐	☐
12.1	12.2	12.3	12.4

13. If you currently have treatment at a Chiropody Clinic or Surgery, what is your general view of the facilities ? (Tick ONE box if appropriate)

Very poor	Poor	Good	Very good
☐	☐	☐	☐
13.1	13.2	13.3	13.4

The next set of questions refer to the Chiropody treatment you receive.

14. Which of the following would you now <u>expect</u> to have as part of Chiropody treatment ?
(Tick <u>ANY</u> boxes which apply).

"Chiropody for life"	A foot assessment followed by a plan for treatment	To be shown how care for your own feet'	To eventually be discharged
☐	☐	☐	☐
14.1	14.2	14.3	14.4

15. What type of Chiropody <u>did you have</u> in the last year? (Tick <u>ANY</u> boxes that apply)

"Chiropody for life"	A foot assessment followed by a plan for treatment	To be shown how to care for your own feet'	Eventual discharge has been discussed.
☐	☐	☐	☐
15.1	15.2	15.3	15.4

16. How <u>satisfied</u> are you with the type of Chiropody you received in the last year ?
(Tick <u>ONE</u> box)

Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
☐	☐	☐	☐
16.1	16.2	16.3	16.4

17. If the plan for your footcare does include care of your feet by you/your carer between treatments, how satisfied are you with the information you were given in the last year on how to do it ? (Tick <u>ONE</u> box)

Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
☐	☐	☐	☐
17.1	17.2	17.3	17.4

18. How strongly do you now feel about older people/their carers looking after basic foot care needs when they are able to ? (Tick <u>ONE</u> box).

Strongly disagree	Disagree	Agree	Strongly agree
☐	☐	☐	☐
18.1	18.2	18.3	18.4

19. What results do you <u>hope</u> for from the treatment ? (Tick <u>ANY</u> boxes which apply).

Cure	Reduce Problem	Advice	Not sure
☐	☐	☐	☐
19.1	19.2	19.3	19.4

20. Do you feel that Chiropody is giving the results you hoped for ? (Tick ONE box)

Yes	No	Don't Know
☐	☐	☐
20.1	20.2	20.3

21. How frequently do you now expect to get your treatment ? (Tick ONE box).

Regular number of weeks	As needed by patient	Set by Chiropodist	Agreed between Chiropodist & Patient	Don't know
☐	☐	☐	☐	☐
21.1	21.2	21.3	21.4	21.5

22. During the last year how has the date of your follow up treatment been decided ?
(Tick ONE box)

Regular number of weeks	As needed by patients	Set by Chiropodist	Agreed between Chiropodist & Patient	Don't know
☐	☐	☐	☐	☐
22.1	22.2	22.3	22.4	22.5

23. How satisfied are you with this arrangement for your follow up treatment ?
(Tick ONE box)

Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
☐	☐	☐	☐
23.1	23.2	23.3	23.4

****

Next I would like to ask you about the Chiropody service in general.

24. In your view, how has the organisation of the Chiropody service appeared in the last year ?
(Tick ONE box)

Very disorganised	Disorganised	Organised	Very organised
☐	☐	☐	☐
24.1	24.2	24.3	24.4

25. Have you any suggestions which would reduce the number of people who fail to turn up for their Chiropody appointments ? (Tick ONE box)

Yes	No
☐	☐
25.1	25.2

If yes, please provide details below

....

....

....

....

(Question 26 about length of time as a Chiropody patient has been deleted from this follow up survey)

27. How satisfied have you been in the last year with the attitude of the Chiropodist(s) you see ? (Tick ONE box)

Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
☐	☐	☐	☐
27.1	27.2	27.3	27.4

28. Overall, how satisfactory has your experience of the NHS Chiropody Service been over the last year ? (Tick ONE box)

Very unsatisfactory	Unsatisfactory	Satisfactory	Very satisfactory
☐	☐	☐	☐
28.1	28.2	28.3	28.4

29. Have you any other comments to make about the Chiropody Service?

Yes	No
☐	☐
29.1	29.2

If you answered yes, please provide details

....

....

....

....

30. Please indicate if you required help to complete this questionnaire. This will help me in planning future surveys. (Tick ONE box)

Yes	No
☐	☐
30.1	30.2

33. Thank you for completing this questionnaire. I shall also be undertaking a small number of interviews by phone to hear more about the issues that have been raised. If you would be willing to be interviewed by me, please tick the box and be sure to give your name and address below and a telephone number. If you are selected, I will arrange a time convenient to you for the interview later in the year.

(Please tick the box **and give address and phone number below**)

Willing to be interviewed
☐
33.1

34. Please indicate if you would like a summary of the final report which will be available in early 1996 and give your details below. (please tick box)

Would like report
☐
34.1

Name...

Address..

....

....

....

Please also give your telephone number...

or if you wish to remain anonymous, please contact me separately requesting the report.

Mrs A Squires, QA Officer, Barking & Havering Health Authority, The Grange,
Gubbins Lane, Romford, Essex RM3 ODD

Happy Feet Telephone Interview 1995 **Code** ______________

Name ______________________ **Phone number** ______________ **Date** ______________

TAPE NUMBER	SIDE

Name p3
Q 13

Is that Mr/S ? [____] This is Mrs Squires from the Health Authority. You agreed to take part in an interview about Chiropody to help us improve the service you receive. Is it convenient for you to talk now ? [____] Before we start, can I make sure you can hear me clearly [____].

Firstly I would like to explain how the interview will take place. I am going to ask you some general questions about the Chiropody service you receive. I would just like you to give me your opinions. If you would like me to repeat any question, please just ask me. The interview will also be confidential and no one else will be told the comments you make.

With your agreement I would like to tape record the interview to help me make notes. Are you happy for me to do that, the recording will be destroyed afterwards [____]

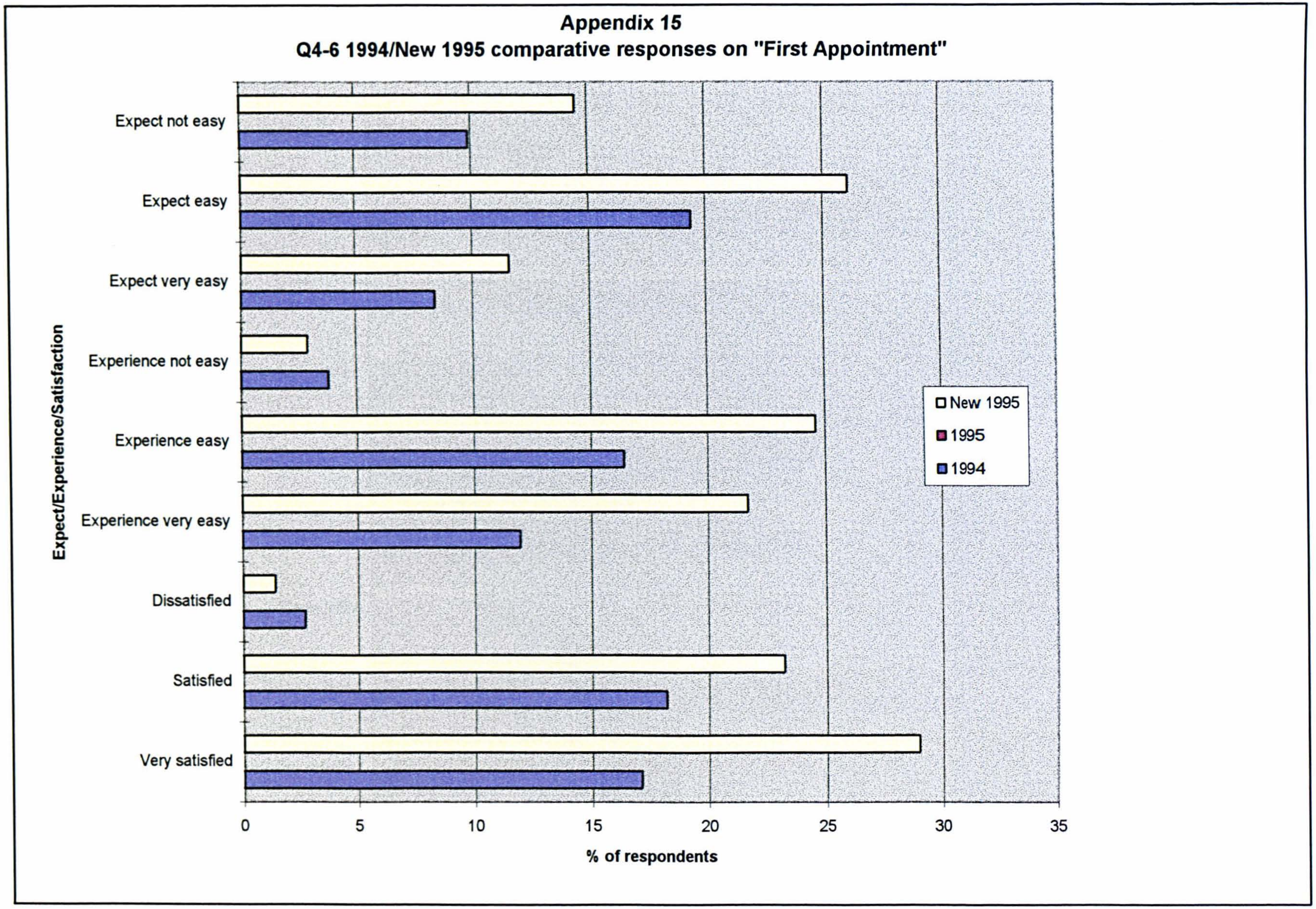
The interview will take about 15 minutes, and I would just like to make sure you are quite comfortable before we start [____].

	Q2/3 Chiropody Information **The first question is about general information on the care of your feet.**	
2/3 A	People have told us that information about foot care is important to them. Could you tell me what sort of information you would like to have about the care of your feet?	
2/3 B	How would you expect to get hold of such information ?	
	The next question is about how the service is viewed by men. Some men told us on their forms that they had previously thought Chiropody was only for women.	
2-3 C	Do you think that Chiropody is available to both men and women ?	
	Q 4-9. **The next question is about making Chiropody appointments.**	
4-9	Some people have said they find it difficult to make Chiropody appointments. Do you have any suggestions that would make the situation easier ?	
	Q13 Facilities (check if they go or not) **The next question is about the facilities at the clinic you attend.**	
13 A	What sort of things do you particularly like about the clinic?	
13 B	*? probe—could you tell me more about that*	
13 C	What sort of things do you particularly dislike about the clinic ?	
13 D	*? probe—could you tell me more about that*	
13 E	How could this be improved ?	

	Q 14/15/16 Chiropody treatment **The next question is about Chiropody treatment.**	
14/15/16/A	Some people have told us that as pensioners they feel they have a right to chiropody for the rest of their lives, irrespective of whether they need it---how do you feel that they form this view ?	
14/15/16/B	? *probe*	
14/15/16/C	What are your views on discharge from Chiropody when your treatment has finished ?	
14/15/16/D	? *probe*	
	Q17/18 Self care	
17 A	What information would help you continue to care for your own feet ?	
17 B	? *probe*	
	24 Organisation **The next question is about the overall organisation of the Chiropody service**	
24 A	Some people feel the service is well organised----what sort of things would give you that impression	
24 B	Some people feel the service is disorganised---what sort of things would give you that impression.	
	Q27 Attitude **The next question is about the attitude of the Chiropodist**	
27A	Firstly, what sort of attitude gives you a good feeling	
27B	What sort of attitude makes you feel upset	
	The last question I would like to ask you is about what you feel are the worst and best parts of the Chiropody service overall.	
28A	Firstly can you describe what you feel are the worst aspects--	
28B	What suggestions would you make for improving them ?	
28C	And secondly can you describe what you feel are the best aspects of the service?	

Before I end the interview Mr/Mrs/Miss________________ can I thank you for agreeing to take part. I will be sending you a short report on my research in due course. Thank you very much again. Good Bye.

Thesis/Phone doc. 12/10/95

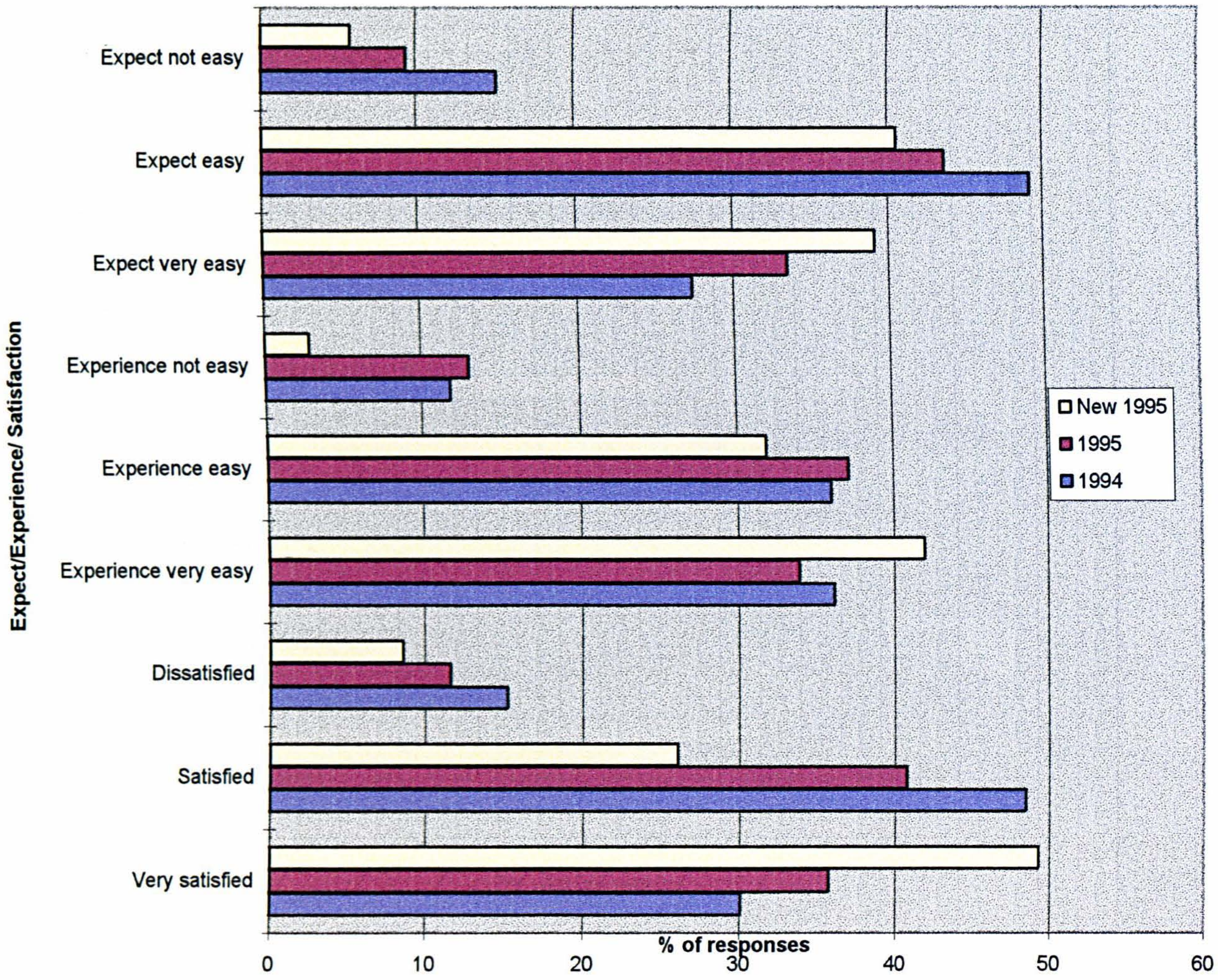


Appendix 15

Q4-6 1994/New 1995 comparative responses on "First Appointment"

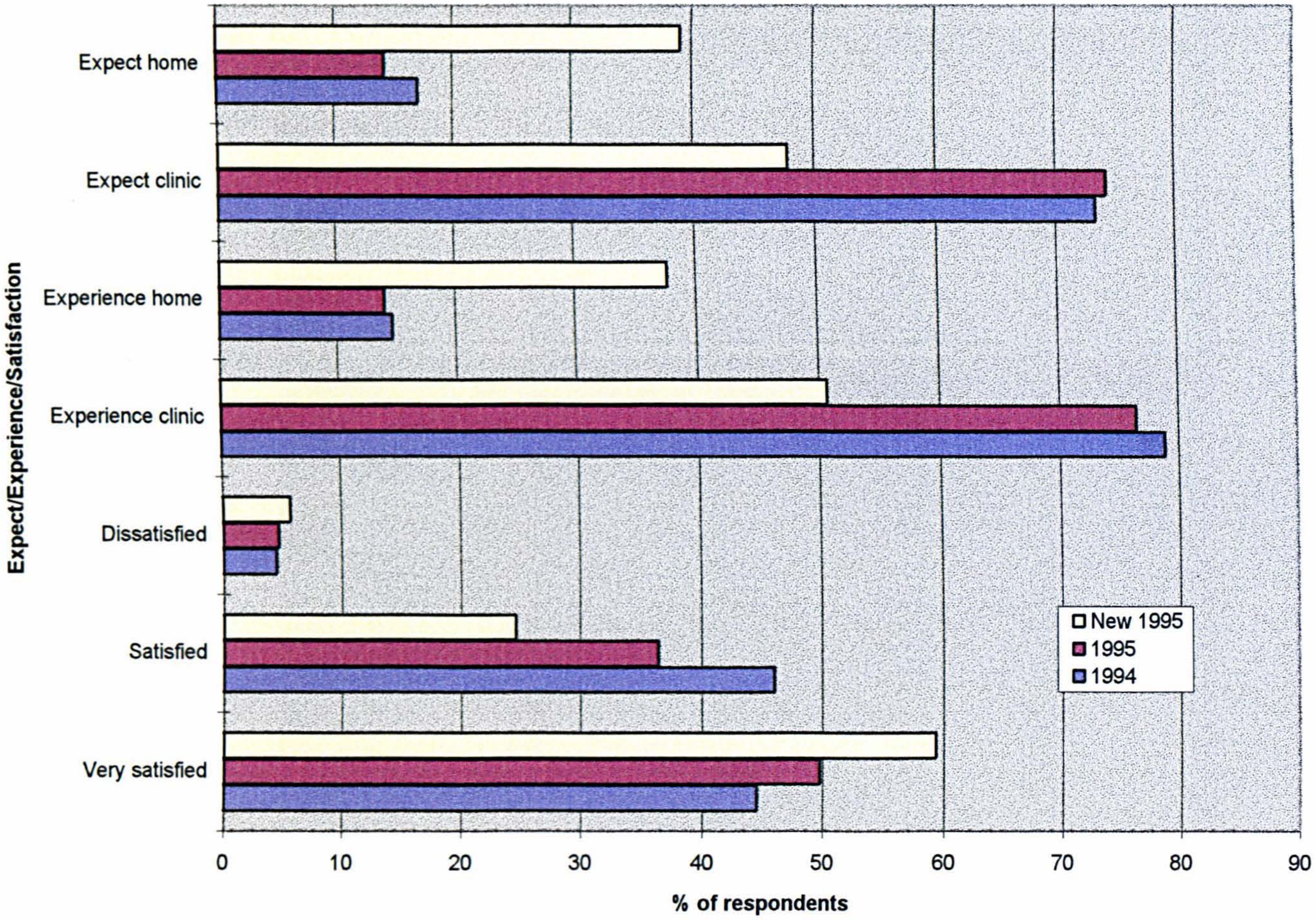
Appendix 16

Q7-9. 1994/1995/New 1995 comparative responses on "Follow up appointments"



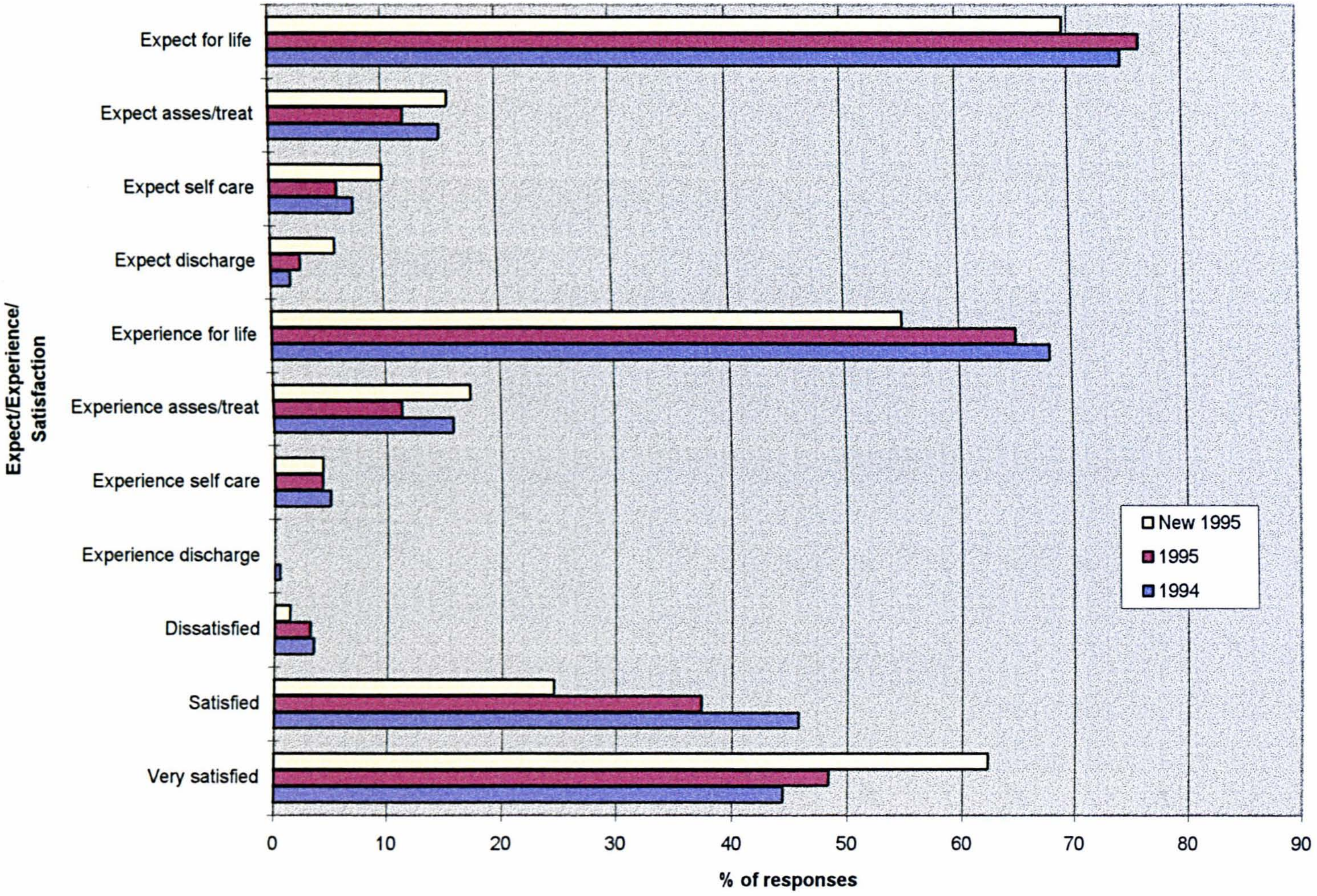
Appendix 17

Q10-12. 1994/1995/New 1995 comparative responses for "Treatment Venue"



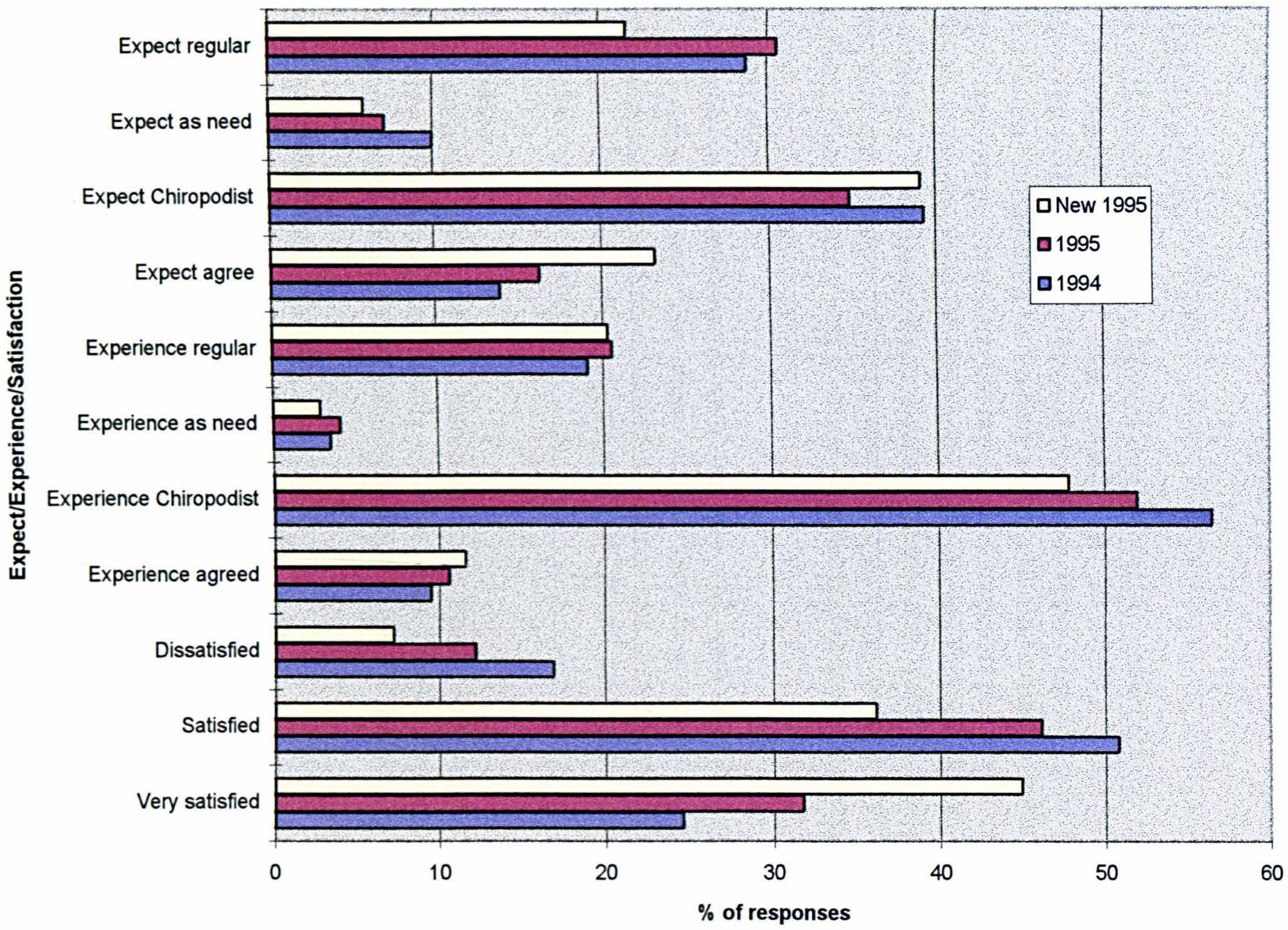
Appendix 18

Q14-16. 1994/1995/New 1995 comparative responses for "Type of treatment"



Appendix 19

Q21-23. 1994/1995.New 1995 comparative responses on "Frequency of follow up treatment"



Appendix 20

Barking & Havering Health Authorities

Unified Commissioning Project

Summary report on 1994 "Happy Feet" survey and interview

Introduction

The NHS Reforms require Health Authorities to undertake an assessment of the healthcare needs of their population. In 1990, such an assessment undertaken locally found chiropody for those aged over 75 to be a particularly high request. In addition to funding additional chiropody to meet this need, a project was set up to review the service and consider the views of key groups in future commissioning of chiropody. This survey formed part of that process by obtaining information from patients which will now be debated with the other key stakeholders to work towards improving overall satisfaction. This summary report is being sent to those patients taking part who requested it.

The survey

The number of questionnaires sent out was 782, and after one reminder 598 (76.5%) were returned. The overall results were as given below, and each was analysed against a number of variables such as age groups, gender and locality. Significant variations between groups are indicated and were further explored in the subsequent interviews.

Information

Of the patients, 86% felt that information on health services was important. Chiropody information was mostly obtained from the chiropodist, a friend and the doctor ,and such sources varied between groups; 82% found it to be of use.

First appointment

Overall, 35% of the patients were satisfied with the arrangements for making the first appointment, with significant variations between groups.

Follow-up appointments

Overall, 79% of the patients were satisfied with the arrangements for making follow-up appointments, with significant variations between groups.

Venue for treatment

Of the patients, 91% were satisfied with the venue for their treatment

Clinic facilities

Overall, 82% of the patients who visited a chiropody clinic or surgery were satisfied with the facilities, with significant variations between groups.

Type of treatment

Of the patients, 90% were satisfied with the type of treatment that they received.

Self-care of feet

Of the patients, 45% felt that older people/their carers should look after basic foot care needs when they are able to; 47% were satisfied with the information that they received on self-care.

Outcome of treatment

Of the patients, 82% felt that they were getting the results that they hoped for from treatment.

Frequency of treatment

Overall, 75% were satisfied with the method for deciding the date of the next treatment, with numerous significant variations between groups.

Organisation of the chiropody service

Of the patients, 85% were satisfied with the overall organisation of the service, with significant variations between groups.

Patients not attending for treatment

This was an open question, and comments to reduce the number of wasted appointments included:

- those in most need of an appointment were most likely to attend
- transport availability
- availability of clinic telephone number
- reminder system
- policy for persistent offenders.

Attitude of chiropodist

Of the patients, 90% were satisfied with the attitude of their chiropodists.

Overall satisfaction with the chiropody service

Overall, 89% were satisfied with the overall chiropody service.

The interviews

A number of issues were highlighted from the survey which required further consideration, and these formed the basis of the telephone interviews to a sample of the survey respondents. The results are as follows.

Information

Topics: what self-care safe to do; what types of lotions to use; where to obtain implements.
Style: written; demonstration; diagrams.

Appointment system

There was a strong preference for making the appointment at the time of the treatment. The times of domiciliary visits should be acceptable to older people (e.g. after 10 am unless otherwise requested). Altered dates and chiropodists not turning up for domiciliary visits were of concern.

Venue

Home visits: should be available for the housebound, for those in poor health and for those unable to travel.
Clinics: there was lack of information on what was available and where; parking was limited; public transport was important; and an ambulance was appreciated.

Facilities

The cleanliness, positive attitude of staff, comfortable chairs, information about delays and efficient treatment were all appreciated.

The lack of privacy, rushed treatment, inappropriate use of gloves, poor attitude, lack of help to get in and out of taxi, delays/short treatment due to late arrival of a patient were all of concern.

Treatment

"Treatment for life" was not a generally accepted comment. Some felt that it was deserved, some that these days no one has any rights and some that everything is taken for granted by particular individuals.

Frequency of treatment

Most felt the that frequency of treatment was decided by the chiropodist. Emergency requests between treatments were dealt with within three or four days which was appreciated.

Recommendations from the survey and interviews

1. **Criteria** should be established, agreed, published and implemented, including:
   - venue (noting age, housebound, ill, unable to travel)
   - treatment and goal setting
   - follow-up appointments and frequency.
   - personal foot care
   - discharge and non-attenders.

2. **The lack of clarity regarding "chiropody" and "personal foot care"** needs to be addressed and appropriate arrangements made for each.

3. **The appointment system** should be reviewed, and the system published. For domiciliary visits, this should be at a time of day convenient to the patient and within daylight hours for staff security. The importance of the chiropodist and the patient keeping the appointment were emphasised. Transport options, clinic telephone number, and reminders should be considered, as well as patient contact numbers.

4. **Information** on all aspects of the service should be available in suitable formats including public and individual demonstrations, which should be supported with written information including diagrams. Information on safety of self-care, and general information on lotions and purchase of implements should be included. Relevant sources for distribution should be explored including chiropody departments and libraries. The availability of the service to men as well as women should be clarified.

5. **Clinics:** choice of clinics should be available, and facilities improved, especially establishing a compromise between privacy and safety.

The contribution of patients, carers and Barking and Havering Old People's Welfare Committee to the completion of the survey and interviews is acknowledged.

Amanda Squires, Quality Assurance Officer, Barking and Havering Health Authority

February 1995

CLINIC ADDRESSES AND TELEPHONE NUMBERS

Annie Prendergast Health Centre
Ashton Gardens, Chadwell Heath
0181 590 1086

Brentwood Community Clinic
Highwood Hospital, Geary Drive
01277 221313

Coram Green Clinic
Coram Green, Hutton
01277 234291

Five Elms Health Centre
Five Elms Road, Dagenham
0181 593 7241

Harold Hill Health Centre
Gooshays Drive, Harold Hill
01708 377004

Harold Wood Clinic
Gubbins Lane, Harold Wood
01708 340022

Hornchurch Clinic
Westland Avenue, Hornchurch
01708 440315

Porters Avenue Chiropody Clinic
Porters Avenue, Dagenham
0181 592 8223

South Hornchurch Clinic
South End Road, Rainham
01708 552821

Thames View Health Centre
Bastable Avenue, Barking
0181 594 4233

Upminster Clinic
St Mary's Lane, Upminster
01708 226170

Vicarage Field Health Centre
Vicarage Drive, Barking
0181 591 5466

Victoria Centre
Pettits Lane, Romford
01708 726727

Answerphone may be in use

BHB
COMMUNITY HEALTH CARE

A GUIDE FOR PATIENTS ON USE OF THE CHIROPODY SERVICE

Help us to help you

You can help us to give you the best possible service by

- carrying out your part of the agreed plan of treatment
- keeping to the time of your appointment
- giving at least two working days notice to the clinic you are due to attend if you are not able to keep your appointment.
- contacting the Central Chiropody Office on: **01708 - 726727**, giving the date, time and place of the appointment if you have not been able to let the clinic know you cannot attend.

> Please note that people who miss two consecutive appointments without giving prior notification, are not offered further appointments and will need to be referred again to the service if they feel they still need treatment

Care by a Chiropody Assistant

People who need only simple foot care but who are classed as "at risk" due to an associated medical condition affecting their feet may have treatment from a Chiropody Assistant who is supervised by a Chiropodist.

The Chiropody Ambulance Service

People who are able to use public transport, Taxi-card, Dial-a-Ride and other car services, or transport from a friend or relative make their own arrangements to attend for chiropody treatment.

The chiropody ambulance service is for people who are not able to use, or are unsuitable for, other kinds of transport.

Emergency Chiropody Treatment

A limited service is available for emergency problems, such as a painful and infected foot. Treatment for the **affected part** is provided as quickly as possible and **non-emergency** conditions are treated later.

- To obtain emergency treatment phone the clinic you normally attend. If there is no one available to deal with your query, please phone **01708 - 726727**

Visits to Your Home

Chiropody treatment is provided in your own home if you are unable to leave your home with or without assistance. We visit

- People who are chair- or bed-bound or are unable to get to the ground floor
- People who are attached to non-portable equipment, such as continuous oxygen therapy
- People suffering with agoraphobia
- People who are unable to make their own way to a clinic or use the chiropody ambulance

People who have a temporary disability may receive home visits while the disability lasts.

Visits to Residential Accommodation

Chiropody is provided for residents who have been assessed by the visiting NHS chiropodist as needing treatment by a chiropodist.

"Block-booked" chiropody sessions are arranged if there are sufficient residents who need treatment.

Alongside this, basic training is given to care staff to carry out simple foot hygiene for residents.

People receiving simple foot maintenance from care staff are able to see the chiropodist if necessary.

What does the Chiropody service do ?

State Registered Chiropodists assess people who are referred to the service.

A person with a foot condition and/or associated medical condition which needs treatment by a State Registered Chiropodist, is offered a course of treatment. This includes access to appropriate treatment from the Chiropody Services of BHB Community Healthcare Trust.

During an assessment the Chiropodist agrees a Care Plan with you which you both sign. A copy is given to you, so that you can carry out your part of the plan.

Simple foot hygiene care, such as maintenance of toenails, does not normally require the skills of a Chiropodist. Carers are given instruction on how to carry this out.

Chiropody normally takes place at a clinic convenient to you that has a vacancy.

Please ask your chiropodist for up to date requirements to become a chiropody patient

For enquiries about Chiropody Services please contact:

Chiropody Services Manager
Victoria Centre
Pettits Lane
Romford, RM1 4HP
01708 - 726727

The Trust welcomes feedback on all it's Services. If you have any comments, compliments, complaints or suggestions please tell one of our managers, or contact:

The Trust Complaints Officer,
First Floor, Suttons View,
St George's Hospital,
Hornchurch, RM12 6RS
01708 - 465314

Healthline

Free Confidential telephone service giving information on health related issues to anyone in Barking, Dagenham and Havering.

0181 596 9000
Monday to Friday 9.30 - 5pm
Answerphone at all other times

Appendix 22

Barking and Havering Health Authorities

Unified Commissioning Project

Summary report on 1995 "Happy Feet" survey and interview

Introduction

The NHS reforms require Health Authorities to undertake an assessment of the healthcare needs of their population. In 1990, such an assessment undertaken locally found chiropody for those aged over 75 to be a particularly high request. In addition to funding additional chiropody to meet this need, a project was set up to review the service and consider the views of key groups for the future commissioning of chiropody. The 1994 survey formed part of that process by obtaining information from patients. Changes were made as a result, aiming to ensure a similar high quality of service irrespective of where it is obtained locally through the NHS. This survey records patients' views on those changes, The results show that the services are only just keeping pace with patients' increasing expectations, but a particular success was improved satisfaction about arrangements for making a first appointment. All the issues will now be debated with the other groups with an interest in the service to work towards further improving overall satisfaction. This report is being sent to those patients who took part in the survey and interviews and who requested a short summary.

The 1995 survey

The number of questionnaires sent out were 782 and 546 (69.8%) were returned. The overall results were as given below, and each was analysed against a number of different groups such as age, gender and locality. Significant differences were further explored in the subsequent interviews.

Information

Of the patients, 86% felt that information on health services was important. Chiropody information was mostly obtained from the chiropodist, a friend and the doctor, and such sources varied between groups; 78% found such information of use.

First appointments

Overall, 52% of new patients were satisfied with the arrangements for making the first appointments (up from 35% in 1994).

Place of treatment
Of the patients, 86% were satisfied with the place for their treatment.

Clinic facilities
Overall, 79% of patients who visited a chiropody clinic or surgery were satisfied with the facilities, with different views between groups.

Type of treatment
Of the patients, 86% were satisfied with the type of treatment that they received.

Self-care of feet
Of the patients, 45% felt that older people/their carers should look after basic foot care needs when they are able to.

Outcome of treatment
Of the patients, 80% felt they were getting the results they hoped for from treatment.

Frequency of treatment
Overall, 79% were satisfied with the method for deciding the date of the next treatment, with different views between groups.

Organisation of the chiropody service
Of the patients, 83% were satisfied with the overall organisation of the service, with differences between groups.

Patients not attending for treatment
This was an open question, and comments to reduce the number of wasted appointments included the following:

- those in most need of chiropody were most likely to attend
- the date and time should be agreed between patient and chiropodist
- the clinic telephone number should be made available, and the telephone answered
- a reminder system should be considered for those likely to forget
- the policy for persistent offenders should be published.

Attitude of chiropodist
Of the patients, 86% were satisfied with the attitude of their chiropodist.

Overall satisfaction with the Chiropody service
Of the patients, 86% were satisfied with the overall chiropody service.

The 1995 interviews

A number of issues were highlighted from the survey that required further consideration, and these formed the basis of the telephone interview to a sample of the survey respondents. The results are as follows.

Information: should be provided, not have to be asked for. What implements to use and where to get them was still needed.

Clinics: time-keeping by staff, friendliness and the facilities were appreciated. Facilities in some clinics, help for disabled people and treatment by the same chiropodist could all be improved.

Discharge: was seen as a possibility when the chiropody problems had been dealt with, so long as nail cutting could be provided, with access back into the chiropody service when it was needed.

Measures of a good service were seen as: good time-keeping; holiday and sickness cover arrangements; availability of advice; home visits on time; professional; sufficient notice of appointment; acceptable frequency; no rush; and advice of cancellations. The end of treatment re-booking system was appreciated

Measures of a poor service were seen as: inconsistency of staff; carelessness; rushed treatments; lack of patience; lost cards; missed appointments; distant clinic sites; lack of physical help; and particularly a postal appointment system.

Staff attitude: a humane attitude and time for “a chat” were *very* highly appreciated.

Recommendations from the survey and interviews

1. Information
A review of all the information requested by patients and provided by chiropodists is needed. As much general information as possible, including criteria for treatment, transport and home visits, should be included in a single leaflet. Information and implements for self-care and where to obtain them are needed.

2. Failed appointments – by patients
A policy should be developed and included in the leaflet to ensure that patients realise the importance of cancellation, to avoid wasted appointments. The current situation should be displayed in the clinics.

3. Failed appointments – by chiropodist
The Health Authority will monitor the situation each quarter.

4. The appointment system
There was a strong preference for making the appointment at the time of the treatment. The services should compare their system with others, and improve on it during 1996/7.

5. Personal footcare plans
At the first appointment, the footcare needs of each patient will be discussed and agreed between the chiropodist and patient. This will include self-care, chiropody treatment, the place of treatment, frequency and anticipated discharge date.

6. Nail cutting
As some patients are attending professional NHS chiropody services just for simple nail cutting, a separate service will be considered to provide help for these people.

7. Staff and facilities
A review of all premises is required to ensure that they reach the highest standards, and are sited at the most convenient location for patients.

The contribution of patients, carers and Barking and Havering Old People's Welfare Committee to the completion of the survey and interviews is acknowledged.

Amanda Squires, Quality Assurance Officer, Barking and Havering Health Authority

December 1995

Appendix 23

Nail-cutting proposal

Age Concern England (ACE) (as proxy for the voluntary sector) and the Society of Chiropodists and Podiatrists (1995) produced guidelines for Volunteer Nail Cutting Services with the following recommendations:

- Initial assessment must be undertaken by a State-Registered Chiropodist (NHS or private).
- Volunteer selection process against agreed criteria.
- Nail cutters to be trained in techniques and conditions requiring onward referral.
- Each client taken on must have an annual re-assessment by a State-Registered Chiropodist.
- Arrangements for sterilisation of instruments.
- Records to be kept in line with NHS requirements.
- Insurance cover to be provided.

The flow of people with felt need for nail cutting is represented in Fig. A23.1 whereby individual need within the community may be identified after health promotion or carers' training, resulting in self-referral to chiropody. Where this is to an NHS service, the chiropodist would identify need at the assessment and could refer on to nail cutting as appropriate. All such patients would have an annual reassessment by a State-Registered Chiropodist.

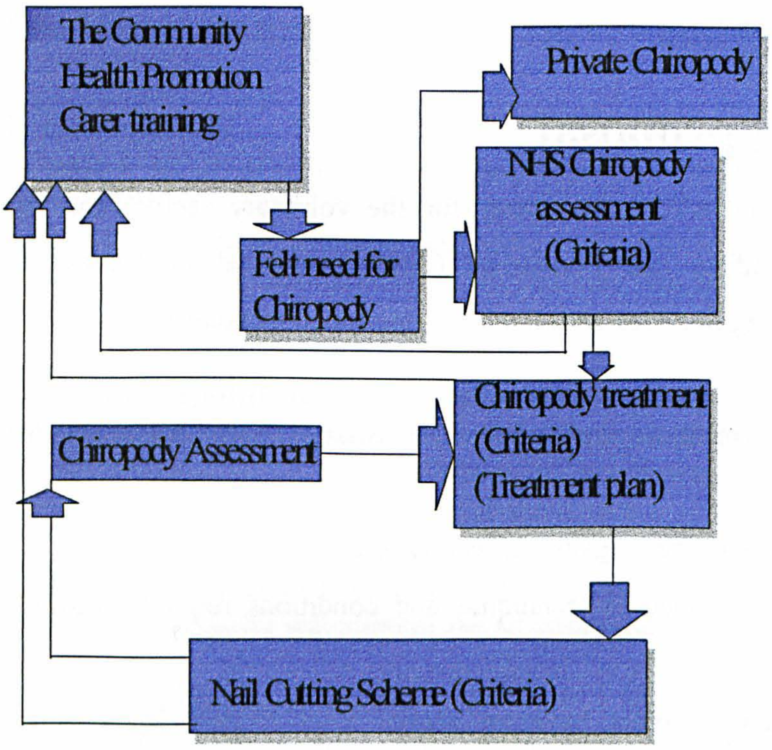


Fig. A23.1 Flow chart of nail cutting service

To consider the implications in Barking and Havering, a small multiagency group was set up to progress the issue further and the District Chiropody Service undertook a one-month clinic workload sample survey (3,600 patients), which indicated that 5% were attending for nail cutting of whom 37% would also need ongoing chiropody and 1% regular chiropody; 48% could be discharged from chiropody. Application of the model to the total BHB caseload would result in 595 patients suitable for nail cutting (Table A23.1).

	Sample 3,600 BHB	**Total BHBHA ? 22,000**	**Proposed action**
Attending for nail cutting	180/3,600 (5%)	5% 22,000 = 1,100	
Suitable for self care/nail cutting – not at risk	115/180 (63%)	63% 1,100 = 693	**Explicit criteria**
Suitable for training of willing carer	17/115 (15%)	15% 693 = 103	**Train carer**
Having Health/Social support	20/115 (18%)	18% 693 = 125	**Train carer**
Need concurrent occasional chiropody	42/115 (37%)	37% 693 = **256**	**Shared care**
Need concurrent regular chiropody	1/115 (1%)	1% 693 = **7**	**Shared care**
Need nail cutting only – discharge from chiropody	56/115 (48%)	48% 693 = **332**	**Training/Cutting service**
Total for nail cutting		**595**	

Table A23.1 assessed need for nail cutting service

The reduction in caseload through this proposed service would enable an improvement in service quality, especially waiting list and frequency, which continued to be subjects of complaints. The nail-cutting need for people not attending NHS chiropody is unknown, and it was recommended that discussions with Social Services were necessary to work jointly on an ultimate single nail-cutting service without prejudice to client status. The need to develop a nail-cutting service was agreed, funding was allocated by the Health Authority, and specifications were established. Initial indications from the outcome of the total reassessment of all BHB patients supported the need for such an approach.

References

SOCIETY OF CHIROPODISTS (1995) Voluntary Nail-Cutting Guidelines – The Society and Age Concern. *Journal of British Podiatric Medicine* **50** (5): 74–77.