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The Role of Trust in Relation to How Quality in Mental Health
Services is Perceived: A Critical Systems Thinking Approach

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Abstract

This research explores the role of trust in relation to how the quality of care provided by the Humber Mental Health NHS Teaching Trust (HMHTT) is perceived by stakeholders.

A Participatory Action Research Project (PAR) was carried out within an overarching framework of Critical Systems Thinking (CST), using a modified form of Soft Systems Methodology (SSM) (Checkland and Scholes, 1990; Checkland and Poulter, 2006) to structure the process of gathering information regarding perceptions of service quality, communication among stakeholders as individuals and groups, and trust in the system and thinking critically and creatively about the issues raised. Semi-structured, face-to-face interviews were conducted with 14 service users, 5 carers, 6 service providers, and 3 decision-makers, to build up a rich picture of the situation, and workshops were held to identify and model relevant systems and generate proposals for change.

Root definitions and conceptual models were generated by service users and carers for two activity systems identified by them as priorities for attention: Communication and Carer Involvement, and forwarded to service providers for feedback. The issues raised were carried forward to the Trust's planning and budgeting agenda, and were disseminated more widely within the Trust, to inform subsequent action.

The research contributes to theory on relational quality by providing rich data and conceptual models on the complex interrelationships between trust, communication and perceived quality and points to the value of explicit incorporation of trust in CST theory and practice.

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List of Abbreviations

A&E	Accident and Emergency
AR	Action Research
BSI	British Standards Institute
CA	Carer
CATWOE	Customers - Actors – Transformation – Weltanschauung – Owners – Environment
CHC	Community Health Council
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COREC	Central Office for Research Ethics Committees
CPN	Community Psychiatric Nurse
CSH	Critical Systems Heuristics
CST	Critical Systems Thinking
DM	Decision – Maker
FT	Foundation Trust
GP	General Practitioner
HMHTT	Humber Mental Health NHS Teaching Trust
ISO	International Standards Organisation
KCI	Knowledge Constitutive Interests
LREC	Local Research Ethics Committee
MIND	The name of a charity dealing with mental health issues
MOSOS	Monitoring Our Services Our Selves
ND	New Dawn

NHS	National Health Service
NWMA	Nuclear Waste Management Agency
PALS	Patient Advice Liaison Service
PAR	Participatory Action Research
PPI	Patient and Public Involvement Forum
PR	Service Provider
PTSD	Post Traumatic Stress Disorder
R&D	Research and Development
RD	Root Definition
RV9	Code number of the UCRP
SERVQUAL	Service Quality
SOSM	System of Systems Methodologies
SSM	Soft Systems Methodology
SU	Service User
SVS	Salient Values Similarity
TQI	Trent Quality Initiative
TQM	Total Quality Management
TSI	Total Systems Intervention
UCRP	User Centred Research Programme
UK	United Kingdom
VSM	Viable System Model

Chapter One

Introduction

1.1. Background and Research Problem

In the past decades, research attention (for example, Gregory and Walsh, 1993; Gregory et al., 1994; Peckham, 1995; Walsh, 1995; 1999; Harrison et al., 2003) has been paid to the issue of quality in the National Health Service (NHS) and ways of improving it, particularly in the light of high – profile cases of neglect and malpractice, and reported loss of confidence in the service (Mechanic, 1996; Innes, 2003a). However, despite prolonged discourse and successive improvement or assurance initiatives over the years, quality is still seen as a problematic issue in the NHS. Previous attempts to address the problem of quality have tackled it from two perspectives: the technical (objective) and relational (subjective).

The technical perspective deals with observable, measurable features expressed, for example, in performance indicators (NHS Executive, 1999; van Zwanenberg, 2003; Clinical Negligence Scheme for Trusts (CNST), 2006) and technical instruments such as Total Quality Management (TQM). Such approaches, however, neglect and may undermine less tangible aspects of service quality and patients' (service users') benefits (Ludbrook and Gordon, 1999; Lally and Thomson, 1999). TQM has faced problems due to conflicting perceptions and values, use of inappropriate measuring tools, and damaged professional pride (Sitkin and Sitkel, 1996). In fact, quality improvement efforts are difficult because in a service context:

- Most products are intangible.
- Service consumption is not controllable.

- Quality cannot be ‘designed – in’ in advance, but is the outcome of experience and perception – there is a distinction between objective and perceived quality.
- Different groups have different requirements and priorities.

For these reasons, technical solutions are not enough. A holistic approach is needed, that takes account of roles, attributes and relations between different groups and functions; hence, the emergence of the relational approach.

The relational perspective deals with relationships among stakeholders. This involves various factors, notably communication, which is essential for articulating needs, understanding responses, and taking coordinated action. Researchers who, dissatisfied with the early focus on technical aspects of quality, started to look at the subjective dimension include Parasuraman et al. (1985) who tried to understand quality from consumers’ perspective, in terms of expectations vs. experience (the 5 – gap model – see explanation below): subsequently Parasuraman et al. (1988) developed the SERVQUAL model in which attributions of service quality are influenced by intangibles such as the reliability of the service, assurance in the knowledge and competence of staff, the responsiveness of personnel, and empathetic understanding of clients and their needs. Although developed in a marketing context, the model has been applied in a variety of settings, including health, reflecting the increasing trend to view health services as products in the market. SERVQUAL has practical and theoretical disadvantages (the difficulty and validity of measuring expectations, number and classification of dimensions, focus on process at the expense of outcome measures). However, much research in health care (Higgins et al., 1991; Vandamme and Leunis, 1993; Buttle, 1996; Smith, 1995) supports the importance of the SERVQUAL dimensions. In another typology (Maxwell, 1992) health service quality is

divided into: Effectiveness, Acceptability, Efficiency, Access, Equity, and Relevance. However, there is a trade – off among these dimensions (e.g. the “post – code lottery” for high cost treatments whereby the effectiveness of a treatment for a small number of people has to be balanced against efficiency in the service as a whole; as a result, some centres provide or make referrals for certain treatments whilst others do not, so access depends on where the service user lives). Also some features could not be evaluated by consumers, so this approach reflects predominantly the provider’s perspective. For Walsh (1995; 1999) the need was for what he termed “critical quality”, where dialogue is promoted and embedded in the system, and social action – that is, action by individuals and organisations directed towards realisation of a social benefit – can be coordinated between producers and consumers. This, he argued, requires adequate structural arrangements, opportunities for participation and communicative competence of participants. Hart (1999), too, took a relational perspective, using the SERVQUAL model to measure, quantitatively, the gap in health care settings.

A common feature of these approaches was that they pointed, explicitly or implicitly, to the importance of trust. For example, the Assurance and Reliability dimensions of the SERVQUAL model correspond to dimensions of trust identified in the literature (Misztal, 1996; Mishra, 1996). Trust is also a prerequisite for the undistorted dialogue on Habermasian principles (see Chapter Three), advocated by Walsh (1995, 1999). In fact, Checkland et al. (2004) have suggested that concentrating more on developing trust by greater openness and sharing of information may improve the quality of care delivered, both directly, through facilitating accountability, and indirectly, by improving the moral motivation of health care professionals on whom quality of care

depends. The need to rebuild trust in health care has been debated in a variety of literature, both in the UK (e.g. Harrison et al, 2003) and in the USA (Shore, 2007). However, the role of trust in perceptions of service quality had not been adequately explored, and my aim in this research was to contribute towards filling that gap, by exploring the role of trust with special reference to Humber Mental Health NHS Teaching Trust (HMHTT). The rationale for focusing on this segment of health care is explained in Chapter Five, Methodology.

1.2. Research Questions

Ultimately, the central issue is one of perception. Quality ‘measures’ such as SERVQUAL are actually concerned with how quality is perceived rather than objective measures. Trust, similarly, emerges in the literature (Misztal, 1996; Sztompka, 1999; Innes, 2003a) as a matter of perception (whether experience – based or not) – of the trustee’s competence, reliability, integrity, good intentions and so on, at least some of which can be seen as quality issues. The research question was therefore formulated as, “what is the role of trust in relation to how quality in Mental Health Services is perceived”?

This issue was explored through several secondary questions, focusing not only on quality and trust, but also on communication, a common thread in the relational quality and trust literatures. Each question, in turn, raised number of sub-questions and issues, as follows:

1. How do stakeholders currently perceive quality in the service provided by HMHTT?
 - What does quality mean to the participants?
 - Do different stakeholder groups agree in their perceptions of quality?
 - How far is the participants’ ideal of quality met in practice in the service?

2. How do stakeholders in the HMHTT communicate?

- How do they feel about the quality of communication?
- Are there obstacles to effective communication?

3. What does trust mean to stakeholders in the HMHTT context?

- Cognitive - do service users see providers as competent, reliable, etc?
- Affective - how do service users / carers feel in interaction with providers?
- Behavioural- how do service users' /carers perceptions and feelings influence their behaviour (e.g. compliance with treatment, involvement in research, involvement in designing the service, involvement in the decision making process)?
- How important is trust to stakeholders?
- Do different stakeholder groups agree in the meanings they attach to trust?
 - What factors can be identified as conducive to trust?
 - What factors can be identified as barriers to trust?
 - What action (chosen and implemented by stakeholders) can be taken to facilitate the supporting factors and reduce the barriers to trust?

It should be noted that, because of the time-limited nature of this project, together with the nature and time-scale of the decision-making process in the NHS, the implementation of action continued beyond the limits of the project itself. Whilst certain changes were implemented and their impact observed within the research (as will be seen in Chapter Six) others were carried forward to HMHTT's agenda for the following year.

1.3. Research Significance

The quality of healthcare depends not only on the technical effectiveness of the diagnosis and technical treatment of illness, but also upon the effectiveness of the relationship between the patient and the practitioner. Hitherto, there has been enormous emphasis on technical improvement, but very little on the human relationships involved, even though quality may be said to emerge from human relationships and is even defined in terms of human relationships. This research, therefore, makes an original contribution in an under-researched field by exploring the role of trust in relation to how quality is perceived.

In an attempt to establish what previous efforts, if any, have been made to consider quality from a trust perspective, a search was made of 12 databases using 20 separate keywords and three combinations of keywords (see Appendix 1). As can be seen from the tables, trust and quality are frequently mentioned, but a closer look at the materials revealed that the majority were irrelevant and there was little of any substance or value.

A significant feature of the work, therefore, is its contribution to knowledge in the fields of trust and quality. It takes a holistic, multidisciplinary view of trust, in contrast to the predominant practice of viewing trust from a single perspective (sociological, psychological, and so on). It also provides insights into the complex interrelationships among service quality, communication and trust, thereby enhancing understanding of relational quality. Whilst this discussion and modelling take place with specific reference to HMHTT, “thick descriptions” (Geertz, 1973) of constructs, context and methods are provided which will enable evaluations to be made of the transferability (see Chapter Five of this thesis) of insights to other contexts.

The research also contributes to the field of CST, first by highlighting ways in which a more explicit consideration of trust may be incorporated in existing methodologies, and second through critical reflections on a methodology-in-practice which may be of benefit to future researchers.

In addition to its theoretical contribution, moreover, the research has practical value, initially for current service users, carers, service providers and decision-makers in HMHTT and potentially for future stakeholders. It brought about and facilitated a process of engagement between members of different stakeholder groups, leading to agreement to address specific issues of concern in relation to perceived quality, and suggestions (generated by participants) as to how this may be done. The techniques used for structuring debate can be continued to generate and implement further change proposals and address successive new problematic situations in an ongoing process.

1.4. Methods

The research, a project within the User Centred Research Programme (UCRP), operating within HMHTT, took the form of a Participatory Action Research (PAR) project within an overarching framework of Critical Systems Thinking (CST). CST is an approach to improvement, grounded on three basic commitments: critical awareness of the implications of the context of choices, and of the assumptions and interests underlying them, complementarism (see Chapter Four) in the selection of methods and techniques, according to the nature of the problems and contexts to be addressed, and emancipation – the pursuit of people’s well – being and empowerment by addressing power relations (Flood and Jackson, 1991a; Jackson, 2000; 2003).

Soft Systems Methodology – SSM (Checkland and Scholes, 1990; Checkland and Holwell, 1998 and Checkland and Poulter, 2006) was used as a technique to structure data gathering and thinking about the facilitators and barriers to trust.

The research was carried out in two phases, Phase One, “Finding Out”, fulfilling stages 1 and 2 of the SSM; and Phase Two, “Engagement”, fulfilling stages 3 – 7 of the SSM, encompassing identifying and modelling relevant systems, comparing these ‘ideal-types’ with the status quo, and agreeing and implementing changes.

The purpose of Phase One, “Finding Out”, was to explore the perceptions of individual HMH service users, providers, and administrators, concerning quality, communication and trust in health services. This was done by means of semi – structured interviews, in order to allow participants’ own opinions, concerns and priorities in relation to the core topic areas to emerge, and so build up a rich picture.

The purpose of Phase Two, “Engagement”, was to take up in a series of workshops, issues uncovered in Phase One, for exploration from the multiple perspectives of the various stakeholder groups – clients, decision makers, professionals and witnesses in order to open up communication between them and give an opportunity to view the issues of concern from each others’ point of view. In particular, the aim was to encourage and facilitate identification of factors facilitating or constituting barriers to clients’ trust in Humber Mental Health NHS Teaching Trust (HMHTT) and its services, and creative thinking about how these might be addressed.

A detailed rationale for and explanation of the research methods, including participants, procedures and methods of analysis will be found in Chapter Five.

1.5. Thesis Structure

The remainder of the thesis is divided into six chapters, as follows:

Chapter Two contains a review of literature contributing to an understanding of quality – in general, in services and in health care specifically. The concepts of strategic and normative quality are explored in turn and a significant gap in quality literature and practice is identified, in the relative lack of attention to trust.

Chapter Three seeks to build a broad picture of the issues in relation to trust, from multiple perspectives: sociological, psychological, business and philosophical. Trust is shown to be a complex construct, serving a variety of functions, and influenced by the characteristics of the person who attributes trust, of the trustee and the context.

Chapter Four introduces Critical Systems Thinking (CST), as the framework used in this study for conceptualizing and exploring trust in the health care context. Some basic themes of the CST are examined and the relevance to them of trust assessed in the light of Habermas' (1968; 1972; 1981a; 1984a) theory of knowledge constitutive interests. Total Systems Intervention (TSI) "as the practical face of CST" (Clarke and Lehaney, 1997: 615) is introduced. Then, each of the knowledge constitutive interests is considered in more detail and deficiencies in the addressing of trust are identified. Finally, some suggestions are put forward as to how CST's commitments to critical awareness, theoretical and methodological pluralism and, ultimately, emancipation, could be enhanced by the explicit incorporation of trust issues.

Chapter Five provides an explanation and justification of the research design and methodology. It begins with a discussion of the research paradigm, locating the project within the phenomenological tradition. It is explained that CST is used to underpin a

participatory action research (PAR) project exploring perceptions around trust and service quality in Humber Mental Health NHS Teaching Trust (HMHTT). Stakeholders are identified and the recruitment of participants is explained. Two phases of research, ``finding out``, based on semi structured interviews, and ``engagement``, based on a series of workshops, are reported. Quality criteria (validity, reliability and alternatives proposed for phenomenological research) and ethical issues are also discussed.

Chapter Six reports the outcomes of the two phases of the research. Stakeholders' perceptions around quality, communication and trust in relation to health care are discussed at length, highlighting conflicts of interest. Personal and institutional factors which serve as barriers or enablers of trust are identified. Participants' engagement in identifying relevant systems of interest and generating proposals for change is reported.

Chapter Seven contains a reflective discussion on the research outcomes. Contributions to theory, to practice and to methodology are highlighted. Limitations of the research are identified, and suggestions are offered for further research.

Chapter Two

Towards an Understanding of Quality

2.1. Introduction

The last 20 years have seen the emergence of an extensive literature on the importance of quality, for example, Oakland (1993), Hutchins (1990), Ellis and Whittington (1993) and Flood (1993). Most of these writings have focused on manufacturing industry, although a distinct body of literature addressing quality issues in the health sector has also developed (Walsh, 1995).

Eminent authors in the quality field have predominantly defined quality in terms of product conformity to consumer requirements. In the same way, definitions of quality formulated by individual companies and listed by the UK Department of Trade and Industry focus on the concept of meeting customer requirements. In the health context, attempts have been made to identify quality attributes as a guide to standard-setting, performance measurement and review.

In relation to both industrial and health settings, quality has been perceived predominantly as a strategic tool mediating between the interest of consumers to receive value for money and that of producers to maximize profit. Walsh (1995) identified this by the term strategic quality, as distinct from normative quality, which refers to standards of expectations, and critical quality, which involves the coordination of social action between communicatively acting consumers and producers.

In this chapter, the concepts of strategic and normative quality will be explored in turn. The application of these concepts of quality in the health service will be discussed in light of the recent preoccupation with technical solutions, such as Total Quality Management (TQM). In light of the limitations of these views of quality, Walsh's concept (1995) of critical quality will be introduced as the foundation for a new approach to quality management which is the goal of this study.

2.2. Strategic Quality

In traditional markets, quality was governed by immediate customer feedback, in that a product that failed to find acceptance with customers remained unsold and was a loss to the producer (Flood, 1993). Alternatively, it was subject to the normative controls of monopolistic guilds and the apprenticeship system (Ellis and Whittington, 1993). Developments in transport and technology and the new patterns of production and distribution that emerged as a result, however, led to a tendency for quality to be mediated through strategic action (Walsh, 1995). Quality was defined primarily by powerful producers, for the strategic reason of minimising production costs. Although it was recognized during World War II that quality had military value as a variable of strategic importance to both customer and producer, however, full exploration of commercial value did not occur until the 1980s. The Japanese led the way in exploiting generalised feedback on products, which had been neglected or ignored by British producers, creating a new two-sided strategic view of quality based on “a marketing mentality”(Hutchins,1990:22). Subsequently, British writers and manufacturers, too, began to assert the commercial value of quality, a key role being played by the formulae and injunctions of the ‘quality gurus’.

A pre-eminent figure in the quality movement was Deming, who was concerned with reducing process variability in order to improve product consistency, and eliminate waste. He also developed techniques of sampling for consumer survey purposes (Flood, 1993) as a means of ascertaining customer requirements. In his later work, Deming (1986) “tried to shift emphasis from narrowly-defined strategic and normatively regulated actions to more broadly participative action” (Walsh, 1995:208) but a strongly strategic orientation can still be discerned in his emphasis on the role of leadership and management ‘explanation’, and his implicit management cybernetic view of organisation.

Juran (1988), like Deming, took an implicitly management cybernetic approach, but differed from him in viewing quality as a management issue, rather than one of statistical control of processes and outputs. His narrowly prescribed political and cultural view of the workforce (Flood, 1993) perceived them as rational utility maximising actors who could be induced to pursue quality goals by means of strategic reward and punishment systems.

A more integrated approach to quality management was proposed by Crosby (1980) who paid explicit attention to the meaning and measurement of quality. He defined quality in terms of conformance to standard, thereby avoiding cost in replacement or reworking. From this perspective, the only useful measure of quality is the cost of non-conformance and the only performance standard is zero defects. Like that of Deming and Juran, Crosby's model of organisation was drawn from management cybernetics and he emphasised strategic action towards employees.

In contrast to these American 'gurus', Ishikawa (1985), instead of presenting a standard recipe for managing quality developed through his theory of 'Total Quality' a kind of group responsibility system, in which workers are given more autonomy than in Deming, Juran and Crosby's approaches. His approach combines vertical cooperation between managers, supervisors and workers, with horizontal cooperation between departments and functions (Flood, 1993), with a predominant focus on the marketing function. A key tool for the implementation of Total Quality is Quality Circles, groups of employees trained to identify, analyse and solve quality problems. Despite the apparent scope offered by Quality Circles for enhanced creativity, autonomy and participation of employees, Hutchins (1990) and Flood (1993) question whether, given prevailing attitudes in British industrial management, they can be implemented as intended; instead, they suggest, such circles are strategically controlled or marginalized.

In Walsh's (1995) view, the problem underlying such behaviour is the lack of trust, on the part of resource "owners", in those employed to use and create resources.

Notwithstanding the differences among the four gurus in their prescriptions for managing employees, and the degree of scope they allow for dialogue, they share the same basic perception of quality. Their approach is one in which quality is strategically mediated between the self-interested requirements of producers and consumers; producers recognize and meet customer requirements, only in so far as they can do so at acceptable cost, and that by so doing they reap competitive advantage and profit, but meaningful dialogue between the two parties is lacking and there is no development of trust. This has implications for quality, because lack of trust tends to distort communication, rendering it ineffective and inefficient, and in such a situation, mistakes are more likely. If there is a lack of trust, therefore, the lack of communicative effectiveness will result in low quality, high risk, higher cost and lower efficiency, while trust tends to produce the reverse effect. Given these serious implications of the lack of trust and communication, failure of the quality gurus adequately to address these issues is a major shortcoming of their work.

2.3. Normative Quality

Normative Quality entails the specification of qualitative or quantitative standards of expectation, the compliance with which is enforced by regulations and sanctions, rather than being left to the operation of market forces (Walsh, 1995; 1999). Ellis and Whittington (1993) see the clearest sign of normative quality in product standardisation, which was introduced as a way of cutting costs and facilitating manufacture. Producers whose goals lacked certain attributes risked losing customers to others whose products possessed the features considered desirable. On the other hand, exceeding generally accepted standards was simply a waste of money. Thus, certain attributes would become industry norms.

In Great Britain, a pioneer and leader in the strategic propagation of standards was the British Standards Institute (BSI) which originated in 1901 as a civil engineers' committee formulating standard specifications for heavy industrial goods. The scope of BSI's activity was gradually extended, first, in World War II, to munitions, and subsequently to a wide range of manufactured products, contributing to the spread of normative quality in British industry.

More recently, the standards of the International Standards Organisation (ISO) have been introduced in many industries, although the ISO could be accused of an excessive concern with documentation systems¹, rather than objective evaluation of products themselves. This implies in turn that what counts is not so much the quality of the company's products, as the quality of its bureaucracy.

Proponents of normative quality would no doubt argue that standards engender trust in the quality of (for example) the food produced by a company. Some companies promote their products citing kite marks and the like as a "Sign of Trust". The British Standard Institute (BSI) and International Standards Organisation (ISO) are, in essence, guarantees. But what exactly is the nature of the guarantee? Usually, the guarantee² is seen in terms of authority; the implication is that BSI or ISO are authoritative organisations and that a company conducting its operations according to their standards invites and merits trust in its products or services. Based on the attribution theory, conformance to ISO or BSI is expected to induce the public to attribute trustworthiness or excellence to the product or service. This, however, is contrary to the argument (McLain and Hackman, 1999) that trust is earned and conferred based on previous experience.

¹ Practical experience (attending an ISO Training programme at the National Food Company, Jeddah – Saudi Arabia).

² The guarantee is, however, contentious, as are all guarantees, since under any system, a mistake or accident could still compromise quality. The idea that BSI and ISO are not so much guarantees as labels inviting attributions of quality (and, hence, trust) was born in a discussion with a former colleague in the National Food Company, Jeddah, Saudi Arabia.

Although our discussion so far has focused on the application of normative quality in manufacturing, the concept also plays a significant role in health care. Like other professions, the health care professions regulate quality by setting certain standards of theoretical knowledge and practical competence that must be demonstrated in examination as a requirement for professional registration. They also have published, legally enforceable codes of conduct, making explicit the principles according to which work is to be carried out, and setting out the rights of providers and clients. Professional codes can be linked to corporate mission statements, in that the underlying intention is to create a quality culture, but unlike them, they create legal as well as professional obligations for the members concerned.

As indicated in a later section, however, normative quality in the NHS has gained additional impetus and taken new manifestations with the Patients' Charter, performance indicators and league tables which may, in fact, be counter – productive. This is because they encourage a focusing of attention on limited, measurable goals at the expense of others which may be equally or more relevant to patient needs and service quality.

In manufacturing, companies increase their sales by improving their products' quality. In so doing, their focus is on trying to do things right (they are concerned predominantly with efficiency). In the health service, however, the goal is to have more healthy people and improve the quality of life (Department of Health, 1992), and thereby to increase people's feeling of satisfaction about the service they receive. In this case, the main concern is with doing the right things (i.e. the concern is with effectiveness). These are quite distinct concepts, and there is a danger that the concern with effectiveness appropriate to such a service is undermined by the preoccupation with efficiency.

2.4. Total Quality Management (TQM)

Total Quality Management (TQM) is perhaps the best known and most keenly advocated form of quality management in industry (Walsh, 1995) while Spackman (1993) reports its implementation in the NHS. However, its use has been criticised by Walsh (1995) on the ground that important issues in TQM are often neglected or not correctly understood by its users, while Flood (1993) draws attention to serious shortcomings in the method itself.

TQM has been described as a holistic interaction of terms, methods and internal markets, facilitated by leadership (Witcher and Wilkinson, 1990). One of the cornerstones of TQM is the idea of the 'quality chain' whereby organisations are perceived as a set of interconnecting processes, each with its own inputs and outputs. Every employee is a participant in some process, receiving inputs from others and producing outputs for others; thus, everyone is simultaneously a customer and supplier (Oakland, 1993; Walsh, 2000). Defects at any point in this chain can create defects all along the chain, leading to dissatisfied customers and the waste of time and resources. The principle underlying TQM is the avoidance of such waste by conformance of output with the requirements of customers, whether internal or external.

TQM claims to be 'total' because of its philosophy that quality involves 'everyone, everything and all issues' (Flood, 1993). Nevertheless, despite a sophisticated "tool-kit" (quality circles, fishbone diagrams, Pareto charts and so on), TQM retains the limited 'machine-like thinking' (Morgan, 1997) of management cybernetics. In consequence, there is a danger of its being used in an autocratic means by those in power (Jackson, 1991a, 2000). It can be criticised as focusing on strategic action at the expense of dialogue, as it is concerned with minimizing error in the pursuit of a goal, with no critique of the validity and value of the goal itself.

TQM initiatives in the UK have been fraught with problems, arising not only from the shortcomings of the theory itself, but also from values and structures prevalent in industry, prioritising of short-term gains over long term development, assignment of roles without consideration of attitude and aptitude, and vague and meaningless corporate objectives (Witcher and Wilkinson 1990). In the absence of a participative culture, machine-like teams are formed and sustained by strategic action, rather than dialogue.

The deficiencies of TQM have been discussed by Flood (1993), based on Habermas' (1968, 1972, 1999a) "[*Erkenntnis und Interesse*] knowledge-constitutive interests", and suggestions made for its improvement. He makes use of three perspectives: machine-like traditional management thinking, brain-like cybernetics thinking and socio-cultural systems thinking, and criticises the dominance of machine-like thinking in most quality initiatives, including TQM. To overcome the lack of holism which, contrary to its claims, he sees as a serious weakness of TQM, he advocates the viable system model (Beer, 1979, 1981) of organisation design. He argues that the Viable System Model (VSM) offers a flexible design capable of achieving the delicate balance between the autonomy which is a prerequisite for human creativity and freedom, and the regulation needed for the attainment of social goals. He suggests that achieving this will result in the production of social goods rather than social ills.

Elaborating on Flood's suggestion, excessive interference in an implementation and erosion of autonomy by the controller weaken the viability of the system, because the implementation has to be autonomous within itself and coordinated for autonomy; the role of the controller should be confined to making minor adjustments. Coordination between the parts promotes the growth of trust, which in turn facilitates autonomy; autonomy is most likely to be conferred on people judged to have the necessary competence, reliability and integrity (McLain and Hackman, 1999).

In practice, however, whether social goods are produced, whatever the balance between autonomy and control, depends on the nature of corporate goals and whether those goals are decided strategically by the board of directors, or agreed through debate, as Flood (1993) advocates. Flood recommends the use of various techniques for encouraging and facilitating debate, such as Interactive Planning (Ackoff, 1981) and Soft System Methodology (Checkland and Scholes, 1990) as well as the Quality Circles mentioned earlier. Nevertheless, he acknowledges that design and debate, although necessary, are not sufficient conditions for freedom, due to the possibility of their coercive exploitation to serve the interests of powerful groups. For this reason, he asserts the importance of empowering people by such methods as Critical Systems Heuristics (Ulrich, 1983), though he also argues that further development in empowerment approaches is necessary. Walsh (1995) argues that the most effective way to achieve such empowerment is by structurally binding democratic dialogue processes into life. He proposes this as the basis of a new approach to quality which he terms “Critical Quality” and will be considered later in this chapter.

2.5. Quality in Health Care Systems

Quality is not a new issue in health care. Ellis and Whittington (1993) cite examples such as Florence Nightingale, who created a new normative quality for hospital care; and E.A. Codman, an American physician whose ‘End Results Hospital’, they interpret as an example of two-sided strategic quality, with the focus on the outputs of the service. More recently, the normative quality of health care has been spread by systems for regulating the training and registration of health care professionals. The OECD takes a normative approach when it defines quality of health services as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professionals’ knowledge” (OECD, 2004:33).

In recent years, the introduction of market disciplines into the NHS has brought a new strategic focus on reduced cost and improved value for money (Gregory and Walsh, 1993) which may run counter to the 'caring externality' - the characteristic of altruism that seems to form an element in the motivation of health care professionals. Moreover, responsibilities for quality are dispersed and dialogue between the NHS professionals is lacking (Ellis and Whittington, 1993). Despite the detailed specifications required for NHS contracts, there is still heated debate about the quality of NHS provision.

McLoughlin and Leatherman (2003) report significant problems with the quality of health care in the UK, among other countries. This is reflected in the perceptions of stakeholders (doctors and patients), in unintentional harm to patients, in overuse of ineffective care (such as antibiotics for upper respiratory tract infection) and underuse of effective treatments (such as Beta – blockers to prevent recurrent heart attacks).

A difficulty facing efforts to assure and improve health care, particularly in relation to the traditional strategic and normative approaches, is that health care is a service, and services are basically intangible. Although there are tangible elements associated with the service offering, much of the service consists of performances and experiences, rather than products (Zeithaml et al., 1990). As Walsh (1999:42) expressed it, "Each individual patient – health service episode consists of an intangible, ephemeral, unique, highly variable and contentious process". For this reason, the criteria customers use to evaluate it may be complex and difficult to capture precisely. Health is not a unitary concept; it includes biological, social, economic cultural and environmental aspects (Blaxter, 1992). Moreover, customers do not evaluate service quality solely on the outcome of the service (e.g. how much "better" a patient is after treatment, or what information has been provided); they also consider the process of service delivery (e.g. how involved, responsive and understanding the practitioner was

in carrying out the treatment or providing the information). This reflects the distinction made by Grönroos (1982) and subsequently maintained by Rust and Oliver (1994), Brady and Cronin (2001) and Kang and Fames (2004) between technical quality (what service is provided) and functional quality (how the service is provided). In the absence of the necessary expertise to evaluate technical quality, patients tend to rely on the functional aspects of service delivery when they judge quality in health care (King and Fames 2004; Wong 2002)

It is therefore difficult to know what to measure, and how to measure it, as well as how to interpret the results. What is visible and measurable may not be where quality problems actually lie. Walshe and Offen (2001), commenting on the lessons of the Bristol cardiology scandal, argue that while the symptoms of failure may be seen in poor standards of care and avoidable mortality and morbidity, the source of the problem is usually organisational, for example organisational leadership, management structure and systems, organisational culture and inter-professional relationships.

Another difficulty associated with quality in health care is that it is an 'experience product', one that cannot be evaluated until it is used. This means that, in contrast to a manufactured product, 'conformance' cannot be 'designed-in' in advance.

Here, an important distinction should be made between two conceptualizations of the construct of quality, namely, between objective quality and perceived quality. Whereas objective quality is a tangible, measurable attribute, defined in terms of conformity to standards (Deming, 1986), perceived quality is the consumer's judgement about an entity's overall excellence or superiority (Zeithaml et al., 1990). Because it involves, not an objective aspect or feature of a thing or event, but the individual's subjective response, it is "a highly relativistic phenomenon that differs between judges" (Holbrook and Corfman, 1985:33).

In a service context, the concept of quality must often be conceived in these more subjective terms, due to the intangible nature of much of the service offering. From this perspective, perceived quality is a form of overall evaluation (Olshavsky, 1985), a relatively global value judgement (Holbrook and Corfman, 1985) of a service, similar to attitude.

This, however, raises a further problem of conflicting values. Since service quality is perceived subjectively, a service will be evaluated differently by different groups. Ovretveit (1994) identifies three distinct perspectives on quality:

- Client quality – what clients and carers want;
- Professional quality – whether the service meets needs as defined by professional providers and referrers, and techniques and procedures are correctly carried out;
- Management quality – efficient and productive use of resources, within limits set by higher authorities and purchaser.

These may be said to correspond to the notions of functional or relational, normative and strategic quality respectively. Given these different perspectives, therefore, in any discussion of quality, or initiative to “improve” it, it is necessary to ask, “quality from whose perspective, based on what values and for what purposes?” (Graham, 1990 :9). Specification of quality standards implies the privileging of one set of values over others. Usually, it is the consumer whose values are ignored (Sanderson, 1987, cited in Walsh, 1995). Although in the 1990s, initiatives were taken to invite consumer feedback on NHS quality, they were, as Walsh argues, more akin to standard marketing strategies than calls for dialogue. A limitation of patient satisfaction surveys is that respondents can only answer within the terms of reference of the questionnaire - decided by providers or administrators- which may not reflect the specific issues and values relevant to them. Jenkinson et al. (2002) point out that attitudes to services do not

provide much insight into the nature of services. Moreover, the positive ratings typically elicited are not sensitive to specific problems in the quality of care delivery. Moreover, since they rarely ask patients about the value to them of their treatment, they do not discriminate between good and bad practice. Unless consumers have the opportunity to challenge the validity claims implicit in such instruments, they cannot provide meaningful input to quality decisions. In this way, the strategic interests and actions of purchasers and providers predominate, and the potential for coordinated action between stakeholders is thereby restricted.

The discussion so far has highlighted the theoretical and practical difficulties of applying traditional strategic and normative concepts of quality (which were developed in the context of products) to services such as health care. Some writers, however, have tried to formulate an understanding of quality in a service context, which reflects the intangibility of much of the service offering and the role of service users' perceptions in the formation of quality attributions. In this way, they offer possible answers to the dilemma mentioned, of what to measure, and how. In a service context, consumer perceptions of quality are widely seen as stemming from a comparison of what they feel organisations should offer (i.e. expectations) with their perceptions of what is actually provided (Sasser et al., 1978; Parasuraman et al., 1988; Zeithaml et al., 1990). Hence, perceived service quality is judged in terms of the 'degree and direction of discrepancy between consumers' perceptions and expectations' (Parasuraman et al., 1988:17). It should be noted that in the quality literature, the concept of expectation is normative, rather than predictive as it is the consumer satisfaction literature (e.g. Oliver, 1981). In other words, in relation to quality assessment, expectations are viewed as desires or wants of consumers; what they think a service provider should offer, rather than would offer.

Consumer expectations may be formed and moderated in the light of a variety of influences: word – of – mouth communications from other service users; the personal needs of the individual; past experience with using the service; and external communication from service providers.

Discrepancy between customer expectations and the perceived quality of the service received is said to occur as a function of four other gaps or shortfalls in service delivery:

- Gap One is the gap between management's perceptions of the public expectations and the public's actual needs and desires; in other words, management have a mistaken idea of what consumers want.
- Gap Two is the gap between the service provider's perception of client expectations and the specifications of service quality under which the services are governed; that is, managers know what customers want, but fail to set appropriate standards to assure it.
- Gap Three is the gap between the specifications of the service quality and the actual service delivered; standards are in place, but are not met.
- Gap Four is the gap between the actual service delivered and what the service organisation communicates to the clients about what it will deliver: organisations may 'over promise' beyond their capacity to deliver, raising unrealistic expectations.

(Parasuraman et al., 1985:44)

Gaps one and two are managerial gaps, while gaps three and four result from the performance of the front line of service delivery. The idea is that by closing gaps one to four, the overall quality gap can be eliminated. In other words, quality requires that

managers understand what consumers want, set appropriate standards accordingly, communicate these accurately to consumers, and deliver on the promises made.

Parasuraman et al. (1988), based on focus group interviews with consumers of a range of services, concluded that the general criteria customers use in judging service quality are much the same, irrespective of the service. They classified these into 10 dimensions or attributes, as follows:

- Tangibles: the appearance of physical facilities, personnel and equipment.
- Reliability: ability to perform the promised service dependably and accurately.
- Responsiveness: willingness to help customers and provide prompt service.
- Competence: possession of the required skills and knowledge.
- Courtesy: politeness, respect, consideration, and friendliness of personnel.
- Credibility: trustworthiness, believability, honesty of the service provider.
- Security: freedom from danger, risk or doubt.
- Access: approachability and ease of contact.
- Communication: keeping customers informed in language they can understand and listening to them.
- Understanding: making the effort to know customers and their needs.

Subsequent factor analysis resulted in the consolidation of competence, courtesy, credibility and security into a broader dimension, labelled Assurance, and of access, communication and understanding into a dimension called Empathy. Service quality, therefore, is conceived as encompassing dimensions of tangibles, reliability, responsiveness, assurance and empathy.

As noted previously, Parasuraman et al. (1988) theorized that when service users' perceptions of a service as experienced fail to conform to their expectations, a 'quality gap' results. They attempted to evaluate quality and measure the 'quality gap' quantitatively, using a 22 – item questionnaire, SERVQUAL, in two modes, one

measuring expectation in relation to specified service attributes, the other measuring perceived experience of the same attributes. Subsequently, researchers have criticised this instrument on theoretical and practical grounds [detailed reviews of this critique can be found in Smith (1995) and Buttle (1996)]. Moreover, subsequent researchers using SERVQUAL, or a modified version of it, have variously found fewer, more, or differently named dimensions than those claimed by Parasuraman et al.(1988) – see for example, Carman (1990), Headley and Miller (1993) and Vandamme and Leunis (1993). Richard and Allaway (1993) argued that outcome as well as process measures should be included, although Higgins et al. (1991) considered that outcome quality is encompassed by the dimensions of reliability, competence and security. Buttle (1996) argues that expectations cannot be measured in absolute terms and that, moreover, consumers do not evaluate service quality solely in relation to expectations.

In addition to the limitations of SERVQUAL debated in the literature, it could also be argued that it does not necessarily provide an answer to the disadvantages of the strategic and normative approaches, because it could be used to serve those ends. It would be used strategically, because respondents can only answer in terms of the items offered in the questionnaire. Although the original SERVQUAL instrument may be modified, it will still be shaped by the interests and preconceptions of the individual or organisation using it. Moreover, the SERVQUAL approach to some extent reflects a normative approach because the ‘prescription’ for filling the quality gap is, at least partly, concerned with standard – setting.

Whatever the difficulties associated with the SERVQUAL questionnaire itself, however, there is evidence to support the salience, in the health care context, of the quality dimensions identified by Parasuraman et al. (1988). For example, when Baeza and Calnan (1999) explored different stakeholder groups’ perceptions on service quality, using a qualitative, interview – based approach, the response included waiting

times, a 'clean and easy' environment, professionalism, courtesy of staff, and immediate answers to questions. The first two of these are tangibles, the next two are components of the SERVQUAL dimension of assurance, and the last falls within the definition of responsiveness. Similarly, when Hart (1999) asked service users what makes a 'good clinic', the features considered of most importance were friendliness of staff, quality of communication, and helpfulness of staff, which can be seen as corresponding to the dimensions of assurance, empathy and responsiveness, respectively.

Versions of the SERVQUAL instrument have been applied in clinics and general practice settings (Soliman, 1992), among hospital in-patients and among discharged hospital patients (Youssef et al., 1996), revealing the importance attached to reliability and empathy, in particular. However, in a study to determine the attributes which consumers use to evaluate health care, Bowers et al, (1996) found that other dimensions, such as caring, which is not mentioned in SERVQUAL, and communication which is hidden by being assimilated into 'empathy', were identified by focus groups as important. They suggested that the SERVQUAL elements are not sufficient to define the construct of health care quality.

Another typology of service quality dimensions, developed specifically for health care, and one which has been very influential, is provided by Maxwell (1992), who suggests that service quality consists of six dimensions, as follows:

- Effectiveness: the technical quality of treatment.
- Acceptability: the way the service is delivered.
- Efficiency: maximum output for a given input
- Access: availability of treatment when needed
- Equity: fair treatment of patients relative to others
- Relevance: appropriate balance of service, given the needs and wants of the population as a whole.

The first of these is an outcome measure. Two others, acceptability and access, are process measures which can be compared to those proposed by Parasuraman et al. (1988); it could be said, for example, that the SERVQUAL dimensions are in fact an elaboration of the idea of acceptability. The dimensions of efficiency, equity and relevance have attracted particular attention recently in relation to media reports of a so – called ‘‘post – code lottery’’ in relation to provision of high – cost treatments such as some breast – cancer drugs, and the resultant debate on how limited resources can best be targeted. This controversy has highlighted the trade – off that exists among these quality dimensions; it has also shown that evaluation of some of these features involves clinical and financial knowledge which would not generally be possessed by service users. Thus, Maxwell’s (1992) typology seems to be oriented more to the perspective of service providers.

More recently, Donabedian (2003) identified seven components of quality in health care:

- Efficacy (ability of science and technology to bring about improvement in health)
- Effectiveness (the degree to which attainable improvements are actually achieved)
- Efficiency (ability to lower cost of care without diminishing improvements in health)
- Optimality (balance between costs and benefits)
- Acceptability (consistency with the wishes, desires and expectations of patients and their families; it includes accessibility, patient – practitioner relationship, amenities, patient preferences and fairness)
- Legitimacy (conformity to social preferences as expressed in norms, laws and regulations)

- Equity (conformity to principles regarding what is just and fair)

Clearly, there is no single universally applicable definition of service quality. However, there is a common recognition that “the personal touch is vital in quality management” (Walsh, 1999:44). Service quality has both tangible and intangible dimensions. As noted previously, the prevailing focus in NHS improvement initiatives is on the tangible dimension. However, a comprehensive approach to quality must take account also of the intangible elements of service performance which may account for a large part of consumers’ quality judgements. Despite their limitations, SERVQUAL (Parasuraman et al., 1988), Maxwell’s (1992) and Donabedian’s (2003) frameworks are of interest as they give some indication of the range of service attributes that may be important to stakeholders, and they offer a reminder of the need to include intangible human elements as well as tangibles when investigating and planning to improve service quality. This is particularly important because, as Press (2006) points out, health providers cannot guarantee cure – this depends on the medical problem, patient’s age, condition, lifestyle, support system, etc. However, it may be argued, it can (or should) guarantee care: appropriate technical interventions, empathy, information, and concern for patients’ emotional and physical comfort.

2.5.1. Are recent approaches to quality in the NHS satisfactory?

The NHS has in recent years shown a tendency to favour the implementation of quality approaches within some sort of ostensibly comprehensive theoretical framework; a result of this has been the widespread adoption of ideas such as TQM (Walsh, 1995). Questions have, however, been raised about the appropriateness of individual models of organisation for the NHS, because of the intangible nature of its services, the size and complexity of the system, and the fact that managerial control over health professionals is weaker than that exerted over workforce in industry (Ellis and Whittington, 1993).

Indeed, TQM has by no means been universally successful, even in the industrial environment in which it was conceived. Sitkin and Roth (1993) attribute the failure of many TQM programmes to the adverse impact on organisational trust resulting from the imposition of highly formalized management controls in ambiguous, non-routine task conditions.

Their view is supported by Sitkin and Stickel's (1996) study of a TQM programme in a corporate basic research laboratory, within a major U.S. technology corporation. TQM had been successfully implemented in the cooperation's manufacturing and marketing operations, but the extension of the programme to its research laboratories proved problematic. The TQM initiative had taken place in a context where mutual suspicion prevailed, between the laboratory staff, who felt their work was not understood by corporate management generally, and the corporate managers who perceived the laboratory staff as unaware and unconcerned about business considerations. The existing tensions were aggravated by the TQM programme, which brought with it the introduction of precise measurement tools and standardized problem-solving procedures. In the scientists' view, the non-routine, pioneering nature of their research did not lend itself to measurement and standardisation of this kind; moreover, they felt problem-solving skills they were already using were unrecognised or undervalued. They also resented what they perceived as the attempt by the TQM trainers to impose a uniform set of values. Although some aspects of the TQM were appropriate to their values and practices, they showed a selective preoccupation with those that did not fit, clearly reflecting the self-perpetuating nature of distrust. Management, for their part, saw the objections to the quality programme, however objectively explained and argued, as evidence of scientists' unwillingness to approach problems systematically or coordinate with others.

There was a reluctance within the organisation to recognize that any specific subgroup or subtask had special or different needs.

Sitkin and Stickel (1996) interpreted the distrust triggered by the imposition of precise measures and highly structured procedures as reflecting, not only the 'deskilling' issue, but also a sense of moral outrage (Bies, 1987) or professional insult (Kramer, 1994). They further noted a tendency for distrust to exacerbate in-group conformity and out-group resistance, causing groups to become entrenched in isolation from each other. They suggested that the expression of formal specifications in terms of broad objectives, rather than precise measures or specified standard procedures, might have allowed more flexibility for members of the organisation to adhere to the spirit of the rule, while adapting it to the exigencies of their individual situation.

The observations of Sitkin and Stickel (1996) with regard to this particular TQM initiative carry a strong implication that trust and distrust are not necessarily exclusively based on issues of reliability and competence. If this is so, the problem may not be capable of resolution simply by technical means. Attention also needs to be paid to creating and sustaining shared values, and to repairing damaged personal and professional pride.

The failure of the TQM in the case reported can be attributed to a narrow perspective which privileged a particular type of problem-solving structure, and failed to take account of the different roles, activities and relations of different groups and functions within the organisation, or to understand the social and psychological issues involved. In this respect, it is noteworthy that Ackoff³ criticises the tendency in management to approach systems improvement from a blinkered perspective which focuses narrowly on certain parts of the system, and fails to take a holistic view of the system overall. This shows a misunderstanding or neglect of the essential nature of a

³ Better Management for a Changing World, Part II: The Big Picture, Video Cassette series (held by the Business School, The University of Hull)

system, which by definition has synergies and essential properties which do not reside in any of the parts individually, but are the outcome of their interactions. Thus, to break down the system is to lose these defining properties.

The rule – based approach to quality recently introduced by the government of the UK may prove equally counter – productive. In a succession of government papers, the UK government has since 1997 set out a “new vision” for the NHS in which “quality” is repeatedly invoked as one of the key principles underlying the changes (Department of Health, 1997; 1998; 2000). In addition to introducing a new, vaguely described concept labelled “clinical governance”, the government brought in a number of new legislative measures aimed at quality assurance. A new inspection body, the Commission for Health Improvement (now the Commission for Healthcare Improvement and Inspection) was established. The National Institute for Clinical Excellence was entrusted with providing individual practitioners and hospitals with guidelines on appropriate treatment. Annual practitioner appraisal and regular certification of fitness to practice were introduced, and a star – rating system of performance appraisal against targets was introduced (Checkland et al., 2004).

Checkland et al. (2004) suggest that quality improvement would be better served by a new concept of accountability based on openness and transparency in the relationship between doctors and patients, as a means of increasing trust and shared decision – making. The search for improved quality of care thus becomes a shared project between them.

There is a danger, however, that reforms under the new clinical governance regime may be misunderstood. Freeman and Walshe (2004) in a national survey of perceptions concerning the importance of, and progress in, aspects of clinic governance in the NHS Trusts, found a strong prioritisation of the assurance agenda. However, they raised concerns about the ability of the NHS organisations to tackle the long – term

quality improvement agenda. They suggested that NHS trusts appear to have concentrated on structural mechanisms such as committees, policies and resources, rather than on the substance of the reforms.

The lesson from these reports is that in any attempt to improve quality within the health care system, it is necessary to look at the system as a whole (and as a part of the social system) and not to divide it into parts (quality, communication, and production management or departments) and hence identify the components of that system, which are purchasers, providers, users (internal and external) and stakeholders. Furthermore, it must be recognized that the system has to serve multiple interests; those of its components (users, providers and purchasers, equally), those of the larger social system of which the system (health care) is a part, and the objectives of the system itself. Moreover, attention is needed to the quality of communication between stakeholders.

In view of the political, cultural, communicative and structural shortcomings of existing quality initiatives, Walsh (1995) argues, there is a need for an alternative approach, which he calls “*Critical Quality*”.

2.6. Critical Quality

Walsh (1995) coined the term ‘critical quality’ to refer to a situation where dialogue is not only promoted but embedded in the system, thereby enabling the coordination of social action between communicatively acting producers and consumers. There are a number of prerequisites for the achievement of critical quality.

In this section, Walsh’s concept and its theoretical underpinnings are explained, after which recent dialogue initiatives in the NHS are discussed in the light of the critical quality requirements.

2.6.1. The concept and philosophy of critical quality

In developing his concept of critical quality, Walsh (1999) drew on Habermas' (1981a,b; 1984a;1987;1999b,c) critical social theory which sought to show how social and technical developments (of which health services are an example) could be pursued in a way that serves human society without oppressing any individuals or groups. Walsh asserts the need for health care to permit and, indeed, actively encourage communication which is not distorted by unequal power relations. The difficulty faced by the health service in practice is that the participants may not be equally committed to rationality, openness, equality, and the achievement of understanding. Moreover, there is an imbalance of power between staff and patients.

For these reasons, communication is distorted. Such conditions are in contrast with those advocated by Habermas, whereby action is coordinated through the exploration of communicative acts oriented towards reaching understanding (Habermas, 1984b). His proposed "ideal speech situation", in which there are no influences, such as strategic manipulation, rigid perceptions, one-way communication and self-deception, has never been achieved in reality, but it provides a goal for the health services to work towards.

The aim is to have a situation in which all stakeholders in the services - planners, administrators, medical personnel and patients-can participate fully in rational debate and action, without the undermining effects of inequalities of power and influence, and are free to challenge each others' claims. A problem with Habermas' discussion, however, is his failure to explicate the way such communication would be achieved in practice. Walsh (1995) argues that suitable arrangements to promote and facilitate the sort of dialogue between subjects in the public sphere which Habermas envisages need to be institutionalized in an accessible process. Such a process must allow people to challenge the validity claims - to indicate their lack of understanding to challenge the

'facts' put forward to call into question other participants' sincerity, or express doubt as to the morality of a viewpoint or proposed course of action. Unless such opportunities are available, decisions will be made on the basis of incomplete information, or may be swayed by coercion. The opportunity to challenge validity claims, and the principle that those who make assertions or propose actions should be required to defend them in the face of such challenges are the essence of democratic dialogue. Habermas implicitly holds out the hope that conditions can be created for such dialogue to take place.

2.6.2. Dialogue in the NHS

The achievement of critical quality implies that participants in dialogue have the means to change the quality of production, that all those affected by and involved in the provision and utilization of health services can participate, and that dialogue is genuine, that is, motivated by a commitment to understanding; and free from distortion. However, the quality and communication initiatives carried out within the NHS in recent years have fallen short of these ideals.

One aspect of the relations among stakeholders that has attracted concern is the different perspectives and sometimes tense relations between two groups of providers: managers and the health professionals themselves. The potentially conflicting values of these groups have been highlighted by Walsh (1995). Edwards (2003) expressed similar concerns about relationships between doctors and managers, consistent with Walsh's view. Edwards (2003) suggested that good relationships in organisations seem to be associated with better outcomes for patients, and poor relationships may have a direct adverse impact. He argued, therefore, that attention should be paid to finding ways of repairing and renegotiating such relationships.

Perhaps of even more concern, however, is that comparatively little consideration has been given by health professionals to the voice of consumers and their potential to contribute in quality management. This is despite the fact that defining this

role has been on the NHS R&D agenda for at least the last decade (Peckham, 1995). Moreover, a report on social service for the Department of Health (James, 1992) contained the suggestion that quality should be viewed primarily from the perspective of the service user. Guidelines for health authorities on polling the views of local people (National Health Service Management Executive, 1992), however, perpetuated a strategic view of quality, in that they concentrated on obtaining marketing information that would have strategic utility for purchasers. Concern to improve the level of consumer involvement has led in recent years to the Patient Partnership Strategy (Walsh, 1999). The strategy document admits that health services need to be more responsive to the needs of users, and that this entails planning to provide patients with the information they need in order to make informed choices; to promote users' involvement in their care and to ensure that users have the knowledge, skills and support to contribute effectively in influencing NHS planning.

Since the strategy was introduced in 1996, a number of local patient partnership initiatives have taken place, which could potentially contribute to critical quality. Service user forums, citizens' juries and advocacy schemes are examples (Walsh, 1999). These initiatives have, however, not always been successful and have been fraught with difficulty.

Van Wersch and Eccles (2001) draw attention to difficulties of communication experienced in consumer involvement initiatives in the health service. When individual patients were included in a guideline development group they contributed infrequently, had problems with the use of technical language, and their contributions were not acted on. Expanding the technical elements to patients in a workshop was effective in enabling them to engage with the process and make relevant suggestions, but was resource intensive. A solution was found in the use of a patient advocate within the guideline development group, who was confident in speaking, used to having

discussions with health professionals, and familiar with medical terminology. The authors concluded that there is no one right way to accomplish patient involvement and that further work on how to achieve it is needed.

A particular area in which little headway has so far been made, according to Walsh (1999) is that of informed consent. Walsh (1999) points out that simply providing more or better information will not lead to informed consent. The crucial need is not for more information, but for more understanding. Patients do not need to know as much as physicians; but they need to be able to take part in dialogue towards mutual understanding between patient and clinician. No reference to such dialogue is contained in the current strategy, and it would need time and commitment which seem to be lacking. As long as the patient partnership strategy continues to be lacking in genuine dialogue, only strategic and normative approaches to quality management in the NHS can be expected.

It is to the lack of such dialogue that Walsh (1995) attributes the NHS “quality gap”. Without it, individuals and groups cannot coordinate their actions but must make decisions on an ad hoc basis. This results in inconsistency, which reflects the inequalities in power among them. In his view, by bringing together NHS purchasers, providers and users to take part in genuine communicative action, it might be possible to arrive at some common understanding of the concept of quality, the facts of the existing situation, and the rightness and genuineness of proposed courses of action. An exploratory attempt to arrange a critical dialogue on quality within the NHS was made by Walsh and his colleagues (Gregory et al., 1994) which offers a starting point for a model of critical quality. That project is reviewed next.

2.7. The Trent Quality Initiative (TQI)

The TQI was an uncommissioned research project, involving more than 30 NHS stakeholders (including purchasers, providers and users) in an effort to create rigorous multi-agency dialogue. To facilitate dialogue, given the disparities among participants in terms of their communicative competence and power, and their different interests, an iterative series of alternate peer group meetings and multi-agency meetings of peer group delegates was held. The thinking was that peer group meetings would enable participants to formulate viewpoints and develop their communicative competence in a comfortable, non-threatening context, while the multi-agency meetings would subject the ideas arising in peer groups to further consideration from varied perspectives and provide an opportunity for the synergistic generation of creative insights.

Following the initial identification of nine stakeholder groups, through user groups already known to the research team, formal and personal approaches were adopted to invite participation. Those who volunteered were grouped into six peer groups: purchaser management, provider management, provider-nurses, provider-mixed professionals, Community Health Council and NHS users.

Each meeting was facilitated by a university researcher. Participants were asked to read all relevant documentation prior to each meeting, accept the direction of the facilitator, and listen attentively to all contributions. While listening, they were to think about the understandability, sincerity and acceptability of each utterance, as well as whether or not they agreed with the speaker's use of information and /or experience. If a listener had doubts about any utterance, from any of these points of view, she/he was to ask for clarification. Issues that remained without agreement in any meeting were referred for further discussion. In the case of peer group meetings, the aim was to arrive at a summary of viewpoints, collectively owned by the peers, which a delegate would then take into a multi-agency meeting. This collective ownership of viewpoints gave

participants protection from being associated individually with a viewpoint that could potentially be strategically damaging to them, thereby removing a possible source of strategic distortion that could constrain their contribution.

Since the research, although uncommissioned, attracted funding from the Trent Regional Health Authority, it was necessary to begin with a clearly structured agenda, in order to satisfy funding requirements. To satisfy this need, while also satisfying the common basis for participation, Ulrich's (1983) Critical Systems Heuristics (CSH) was taken as a starting point. Phases One and Two focused on four of Ulrich's questions in the IS mode, in order to identify current arrangements for quality in the NHS. Phase 3 looked at the same questions in the OUGHT mode to decide who should benefit from NHS quality system design, who should be able to change the measures of success, who should be involved in system design and who, from those affected, should be involved.

In his evaluation of the TQI, Walsh (1995) discussed several substantive issues raised by the process: empowerment and representation; participation in decision-making, and meta-dialogue, which will now be considered.

2.7.1. Empowerment and representation

One of the basic purposes of the TQI was to empower people who might otherwise have been marginalized in decision-making (Gregory and Walsh, 1993). This raises the question of the communicative competence of participants, both to handle incoming data and to represent themselves and their communities effectively. Facilitation played an important role in this respect, in terms of guiding and encouraging the use of guidelines. Interestingly, moreover, Walsh (1995) notes that in the final meeting of the project, none of the NHS professionals volunteered to speak on behalf of their multi-agency groups; the final representatives, despite being outnumbered by the NHS professionals, were one NHS user and two CHC members. It may be that the professionals were losing interest because they were not winning the

arguments. This is a problem of a time-limited project; in an on-going dialogue process, anyone who lost interest would drop out and new committed participants would take their place. The loss of commitment of some professionals, however, may also be seen as a reflection of the extent to which NHS users were empowered. Certainly, their views were formulated, heard and challenged in the dialogue.

Closely related to the issue of empowerment is that of representation. Who should be involved in such a dialogue? Walsh (1995), as noted earlier, argued that all stakeholder groups should be involved and he suggested that it was a significant weakness of the TQI that very few senior decision-makers took part. Romm⁴ however, has a different perspective. In her view, trying to set up a dialogue does not require the institution of one pattern of relationship within the system and she argues that it may not be necessary immediately to introduce senior people, as this might have stopped the middle managers from saying what they wanted to say; certainly, in the TQI it was desired to ascertain the views of the middle managers. In this sense, the low representation of one group may have helped to empower another.

There is also the problem that it is not possible to bring in all users. Thus a boundary question is raised (see Chapter Four). It is feasible to involve a certain number of representatives⁵ of specific users, and one would try to set up the dialogue in a way that would ensure that the representatives are sufficiently representative of the group; “sufficiently” rather than fully, because full representation cannot be guaranteed. Ulrich (1983) for example, suggests including advocates for future generations. The problem with this is that advocates might think that they know what future generations would want from a particular system; but they cannot know absolutely without engaging in

⁴ Lecture Communication with Dr. Norma Romm (Management Research - MA Management Systems) Hull Business School, Centre for Systems Studies, The University of Hull, Hull, U.K.

⁵ The issue of representation is raised by Habermas (1992) in relation to communicative competence. Whereas originally (Habermas, 1981a,b) he appeared to advocate that everybody should be able to challenge validity claims, he later accepted that communicative competence may be too difficult for some people to develop. He therefore proposed the use of steering mechanisms by which certain people could be trained as advocates, in order to ensure that the claims, concerns and issues of all stakeholders are fully represented in the negotiations.

dialogue with future generations, which is not possible. It is never possible to be 100% certain that the representatives used are representative enough of the range of stakeholders. All that can be done is to try to achieve as comprehensive a representation as possible (Churchman, 1979). This dilemma calls to mind Churchman's comment about the systems view, that it makes people aware of the necessary incomprehensiveness and lack of comprehensibility of the system in focus.

2.7.2. Participation

Regarding participation, the critical questions (based on Ulrich, 1983) referred to earlier required participants to give explicit consideration to the identity of beneficiaries and decision-makers. A broad distinction emerged between those who supported broad participation and consumer-led decision-making, and those who supported a narrower form of participation, with decision-making led by experts. Specific participation-related issues such as patient involvement and informed consent were referred to peer groups for discussion, such delegation being based on the multi-agency group's consensus on a peer group's expertise or need to confront a particular issue. At the peer group meetings, proposals for action on these issues were formulated, and challenges to the acceptability and feasibility of broader participation were raised. Some of the proposals that emerged were broad and general, for example, setting up receptive forums (Gregory et al., 1994). In other cases, however, groups put forward lists of detailed activities for enhancing participation, for example, in relation to raising the profile of the CHC, enhancing the design and monitoring of community health care; and complaint handling. Walsh (1995), however, expresses the view that throughout the discussion of participation, the approach of the professional groups was strategic; it did not reflect a view of users as discerning and potentially competent decision-makers. Ultimately, no consensus and coordinated actions on ways of implementing proposals on participation were achieved. in the context of the end of dialogue- the end of the

project and, hence, the absence of opportunity to respond to implicit and explicit challenges to the acceptability and feasibility of broader participation- the status quo of expert-led decision remained.

2.7.3. Meta-dialogue

The third issue raised in Walsh's (1995) retrospective analysis is that of meta-dialogue, by which he meant the flow of thematic argument between meetings as well as within them. Among the themes he defined in this respect are resources, motivation and patient rights although, as Walsh points out, these were identified in hindsight and participants in the TQI were not necessarily aware of them at the time. This may account for the dissatisfaction expressed by some participants who commented on muddled thinking and lack of a recognisable framework, or who lamented the lack of 'outcome' of discussions. Lack of awareness of meta-dialogue may be to some extent an efficiency problem that would be overcome with practice and familiarity with the jargon and concepts used by other speakers. It is also possible that dialogue in a project of this kind would be enhanced by providing feedback on the identity of the issues raised and the nature of the validity claims raised or redeemed between meetings. Walsh (1995) argues that one way to achieve this might be to invert the TQI process, so that stakeholders in the community form groups in the meta-dialogue, and the output of their meetings would be analysed by stakeholder peer groups, with the help of selected advocates and experts (the dialogue), and their responses fed back to the meta-dialogue. Diversity of viewpoints formulation could still be achieved by some sort of 'outreach' to the most marginalized groups in the community. People who are unable to engage in formal dialogue can at least participate by proxy, through an advocate. As long as expert advocates are given legitimacy by their direct relation to a constituency stakeholder, such an arrangement need not result in the creation of a new mode of expert domination.

Based on the TQI experience, Walsh (1995) proposed two alternative ways for implementing critical quality in the NHS: an incremental approach involving the structural linking of dialogue groups with points of access to existing decision-making mechanisms within the NHS, and a radical approach of broad, government-implemented restructuring of the NHS, informed by dialogue in democratic bodies that would involve purchasers, providers and users in determining service specifications. In either case, dialogue would be conducted following the TQI guidelines.

2.8. Conclusion

In both industrial and health sectors, the issue of quality has traditionally been viewed in strategic and/or, more recently, normative terms. From the strategic standpoint, quality is defined in terms of a compromise between the selfish requirements of producers and consumers. From a normative perspective, it is based on standards of entitlement and expectation, guaranteed by inspection, professional regulation and labelling. Both approaches result in a tendency to approach quality improvement through technical tools and procedures. This has been seen recently in the health service, where quality initiatives have borrowed from industry such solutions as performance indicators and TQM. However, the appropriateness of such solutions to complex intangible services such as health care has been called into question and possible damaging effects on trust have been demonstrated. From Ackoff's perspective, what is needed is a more holistic solution, which looks at the system as a whole, rather than applying piecemeal remedies to its parts. In Walsh's view, a solution can be found in the concept of critical quality, based on undistorted dialogue among stakeholder groups, aimed at mutual understanding and coordinated action.

It has been shown that recent initiatives in the NHS do not meet Walsh's (1995) criteria of critical quality, due to the failure sufficiently to involve consumers, and the distortion of dialogue by unequal power relations. Whilst the TQI demonstrated the

feasibility of Walsh's (1995) alternative proposal for dialogue on Habermasian principles, the success of the project was from some perspectives limited, raising difficult issues with regards to who is / should be / can be empowered, representation, the communicative competence of participants, and the extent to which participation in decision-making is affected. It could be argued that to achieve critical quality, the trust dimension of critical social theory needs to be strengthened. Building on ideas from CST, effort needs to be made to develop trust, initially in the process itself and, subsequently, in other participants and in the social system concerned.

It could be suggested that enhancement of trust between various stakeholders would itself lead to a more favourable perception of quality. At present, for example, part of the "quality gap" is service consumers' suspicion that the providers of the service are very often trying to cut corners or not fulfil their obligations properly, so they have little trust in the providers of the service. They believe that the providers of the service at top level, "the managers of the service", are not sincere. In order to demonstrate that trust can be put in the providers and that trust could be replicated, it is necessary already to be in a situation in which dialogue is taking place, because trust can only be checked and proven justified or otherwise, through dialogue and experience. If trust were developed through critical discourse, and attention paid to maintaining that trust in subsequent action, action could more readily be co-ordinated to bring about desired changes, and both quality and social trust would be enhanced as a result.

Taking as a point of departure this contention that a significant gap in quality initiatives so far has been the failure to pay adequate attention to issues of trust, the rest of this thesis explores, theoretically and empirically, how trust between NHS stakeholders can be promoted and contribute to action on quality. In the next chapter, I pave the way for this endeavour by developing a multi – dimensional understanding of the nature of trust.

Chapter Three

Trust - The Underestimated Power: A Review of the Literature

3.1. Introduction

In the previous chapter it emerged that a key issue in the approach to quality is trust. Whilst comparatively neglected in quality research, trust can be seen as both an input to and an outcome of the kind of dialogue advocated by Walsh (1995; 1999) and this is the aspect of his work which this research seeks to develop.

This chapter, therefore, establishes the conceptual foundation for this dimension of the study by building up a broad view of the issues in relation to trust, considered from multiple perspectives.

The study of trust is, however, fraught with difficulty, partly because of confusion caused by similarities and overlaps with other similar constructs. One distinction to be made is that between trust and cooperation. Although trust can lead to cooperation behaviour, the two are not necessarily linked because cooperation can spring from motivations other than trust (Mayer et al., 1995). Certainly, it is a complex and difficult topic – Habermas himself decided not to pursue it (Habermas, 1999b:137). All the more reason, then, that a sustained account should be given of the issues in relation to trust.

Confidence is another term often used synonymously with trust (Cook and Wall, 1980; Coleman, 1990). Although both refer to expectations that may ultimately be disappointed, Luhmann (1988) considers them to be different. He argues that trust involves the recognition and assumption of risk, while confidence does not.

Predictability is also related to trust, in that both are means of uncertainty reduction (Lewis and Weigert, 1985) but predictability alone does not create trust; it may be predictable that a referent will behave badly. Mayer et al. (1995) suggest that

predictability should be linked to cooperation, rather than trust; if it is predicted that a party will behave positively, one is more likely to be disposed to cooperate with that party.

Trust is studied and discussed in several distinct strands of the social literature, with each discipline adopting a particular focus. Three main perspectives are identified by Lewicki and Bunker (1996):

- 1) Personality theorists view trust as an individual expectation of others which is influenced by early psychological development. They focus particularly on individual differences in the propensity to trust and the factors underlying such differences.
- 2) Sociologists and economists are concerned with trust in relation to institutions. Their interest focuses on the attitudes of individuals towards institutions, on the factors that create or destroy trust within and between institutions, and the way trust or its absence influences institutional behaviour.
- 3) Social psychologists view trust in relation to the management of risk in dealings between individuals or groups, and on the mechanisms involved in the attribution or withholding of trust.

In order to capture the richness and complexity of the concept of trust, a multi-disciplinary approach is taken in this research. This chapter is, therefore, divided into four main sections, each reviewing trust from a different perspective. Section one looks at trust in sociological terms; section two presents a psychological perspective; section three explores the business literature on trust, which draws on the foregoing perspectives, while section four highlights some philosophical contributions that explore trust issues.

3.2. The Sociological Perspective of Trust

Scholars who have examined the social function of trust in society have highlighted several features of the concept. First, there is a distinction between interpersonal (micro-level) trust; and system (macro-level) trust. The operation of trust at both these levels has been asserted, *inter alia*, by Luhmann (1988) and Misztal (1996). Putnam (1993) distinguishes between the intimate interpersonal trust generated in close – knit groups and a more general trust in the broader social system which, he claims develops out of experience with interpersonal trust.

Sociologists claim that through interactions with others, different types of trust are engendered: cognitive, emotional and behavioural (Kasperson et al., 1992; Koller, 1998; Lewis and Weigert, 1985). Cognitive trust is the outcome of an exercise of judgement, based on what we know about the individual or institution concerned. Close social networks, by increasing the knowledge available, facilitate such judgements and increase cognitive trust. Emotional trust, in contrast, is an affective response to the other which may occur even in the absence of knowledge, or when what we know is unfavourable. Behavioural trust is a manner of acting towards the other, based on expectations of their behaviour, for example, performing a favour in the expectation that it will be returned. Such behaviour entails risk; individuals and institutions do not always respond as expected. Nevertheless, it is important in encouraging both cognitive and emotional trust and serves as a basis for cooperation in society (Kasperson et al., 1999).

These different kinds of trust may prevail in varying degrees according to the social context. For example, between family and friends, emotional trust may be high, whereas in relations with those outside the “in-group”, behavioural and cognitive trust may have more salience. This distinction is similar to Luhmann’s (1979) and Scwheer’s (1997) distinction between interpersonal trust, which operates in small, close-knit,

relatively homogeneous societies and systemic trust, applicable to bureaucratic institutions in modern, complex societies. It is also in line with Putnam's (1993) distinction between personal and social trust.

3.2.1. The social functions of trust

Sociologists perceive trust as fulfilling a number of functions in facilitating social engagement at both the micro (interpersonal) and macro (social) levels.

Trust reduces the complexity of decision-making (Luhmann, 1988), through the predictability and reliability of interactions (Misztal, 1996) and by allowing responsibility for understanding and managing certain kinds of risks to be relinquished to others. Thus, social trust is a simplifying strategy that helps individuals to cope with environmental complexity; for example, when a patient trusts a doctor to know about the alternative treatments available for a particular health condition, and to select the one that is most appropriate, or when individuals trust the health system to manage the risk of an epidemic; this in turn enables them to take advantage of a wider range of activities and social relationships (Earle and Cvetkovich, 1995).

Trust is also said to promote cooperation and collaboration, and hence, collective efficiency (Cvetkovich and Löfstedt, 1999). Of course, it may also lead to conflict, where trust is abused; this point is considered in a later section. Misztal (1996) offers a detailed analysis of the function of trust, asserting that trust promotes mutual respect among individuals with different interests and perspectives, solving the free rider problem and encouraging open-mindedness, which in turn facilitates communication and dialogue.

Studies in the past decade suggest that trust plays a number of central roles in the civic culture (Metlay, 1999). For example, it is said to influence how individuals perceive technological risks (Flynn et al., 1993); to catalyse regional economic development (Putnam, 1993); to facilitate interaction within organisations (Meyerson et

al., 1996) and to contribute to the political legitimacy enjoyed by democratic regions (Inglehart, 1990).

In this respect, trust is seen as associated with democracy, both promoting “meaningful public dialogue” (Kasperson et al., 1999:27) and being enhanced by such dialogue. Williams and Matheny (1995) relate the importance of public dialogue to the existence in society of a variety of parties with different interests, assumptions and frames of reference, which need to be identified and clarified in order for judgements to be made, on which trust will either be attributed or withheld – for example, in the health care system, the perceptions, needs and priorities of doctors, administrators and patients are likely to be different. Barber (1983) makes a similar point. Thus, sociologists perceive democratic contexts in which citizens have opportunities to acquire knowledge, or make independent judgements and act accordingly as contributing to building a “culture of trust” (Inglehart, 1997:165). Social trust, in turn, by encouraging a spirit and behaviour of social cooperation, is conducive to the smooth operation and governance of social institutions (Kasperson et al., 1999). The reciprocal relationship between trust and cooperation is captured by Putnam (1993) in the claim that “trust lubricates cooperation ...and cooperation... breeds trust” (p 171).

These rich webs of relationships and participation (White, 2001) within social networks, which promote coordination and co-operation for the benefit of their members (Putnam, 1995), are termed ‘social capital’. Some writers on this theme, such as Bourdieu (1972, cited in White, 2001) focus simply on the idea of social networks as a valuable resource, while others such as Fukuyama (1996) and Putnam (1995) emphasise the role of trust in this process.

In recent years, the concept of social capital has the attention of politicians, and the desirability of partnership and stakeholder involvement in, for example, public services has been a topic of debate. There have been two main, potentially conflicting

approaches to the notion of social capital, reflecting contrasting perspectives in social science. The neo-liberal strand is concerned with the importance of social trust in creating conditions conducive to economic renewal and problem-solving (Giddens, 1998). In contrast to this is the statist perspective, which views social capital in relation to other kinds of capital – cultural, economic and symbolic- and is concerned with the implications of the unequal distribution of social capital among members of society. It has been suggested (White, 2001) however, that these two strands actually represent stages on a continuum, in which both individual empowerment and social justice concerns are highlighted.

3.2.2. Factors influencing trust

Although trust is to some degree an expectation raised by the perceived qualities of the trustee, which may be confirmed or destroyed by the behaviour of the individual or organisation concerned, the propensity to trust is also related to the characteristics of the person bestowing or withholding trust. Education and age, for example, are important in two ways, as Westle (cited in Lange, 2001:35) pointed out. Elderly people tend to be more suspicious than younger ones. This may to some degree be a result of the lower quality of education quality of former times, since lack of education is connected to social helplessness. Indeed, perhaps helplessness is more to be blamed than a lack of education per se for suspicious behaviour. It is possible that for elderly people, a higher level of suspicion works as a protective shield.

Trust is also influenced by social rank. It is easier to establish a trustful relationship if both parties are on the same social level, with a so-called horizontal communication, than between members of different social levels (vertical communication). A vertical begging-for-confidence behaviour that goes upstream is often seen as an attempt to gain social status and reduce hierarchical distance, so an underlying good intention is overlooked (Putnam, 1993). A vertical begging-for-

confidence behaviour that goes downstream can easily cause suspicion that the superior means to sound out his subordinates or use them as his instruments in some other way. Such suspicions are not roused when two people of equal status are communicating. Thus, it is easier for people to communicate when they are on the same level.

When there are strong social relations within a group, members of that group will trust each other more easily. This can, however, have unwanted effects. Strong relations within a group can result in a strong mistrust of outsiders. Schweer (1997) argues that people who voluntarily become members of groups with strong internal relations are often more suspicious of outsiders than members of groups with loose internal bindings. He also advises that foreign members in certain groups have more social trust than others.

3.2.3. Social mistrust

A number of social theorists (Lipset and Schneider, 1987; Putnam, 1995) see a decline in levels of social trust in the second half of the twentieth century. Some, such as Lipset and Schneider (1987) attribute the cause to specific events such as Vietnam and Watergate – a view which may reflect the U.S context of their work; it is conceivable that the factors that induce mistrust may differ from one culture to another. Putnam (1995) however, considers mistrust to be a function of a decline in social networks. He perceives this as, to a large degree, caused by the ascendancy of the media, in particular, television, both because of the nature of the viewing activity, which does not require interaction with others, and because of the negative images conveyed in the media, which encourage cynicism and suspicion. On the other hand, social mistrust may be a rational response of individuals and groups who find that the institutions they have trusted to meet their needs have failed to do so (Breyer, 1993).

In Bristol, a public inquiry was launched following concerns about high death rates in paediatric cardiac surgery, with the result that one of the surgeons involved and

a radiologist who was at the time chief executive of the hospital, were struck off the medical register (Walshe and Offen, 2001). Inquiry is still ongoing into death certification procedures, following the conviction in 2000 of Dr Harold Shipman for the murder of 15 of his patients, and subsequent discovery that the actual number murdered by him was probably more than 200 (Checkland et al., 2004). Other scandals that have contributed to reduction of public trust in health service include a furore over inadequate screening of blood products in France, and the death of a journalist in the USA as a result of a fatal overdose of chemotherapy (Checkland et al., 2004). In addition to these high – profile scandals, erosion of public trust in healthcare has been ascribed to increasing pressure on NHS budgets (Taylor-Gooby and Hestie, 2003) and a general change in social and cultural values, such as the overall decline in deference to authority and increasing reliance on personal judgments (Beck, 1986; Giddens, 1991).

Checkland et al., (2004) make a distinction between public confidence and public trust. They see the former as related to perceptions of the ability of systems to manage and deal with potential risks, for example, through regulation. Public trust, in contrast, is more to do with individual experiences and interpersonal aspects of care delivery, and with moral choices in the face of uncertainties. Research suggests that it is the former that is being eroded.

Calnan and Sanford (2004), for example, in a survey of public trust in healthcare in England and Wales, found that distrust was highest in relation to the macro level issues of organisation and provision, particularly in relation to waiting times and the impact of cost-cutting. In other words, their distrust was in systems, rather than individual practitioners.

Social mistrust may not be wholly negative, but may contribute in the imposition of checks on the power of economic and technical elites. For this reason, Kasperon et

al. (1999) argue that an appropriate balance between trust and mistrust is to be desired, rather than simply the maximization of social trust.

The UK public's distrust of government is, in general, extremely high (Social and Community Planning Research, 1995, 1997), a feeling expressed, for example, in widespread allegations of the government's lack of concern over BSE and Gulf War Syndrome (Löfstedt and Horlick-Jones, 1999) and more recently the "foot and mouth" crisis. According to some commentators, public distrust in central authority has been made worse by a sense of alienation. During the BSE scare, for example, media coverage expressed the feeling that the public had been treated as 'ignorant, stupid and innumerate' (*Independent*, 1996).

Feelings of social mistrust and the anger they generate can be explained in part by the complex relationship between trust and dependency. Wynne (1996) argues that lack of explicit social dissent may not always indicate the existence of trust, but may simply be a function of the social reality of dependency. Lay people, for example, are all too aware that they rely on experts to protect them from health, financial and other risks. For this reason, they are concerned about indications that this 'quasi – trust' is, or is not justified. When the institution does not conform to expectation, the lay-person not only feels his/her trust has been betrayed, but is angry with him/ her self for "allowing" dependency on an unworthy institution (Bradbury et al., 1999).

Suspicion, whether justified or not, can lead to a vicious cycle: The lack of social trust causes a rejection of the political system; those who do not trust the political order are not willing to participate in it and thus do not find a way to accommodate their conflicting interests; again, this leads to a lack of feeling acknowledged and a confirmation of one's suspicion.

3.3. The Psychological Perspective of Trust

3.3.1. What is trust?

Over time, authors have offered a variety of definitions of trust (Bradbury et al., 1999). However, a useful framework for understanding the psychological perspective of trust is that of Lewis and Weigert (1985) who see trust as a social and relational construct encompassing several components or dimensions: cognitive, affective and behavioural.

The cognitive dimension of trust involves a process of judgement formation, in which attributions of trustworthiness are made or withheld on the basis of available information. Such attributions are influenced by the trustor's perceptions, based on evidence, that the trustee is technically competent (Kasperson, 1986; Kasperson et al., 1992); unbiased (Renn and Levine, 1991) honest and open (Peters et al., 1997).

The affective dimension is concerned with trust as a relational construct – an emotional bond experienced between individuals or members of a social group, based on familiarity and reinforced by shared values (Earle and Cvetkovich, 1995; Kramer and Tyler, 1996).

As a behavioural construct, trust is concerned with expectations as to how others will act, which in turn influence the behaviour of the one who offers or withholds trust. It includes such behaviours as dedication, commitment and care (Kasperson et al., 1992; Covello, 1992).

3.3.2. The attribution of social trust

Although, as indicated previously, the decision whether or not to confer trust is based to some extent on knowledge of the person concerned (Cvetkovich, 1999), in practice it is rarely, if at all, that full information is available on which such a judgement may be made. Humans therefore interpret the evidence available to them in the light of stored social knowledge (Bruner, 1958). It has been proposed that a key element of this process is the perception of a commonality of values between the observer and the

person or institution observed. In other words, attributions of trustworthiness tend to be bestowed on those perceived as reflecting certain values judged by the observer to be important in their decisions and actions in particular sphere (Earle and Cvetkovich, 1995).

Support for this theory, termed the Salient Values Similarity (SVS) hypothesis, is offered by Earle and Cvetkovich (1999) based on an experimental study. According to their responses to a questionnaire, over 400 participants were scored on three categories of cultural theory (Dake and Wildavsky, 1990): Egalitarian, Individualistic and Hierarchical, and assigned to one or other of these categories based on their relative scores. Participants were also asked to read short messages in the form of simulated newspaper stories. The first part of each story concerned the proposed establishment of a new Nuclear Waste Management Agency (NWMA). The second concerned the decision – making process to be used by the (fictional) agency. This second part was prepared in three forms, each form reflecting the relevant values of one or other of the three cultures. The alternative versions of the text were distributed to respondents at random. After reading the passage, participants were asked to complete a six-item scale which measured their attitudes towards the NWMA, in terms of their perceptions that the new agency shared their values. They were also asked to rate, on a scale of 1 to 7 (from ‘completely’ to ‘not at all’) the extent to which, based on the ‘article’ they had read, they would trust the NWMA. There was a high correlation ($r = .66$, $p < .001$) between trust ratings and scores on the measure of perceived values. Moreover, trust values and attributions of social trust were highest where the stories assigned to respondents reflected their own culture categories: Egalitarian, Individualistic or Hierarchical.

The findings led Earle and Cvetkovich (1999) to conclude that social trust is associated with group membership. Individuals are predisposed to trust others who are,

or are perceived to be, members of the same in – group and are less inclined to trust those outside the group boundaries.

3.3.3. The propensity to trust as a social attribute

Psychologists, like sociologists, have seen the propensity to trust as being, in part, shaped by the characteristics and experiences of the trustor.

Social isolation, for example, has been said to breed suspicious tendencies. Zimbardo and Leippe (1991) examined the behaviour of the geriatrically deaf guests of an old people's home. They found that deafness, especially when it is not noticed, keeps people from communicating with others and causes problems similar to those of people who do not speak a foreign language, and have difficulty understanding non-familiar, institutionalised jargon. In these cases, suspicion grows from communication barriers.

Suspicion is also a unique feature of one's character. The tendency for suspicion is different in different people. Psychologists are trying to measure such characteristics. As Lange (2001) reported, scientists in Arizona State University have found that people who lie and cheat themselves suspect the same in others. Such behaviour is easily reinforced. People who interact suspiciously will experience discomfort and legitimate their own abnormal attitude by believing that others' intentions are hostile. Their view of the world is determined by their mistrust in other people and institutions. Those people seek out information which sustains their paranoid view of the world. They readily consume media reports about cunning fraudulences and assaults, stories that appear to prove that helpfulness and kindness do not pay but will be unashamedly abused.

People differ in the degree of difficulty they have in deciding who they can trust and who not. According to Lange (2001), there is a faculty of discrimination that some scientists believe to be part of social intelligence, which is possessed by people who trust rather than people who do not. This would explain how it can be possible that

some people always fall for simple tricks. They are obviously not suspicious enough when they think they can get something for free or without having to make an effort. People who are gullible in this way are likely to have their trust abused and may then lose confidence in their judgement. In fact, those who can receive suspicious signals and know how to interpret them can trust better. The most important characteristic that comes with the ability to trust is self-confidence. Those who trust in themselves, good intentions and motives included, will trust in others as well. Lange (2001) asserts that those who are not self-confident will always be seeking for treacherous motives.

3.3.4. The asymmetry principle

While trust is created slowly and may require many confirmatory instances of trustworthy behaviour in order to be established, it is destroyed much more readily – a single mishap or mistake may suffice – and once lost, may never be regained. As Innes (2003a:17) argues, “Trust is gained incrementally but lost catastrophically”. Slovic (1999) refers to this imbalance as the asymmetry principle.

There are several reasons why the human psyche is more inclined towards distrust than trust: the greater visibility or higher profile of trust – destroying events, such as discoveries of mismanagement or negligence, than of positive (trust – inducing) events such as the safe, uneventful operation of a piece of equipment; the greater influence on attitudes of negative, as opposed to positive events (Slovic et al., 1993, cited in Slovic, 1999); the greater credibility attached to sources of bad news than good news (Kraus et al., 1992); and the self – perpetuation of distrust by inhibiting relationships which would allow trust in the competence or good intentions of the object to be re-established, and by colouring the way events are perceived and interpreted (Slovic, 1999).

3.3.5. Trust, power and control

Trust is an expectation about a relationship (Cvetkovich and Löfstedt, 1999), either with a particular individual, or with members of a particular group. The characteristic of trustworthiness is attributed based on an expectation of how the trusted individual or group will behave relative to the interests of the one who trusts. It is thus inevitably bound up with issues of power and control.

According to Cvetkovich and Löfstedt (1999), trust implies an asymmetry in power relations. In the NHS, for example, an imbalance of power between professionals and clients exists, *inter alia*, because of the possession by professionals of specialised knowledge (Checkland et al., 2004). Given the complexity of the body, the speed of technological development and changing patterns of disease, it is difficult for lay people to understand medicine, so they have no option but to trust (Houldcroft, 2003). The trustor, in yielding control over decisions and behaviour control to the trustee, takes up a dependent position. Cvetkovich and Löfstedt (1999) note, however, that this does not necessarily cause the trustor to feel weak and powerless, because bestowing trust does not mean relinquishing all forms of control; rather, a trade-off occurs, whereby in exchange for relinquishing behavioural and decision control, to the trustee, the trustor gains cognitive control (for example, thinking that a health risk will be controlled) and secondary control (choosing where his/her trust will be bestowed).

An implication of the yielding of control and consequent subordination involved in trust is that it involves a risk that one's trust will be violated. Thus, there is another trade-off wherein a primary physical risk (how to protect oneself from a given hazard) is traded for social risk (the possibility that the trustee may not be trustworthy) which is followed by a further physical risk (if the trusted person / organisation is not trustworthy, the expected protection may not materialize).

Thus, trust is a mechanism for risk management. To trust somebody reduces our doubts and fears. There is a deep psychological need for trust at times of vulnerability (Cohen, 2007). According to Luhmann (1988), mastering life is mainly composed of the reduction of its complexity. Since we cannot check everything ourselves and are thus unsure, we have to follow advice and rely on it. This gives us an opportunity to partly reduce our responsibility. We delegate a portion of liability for action to others who are to be trusted, but we also have to be willing to face the consequences of this act. Within this willingness to face consequences lies our vulnerability when we trust.

This applies both at the individual and institutional levels. Trust and suspicion are not aimed solely at individuals, but also at institutions, organisations, groups and nations. One can have faith (or not) in the constitutional state, in the social market economy, in scientific progress, or in the politics of a certain party. Nevertheless, there is a difference between trust in people and in institutions, namely, mutuality. Persons can trust each other, and only then will their trust be permanent and grow. Trust in an institution cannot be responded to personally. As Kasperson et al. (1999) comment, social distrust holds powerful organisations in check, generates control mechanisms and encourages realistic appraisal of the performance of elites and institutions. Thus, they conclude that a certain level of social distrust is desirable to enable a democratic society to function.

3.4. The Business Perspective of Trust

In the last two decades, there has been a growing interest in trust in the business literature, which has drawn heavily on the sociological and psychological perspectives.

Organisational scholars have viewed trust as a mechanism of organisational control, in a number of respects: as an alternative to price and authority (Bradach and Eccles, 1989), as a reaction against opportunism in transaction cost economics (Bromiley and Cummings, 1992, cited in Creed and Miles, 1996); as a key factor in

managerial philosophy (Sitkin and Roth, 1993) and as a necessary element in the operation of network forms of organisation (Miles and Creed, 1995). In the management literature, trust has been recognized as a major issue in building supplier relations (Business Week, 1992, cited Creed and Miles, 1996), as a basis for problem-solving (Malnight, 1989) and as a means of promoting growth and success in the IT industry (Yoffie, 1984).

In the business field, researchers have recently highlighted the central role of trust as an essential feature of effective cooperation within and among organisations (Powell, 1990; Ring and Van de Ven, 1992; Kramer, 1993).

At the same time, a second strand of research has focused on the increased 'legalization' of organisational activities (Edelman, 1990; Sitkin and Bies, 1994) whereby formal organisational mechanisms have been applied as substitutes for interpersonal trust. Such studies provide conflicting evidence of the role of formal controls; they may promote trust (Sitkin, 1995) or they may be impediments to trust (Sitkin and Roth, 1993), although the relationship between formal procedures and standards and the erosion of trust has been outlined in only general terms.

Some researchers (Zucker, 1986; Sitkin and Bies, 1994) have suggested that one motivation for adoption of legalistic mechanisms is to repair changed trust. In the view of Sitkin and Roth (1993), however, the effectiveness of this approach depends on the clarity of task requirements, enabling inputs, transformation processes and outputs to be identified. However, if there is uncertainty as to the nature and scope of the task at hand, or a lack of shared values, applying formal control mechanisms may simply have the effect of creating or intensifying feelings of difference, leading to widespread feelings of distrust.

This section explores a number of key themes in the business literature on trust: types of trust in business relationships; dimensions of trust and the concept of

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trustworthiness as a management competency; the relationship of trust to organisational form and management philosophy; the impact of trust on organisational behaviour, and issues of mistrust in organisations.

3.4.1. Types of trust in business relationships

According to Shapiro et al., (1992), three kinds of trust are involved in the development of a business relationship: deterrence - based, knowledge- based and identification-based. In the first, certain behaviours are expected of the trustee, on the basis that sanctions will be invoked if the required behaviour is not sustained. In the second, attributions of trustworthiness are made based on available evidence which enables the likely behaviour of the trustee to be predicted. The third kind of trust is the outcome of an emotional bond characterised by understanding, empathy and shared values. Lewicki and Bunker (1996) offer a similar typology, although they use the term, calculus-based trust, to refer to the first type. They also propose that the three types of trust are linked in an iterative sequence whereby trust evolves, achievement of each level facilitating development of trust at the next level. They are at pains to point out, however, that this is not a normative model. They do not claim that any stage is better than another. Relationships have different purposes and, accordingly, most people have relationships of each type, depending on the context. Many business relationships, for example, never evolve beyond the calculus-based stage.

3.4.2. Dimensions of trust and the concept of trustworthiness

Because of the risk involved in transaction, managers must concern themselves with the trustworthiness of the other party (Ring and Van de Ven, 1992). In the context of fiduciary relationships, trust is said to be based on belief in the professional's competence and integrity (Lieberman, 1981). Mishra (1996), based on a review of the trust literature, views trust as encompassing four dimensions: competence, openness,

concern and reliability. He then goes to explore the salience of these dimensions in the organisational context.

Competence is a major part of the trust placed in subordinates by managers. At the same time, managers themselves are judged – and trusted, or not- on their competence in decision-making. Competence - based trust also arises at inter-organisational levels, for example, when a buying organisation feels assured of the ability of supplier to meet its quality standards. Other writers have referred to a similar concept under the term, ability. *Ability* is a group of skills and competences that enable a party to have influence within some specific domain. Because ability is domain specific, trust is domain specific (Zand, 1972). For example, an individual may be trusted to perform a technical analytic task, but not to initiate contact with an important customer (Mayer et al., 1995). Safran (2007) in a health care context interpreted this dimension as the practitioner's clinical knowledge and skills.

The concern dimension of trust refers to the expectation that a relationship will, at the very least, not be abused by one participant to the detriment of the other, and ideally that the self – interest of each party in a relationship will be moderated by concern for the well-being of others. Again, the concept is referred to in various ways. An alternative term sometimes used is *Benevolence*, which Larzelere and Huston (1980) define as the extent to which a trustee is believed to want to do good to the trustor. Safran's (2007) concept of doctor as patient's fiduciary agents', implying that doctor the will act in the patient's best interests, falls into this dimension.

Reliability refers to consistency between words and action. Mishra (1996) notes that reliability has often been cited as a salient factor in assessments of leaders' trustworthiness.

The latter dimensions, concern/benevolence and reliability are in some writings combined under the theme of Integrity. *Integrity* is concerned with the trustor's

perception that the trustee adheres to a set of principles that the trustor finds acceptable (Mayer et al., 1995). Integrity has been seen as a prerequisite for trust by Lieberman (1981) and Butler and Cantrell (1984) among others. Safran (2007) took integrity as one of her criteria for trust in health care, defining it as honesty, truthfulness, confidentiality and open communication. Sitkin and Roth (1993) also related trust to beliefs and values, but focused on congruence between the values of the employee and those of the organisation

3.4.3. Trust in relation to organisational form and managerial philosophy

Creed and Miles (1996) suggest that the levels and kinds of trust operating in the business context are directly linked with the form of organisation and with prevailing managerial philosophies. Levels of organisational trust are significantly influenced by managers, because it is they who define and implement rewards and sanctions, which are likely to be perceived as conveying messages of trust or distrust, and because they have control of most sources and channels of information (Pfeffer, 1992). Managers' core beliefs or philosophies, which are institutionalised attributions about the trustworthiness and reliability of subordinates, particularly the extent to which they are considered capable of responsible self-direction and self-control, set the tone of trust or distrust for the organisation as a whole. Creed and Miles (1996) trace the evolution in such philosophies from the basically distrustful traditional 19th century philosophy, which emphasized the limited competence of subordinates and incongruence of values between managers and employees, towards more trusting human resources perspectives, which assume greater need and potential for achievement and creativity.

In Creed and Miles' (1996) framework, each of these managerial philosophies is associated with a typical organisational form; entrepreneurial, functional, divisional, matrix and network, each with its own trust implications. Whilst, in any form of organisation, the level of trust or distrust could have an effect on morale, Creed and

Miles are more concerned with the impact on operations. From this perspective, they argue that an entrepreneurial firm has no specific trust requirements. The functional form, however, depends on short-term delegation of operating responsibility to functional specialists, and a certain level of trust in employees' capability, responsiveness and cooperation is needed in order to benefit from their expertise. In a divisional firm, corporate managers must trust not only the capability of divisional managers, but also that their values are congruent with those of other divisions and of the corporation as a whole. In matrix organisations, they argue, trust is seen in the degree to which mechanisms are created for decision-making at project levels, and in the extent to which mechanisms are allowed to function autonomously.

They perceive the greatest need for trust, however, in network organisations, where trust in and respect for the reciprocal relationships between upstream and downstream partners are crucial. Trust failures, depending on the form of organisation, can have various consequences, from reduced efficiency to the total failure of the firm.

3.4.4. Trust-based forms of governance (trust as a basis for network function)

Powell (1996) describes several ways in which trust –based governance can be operated in a various kinds of organisational network, although the source of trust is different in each, as follows:

1) Industrial districts :

These are networks based on ties of place and kinship. The matrix of production in the region, rather than the individual firm. Typically, firms are grouped in zones according to their product, and work is carried out through extensive collaborative subcontracting agreements. Risk is attenuated through the building of a cooperative infrastructure. In such regions-examples can be found in north central Italy and south-western

Germany (Piore and Sabel, 1984) – trust is based on norms of reciprocity and civil engagement (Putnam, 1993).

2) Research and development Partnerships :

In this kind of network, initial commitment to a relationship is generated by common membership in a professional / technological community (Powell, 1993, cited in Powell, 1996). Such membership allows sustained contract outside of commercial relationships, enabling reputation to be built and information to be exchanged. Von Hippel (1988) gives an example of technological cooperation among engineers in a segment of the steel industry, showing how costs were reduced and innovation facilitated as a result.

3) Business groups :

The business group is a network of firms that regularly collaborate over the long term, the best-known examples being the Japanese *keiretsu* and Korean *chaebol*. In these alliances, trust is built on shared historical experiences and obligations (Dore, 1987) and advantages of group membership.

4) Strategic alliances:

In contrast to the other three forms of network, in which trust arises through proximity and common membership, strategic alliances are calculatively formed as a result of mutual dependencies. In the absence of “natural” bases of trust, they tend to rely on contractual arrangements to safeguard against opportunism.

Nevertheless, Powell (1996) admits that such a typology is over-simplified. Culturally homogeneous regions do not necessarily display high levels of trust; while rational calculation may not provide a sufficient basis for trust within business groups

and alliances, since outcomes are not always consistent with expectations and motives (Baier, 1986). Powell concludes that trust is not always a response to calculation or cultural norms, but can be developed through learning, experience and communication.

3.4.5. Trust and organisational behaviour

Trust both between managers and subordinates and between the organisation and its customers, according to Mishra (1996), influences three key aspect of organisational behaviour: decentralized decision-making, undistorted communication and collaboration.

1) Decentralized decision-making

Delegating decisions to other involves dependence as a result of the ceding of authority. Acceptance of dependence and risk is the essence of trust. Democratic decision-making, however, depends not only on managers' trust in subordinates, but on subordinates' trust in management; employees are more likely to be willing to commit themselves when they perceive their leaders as trustworthy.

2) Undistorted communication

Trust is expected to increase truth and openness in the communication of information whereas, in a situation of suspicion and distrust, information is more likely to be withheld, or used in a deceptive fashion, for fear of punishment, or of the information being abused.

3) Collaboration

Collaboration is behaviour that is both cooperative and assertive, seeking to satisfy jointly the needs of parties that would otherwise be competing or conflicting. Trust has been found to be a *critical factor* facilitating such behaviour. Collaboration requires trust, both that the other party's information is reliable, and that the party's intentions are not exploitive. Trust encourages mutual reliance, as well as acceptance

of the other party's judgements, when these are seen to be grounded on competence and knowledge.

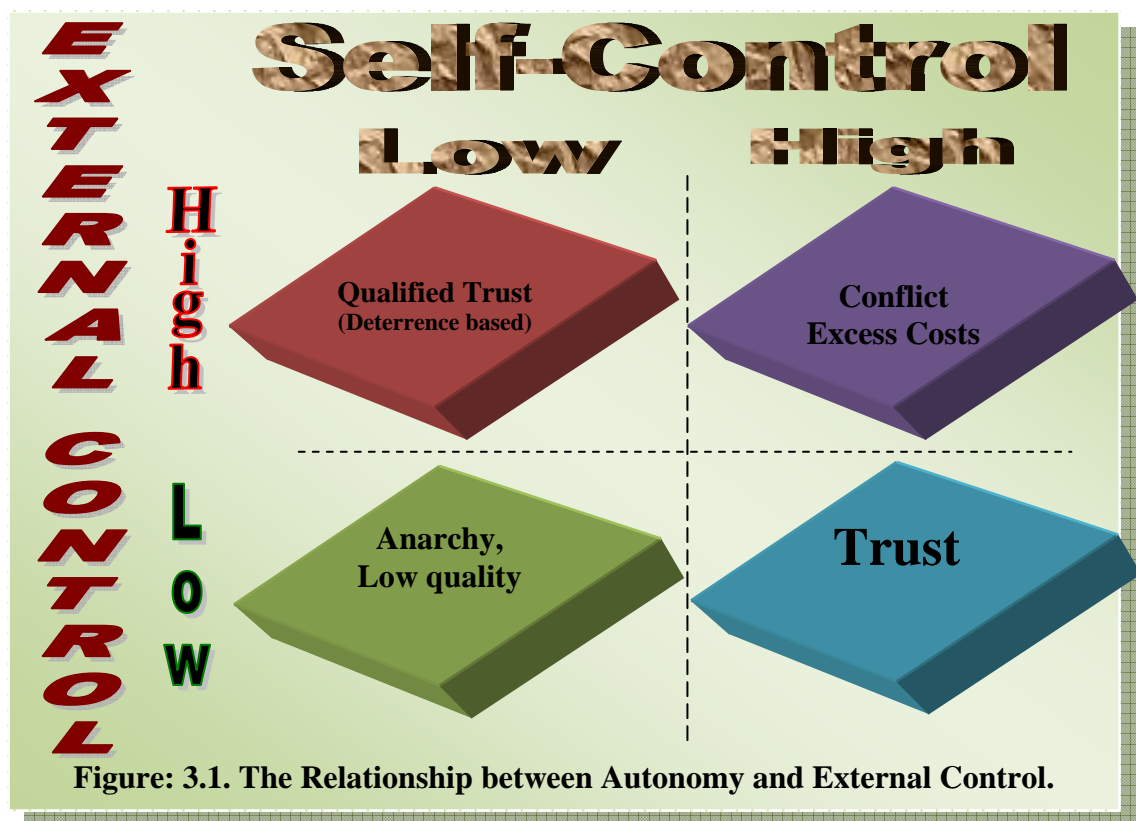
These are reciprocal relationships. While trust encourages these key behaviours, the outcomes will in turn either vindicate that trust or suggest that it has been violated, in which case trust may be withdrawn. Whether or not trust is maintained will depend on how the actions of the trustee impact on organisational resources, and how far the trustee's competence, good will and integrity are believed to influence organisational outcomes.

3.4.6. Trust and control

One aspect of organisational behaviour that has been considered as particularly related to issues of trust is the application of formal control mechanisms. Since any business or service actively involves reliance on others in the pursuit of personal and organisational goals (Mayer et al., 1995) the parties incur risk. One way of reducing risk is to implement controls intended to encourage compliance with desired norms and behaviours, or to deter (with the threat of sanctions) deviations (Meyer, 1983; Sitkin and Bies, 1994). In the modern business environment where workforces are increasingly diverse (Jackson and Alvarez, 1992), there is a move to more participatory management styles and much work is structured around teams (Lawler, 1992). Whereas this is the case, such control mechanisms may not be feasible or may be ineffective. In such a situation, trust is an increasingly salient issue (Larson and LaFasto, 1989), since a substantial degree of autonomy is only likely to be conferred on an individual or work group where there is trust.

Figure 3.1 below illustrates four possible conditions of the relationship between autonomy (understood as self-control) and external control. Where self-control is low and external controls high, there will exist what might be called a qualified trust, equivalent to deterrence – based trust (see 3.3.1.); that is, people are trusted only in so far as there are rules and mechanisms to govern their behaviour, and punishment for

defection. The converse situation (high self-control/ low external control) implies and encourages trust. The remaining positions on the matrix represent undesirable situations for the system: high self-control combined with high external controls is likely to result in conflict (an example has been cited in relation to TQM, see chapter two) and excess cost. Where both self-control and external control are low, quality will be threatened.



The control vs. trust dilemma is well illustrated by the debate on recent developments in the NHS, which is increasingly adopting a 'business' perspective, under pressure of resource constraints and concerns about accountability and efficiency. Davis et al. (1999) interpret these concerns in terms of a 'principal – agent' relationship, where health service managers are both agents of the government, and principals in relation to clinic staff (as agents) in achieving the goal of patient health. Because the various participants in the system have different areas of expertise, and different beliefs and concerns, a need is perceived for control systems to ensure that agents perform in line with principals' requirements and expectations. Such approaches generally involve measuring selected behaviours/ outcomes and monitoring agents' performance.

However, problems arise as to what to measure, and how to interpret and use the information.

One of the goals of recent reforms in the NHS and the creation of the internal market was to introduce a form of managed competition which, it was assumed, would produce efficiency gains. This approach entails extensive use of performance indicators which, in theory, will enable purchasers and users to assess the efficiency with which resources are being utilized.

In an attempt to make performance indicators serve public accountability goals rather than purely managerial objectives, performance tables have been produced specifically relating to guarantees in the Patients' Charter. This approach has, however, been severely criticised by, for example, Lally and Thompson (1999) who cite the example of the indicator, percentage of patients assessed within five minutes of arrival in the Accident and Emergency department to show that the data on which league tables are compiled are not comparable ("assessment" may vary greatly in duration and scope) and that focusing on what is easily measurable may lead to less tangible but nonetheless important aspects of service quality being ignored or even undermined. Ludbrook and Gordon (1999) make similar points in relation to waiting time targets, which may encourage prioritisation of less urgent cases which can be dealt with quickly and easily. Indeed, it has been claimed that in order to meet the targets, managers resorted to a variety of dubious strategies, such as cancelling routine operations, inappropriate admissions to hospital, and rapid transfer out of A & E departments (Carvel, 2003).

The new quality assurance measures introduced into the UK health service can be seen as representing a shift away from accountability based on professionalism and reflective practice, towards accountability based on surveillance and rules (Checkland et al., 2004). In Powers' (1997) view, reliance upon formal performance audits, by implying distrust in professionals, will actually create such distrust.

In contrast to this control – based approach, however, in many other ways the NHS service relies on trust, which underlies the basic principle of professional self-regulation within medicine, compensates for the impossibility of measuring, monitoring and verifying all aspects of agents' performance and motives (Davis et al., 1999), and can be perceived to lie behind the recent work on the operation of the community care market (Mannion and Smith, 1997).

3.4.7. An integrative model of organisational trust

Mayer et al. (1995) draw on sociological and psychological themes to offer a model in which trust is seen as dependent on both the characteristics of the trustee (ability, benevolence and integrity) as perceived by the trustor, and of the trustor's propensity to trust. Parties in business relationship compare the level of trust between them with the level of perceived risk in a given course of action; the outcome determines their willingness or otherwise to engage in risk taking behaviour, such as delegating a critical task to a subordinate, or demonstrating exceptional effort or commitment without certainty of reward.

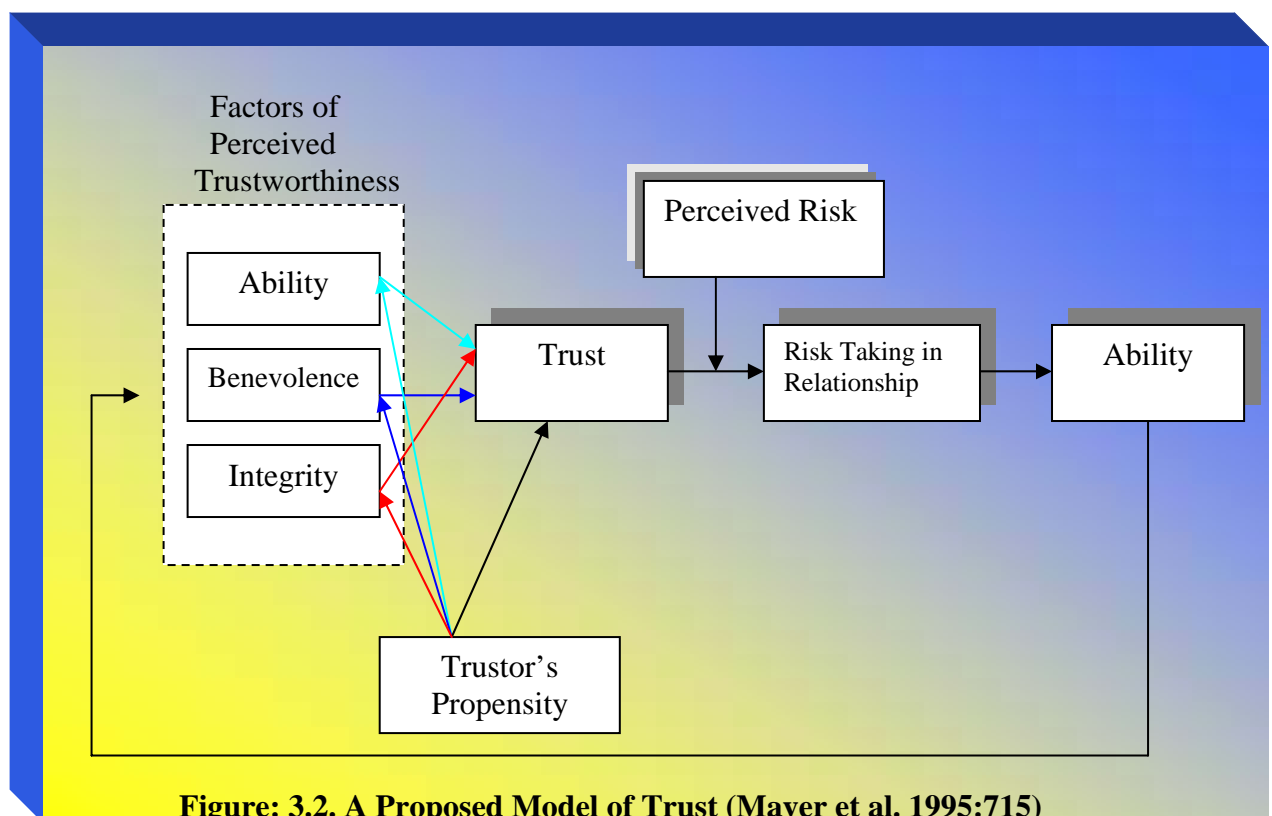


Figure: 3.2. A Proposed Model of Trust (Mayer et al. 1995:715)

Both the need for trust and the evaluation of trustworthiness are affected by the context of the relationship, such as the balance of power in the relationship, the alternatives available to the trustee, and information about the context of the other party's actions.

The suggestion by Mayer et al. (1995) that integrity, benevolence and ability are basis factors that underlie trust has been criticised by Tinsley (1996). He argued that trust should be viewed purely in ethical terms, a view also taken by Hosmer (1995) and Jones (1995). From this perspective, integrity and benevolence, both of which have ethical connotations, would be encompassed within the concept of trust. Ability, however, in Tinsley's view should be separated from trust, and integrated into a concept of capabilities. This, he argues, would be useful in dealing with organisational stakeholders, facilitating analysis of personal competence factors, including innate ability and developed capabilities such as expertise and judgement. As the separate concepts of trustworthiness and competence become better defined, Tinsley suggests, they can be integrated into a model of source credibility, which he considers more 'proactive' in its implications. Under such a concept, managers, employees and other stakeholders would judge a message by asking whether the sender's trustworthiness and competence lend sufficient credibility to the message for it to be relied on and acted upon.

In his critique of the work of Mayer et al. (1995), Tinsley (1996) also argues the need for theories of trust to consider more deeply the problems of extending trust to organisations and groups, rather than specific people. Trust in an organisation implies that one or more members of it will act in a manner that meets expectations. The chances of this happening will vary, depending on which specific individuals in the organisation have responsibility for performance. A change in the personnel holding certain roles may lead to a change in levels of trust.

Mayer and his colleagues (Davis and Schoorman, 1996) responding to Tinsley (1996) dispute the notion that benevolence is an ethical concept, insisting that it is, rather, a quality of a relationship. Regarding Tinsley's comment that a person may be high in capability yet low in trustworthiness, and vice versa, they do not see that as invalidating that model. They do not claim that capability is necessarily equated with trustworthiness, but that both factors will be taken into account in making a judgement, and the outcome will be a statement about trust. Thus, although Mayer et al. (1996a) accept that for some purposes it may be useful to separate ability from other antecedents of trust, they stand by their assertion that in other situations, they act in a cumulative manner.

A further critique of the model of Mayer et al. (1995) focuses on its concentration on the dyadic relationship between trustor and trustee. Wekselberg (1996) points out that trust issues arise in relationships not only between individuals, but also in relationships involving groups and broad social entities. Moreover, even dyadic relationships take place in a wider social context. The decision of a supervisor to trust an employee with the handling of an important account, for example, has implications not only for the supervisor and employee, but for the whole organisation.

As an alternative approach, Wekselberg (1996) advocates analysis of social phenomena based on cooperative interaction. In this approach, participants are linked, not only through what they do to each other, but through what they do to the interactions, all interaction are analysed in their social context, and the focus is on shared meaning, rather than individual meanings. From this perspective, trust is viewed as a belief that other participants of an interaction share common goals and will participate in actions towards these goals. Trust within organisations will depend not only on the characteristics of individuals, as Mayer et al. (1995) appear to suggest, but also on broader organisational processes and structures, such as the level of

participation of organisation members in creation of organisation goals. However, Mayer et al. (1995) view trust from a 'social influence' perspective, which focuses on the examination of relationships at the dyadic level.

Mayer et al. (1996b) view as a false dichotomy the choice between social influence and social interaction perspectives implied by Wekselberg (1996), suggesting, rather, that an understanding of relationships at the dyadic level (social influence) is an essential step towards a broader understanding of the concept. They do not dispute that social context has an impact on trust, but question Wekselberg's implied assumption of the existence of an objective social reality. Social context is, like the characteristics of the trustee, a function of the perception of the participants. In any case, Mayer et al. (1996b) argue, the notion that levels of trust may be affected by variables such as organisational culture (for example autocratic versus participative) does not invalidate their model, but merely adds moderators to it.

3.4.8. Mistrust in business organisations

As previous discussion has shown, the decision to trust involves a willing submission of vulnerability to another, in the expectation that the relationship will bring benefits (Parkhe and Miller, 2000).

When the expectations on which trust is based are violated, trust is disrupted, producing a sense of confusion (Zucker, 1986). This, in itself, may not lead to distrust. However, when the suspicion arises that the disruption of expectations is likely to be generalized to other exchanges, distrust arises (Parkhe and Miller, 2000).

Bies and Tripp (1996) using a "critical incident" methodology with a sample of 90 MBA students investigated ways in which distrust might be engendered in the workplace, and the possible outcomes in terms of victims' response. Trust violations reported by the respondents fell into two main categories: those that violated the "civic order" of rules or social obligations; and those that impugned the victim's social identity

or reputation. The former category encompassed three sub-categories: rule violation (including breach of contract and changing rules “after the fact”); honour violations, such as job responsibilities, stealing ideas, or breaches of confidence; and abusive authority. Identity-related violations included public criticism, unfair accusations, and personal insult (including gender or race-related insults).

Victims responded to such violations in a number of ways. In some cases, criticism led to a determination to work harder to make the critic “eat his words”. More often, however, violations of trust had negative consequences both for the relationship concerned, and for the organisation as a whole: withdrawal of help and support, loss of motivation and reduced work effort on the part of the victim, unauthorized use of company resources, litigation and even violence. Occasionally, victim and perpetrator became caught in a series of actions and counter-actions, causing the feud to escalate out of control.

Sitkin et al. (1994) showed how mistrust could be engendered by inappropriate imposition of highly formalized management controls. In their study of a TQM programme in a corporate basic research laboratory, discussed in chapter two, they found that the introduction of precise measurement tools and standardized problem solving procedures exacerbated prevailing tensions between laboratory staff- who thought these measures undermined their creativity and reflected lack of understanding of their role – and managers who viewed the laboratory staff as uncooperative and unwilling to tackle issues systematically. Perceived incongruence of values between the two groups and damaged professional pride led to a prevailing climate of distrust.

Kramer (1996), who widely examined paranoid ways of thinking in organisations, speaks of a “cognitive asymmetry” between trust and suspicion, meaning that trust is more easily destroyed than suspicion. Suspicion insures against abuse, damage, and disappointment and there are no obligations connected to it. But there is a

certain disadvantage: one cannot easily tell when one is wrong. On the other hand, people can learn from trust. It quickly becomes evident if one was right or wrong. It is not possible to learn from mistrust, because suspicious people will not even give anyone a chance to prove their good intentions. When they are offered help, they suspect evil intentions, they cannot recognize others' competence, and do not like to be obligated to repay a favour, let alone make advance concessions, which are a normal thing in trusting relationships.

Before damaged trust can be repaired, the violator must recognize and acknowledge that violation has occurred, determine the nature of the violation, admit that the act was “destructive” of trust, and accept responsibility for the violation (Lewicki and Bunker, 1996). The next step is for the victim to request or the violator to offer some token of appeasement (an apology and /or some form of redress) as a basis for forgiveness and the rebuilding of trust.

3.5. The Philosophical Perspective of Trust

An important contribution to the philosophical understanding of trust was made by Goffman (1959) whose work subsequently influenced Habermas and, through him, writers on Critical Systems Thinking (CST).

Goffman (1959) viewed personal (individual and group) relations from a symbolic interactionist perspective. Dramaturgy is the study of the structure and effect of Drama, the form of literature in which the actor tries to manifest in words and action something of his/her subjectivity, such that the audience perceive him/her in a specific way and accept the ideas he/she tries to convey.

Goffman viewed human interaction, in “dramaturgical terms” as a “performance” designed to create “impressions” of the actor in the perception of the audience. Such interaction and the associated exchange occur during the courses of an “encounter” with an audience. In other words, by bringing to the fore something of

his/her subjectivity, the actor aims to be seen by the audience in a particular way, and so create a social identity for him/herself.

The actor who wants to bring his subjectivity (subjective world) into the social objectivity (objective world) should, first of all, be convinced of what is he trying to bring (the idea), and incorporate certain parts of reality in her/ his acting, in order to gain the trust of the public. Through persuasion and trust, the public will be enabled to accept the product of the actor and transfer it into their social objective world.

From this perspective, an actor can only be said to “have” desires and feelings in the sense that he or she can express them to an audience – and in such a manner that the audience trusts the actor’s “performance” and so attributes to him/her the feelings expressed.

Of course, actors giving a ‘performance’ may be sincerely conveying actually felt perceptions and beliefs – or they may be consciously and cynically manipulating the perceptions of others in order to present an image consistent with particular norms and values. In this respect, the concept of social identity is similar to that of the ‘front’, a stable aspect of performance by which the actor fulfils the duties of a given role and communicates that role consistently to others, so that the performance defines the role and what it means for the audience. Goffman points out that actors may seek to legitimate their social role by deliberately displaying socially desirable characteristics, whether or not they reflect the actor’s private behaviour. This, in turn, raises the question of the actor’s sincerity, which is open to challenge; in other words, the performance may not be trusted in this regard. Goffman highlighted the concept of spontaneity, by which he meant the presentation of a front that appears uncontrived, thereby allowing the audience to recognize the “true” self of the individual.

The importance of the concept of performance can perhaps be illustrated with reference to Marx. Taking the idea of Heidegger (1953) in “*Sein und Zeit*” (Being and

Time) it could be said that Marx' failure was one of performance. Although convinced of his own ideas, he was too inward – looking and insufficiently aware of how he was perceived by others, and so he was unable to transfer his subjectivity into the social objective world of his audience. Thus, they did not trust his performance and did not accept his ideas.

As noted previously, the ideas of Goffman (1959) were subsequently taken up by the philosopher and political thinker, Habermas, who integrated them, together with insights from Weber and Durkheim, into the 'Theory of Communicative Action' (Habermas, 1981a, b; 1999b, c).

Habermas' intellectual roots are in the 'Frankfurt School' founded by Theodor Adorno and Max Horkheimer and his work can be seen as an effort to apply their 'critical theory' to the problems of society. His theory of communication combines philosophical reflection with Habermas' concern, following the experience of the wars and repressive, regimes of the twentieth century, to challenge violence; not only military violence, but the violence of the language as a means of domination, a highly sophisticated mechanism through which argument is suppressed to serve political interests and thus decisions are deprived of a logical foundation. Against this background, Habermas saw the development of forms of communication based on reason as an existential necessity, democracy a matter of survival.

'The Theory of Communicative Action' (Habermas, 1981a, b; 1999b, c) reflects the contemporary debate between "lifeworld" and "system". Drawing on Weber's typology of instrumentally rational, value-rational, affectual and traditional action, Durkheim's normatively regulated action, as well as Goffman's dramaturgical action, Habermas (Habermas, 1981a, b; 1999b, c) analysed types of action according to which of three worlds (Popper, 1979) – objective, social and subjective, the actor is dealing with, and the various kinds of claims – to truth and efficacy, rightness or sincerity –

that are made, explicitly or implicitly, by the actor in these different kinds of action, which are open to challenge by others.

To these types of action, referred to above, he adds a fourth, communicative action, to produce the following typology:

1. Teleological (strategic) action:

The concept of teleological action is concerned with the relations between an actor and the objective world, in relation to which he/she can form beliefs and develop intentions. Two issues are in question: whether the actor has succeeded in bringing his/her perceptions and beliefs into agreement with the existing state of affairs in the world or, conversely, whether he or she has managed to bring the state of affairs in the world into line with his/her intentions. Any claims he or she may make in relation to either issue are open to challenge by others on the grounds of both truth (the actor's claim as to what pertains in the world is true or false) and efficacy (the actor has achieved or failed to achieve the intended effect in the world) (Habermas, 1981a, b; 1999b, c).

Strategic action, similarly, assumes a single objective world, in relation to which rational autonomous action is possible, but in this case, the actors are goal-directed subjects, who aim to maximise their utility by anticipating and influencing the decisions of others. Actors cooperate only to the extent that to do so is consistent with their rational self – interest.

2. Normatively – regulated action

This concept supposes relations between an actor and two worlds: the objective world, and the social world in which he/she plays a role. Actors within a specific social world develop rules and expectations which determine the legitimacy or otherwise of various behaviours in interpersonal relations between group members. This is what is

meant by norms. A norm is developed and sustained because it contributes to the common interest of the in – group. This type of action may be challenged in terms of rightness (whether or not it is consistent with existing norms) and validity (whether the norm has value for the in – group in a given situation, such that it deserves recognition).

3. Dramaturgical action

This kind of action is concerned with relations between the actor and the subjective and objective worlds. It is a kind of action in which the actor discloses her/his subjectivities – thoughts, attitudes, feelings and so on – to others, without strategic intent or influence by group norms, but offering a pure and sincere interpretation of the situation. Just as the audience can challenge the propositions of the objective world and the norms of the social world, they can challenge and make judgements on the sincerity of the actor's expression of her/his opinions, desires and feelings in the subjective world.

4. Communicative action

This kind of action involves the actor not only taking a position in relation to at least one of the three worlds – objective, social and subjective – but also engaging in a relationship with other actors, with the aim of arriving at a mutual understanding and consensus. It is not the same as an act of communication, such as speech, although Habermas acknowledged the role of language as a medium through which interpretations are negotiated (Habermas, 1995).

Communicative action is teleological in the sense that it has an objective, which is pursued instrumentally through language. That objective is understanding. In communicative action, the actor is not trying to manipulate others for strategic purposes, nor is she/he being controlled by social norms; the action is an expression of a genuine desire and effort to arrive at a mutual understanding. Understanding is the essential purpose of communication, which is necessary in order to allow coordinated

action for the satisfaction. Thus, it is through communicative action that all other action is coordinated.

Understanding, in Habermas' view, involves two elements. The first kind of understanding with which he is concerned, is participants' understanding of the actions referred to, and of the claims (to truth and efficacy, rightness, or sincerity) embodied in the speech act. The second kind of understanding occurs when speaker and listener reach some level of agreement on the referent and the claims of the speech act, which makes it an acceptable basis for the coordination of action between them. This may not be a full agreement. Action may be coordinated on the basis of partial agreement, where participants recognize and accept their differences, and are willing to move forward on this basis.

Trust is not explicitly addressed in relation to communicative action, although it is invited by the underlying assumptions that actors are able and willing, if challenged, to defend their claims by means of rational argument. In this sense, the actor offers a warranty (Habermas, 1981a, b; 1999b, c), which gives his/her arguments binding force as a foundation for agreement and coordinated action (White, 1988). In practice, however, actors do not always offer such a warranty. Commitment to *dialogue*, undistorted by strategic and normatively regulated action, is needed if communication and understanding are to be achieved.

Although Habermas' theory implies a concern with trust, since any of the validity claims can be challenged (i.e. the audience may not 'trust' the actor's factual claims, right intentions or sincerity) he does not, however, develop this aspect explicitly. Even dramaturgical action, the most clearly related to trust, is relatively neglected, except in so far as it is a precursor to and condition for communicative action.

3.6. Conclusion

Trust has been explored from a number of different perspectives, with each discipline interpreting the subject in the light of its own interests and concerns. From the perspective of personality theorists, trust is an individual expectation or emotion with roots in early psychological development. Literature in this field focuses on individual differences in the inclination to bestow or withhold trust and the factors that shape these tendencies. Sociologists are interested in trust in relation to institutions, focusing on the attitudes of individuals towards institutions, and on the nature, operation and function of trust within and between institutions. These perspectives are integrated by social psychologists in explanations of trust in terms of expectations related to risk in interpersonal transactions, and investigation of mechanisms by which trust is created or destroyed at interpersonal and group levels (Lewicki and Bunker, 1996). Elements of all these perspectives can be found in the business literature.

Although interpretations of trust reviewed here contain differences of perspective and focus, there are many similar and overlapping areas. From all four disciplinary perspectives, trust is seen as a form of social engagement, with cognitive, behavioural and emotional dimensions. In the business literature, these elements are labelled knowledge-based, deterrence-based and relational trust. In the philosophical literature, the distinction is not made explicitly, but can be inferred from the concerns with objective truth (cognitive), willingness to take on board the actor's subjectivity (emotional), "performance" and consensus (behavioural). These approaches differ, however, in their focus with respect to these components of trust; the psychological literature, for example, is particularly concerned with the cognitive processes involved, while the business literature places more emphasis on behaviour, e.g. the exercise of fiduciary responsibility, the impact of trust on decision-making, and the relationship to motivation and work effort.

Trust is seen as serving a variety of social functions. In the psychological and business perspectives, it reduces risk, uncertainty and complexity; in the sociological literature, in Habermas' philosophy and in business literature it is linked to cooperation, participation and democracy.

Trust is a complex construct, influenced by three sets of characteristics- of the one who attributes trust, of the trusted individual or institution, and of the context. The sociology and psychology literatures highlight the influence of trustor characteristics such as age, education, status, group affiliation and social isolation on the propensity to trust, the business literature highlights characteristics inviting trust, such as openness, competence, reliability, and care, while the psychology and business literatures provide insight into the influence of context. These dimensions can also be perceived as implicit in the philosophy literature, for example in the concept of a dramaturgical 'performance' and the response to it.

A feature shared by the sociology and business literatures is an awareness of the difficulty of measuring intangibles like trust. The business literature highlights the resulting tendency to focus on formal controls such as performance indicators, in business organisations and even in social service organisations such as health service, which find themselves forced for economic and political reasons to adopt a strategic orientation, even though some writers in the business field have begun to question the validity of formal quantitative controls as substitutes for trust.

It is noticeable that, although the pools of literature discussed here shed light on the nature of trust and its functions for organisations and society, they provide no guidance as to how to build trust. The question now arises whether this issue has been addressed by Critical Systems Thinking (CST). In fact, there is little explicit reference to trust in the CST literature, except by Walsh (1995, 1999), and even he addresses it only briefly, in his discussion of dramaturgical action, which he interprets in terms of

sincerity. This lack of explicit attention to trust perhaps reflects the relative neglect of the issue by Habermas, on whose work CST was grounded. The questions now arise, can the commitments of CST be met without trust? Is trust an outcome or condition for CST? How can a trust dimension be developed within CST? These issues will be explored in the next chapter.

Chapter Four

Developing a Trust Dimension within Critical Systems

Thinking

4.1. Introduction

The purpose of this chapter is to introduce Critical Systems Thinking (CST) as the framework used in this study for conceptualizing and working towards trust and, ultimately, addressing quality perceptions in the health care context. It was shown in Chapter Two that in a service context, subjective perceptions of quality, as well as action to improve objective quality, involve issues of trust. Chapter Three, in turn, showed that trust is linked to concepts such as integrity and sincerity. Trust is seen to be important in terms of reducing complexity and risk, and facilitating communication and cooperation at the dyadic, organisational and community levels of social systems.

These concerns were shown to be reflected, directly or indirectly, in Habermas' (1981a,b; 1984a;1987;1999b,c) theory of communicative action, which alongside the theory of Knowledge Constitutive Interests (KCI) (1968, 1972, 1999a) discussed in this chapter, is an important source on which CST draws against this background, this chapter explores how CST can be used to build up trust and facilitate dialogue and, eventually, coordinated action, as a way of addressing the quality improvement concerns raised in earlier chapters. It attempts to answer the questions: is trust explicitly addressed in CST? If so, where and how? If not, where and how can a trust dimension be developed or made more explicit?

At the outset it should be acknowledged that CST is a highly complex and diverse field, which is constantly evolving as its exponents learn, exchange ideas and reflect critically on their practice. It is not claimed, therefore, that the review contained in this chapter is comprehensive. It is an admittedly selective account, focusing on

certain strands which have been significant in the early development and later revisioning of CST, and which appear to have particular thematic links with various strands of the trust literature.

The chapter contains four main sections. Section one contains an examination of some basic themes in CST, and an assessment of the relevance of trust to them, in the light of Habermas' (1968, 1972, 1999a) theory of knowledge-constitutive interests. Section two includes the meta – methodology, Total Systems Intervention (TSI), which represents the practical face of CST. Then, in section three, each of the knowledge constitutive interests (KCI) is considered in more detail and deficiencies in the addressing of trust are identified. In section four, some suggestions are put forward as to how CST's commitments to critical awareness and theoretical and methodological pluralism could be enhanced by the explicit incorporation of trust issues, with beneficial implications for the third commitment, to emancipation.

4.2. The Basic Commitments of CST

Critical systems thinking has often been described as being grounded on three basic commitments: to critical awareness, which means examining the implications of the context of choices, and of the assumptions and interests underlying them; to emancipation, addressing power relations in the pursuit of 'improvement'; and to complementarism, in which various approaches are used in a complementary fashion, according to the nature of the problems and contexts to be addressed (Flood and Jackson, 1991a).

This is a somewhat simplified approach; there is, in the CST community, debate over the number and labels of the commitments. Writing separately from Flood, Jackson (1991b), for example, offers a more detailed analysis with five commitments. He identifies social awareness as a separate commitment, rather than a dimension of critical awareness, and divides pluralism (an alternative label for complementarism)

into theoretical and methodological pluralism. It has also been questioned whether indeed these are “commitments” or simply themes for debate (Midgley, 1996). Whatever their status, as commitments or themes, these concepts nevertheless underpin and permeate many writings on CST’s philosophy, methodology and practice. For this reason and, moreover, because as will be seen, there are implicit connections to trust issues, the concepts of critical awareness, emancipation and complementarity provide a useful starting point for this discussion.

4.2.1. Critical awareness

Critical awareness might be said to be the most fundamental principle of CST, which emerged as a result of the critique of earlier systems approaches (Jackson, 2000). Jackson sees critical awareness in terms of reflection on the underlying assumptions of various methodologies. These critiques drew heavily on social theory. For example, Burrell and Morgan’s (1979) typology of social science paradigms was used to critique assumptions about the nature of social reality (whether it has an objective existence or is subjectively constructed by social actors) and social science (whether it is/should be concerned with regulation or radical change). This reflection was initially shaped by Habermas’ (1968, 1972, 1999a) theory of knowledge-constitutive interests (Jackson, 1991a, 2000).

Habermas argues that human life is governed by two anthropological imperatives: work and interaction. ‘Work’ enables people to achieve goals and bring about material well-being through social labour. This impulse gives humans a *technical* interest in predicting and controlling the natural and social environments. In Habermas’ view, however, this interest, which he perceived to be prioritised by modern science, is (on its own), insufficient as a rationale for contemporary human life, and he proposed two complementary interests. ‘Interaction’, he argued, gives rise to a *practical* interest

in managing social relations to achieve mutual understanding, since disagreement among different groups can threaten the reproduction of socio-cultural life. Habermas also perceived, however, that the open and free discussion needed for successful interaction may be impeded by the exercise of power in the social process. For this reason, he proposed a third human interest, an *emancipatory* interest in freedom from power relationships and the false ideologies associated with them. More recent developments in CST have called into question whether these are the only human interests and, as indicated in a later section, the theory of knowledge-constitutive interests has been dropped as the basis for methodological pluralism (Midgley, 1996, 2000; Jackson, 1999, 2000). The theory, nevertheless, is significant in the impetus it gave to more reflective practice (e.g. Flood and Jackson's, 1991b, Total Systems Intervention and Gregory's, 1992, New Constellation). In the author's view the model is a valuable starting point (though not sufficient in itself) for reflection on the goals of various actors in problem situations, possible alternative courses of action and potential consequences of these. Of particular interest for this thesis, moreover, is its usefulness as a coherent framework which offers the possibility of links to several strands in the trust literature, which will be explored in a later section of this chapter.

Another philosophical support for the critical awareness dimension of CST is Habermas' (1981a,b; 1984a;1987;1999b,c) theory of communicative action, discussed in Chapter Three. "Habermas argues that any act of communication makes four implicit validity claims: that what is said is intelligible; that its propositional content is true; that the speaker is justified in saying it, and that he/she speaks sincerely, without intent to deceive" (Giddens, 1985). The latter three claims relate, respectively, to the external natural world, the shared social world, and the internal world of the individual. He argues that communicative action requires open debate in an "ideal speech situation" (free from effects of power) in which any of the validity claims may be challenged by

the participants. In effect, therefore, Habermas established a methodology for critique (Ulrich, 1983, Oliga, 1996). Midgley (1992a) for example, used the idea of three interrelated worlds of understanding as a guideline for boundary judgements to define the system and the area within which critique can be conducted. He argues that the choice of boundaries must be guided by a sense of truth (what can be said to exist, in the objective natural world); rightness (the justification of employing particular boundaries, based on the values of the normative, social world) and subjective understanding (that is recognition of the existence of multiple, diverse perspectives)

Critical awareness also encompasses social awareness (Jackson, 2000). This entails awareness, both of institutional and social forces that influence decisions, and of the consequences of choices that are made; for example, whose interests and what objectives are promoted or sacrificed as a result of a given intervention. This theme can be seen reflected in Ulrich's (1983, 1987) social theory, reflected in the methodology of Critical Systems Heuristics. Briefly, the theory focuses on the need to be critical of the values and boundary judgements made by planners. Building on Churchman's (1979) work on systems boundaries, Ulrich (1983) offers a method of reflecting critically on the boundaries of both participation and subject – matter – not only what 'is' the case, but what the various interest groups think 'ought' to be the case. His work on boundary critique was subsequently extended by Midgley (1992b, 2000) and Yolles (2001) who explore the implications of conflicting boundary judgements for the marginalisation of groups and concerns marginalised between two boundaries, and the difficulty of establishing co-operative relationships between stakeholders, even where there is some overlapping of concerns. A number of CST writers (Ulrich, 1983; Midgley, 1996, 1997a, b; Flood, 1999; Han, 2000) argue that there is a need for boundary critique in all interventions.

4.2.2. Emancipation

Critical awareness led to an understanding that in some problem contexts existing problem-solving approaches were rendered unusable or ineffective due to oppressive power relations constraining the choices of some participants. Out of this awareness emerged a commitment to emancipation. Jackson (1991a, 1991b, 2000) defines emancipation in terms of the maximization of human potential through improvement in quality of work and social life. He asserts that in order to achieve this, it is necessary to fulfil all three of Habermas' knowledge constitutive interests. The emancipatory focus within CST is on the challenge of prevailing social institutions and relations, in order to help people to play a stronger role in shaping their own futures.

Although several writers (e.g. Mingers, 1980, 1984; Ulrich, 1983; Flood, 1990; Schechter, 1991) have proposed emancipation as a key focus of CST, Midgley (1996) has criticised this focus for its separation of issues of human potential from their social and ecological contexts. He also suspects the possible importation from Habermas (1968, 1972, 1999a) of an assumption of a 'march of progress' which is of doubtful validity, as what appears to be progress for us, here and now, may be perceived very differently by communities in other places, or by future generations. Therefore he prefers to speak of 'improvement', temporally and locally defined. Nevertheless, a concern with 'emancipation', in the sense of overcoming coercive constraints on efforts towards improvement can be found in his work. For example, he questions the effectiveness of Ulrich's Critical Systems Heuristics as a method of dealing with coercive contexts, on the basis that in coercive situations the scope for debate is generally closed (Midgley, 1997). His solution, when coercion is experienced, is to fight for change to free up the situation within the wider system (in other words, by setting different boundaries for analysis and engagement) (Midgley, 1997b, 2000).

4.2.3. Complementarism

The theory of complementarism arose out of an awareness that different problems have different features and cannot be addressed effectively by the same methodology. However, different systems methodologies embody different theoretical assumptions about the nature of 'reality'. One response to this fact was the thesis of paradigm incommensurability, whereby different paradigms and methodological approaches are seen as in competition, the favouring of one implying exclusion of the others (Burrell and Morgan, 1979; Jackson and Carter, 1991). Jackson (1991a, 2000) argued that paradigms should, rather, be viewed as complementary alternatives, the selection of an approach being governed by a practical focus on what is valid and effective in a particular situation. This pluralist approach is a key element of CST (Jackson, 1991a; 2000; Flood and Romm, 1995a).

This pragmatism, however, does not undermine or contradict the commitment to critical awareness. The pragmatic and critical interests, which have been linked (by, *inter alia*, Walsh, 1995) to Weber's (1930) formal and substantive rationalities, respectively, come together in the systems of system methodologies (SOSM) (Jackson and Keys, 1984; Jackson, 1987; 1991a; 2000).

The SOSM is a matrix which maps systems methods onto the characteristics (in terms of system complexity and the level of agreement among participants) of the problem context, in order to facilitate critical application of methods where they are most useful. In its original version (Jackson and Keys, 1984) the matrix was four celled, the Participants dimension containing only two categories, unitary and pluralist. Later versions (Jackson, 1987, 1991a, 2000) contain an additional category, 'coercive', in the Participants dimension, to account for the operation of oppressive power relations, thus yielding a six-celled matrix.

It should be noted that the categories contained in the SOSM are not intended to

describe the problem contexts themselves; they reflect, rather, the assumptions about those features underpinning the various methodologies. Jackson (1991a; 2000) argues that as a result of failure to appreciate this point, the SOSM has been used inappropriately as a functionalist tool rather than as an aid to critical reflection. Such an approach would tend to limit an intervention to a simplistic formal rationality, while the crucial substantive end point of the intervention remains neglected. Jackson (1991b, 2000) in contrast, asserts a commitment to reflective practice.

The theory of complementarity, and specifically the SOSM, is action-oriented. Jackson's matrix is a practical tool to facilitate choice among possible methods of intervention. In Jackson's view, such an approach is justified by Habermas' (1968, 1972, 1999a) theory of knowledge constitutive interests. This theory allows Jackson to perceive what at first sight appear to be conflicting and mutually exclusive paradigms as having an underlying common purpose of supporting fundamental human interests. He goes so far as to claim a direct connection between these interests and the elements of the SOSM.

The SOSM and its underlying philosophy have, however, attracted much criticism over the years. Midgley (1996) for example, has challenged the claim of the SOSM to be meta-paradigmatic, arguing that such a position risks closing down the possibility for debate, change and development. Gregory (1992) argues that the SOSM encourages only a single interpretation of each methodology and, moreover, cannot easily take account of developments within methodologies that occur as a result of learning from other perspectives. Another point of criticism (Midgley, 1996) has focused on the limited role perceived within the SOSM for boundary critique, which the SOSM appears to confine to situations categorised as coercive, which in Midgley's (2000) view may lead to important judgements being made without an adequate basis of critical reflection. This point will be discussed further, later.

The critique of the pragmatic presumption of the SOSM and lack of conviction as to the usefulness of knowledge-constitutive interests as the main theoretical ground of complementarism led Flood and Romm (1995a) to take an alternative approach, termed “post-critical complementarism”. In this approach, the focus is moved away from the SOSM. Moreover, the theory of knowledge constitutive interests is abandoned in favour of a post-modernist approach to the problem of paradigm (in)commensurability. The dilemma, in their view is that if different paradigms are incommensurable, they cannot be compared and there is no sound basis for choosing among them; if they are commensurable, they can be integrated and combined, but then they lose the distinct features that constitute their strengths. Flood and Romm (1995a) attempt to overcome those problems by the use of indirect means, such as the use of metaphor, to enable theories to be compared, and by asserting the need for critique of knowledge. Gregory’s (1992, 1996) ‘discordant pluralism’ is cited as an example of an approach which, while resisting the domination of any one theory or practice over others, at the same time allows for argument between them. In Gregory’s approach, logical incommensurability is not a reason for suppression of contrary perspectives and forms of knowledge, so scope is allowed for critical appreciation (Walsh, 1995).

Flood and Romm (1995a) seek to avoid universal generality, favouring instead a dialogue between positions based on local criteria. However, they do not define what is ‘local’, nor do they explain how local people can reach an understanding from which they can proceed to coordinated action.

Midgley (1992b) and Mingers (1995) both found in Habermas’ theory of communicative action an alternative philosophical basis for methodological pluralism, on the basis that existing methods of intervention prioritised the investigation of validity claims in relation to one or other of the three worlds; challenge to claims in the objective, normative and subjective ‘worlds’ cannot be achieved by one method alone.

As we saw in Chapter Two, Walsh (1995) draws on these ideas to argue that decisions on coordinated action aimed at improvement must be based on understanding through effective dialogue. These developments, of course, both reflect and reinforce the discredited status of the theory of knowledge constitutive interests as a basis for methodological pluralism. Nevertheless, it still has value, alongside other perspectives, in relation to critical awareness. This is demonstrated in the following sections, where the theory provides a framework for critical reflection on the place of trust issues within CST.

4.3. Total Systems Intervention (TSI)

Total Systems Intervention (TSI) is a practical operationalising of the key ideas of CST, to guide practitioners in pluralist practice. It encourages creative thinking about organisations using a series of metaphors, as a guide to selection of one or more appropriate systems-based intervention methodology, to address different aspects of problem situations and ensure that the technical, practical and emancipatory interests are all taken sufficiently into account (Jackson, 2003).

TSI is based on seven principles (Flood and Jackson, 1991b):

1. Organisations are too complicated to understand using a single management model or for ``quick fix`` solutions.
2. Organisational issues and problems should be investigated using a range of system metaphors.
3. Issues and problems so highlighted can be linked to appropriate systems approaches to guide intervention.
4. Different aspects of organisational problems can be addressed using different metaphors and approaches in a complementary manner.
5. Different systems methodologies have their distinct strengths and weaknesses which can be understood in order to relate each to appropriate concerns and

problems.

6. TSI provides an iterative, systemic cycle of inquiry.
7. Facilitators and clients participate jointly in all stages of the process.

The TSI process is conceptualised as three phases: creativity, choice and implementation; which may be used in three modes: problem solving, critical review and critical reflection. Critical review is essentially a formulation of the need for critical awareness about the methodologies and methods used. Critical reflection involves post hoc evaluation of the TSI process itself (Jackson, 2000). Each phase can be used in any and in all modes, and the process is iterative, i.e. it is continuous and work may start at any point in the cycle.

The aim of the creativity phase is to mobilise the views of the research population, allowing their own 'reality' to emerge from within. As an aid to this process, a range of metaphors are provided (for example, machine, organism, brain, culture, coalition, coercive system) which focus on different aspects of organisational functioning: structure, human and political aspects. The outcome of thinking creatively about the organisation in terms of these metaphors is a dominant metaphor highlighting a set of issues and concerns to be taken forward to the next phase, where they will form the basis of a choice of methodology for intervention. Although it is expected that one dominant metaphor will emerge which highlights the main issues and concerns, other 'dependent' metaphors may also be pursued into the next phase, to facilitate consideration of other aspects of the organisation which need to be taken into account, alongside (and perhaps modifying) the dominant ones.

In his revised version of TSI, Flood (1995) suggested additional methods of enhancing creativity which could be used alongside or instead of the metaphors provided: 'divergent' metaphorical examination, i.e. allowing participants to devise their own metaphors; brainstorming, idea – writing and other techniques including

idealised design (Ackoff, 1981) and phases 1 – 5 Soft Systems Methodology (SSM) (Checkland, 1989) and attention to the ‘‘ergonomics of reflection’’, i.e. providing conditions (time and scope) conducive to creativity. Whatever method or methods are used, the important principle is to look at the problem situation from different perspectives (Jackson, 2003), and for this reason, Jackson sees Flood’s (1995) suggestions as supplements to, rather than replacements for, metaphor analysis.

In the choice phase, one or more appropriate systems approach to intervention is selected, by relating the nature of the problems highlighted in phase one to the particular characteristics of each methodology. Although the main approach selected should reflect the assumptions appropriate to the organisational context and be consistent with the dominant metaphor, it may be appropriate to bring in elements of other methodologies, to reflect and act on the insights provided by dependent metaphors. The choice should be made in full awareness of the strengths and weaknesses of the available systems approaches (Jackson, 2003). The System of Systems Methodologies (SOSM) was originally offered as a tool for relating the assumptions of various methodologies to the information gained about the organisation context (see section 4.1.3).

Flood (1995) subsequently proposed abandoning the SOSM as impractical. Jackson (2000) in contrast, proposed that it should not be abandoned, but supplemented with critical analysis based on, for example, sociological paradigms, organisational metaphors, and Habermas’ three human interests.

The implementation phase involves employment of the selected system methodology (or methodologies) to arrive at and implement specific proposals, with a view to coordinated change needed for efficient, effective and ethical functioning (Jackson, 2000).

Jackson (2003) acknowledges that it may be difficult in practice to use different

systems methodologies alongside each other, consistent with the dominant and dependent metaphors. In such a case, it may be necessary to grant 'imperialistic' status to one methodology, but this must be made explicit, and its dominance kept under continuous review.

4.4. Where is Trust in CST?

Trust issues have not, on the whole, been explicitly addressed within CST. A rare exception is the work of Walsh (1995), who makes some references to trust in the context of a discussion of dramaturgical action (Habermas, 1999b), which he interprets as concerned with the sincerity of the speakers. As noted by Walsh (1999:44) "this is the basis of trust in all personal and public relationships".

Another reference to trust is found in Romm's (2001) proposal that researchers could, in the way they approach and conduct research, develop trust, using the term "trusting constructivism" to denote the approach she advocates. Midgley (2000), in reporting certain interventions in which he was involved, notes in passing that certain actions were taken with the aim, or had the effect, of developing trust. For example, in one report, he comments that debate among experts about possible methods of intervention was conducted in the presence of the other participants, in order to sustain an atmosphere of mutual trust. In another case, he recalls that preliminary team-building focusing on different terminologies of participants with different disciplinary backgrounds had the effect of developing trust among the participants and also (because participants saw their concerns were being addressed) between them and the intervention team. These are, however, isolated instances. There appears as yet to be no explicit debate on the place of trust within CST, or how it might be incorporated.

This is an important omission because many CST ideas have practical implications in terms of building or undermining trust. The principle of critical

awareness, for example, implies that nothing is accepted at face value. Theoretical approaches, methods of intervention, their implicit assumptions, and the interests served by their use, are all open to challenge. This does not, of course, mean that they are automatically overturned or rejected; but neither are they taken for granted. Advocates of any given assumption, theory, goal or method must be able and willing to justify it if called upon to do so. Moreover, proposed interventions must be subject to critical reflection, so that constraints and concerns can be surfaced. An example is Ho's (1997, cited in Midgley, 2000) method for critiquing the ideology underlying a given course of action. When applied in Tainan city council, Taiwan, it surfaced the concerns of employees that a hidden agenda might underlie the council leader's desire to use Beer's (1985) Viable System Modelling for restructuring. In this sense, accepting the principle of critical awareness may seem to involve advocating personal and social mistrust. On the other hand it can be argued that critical scrutiny of the reasons, conditions and consequences associated with decisions may *promote* trust by increasing knowledge (Shapiro et al., 1992), understanding (Mishra, 1996) and openness (Ouchi, 1981; Peters et al., 1997).

The commitment to pluralism also implies trust-related concerns. When a decision is being made on a problem solving approach, issues of competence are raised; is the chosen method capable of addressing the problem in question, and is the practitioner capable of using it appropriately and effectively (Mingers and Brocklesby, 1996)? As we saw in Chapter Two, competence is one of the elements of trustworthiness (Kasperson et al., 1992; Kirkpatrick and Locke, 1991). Such decisions also raise questions as to the legitimacy of the purpose for which the chosen method will be used, and a presumption is made that it will not be used coercively in order to reinforce inequalities in power relations. This is a matter of integrity, which as we have seen, is another concept associated with trust (Lieberman, 1981; Mayer et al, 1995).

For the purpose of the present discussion, however, I shall focus more on the trust implications of the emancipatory commitment. As Jackson (2000) suggests, the three commitments are in fact closely intertwined, in such a way that it would be possible to “tell the story” of CST through any one of them. I have chosen to focus on the emancipatory commitment because it is the one most closely connected to Walsh’s (1995) concept of critical quality, and because connections to trust issues are particularly evident in relation to the emancipatory commitment, in view of Jackson’s (1991a; 2000) assertion of links to the human technical, practical and emancipatory interests. The technical interest is in achieving goals and improving material welfare by predicting and controlling the environment. The ability to predict requires detailed knowledge of the entity that is to be predicted and is, of course, facilitated if there are perceived regularities in the behaviour of that entity, leading to attributions of predictability. Predictability has been identified as a factor conducive to behavioural trust (Kasperson et al., 1999) and in business is associated with reliability and consistency, attributes which are also considered to connote trustworthiness (Creed and Miles, 1996). Trust, meanwhile, is said to be an alternative to formal external control; in other words, where trust exists, less control is perceived as necessary and more autonomy can be allowed. This is the basis, for example, of fiduciary relationships in business (Lieberman, 1981).

The practical interest in the management of social relations is linked to trust through the assertions of social psychologists and sociologists that trust is both an outcome and facilitator of meaningful social engagement (Kasperson et al, 1999). Knowledge of others promotes cognitive trust (Cvetkovitch, 1999), while emotional responses encourage affective trust (Kramer and Tyler, 1996). Trust, in turn, facilitates social cooperation (Misztal, 1996).

Finally, the emancipatory interest can be seen in terms of the pursuit of a

solution where others can be trusted not to act coercively. Only in such an environment can human beings truly realise their potential. Coercion itself, and control mechanisms introduced to limit coercion in the absence of trust, are both likely to be perceived as placing unilateral restrictions on human freedom. Arguably, it is only those control mechanisms that have been agreed in an atmosphere of mutual trust that will be perceived as genuinely legitimate.

From this perspective, fulfilment of the knowledge-constitutive interests (and, in turn, CST's commitment to emancipation) can be regarded as requiring attention to the building of trust in all its various forms. However, further consideration suggests that the failure to develop a theory of trust explicitly within CST raises significant difficulties. In relation to the technical interest, for example, there are many cases, such as 'one-off' transactions, new relationships, and situations where information is non-existent or deliberately withheld, when prediction of behaviour is not possible. Such situations are likely to engender mistrust. However, even in these unpredictable situations there is empirical evidence that a starting point based on mutual trust provides a more satisfactory outcome to the parties than one based on mistrust (Milgrom and Roberts, 1992). This suggests the importance in CST-based interventions of explicit measures to surface trust issues and build trust among participants, and between them and the intervention team, at the outset. Issues of trust between participants therefore need to be considered in all CST interventions.

The issue of control within the technical interest is also problematic. Jackson (1993) and Midgley (1996) have both raised concerns that this can be used to legitimate exploitation, with humans dominating natural phenomena as undifferentiated resources, whose only value and meaning lies in their availability for consumption (also see Heidegger, 1954, trans, 1978). In Jackson's (1993) view, there is a danger that modern management philosophies and technologies risk the reduction even of human beings to

the level of resources to be exploited. A focus on control implies a lack of trust on the part of the controller (and may invite resentment and mistrust on the part of the controlee), as was shown in the previous chapter (section 3.4.6.). In the researcher's view, an explicit addressing of trust in CST would facilitate greater respect for people as partners in development rather than resources to be (ab) used.

Trust is also a problematic issue in relation to the practical interest. Knowledge and understanding, on which trust could be founded, may not be achievable. Moreover, contextual factors like differentials in power and status may constrain the propensity to trust (Putnam, 1993; Kramer, 1996). In the context of the present study, health care, for example, there are clear differentials between patients and carers, on the one hand, and health care providers on the other. There may also be inequalities in power relations between different members of the health care provision – on medical issues, doctors may have greater power than nurses, but in relation to resources, they may be subject to the power of accountants and administrators, for example. It may also happen that holders of conflicting perspectives become entrenched in their positions in a manner which prevents open discussion (Gregory, 1996). The resulting isolation of positions is likely to engender mistrust which, at the very least, precludes learning (Kramer, 1996) and, more seriously, can lead to conspiracy theories and scapegoating and, ultimately, discrimination and persecution (Lange, 2001). In order to effectively fulfil the practical interest, therefore, measures are needed to promote trust-building dialogue and to repair damaged trust.

In the context of the emancipatory interest, crucial implications for the building and maintenance of trust lie in the boundary judgements involved. Different stakeholders bring different values and concerns to the problem situation; thus even where there is some overlapping of interests, they make different boundary judgements. In consequence they may disparage other parties' concerns and find it difficult to trust

each other (Midgley, 2000).

The boundaries of a system are matters of choice, and the decisions made will determine who participates in a change initiative, how dialogue is structured, and who is affected (and in what ways) by the outcome (Churchman, 1979; Ulrich, 1983). In the national health context, for example, until the last decade, the voice of consumers was largely unheard. More recently, conscious attempts have been made to enable consumers' views to be expressed, and in the Trent Quality Initiative (discussed in Chapter Two), attention was paid to the relationship between consumers and providers. Other relationships such as that between providers and purchasers, however, have been insufficiently considered. Clearly boundary decisions have wide repercussions with potentially significant implications for trust. It will be explained in Chapter Five how these issues were considered in conducting this research.

CST has assumed a responsibility to advocate on behalf of the marginalized, as a means to empower their participation (Flood and Romm 1995b). However, in Ulrich's (1996) view, the emancipatory commitment cannot be fulfilled properly without a methodology to support participation in meaningful dialogue by citizens themselves. His Critical Systems Heuristics (CSH) is an attempt to provide such a methodology through which system boundaries and their implications are critiqued. The use of this methodology, however, may in practice be restricted by its association, in the SOSM, with coercive problem contexts. There is a need, as Ulrich (1983) and Midgley (1996, 2000) have asserted, for critical reflection on boundary judgements in other situations.

Even when a critical boundary judgement has been made as to who should be involved or affected by the issue to be explored, the question remains as to what methods can be used to enable their genuine empowerment and participation. If the participation of affected groups is constrained by the format of the 'dialogue' or 'consultation' (as, for example, is often the case with patient satisfaction surveys) or if

they doubt what use may be made of the information they are asked to provide, cynicism and distrust, rather than trust, will be the result.

4.5. A Way Forward

Although, as has been shown, the basic principles of CST implicitly raise issues of trust, in the absence of explicit ways of recognizing and addressing these issues, difficulties may arise, leading to improvement efforts being thwarted by mistrust. Incorporation of an explicit trust element within CST would strengthen critical awareness and pluralism, thereby enhancing our ability to promote emancipation. The scope for the contribution of critical awareness to building trust should therefore be developed as an explicit aim. Such efforts could be located, for example, within a discordant pluralist approach, which advocates recognition of the impact of the environment and historical context, communication among different world-views and the making of ethical decisions based on understandings of both self and others (Gregory, 1996).

The development and maintenance of trust may also be made an explicit focus of the process of critical boundary judgement. Midgley (1996), following Ulrich (1983), suggests that such critique should take place at the outset of any intervention, and periodically thereafter. This would provide a mechanism for citizens to challenge the validity claims made by experts. Such participation would reduce the risk of certain individuals or groups becoming isolated from the system, a situation associated with disinclination to trust. At the same time it would promote trust by increasing the knowledge and understanding on the basis of which trust attributions are made.

Trust issues also need to be addressed within the pluralism dimension of CST. It would be useful, for instance, to explore more deeply the trust implications within the analysis of political relations among participants. The classification of such relations, in the SOSM, into unitary, pluralist and coercive, is a useful framework which can serve as

a guide to some of the trust issues that need to be surfaced. However, the locating of a problem context in any of these categories must itself be the outcome of detailed exploration through, for example, Ho's (1997) method of ideology critique, or Midgley's (2000) boundary critique. Each kind of political relationship has trust implications which should be explicitly surfaced. In a unitary or team perspective, where participants are willing to agree on a single perspective, does this necessarily guarantee mutual trust? How can trust among team members be built? Where there are multiple perspectives, can sufficient trust be engendered to facilitate cooperation? Are coercive contexts a reflection of mistrust in the ability or honesty of subordinates? How do unequal power relations suppress the concerns of less powerful groups and act to increase social distance (which breeds mistrust)? Even consideration of these issues, however, would not be sufficient for a full understanding of trust. Exploration of the political positions taken by actors in social systems can at best address the behavioural dimension of trust. However, trust is also cognitive and affective (Lewis and Weigert, 1985). Thus, to develop trust, CST needs to take account of these dimensions also. In critiquing and choosing methodologies, the question should be not only what do they assume about political relations, but what they assume about human relationships more generally. This is arguably the starting point for the present research project.

4.6. Conclusion

CST is an approach to improvement, grounded on the themes of critical awareness of assumptions and contextual factors influencing decisions, the complementary use of various theories and practices according to their strengths and weaknesses in a given domain of application, and freedom from coercion. Jackson (2000) associates these "commitments" with the universal human interests- technical, practical and emancipatory- proposed by Habermas (1968, 1972, 1999a). TSI was introduced as the practical face of CST.

The key themes of CST, and the three knowledge constitutive interests, are implicitly related to trust issues. However, difficulties have been identified, which need to be addressed by the incorporation into CST of an explicit recognition of trust issues. Trust issues need to be brought into the thinking of CST, in order to ensure that they will be taken account of in the choice of design of methods. This would strengthen the critical reflection and pluralist dimensions of CST and, in so doing, enhance its ability to develop trust between researcher and participants in critical systems practice, and also to facilitate the building of trust among the various stakeholder individuals/groups involved in a critical systemic intervention – for example, health professionals, patients and administrators. This in turn would enhance the ability of a CST-based project to contribute to emancipation, or improvement in human life. Health service quality is an example; the aim of building a trust dimension in CST, in this study, is to facilitate the kind of communication which Walsh (1995, 1999) proposed as the prerequisite to what he called critical quality. The methods used in this research to generate dialogue in order to understand issues of trust and quality in the NHS and facilitate action for improvement are the subject of the next chapter.

Chapter Five

Methodology

5.1. Introduction

Following from the review of literature on quality (Chapter Two), trust (Chapter Three), and the trust dimension in CST (Chapter Four), this chapter explains the approaches and methods used in conducting empirical work.

The chapter begins with a discussion of research paradigms which locates the project within the phenomenological tradition. It is explained that Critical Systems Thinking (CST) is used to underpin a participatory action research (PAR) project aiming to explore Humber Mental Health NHS Teaching Trust (HMHTT) stakeholders' perceptions around trust and service quality, to identify factors that are conducive to or impede trust, and consider how they might work towards ways of facilitating the former and reducing the latter. Emphasis is placed on the evolutionary nature of the research design, in line with emergent issues in the research and my growing understanding, through critical reflection on the research question and my own role. Stakeholders are identified and the recruitment of participants is described.

Two phases of research are discussed: an initial "finding out" phase based on semi – structured interviews, and a phase of "engagement" in group workshops, in which issues raised in phase one were debated and ideas for change were generated.

Validity, reliability and alternative quality criteria applicable to phenomenological research are extensively discussed, as are the ethical issues involved in the research.

5.2. The Research Paradigm

A paradigm is a world- view or set of assumptions about the nature of the world and the way knowledge is obtained, which has implications both for the methods

selected and for the criteria adopted to assess the quality of the research (Denzin and Lincoln, 1994). In this section, alternative paradigms will be defined and discussed, after which, the assumptions underlying the present study will be made explicit.

Writers on research methodology differ in the number of paradigms they identify and the terminology used to denote them. At the simplest level, several writers make a broad distinction between two paradigms, to which they assign various labels. For example, Creswell (1994) drawing on earlier writers such as Firestone (1987), Guba and Lincoln (1988) and McCracken (1988), identifies two basic paradigms which he calls quantitative and qualitative. The quantitative paradigm is based on the ontological assumption of an objective reality, independent of the researcher, which should be investigated in a controlled, systematic way by a researcher who stands at a distance from the subject of the inquiry. Such research is regarded as impersonal, unbiased and value free. The methodology applied is deductive, based on concepts, variables and hypotheses chosen prior to the study, and remaining fixed throughout the research. The aim is to develop generalizations that contribute to theory and assist in the prediction and explanation of some phenomenon.

In contrast, what Creswell (1994) calls the qualitative paradigm is founded on the ontological assumption that there are multiple ‘‘realities’’, since ‘‘reality’’ is a subjective construction of the actors in a given situation (including the researcher and the reader or audience). Epistemologically, the assumption is that the role of the researcher is to interact with and minimize his or her distance from those being researched, as it is through such interaction between investigator and respondents that knowledge is created (Guba and Lincoln, 1994). The researcher accepts that the research will inevitably be influenced by his or her values and biases, and those of the research participants, and rather than eliminating them, seeks to make them explicit. Such research typically adopts an inductive logic, where concepts and categories

emerge from the research, shaped by the research context, leading to the discovery of patterns or the development of theory.

Other writers, while adopting a similar two – paradigm typology, argue that the terms ‘quantitative’ and ‘qualitative’ are misnomers, and that these terms are appropriate only in relation to methods, rather than the paradigm as a whole (Guba and Lincoln, 1994). They are misleading because, although particular research approaches are often aligned with certain favoured methods, there is no reason why a so – called ‘qualitative’ study could not make use of some quantitative data. Glaser (2001:145) offered the dictum, ‘‘all is data’’ to convey his view that researchers may use any data that is useful and appropriate to the study in question. Ultimately, the distinction between paradigms lies not in the methods or data used per se, but in the way they are used. Writers have adopted various labels to convey this distinction, resulting in a degree of terminological inconsistency and confusion, as the following discussion of typologies and terms illustrates.

Guba and Lincoln (1988), in their early work, distinguished between what they called the ‘conventional’ or ‘positivistic’ paradigm, and the ‘alternative’ or ‘naturalistic’ paradigm, describing them in terms which reflect the same ontological, epistemological and methodological distinction referred to above. Subsequently, they (Guba and Lincoln, 1989) renamed their ‘‘naturalistic’’ paradigm the ‘‘constructivist’’ paradigm, to reflect the idea that ‘‘realities’’ are socially constructed, and suggest that it is equivalent to what is variously called the qualitative, interpretive or hermeneutic paradigm – but again, proposing a simple dichotomy between this paradigm and positivism or ‘‘science’’: “it rests in a belief system that is virtually opposite to that of science ...” (p43).

Salmon (1991) prefers to reflect alternative sets of assumptions in the terms ‘analytic’ and ‘systemic’, the former describing the assumption and methods

appropriate to precision and measurement, the latter being concerned with authenticity and flux. Wadsworth (1998) also identifies a broad division between two paradigms, which she calls "old paradigm" and "new paradigm", equating the former with positivism and the latter with terms such as "critical constructive" and "critical interpretive". These terms (although Wadsworth does not distinguish between them) reflect the fact that within the 'qualitative' or 'new' paradigm, in particular, there are a number of distinct stands, which some writers identify as paradigms in their own right, leading them to produce more complex typologies. In more recent work, for example, Guba and Lincoln (1994) expand the number of paradigms or paradigm groups to four, by including, in addition to the 'positivist' and 'constructivist' paradigms discussed previously, post – positivism, and a set or group of paradigms which they denote as "Critical Theory et al". The latter, in addition to critical theory per se, is taken to include, inter alia, neo – Marxism, feminism and participative inquiry.

Post- positivism, in this typology, represents efforts in the mid to late twentieth century to respond to some of the main criticisms of positivism, albeit within the same basic philosophical framework. Reality is still assumed to exist in an objective sense, but it is recognized that this may be only imperfectly apprehendable. The experimental / manipulative methodology of positivism is modified to encompass more inquiry in natural settings, more situational information, and greater use of qualitative techniques. Nevertheless, post – positivism is seen as sharing with positivism the aims of explanation, prediction and control, the attempt to produce generalizations and cause – effect linkages, attempts and claims to be value – free, and the researcher's role as disinterested informer.

In the "critical" group, "reality" is seen as the outcome of a crystallization, over time, of various social, political, cultural, economic, ethnic and gender factors. Epistemologically, it is assumed that knowledge emerges through interaction between

the investigator and the object of research, and that findings are value – mediated. Inquiry proceeds via dialogue between the researcher and the research subjects.

Denzin and Lincoln (1994) also identify four major paradigms, but draw the boundaries somewhat differently: positivist and post-positivist; constructivist – interpretive; critical (e.g. Marxist, emancipatory) and feminist – post structural. In other words, the basic ontological and epistemological distinctions drawn by Guba and Lincoln (1994) are retained, but there are different implications as to the degree of similarity and difference between approaches. For example, Denzin and Lincoln's alignment of post – positivism within the same category as positivism emphasises the commonalities between them, whereas Guba and Lincoln's typology, which makes post – positivism a separate paradigm, highlights the departure from positivism. As another example, Guba and Lincoln's placing of feminist inquiry alongside Marxist and participative inquiry under the broad heading 'critical theory et al. ' suggests that all three are strands within the same trend, whereas Denzin and Lincoln suggest, by placing it in a separate paradigm, that feminist inquiry is significantly different from the other two approaches. Thus, the same writer (Lincoln) uses two different typologies, when writing with different co – authors, although both articles are of the same date and published in the same edited collection. Such inconsistency highlights the confusion and vagueness that exists even among leading writers on qualitative research.

Mason (1996), however, takes a slightly different approach. Whilst she recognizes different strands of what she terms, broadly, qualitative research, she asserts they are all rooted in the interpretivist philosophical position. Although they might differ in areas of focus and degree of emphasis (for example on practices, discourses, process or constructions) they share a view that the social world is a complex, multi – layered entity represented by such elements, and sensitivity to context in methods of data collection and analysis.

Such similarities result in a variety of treatments of paradigms in the methodological literature, some writers drawing distinctions between terms which others treat as interchangeable. As noted previously, for example, Denzin and Lincoln (1994) identify interpretivism / constructivism as a single paradigm. Schwandt (1994) in contrast discusses interpretivism and constructivism separately as different conceptualizations of human inquiry. At the same time, however, he notes a shared focus on understanding the world through the lived experience of social actors and is “mindful of the risk of drawing too fine a distinction between interpretivist and constructivist perspectives that share a common intellectual heritage” (p119).

A similar situation exists between the critical paradigm group and the constructivist paradigm as described by Guba and Lincoln (1994). They share a transactional subjectivist epistemology, and the use of dialectical methods - that is, the use of dialogue and debate among participants, and between them and the researcher – that aim to reconstruct previously held constructions. Both recognize and make explicit the role of values in an inquiry. The authors, however, differentiate between them on a number of dimensions. They ascribe to critical theory an explicitly emancipatory agenda, whereas constructivism focuses on understanding; they contrast the structural / historical insights of critical theory with the individual constructions in constructivism, and they ascribe to the researcher in critical theory a more authoritative role as advocate, instigator and activist, compared to the ‘participant’ role in constructivism. There is, however, only one interpretation of these approaches, and they admit that the way they choose to group or distinguish paradigms is a “judgement call” (p 109).

Thus the general picture in the literature on paradigms is one of confusion and inconsistency, with paradigms being grouped or split in various ways, and terms open to several interpretations. The confusion is well illustrated by the different uses of the term ‘‘interpretive’’. Some writers (e.g. Schwandt, 1994) use the term interpretive to refer to

a specific research strand or perspective with origins in hermeneutics and phenomenology, and represented by, for example, symbolic interactionism; others (e.g. Creswell, 1994; Mason, 1996) use the term synonymously with such terms as 'phenomenological' and qualitative to denote all non – positivist inquiry; while Denzin and Lincoln (1994) argue that “all research [including positivist] is interpretive, guided by a set of beliefs and feelings about the world and how it should be understood and studied” (p13). To compound the confusion, the latter use the term interpretive in two different ways in the same sentence, when they argue that there are “four major interpretive paradigms” and go on to name one of them as “constructivist – interpretive” (Denzin and Lincoln, 1994:13).

As another example, Denzin and Lincoln (1994) identify 'feminism' as a distinct paradigm, Guba and Lincoln (1994) treat it as a perspective within the 'critical' group, while Schwandt (1994) locates it within the constructivist paradigm.

In this situation, despite the variety of paradigm labels found in the literature, the only point on which the writers seem to agree is the basic distinction between the various 'new' (or 'qualitative', or 'naturalistic' etc) approaches and positivism. As Guba and Lincoln (1994: 109) note:

“Except for positivism, the paradigms discussed are all still in formative stages; no final agreements have been reached, even among their proponents, about their definitions, meanings or implications”

In addressing the issue of a choice of paradigm for this study, therefore, it seems useful, first to return to this basic, broad, two – paradigm typology, in which the detached, objective, deductive approach of positivism is contrasted with more subjective, value – laden, inductive approaches.

The traditional positivist view sees knowledge as objective, representative information that can be obtained by neutral, value-free methods and from which

generalizations and predictions can be derived. Proponents of this view value what they consider to be the greater reliability of information that is produced when potentially distorting influences, such as the researcher's prior experiences, are excluded.

Such a view may be workable and appropriate in the natural sciences, but critics of positivism argue that it does not meet the needs of social sciences, which is concerned with human activity systems (Wadsworth, 1998). This is because social reality is seen as constructed by human beings, through an interpretive process of deriving, using and modifying meanings that phenomena in the world have for them – meanings which guide their behaviour (Berger and Luckerman, 1966). Although there is a great variety of approaches within the non-positivist research tradition, they share a base of phenomenological philosophy which takes lived experience as the primary research object. This notion is rooted in the phenomenological idea of 'lifeworld', first proposed by Husserl (1931) and subsequently developed by others, such as Gadamer (1975; 1976). The concept of lifeworld expresses the belief that "person and world are inextricably related through lived experience of the world" (Sandberg, 2005:43). Hence, the human world is always an experienced world – one that is related to a conscious subject.

The lifeworld, while subjective in the sense that it is the person's experience of reality, at the same objective in the sense that it transcends the subject, as we share it with other subjects, with whom we negotiate understandings of reality. Sandberg (2005) illustrates this well, with the example of the practice, in most European countries, of daylight saving by moving the clock forward by one hour between March and October. This daylight saving becomes an objective fact as a result of this 'intersubjective' agreement. Anyone who tries to ignore it will face difficulties, because it has consequences (for example working and trading hours) which transcend the individual's subjective experience of clock time.

Whilst Husserl (1913, trans,1975) argued that we are always related to reality through our lived experience of it, Heidegger (1927) developed Husserl's arguments by suggesting that not only is reality mediated through our lived experience, it is also mediated through the specific historical time, culture and language in which we are situated. Critical theorists such as Habermas (1999b; c) have similarly suggested that our descriptions of reality are often coloured by taken –for- granted ideologies.

Advocates of non – positivist approaches, based on these assumptions, reject the dualist ontology that separates subject and object, instead regarding subject and object as constructing an inseparable relation (Sandberg, 2005). They argue that it is not possible to produce an objective description of reality, since descriptions are inevitably influenced by the individual's specific historical, cultural, ideological, gender – based and linguistic understanding of reality (Sandberg, 2005).

This means that the aim of social research is not so much to gather facts and observe patterns, as to understand the meanings that people give to their experiences. Whereas researchers in the physical sciences could isolate themselves in artificial settings, carrying out controlled, replicable research with little or no social interaction (Krech, 1946), this is not possible in social settings. Meaningful research requires interaction with the people and organisations whose problems are being investigated.

The positivist approach to research, moreover, proves unworkable in social settings, because the restriction to a supposedly value-free, logical and empirical stance, in an organisational context, can produce knowledge that is irrelevant to members' needs, or even harms their interests (Susman and Evered, 1978). Indeed, it may be questioned whether the objectivity claimed by positivism is actually achievable in practice, or whether this approach simply introduces different kinds of distortion. One reason for this is the dominant role of the researcher, who chooses the research questions and methods, and interprets the findings. Moreover, in their effort to preserve

objectivity, researchers may fail to make explicit their values, experiences and ideas. This may result in participants misunderstanding the nature and purpose of the research. Non – positivist approaches, by contrast, require researchers to be more transparent about why they are interested in the research, and their relationship to the critical reference group¹.

Proponents of the ‘new’, ‘interpretive’ or ‘constructivist’ approach argue that, although data obtained in a positivist study may be more reliable (that is, rigorous), the data produced by non – positivist approaches has the advantage in terms of validity, that is, it may have greater relevance to the context and issues being explored. In practice, however, this is an oversimplification. Research does not require an absolute choice between validity and reliability, relevance and rigour. There is a partial trade-off between them. That is, it may be appropriate or necessary under some circumstances to sacrifice one in order to gain more of the other; but the trade-off is only partial because it may be possible to increase one without wholly abandoning the other. Indeed, by careful choice of strategy and tactics, it may be possible to optimize both the validity and reliability of the research. Some of the rigour that quantitative research offers, for example, can be achieved in qualitative research by using a structured process that embodies dialogue (Dick, 1997).

In addition to the trade-off between rigour and relevance, there is another potential trade-off to be considered, between local and global relevance. Local relevance is relevance to the stakeholders of a particular project, while global relevance, a similar concept to generalisability, is relevance to the wider research

¹ The critical reference group, according to Wadsworth (1998) is the group that has the problem under investigation. In this research, several groups were involved: service users, carers, decision makers (senior managers) and professionals (see section 5.5). Although all were part of the problematic situation, the initial point of reference for the study was service users and carers (see section 5.5.2) and it was they who, in the early phases, identified problems (see chapter 6); in this sense, they could be regarded as the critical reference group. The term is distinct from participants (not every member of the critical reference group may be able or willing to participate, while some participants may not be members of the critical reference group). Nor is it the same as stakeholders, since stakeholders may come from other groups as well as the critical reference group (see section 5.4.2 on participation, and section 5.5.1 on identification of stakeholders).

community. Perhaps the greatest concern regarding qualitative research is that the learning it produces is narrow, situational and bound by context, in contrast to the universality claimed by positivist science (Susman and Evered, 1978). Social settings cannot be replicated exactly (as Heraclitus said, 'a man cannot step into the same river twice'), and this raises the question whether the research outcome produced by qualitative research would be applicable elsewhere. The more the research is responsive and participative at the local level, the greater the risk of reduced global relevance.

The same can be said with regard to credibility (Dick, 1997). Appropriate and effectively handled process, negotiated with the stakeholders, may yield findings that have high credibility for those who were involved in the project, but are less meaningful to those who did not participate.

Thus, it can be seen that both paradigms have advantages and disadvantages, and the choice of either involves some degree of trade – off. Saloman (1991) argues that neither paradigm is intrinsically superior to the other; the choice depends on what features most characterize the particular aspect or unit of the world to be investigated.

In the light of the foregoing discussion, the qualitative paradigm is most suited to this research, which is concerned with a social setting – the mental healthcare system – and is concerned with developing an interpretive understanding of what is occurring, on my own part as researcher, and on the part of the participants. The aim is to enable them to interpret the world in a way that is locally relevant and applicable to them – not to arrive at some ultimate, universal 'truth' about the health service.

Such an approach is particularly appropriate, moreover, because of the inadequate and fragmented nature of existing understanding on the topics of quality and trust (see Chapters Two and Three). According to Creswell (1994), a qualitative approach is appropriate when there is no prior theory to guide the investigation, or when the existing theory is inadequate or incomplete. The same point is made by Dick (1997),

who suggests that qualitative research is useful for exploring substantive areas about which little is known or where a new understanding is sought. This is the case in the present research. It was shown in Chapter Three that there are multiple perspectives of trust within different disciplines, and certain commonalities have been identified, but there is disagreement on the antecedents and consequences of trust and no clear picture of how trust is formed or how it can be built. Similarly, it was shown in Chapter Two that existing theory on service quality is inadequate or incomplete because it does not sufficiently take account of the role played by interpersonal relations. There are some suggestions, in various pools of literature (see Chapters Two and Three) of links between trust and communication (Misztal, 1996; Zimbardo and Leippe, 1991), quality and communication (e.g. Walsh, 1995, 1999; Edwards, 2003), and between quality and trust (e.g. Checkland et al., 2004) but there is no theory which adequately explains how perceptions of service quality in health care are formed or the role of trust in relation to this. In this sense, the present research is exploratory.

The investigation of these matters, moreover, involves phenomena such as thought processes and attitudes, which are difficult to understand through the quantitative methods favoured by the positivist paradigm (Dick, 1997) and can best be captured by taking a qualitative approach.

As noted previously, however, there are several different strands within what writers such as Creswell (1994) broadly term the qualitative approaches, raising the question whether it is possible to specify the research paradigm more precisely. A difficulty here is caused by the prevailing terminological confusion, referred to above, and by the fact that paradigm descriptions found in the literature are inevitably somewhat artificial. Guba and Lincoln (1994) admit that their descriptions are “broad brush strokes” (p117) which may not always be apt at the individual level, while

Creswell (1994) suggests that in practice few studies conform in every respect to the “ideal” version of a single paradigm.

With these caveats in mind, however, I suggest that Wadsworth’s (1998) terms, “critical constructivist” and “critical interpretive” (which she uses synonymously) are appropriate descriptors for this work. To understand these terms it is useful to revisit the four – paradigm typology offered by Guba and Lincoln (1994), in which two paradigms, “critical theory et al.” and “constructivist”, share many common features, as noted previously. Although the authors distinguish between the two on certain dimensions, they do not suggest that they are incommensurable, and in fact this research contains elements of both. In terms of ontology, for example, the “pure” constructivist position is relativistic, assuming “local and specific constructed realities” (p109), while the “pure” critical ontology is said to be based on historical realism. However, it seems to me that the notion that there are individual “constructions” need not preclude the possibility of these being influenced by historical, political, economic and cultural factors. Some degree of commonality of experience of such factors may help to explain the idea of varying degrees of shared or agreed constructions (or what Schwandt (1994, p131) calls “social” construction), thereby resolving an apparent contradiction in the constructivist approach.

As regards the process of knowledge creation, too, the constructivist notion is open to critique. Glaser (2002) for example, questions the idea that data is constructed with interacting interpretations between researcher and participant, suggesting that this only applies to lengthy, in – depth interviews and, moreover, involves some ‘forcing’ on the part of the researcher. In his view, any interpretation is provided by the informant, and for the researcher to add his own interpretations would be “an unwarranted intrusion” (p8). Critical theory, in contrast, does not simply see knowledge as “created” between the researcher and participants, but is more explicit about the

researcher's influence and the mediating role of personal values, that is, the way the researcher's prior assumptions and ideologies can influence the conduct of the research and interpretation of the findings (see for example, Habermas, 1999b). In these respects, therefore, the critical perspective offers a useful balance to the constructivist approach, since it encourages researchers to consciously set aside such values, rather than rushing to make assumptions, and to be open and explicit about their background, their thinking, and their roles and relationships in the research (Sandberg 2005).

Another feature of this study which can be linked to the critical paradigm is its emancipatory aim. By involving and giving a voice to a range of stakeholders in phase one, and facilitating engagement between different stakeholder groups in phase two, the aim was to empower participants to express their needs and concerns and make decisions that they themselves identified as important to them. A problem can be raised, however, in relation to the "transformative" (Giroux, 1988) role assigned to the researcher in some accounts of critical theory, in that it privileges the knowledge or perceptions of the researcher over those of participants, assuming that insight will be generated and change facilitated through the researcher's challenging ignorance and misapprehensions. This assumes that the researcher knows in advance what kind of transformation is needed (Guba and Lincoln, 1994). No such assumption was made in this study. Rather, I saw my role in the constructivist terms of facilitating the emergence and understanding of multiple voices and constructions. Such a role does not preclude change or emancipation – but change will be facilitated as participants are stimulated to act on emerging reconstructions, rather than 'instigated' by the researcher as "expert".

Thus the research is grounded in a transactional, subjectivist epistemology and dialectical methodology shared by critical theory and constructivism, and draws on both paradigms in relation to the ontology, the research aims, and the role or "voice" of the researcher. Writers such as Schwandt (1994) and Wadsworth (1998) report similar

blending of interpretivist /constructivist and critical approaches. Moreover, the implications for research validity are similar; Kincheloe and McLaren (1994) in their discussion of critical theory apply the same concepts of verification (using such terms as trustworthiness, credibility and transferability) as are applied to constructivist research by Guba and Lincoln (1994). These concepts are central to the verification of research quality in the qualitative paradigms, and will be discussed in detail in a separate section.

5.3. Research Design

The purpose of this section is to provide an overview of the research design, both as originally conceived and as it evolved during the course of the research, as well as the thinking that influenced the choice of methodology and methods. The various elements introduced here are discussed in more detail in subsequent sections, to which cross – references are provided.

The research was concerned with the mutual perceptions and communication between stakeholder groups. In other words, the research was concerned with a human activity system, rather than a technical system. Specifically, trust and relational quality were viewed as socially interpreted reality. Such a perspective implies the inappropriateness of nomothetic methodologies based on a positivist epistemology and an objectivist, reductionist stance. Such methodologies, in the present situation, could give rise to context stripping and the exclusion of meaning and purpose (Guba and Lincoln, 1994). What was needed was an ideographic methodology, which could explore activity and opinions.

Moreover, since the research had, in addition to the aim of developing theoretical understanding, a practical aim of facilitating action in a real – world context, it would be appropriate to adopt a method of inquiry which involved those who would be expected to implement any agreed changes, or to be affected by them, giving them “ownership” of the project. As a point of entry into the research, some preliminary

ideas on who might be involved and affected, and possible areas of concern, were provided by the literature (although, as will be seen, both of these were negotiated with participants in the course of the research).

The research of Walsh (1995) identified broad stakeholder groups: patients, practitioners and administrators, and similar categories emerge from other studies of quality in health service, for example Ludbrook and Gordon, (1999). Moreover, the literature reviewed in chapters two and three suggested that these groups may have very different perceptions, needs and interests in relation to trust and service quality – indeed, this is a source of the ‘quality gap’ identified by Walsh (1995). This is not to say that this research was intended to fill the gap but rather to suggest that participation of different stakeholder groups was desirable in order to take account of such differences.

Reason (1994) sees participatory inquiry methods as seeking to establish liberating dialogue with impoverished and oppressed peoples. In the context of this research, it seemed possible that patients, in particular, may be seen as impoverished in relation to access to information (although practitioners and administrators may also be impoverished in the sense of lack of knowledge and understanding of patients’ perceptions and concerns). Moreover, patients may feel oppressed in so far as they feel unable to express true opinions due to the power differential between themselves and providers on whom they rely for needed care. In a different way, practitioners may also feel oppressed, in the sense that economic and political pressures constrain them to pursue targets and performance indicators imposed by non – professionals. It has already been pointed out in the literature review that the trend towards such indicators, in pursuit of regulatory approach to service quality, may actually be counter to clinical effectiveness and may therefore conflict with practitioners’ professional values (Lally and Thompson, 1999).

I should make clear, here, that I did not enter the research assuming that this would be the case, but was aware from the literature that it might be the case and that my choice of research methods should take account of this. My concern was essentially to be open to the constructions of the situation that emerged from those involved in it.

In such a context, a participative form of inquiry was appropriate. Moreover, the implication was that members of all of these groups needed to be included among the participants of this study, both as sources of information as to the present situation, and as contributors in generating ideas for action.

With these considerations in mind, this research took the form of a Participatory Action Research (PAR) project, grounded in Critical Systems Thinking (CST).

CST (see Chapter Four) provided the overarching framework because it is theoretically and methodologically unified. Its role in the research is to gain a critical awareness of the underlying assumptions and implications of methodology, methods and techniques. CST helped me to guide my decision – making in the research, in several ways. At the most basic level it did so by offering a tool, the SOSM – discussed in Chapter Four – which facilitated understanding of and reflection on the philosophical underpinnings of various methods, and their strengths and weakness in different research contexts. CST's principle of what is variously called pluralism and complementarism (Jackson, 2003, more recently, prefers the term “creative holism”) encouraged and facilitated the creative use of a variety of methods or parts of methods as appropriate to address emergent situations in the research.

Throughout the research, with every new situation encountered, whether conflicts of interest among stakeholders, practical difficulties (for example, time constraints of senior managers), or relationships (between myself and participants, or among participants) I asked myself, “What does CST say about that?” At a deeper level, CST informed my thinking by its commitments to critical reflexivity and empowerment.

Thus, I continually reflected on what I was doing, and why, and considered its impact, not only on the research itself, but on the participants to whom I had ethical responsibilities (these issues are discussed further in sections 5.8 and 5.9).

Within this CST project, PAR played the role of the methodology in terms of participation and negotiation of action. The PAR project was conducted as a project within the “User-Centred Research Programme” established in cooperation between a group of NHS Trusts and universities (see ‘participants’ section 5.5 for more details).

The compatibility and linkage between the methods of human inquiry (of which Participatory Action Research is one form) and CST have already been discussed (Levin, 1994; Flood and Romm, 1996) with a focus on their commonality in terms of emancipation and power relations. PAR is not expert driven, but seeks to liberate participants so that they see their own reality, not a substitute reality imposed on them. It recognises the need to expose different viewpoints and the biases inherent in them.

PAR is committed to the technical and the social, consistent with the adherence to the practical, technical and emancipatory interests (Habermas, 1999c) which is one of the underpinnings of CST. Like CST, PAR adopts a complementarist stance. Moreover, critical reflection is built in to the PAR intervention process, in that findings are offered back to the group and disconfirming data sought. PAR is further discussed in section 5.4, while the process of offering findings back to the group is discussed in section 5.8.

The research was originally planned to be carried out in three phases, denoted, respectively, as “Finding out”, “Engagement” and “Suggesting and Testing Solutions”.

The purpose of Phase One, “Finding Out” was to explore the perceptions of individual NHS service users, providers, and administrators, concerning quality, communication and trust in health services. This was done by means of semi – structured interviews, in order to allow participants’ own opinions, concerns and

priorities in relation to the core topic areas to emerge, and so build up a rich picture. The NHS has found ‘discovery interviews’ useful in quality improvement initiatives, as a way of understanding users’ needs in users’ own terms and from their own perspectives, rather than the assumptions and agendas of providers (Department of Health 2003). Similarly, these interviews were expected to provide a deeper understanding of individual perceptions and experiences as a basis to move forward, so that the subsequent phases would be guided by these perspectives, rather than the assumptions of the researcher. In these interviews, it would be possible to go more deeply into individual ‘stories’ and critical incidents than would be feasible or appropriate in a focus group interview.

The outcomes were expected to be twofold: insight into the relationship between communication, trust and quality, derived from the researcher’s synthesis and analysis of the Phase One findings, and identification of themes and issues to be explored by multiple stakeholders in Phase Two focus groups.

The intention in Phase Two, ‘Engagement’, was to take up issues uncovered in Phase One, for exploration from the multiple perspectives of the various stakeholder groups – users, providers and administrators, in order to open up communication between them and give them an opportunity to view issues of concern from each others’ points of view. At the same time it was hoped that this process would begin a process of trust – building which would facilitate coordinated action for improvement in Phase Three. As an example of the relationship and distinction between Phase One and Phase Two: early interviews conducted in Phase One yielded individual stories of one user’s conflict with a nurse about medication when in hospital, and another’s efforts to obtain information about her learning – disabled daughter. A Phase Two focus group was not expected to debate such individual cases, but it was envisaged that underlying themes identified from these stories, such as information policy or the unequal relationship

between patients and practitioners, might be debated. The outcome of this phase would be a shared understanding, and agreement on a specific ‘‘problem’’ to be the focus of an initiative in Phase Three.

To summarise, the distinction between Phases One and Two as originally planned is as shown in the following table:

Table 5.1: Initial Research Design: Phase One and Two

Attribute	Phase One	Phase Two
Perspective	Individual	Multiple
Purpose	Mapping the field Identifying issues	Engagement between groups Trust – building Decision on ‘problem’ for intervention
Focus	Particular experience	General concern
Nature of Issue	Concrete	More abstract
Beneficiary of Learning	Researcher	Researcher and Participants

The intention in Phase Three, ‘‘ Suggesting and Testing Solutions’’ was to use TSI to guide coordinated action among stakeholders to address the ‘‘problem’’ identified by them in Phase Two as a priority for action. The TSI process is a practical operationalising of the key ideas of critical systems thinking, which encourages creative thinking about problems, critical awareness about methods used for solution, and critical reflection on the whole intervention process. It has a number of features which make it suitable for application in conjunction with PAR. It is a combination of research and consultancy within a learning framework, which is consistent with PAR’s involvement of participants as part of the research team, conducting their own research in their own interests.

TSI promotes organisational learning through the inclusion of participants, and casting the researcher as facilitator rather than expert, with the process under participant control and the intention is that it should be possible to continue the process after the researcher has left the research setting.

The same intention that participants will learn to continue the iterative process of improvement is found in PAR. Moreover, I expected critical reflection on this experience to give me an opportunity to consider whether and how “communication” and “trust – building” facilitated decision – making and action for quality improvement – hence complementing the insights on the relationship between quality, communication and trust generated in Phase One (this original design is depicted in figure 5.1).

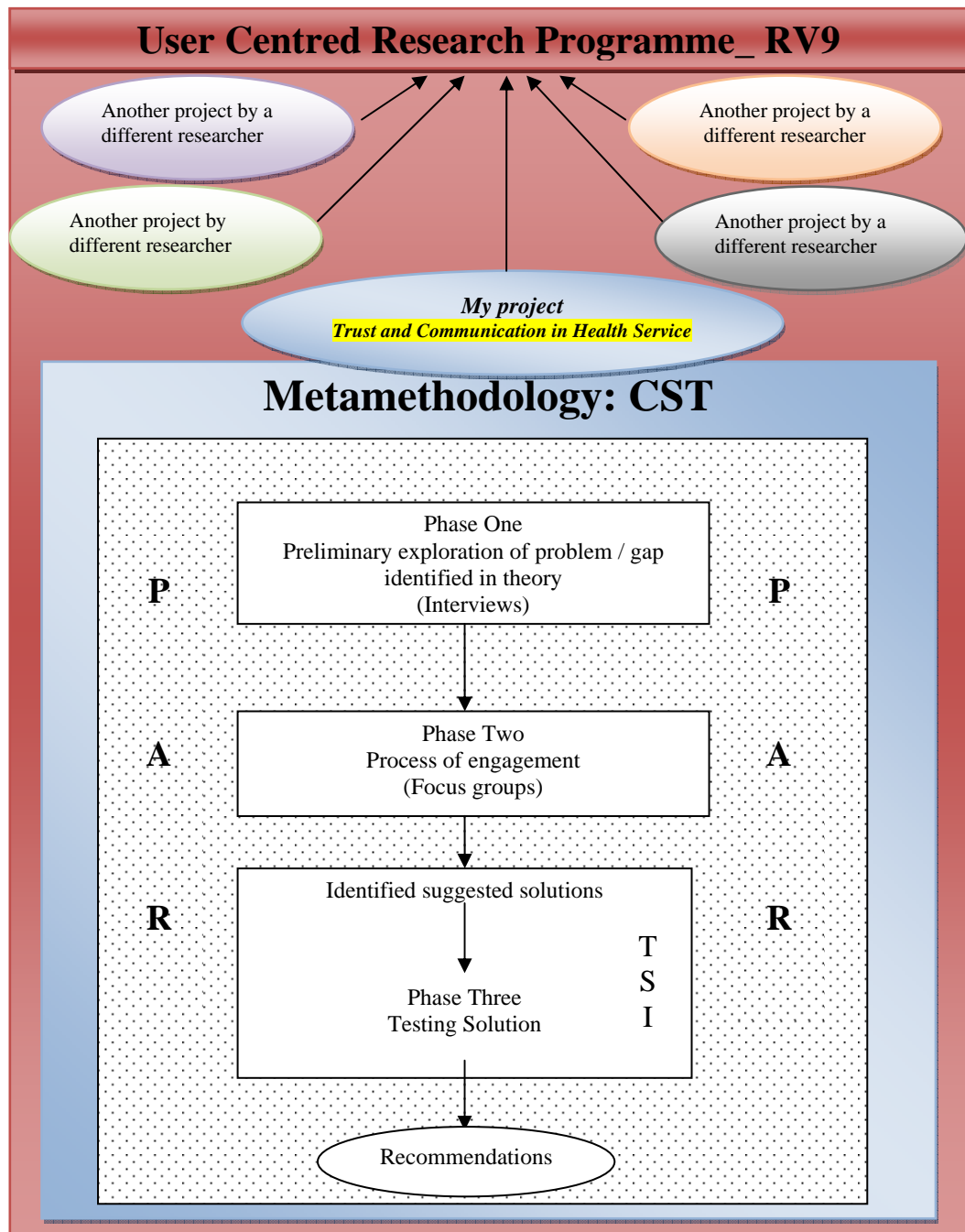


Figure: 5.1. Research Design: Version 1

In practice, the emergent outcomes of the earlier stages of the research resulted in a decision for reasons that will be explained later, not to use TSI, and I will therefore not discuss it further here.

While Phase One was ongoing, however, I became aware that the way I had formulated the research question was problematic. The question was originally formed in the form: “how can trust improve quality”? As I reflected, my improved understanding of the implications of the research question, particularly the word ‘improve`, together with emerging understandings from interviews, led to a growing realization that the question, as formulated, did not accurately reflect the intention of the research. It was potentially confusing, tending to arouse mistaken expectations of some sort of quantitative findings and recommendations, more reflective of a positivist stance. Indeed, I had evidence in the discussion with managers in the Humber Mental Health Teaching NHS Trust (HMHTT) that, being more accustomed to positivist research, they experienced such confusion. Moreover, the original framing of the question had implications which could not be fulfilled, given the prevailing constraints. The question as formulated could not be answered in a cross – sectional study; it would require a longitudinal study in which it was demonstrated, over time, that some change in a positive direction had occurred. This, in turn, would imply some methods for measuring quality. However, it was not the intention of the research to measure quality and, even if it had been desired to do so, a longitudinal study was not feasible. The NHS is a sensitive and costly public service which is the target of successive government measures, resulting in changes of policy, administrative structure and so on. The situation provided no certainty that conditions would remain constant, nor would it be clear how far any ‘improvement` was due to the research intervention and how far to these external influences. At the same time, the interviews were progressing well and yielding useful insights into the issues of trust, communication and quality, in line with

the research interest. The problem lay in the formulation of the question; it was one that was potentially answerable, but in a different environment, with a different kind of research.

The concern, then, was how to formulate the research question to remove the misleading reference to improvement. One alternative considered, during the phase of growing awareness of this problem, was, what is the role of trust in the management of quality? This, however, appeared to imply an emphasis on the service providers' perspective – on what they do in the name of quality – whereas the intention was to include the perspectives of all stakeholders.

Eventually, through reflection on the trust and quality literature and on the outcomes of the interviews I had conducted, the realization emerged that the central issue was one of perception. Trust emerges in the literature as a matter of perception (whether experience – based or not) – of the trustee's competence, reliability, integrity, good intentions and so on, at least some of which can be seen as quality issues. Similarly, quality 'measures' such as SERVQUAL are actually concerned with how quality is perceived rather than objective measures. What I was actually trying to explore through my interviews, was people's perceptions. In order more accurately to reflect the research nature and intention, therefore, the research question was reformulated as, *what is the role of trust in relation to how quality in HMHTT is perceived?*

The concept of role is understood differently in different disciplines and from the perspective of different philosophical approaches. From a functionalist perspective, the word 'role' is equated to function, whereas in the social sciences it is more often used in the interpretivist sense of 'meaning'. It is this second sense of role that is adopted in this study. To examine role in the sense of function would seem to imply a preconception on the part of the researcher, not only that there is a relationship between

trust and quality, but that there is some kind of causation involved. This may be the case, as implied by some of the literature reviewed, but it would be inappropriate to make this assumption in a study which is essentially concerned with the way participants perceive and interpret the issues under investigation.

It would also risk oversimplifying a complex association. Although as indicated in Chapter Two, some literature depicts trust as contributing to perceptions of quality, another interpretation would interpret trust as an outcome of quality or even, as in a sense equivalent to a perception of quality. In the latter case, the relationship is not necessarily a 'function'. Thus, I preferred to view the notion of 'role' in a less limiting sense, leaving open the possibility that participants may see other kinds of connection between trust and quality than that implied by the notion of 'function' (or even, of course no connection at all, depending on their understandings of the two concepts).

The functionalist interpretation also raises the difficulty that, like the concept of improvement, it implies something that can be observed or measured in some way; as it implies that a perception is being created or changed and that this is directly attributable to trust. As indicated previously, objective measurement was not the purpose of this study.

In contrast, to understand 'role' in the sense of meaning accords with the purpose and philosophy of the research. As indicated in the discussion of the research paradigm (see section 5.2) the research was based on an assumption that individuals form their own constructions of the social world, based on their backgrounds, culture, values and experiences. My aim, therefore, was to explore those constructions and to arrive at an interpretation which could be recognized as valid by the research participants. This may, or may not, include some notions of functionality, but it is essentially a question of 'meaning'.

This issue was explored through several secondary questions which are shown as follows

Table 5.2: Secondary questions

Area of Concern	Question	Sub – questions and issues
Quality	1) How do stakeholders currently perceive quality in the service provided by HMHTT?	1. a.) What does quality mean to the participants? 1. b.) Do different stakeholder groups agree in their perceptions of quality? 1. c.) How far is the participants' ideal of quality met in practice in the service?
Communication	2) How do stakeholders in the HMHTT communicate?	2. a.) How do they feel about the quality of communication? 2. b.) Are there obstacles to effective communication?
Trust	3) What does trust mean to stakeholders in the HMHTT context? 4) What factors can be identified as conducive to trust? 5) What factors can be identified as barriers to trust? 6) What action (chosen and implemented by stakeholders) can be taken to facilitate the supporting factors and reduce the barriers to trust?	3. a.) Cognitive - do service users see providers as competent, reliable, etc? 3. b.) Affective- how do service users / carers feel in interaction with providers? 3. c.) Behavioural- how do service users' / carers' perceptions and feelings influence their behaviour (e.g. compliance with treatment, involvement in research, involvement in designing the service, involvement in the decision making process)? 3. d.) How important is trust to stakeholder? 3. e.) Do different stakeholder groups agree in the meanings they attach to trust?

Along with this improved understanding of the research question came a revision of the research design, with a clearer conceptualization of the relationship between its theoretical and empirical components, and a modification of the structure and scope of the empirical work. The theoretical part of the work substantiates the case

that trust is still an issue of concern in the NHS and, based on the trust literature and the quality models of Parasuraman et al. (1988), Maxwell (1992) and Walsh (1995), all of which have connections to trust, establishes a link between quality and trust. Indeed, it could even be said that Trust = Quality. With this link established, the empirical aspect of the work focused on exploring the level of trust, and how it might be enhanced. This was conceived as a two step process:

Phase One: individual interviews; the purpose of which was to explore issues of trust, communication and service quality as a starting point for later (qualitative) evaluation. This phase was to address questions 1, 2, 3 and their associated sub-questions.

Phase Two: Workshops; participants would be shown the data collected, in the form of a cognitive map. The aim in these workshops was to identify from the data, factors that are conducive to trust, and factors that are barriers to trust, and move towards ways of facilitating the former and removing (or at least reducing) the latter. For this phase, it was decided that, for reasons explained in section 5.7, Soft Systems Methodology (SSM) rather than TSI, would be more appropriate. This phase, in which I draw on the reflections presented in Chapter Four (section 4.3), on developing a trust dimension within CST, was intended to address questions 4, 5, and 6.

By reformulating the research question and revising the design in this way (see figure 5.2), ambiguities and inconsistencies inherent in the original conceptualization were removed and the linkage between the research question, theory and empirical work was more strongly and coherently established.



Figure: 5.2. Revised Design

5.4. Action Research

Fieldwork was undertaken between October 2005 and May 2007. An intensive Participatory Action Research (PAR) project was conducted within a Critical Systems Thinking (CST) framework, employing selected research methods, which will be discussed in turn later in this chapter.

For several decades, some researchers have been using a research approach which they variously characterize as ‘action research’, ‘participatory research’ or ‘participatory action research’. Within this trend, there have been different emphases.

Some, particularly in education research, have focused more on the action component (for example, Kemmis and McTaggart, 1998). Others, such as Senge (1990) have focused more on the participatory process. Many in the social sciences have identified it as a distinct research method in its own right (Whyte, 1991; McGuinness and Wadsworth, 1991).

“Essentially participatory action research is research which involves all relevant parties in actively examining together a current action (which they experience as problematic) in order to change and improve it. They do this by critically reflecting on the historical, political, culturally, economic, geographic and other contexts which make sense of it” (Wadsworth, 1998).

Ultimately, good research is that which fits the situation and is suitable to the research objectives (Creswell, 1994). This research is interested in the dialogical process whereby people can explore their worldviews and recognise the assumptions they are making. It also demands the ability to be responsive to change of a situation. Action research is valuable for these purposes.

From Wadsworth’s (1998) perspective, PAR is ‘‘new paradigm’’ research, as PAR, which is to a greater or lesser degree participatory, enables action, and involves some level of ‘‘critical reflexive, sceptical and imaginative inquiry’’ (Wadsworth, 1998, p2). It is consistent with the research philosophy, discussed in section 5.2, which views understanding of the social world as depending on the exchange and communication of multiple and often conflicting interpretations of what is going on, in contrast to the ‘positivist’ stance of ‘old paradigm social science’.

Action research is an approach that challenges the traditional positivist view of knowledge when applied to the social world of human activity systems (in the present case, health care planning, delivery and consumption). It tries to overcome the limitations of positivist research in such contexts – discussed in section 5.2 – by

bringing together the researcher and those involved in the “problematic situation”, in activity which generates learning and leads to change. Thus, action research has twin goals of practice and research which are reflected in Rapoport’s (1970) definition:

“... 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 ethical framework” (Rapoport (1970: 499).

One aspect of the ethical framework is the development of a mutual relationship between researcher and clients, in which the researcher is prepared to address other people’s concerns as well as his/ her own and to involve all parties as active participants in a sharing of experience out of which change can grow (Blum, 1995).

Because action research assumes that the phenomena studied are human artefacts, created for human purposes, rather than existing independently of human beings, and because its aim is to develop guides for action producing desired outcomes, rather than prediction, it has a broader perspective than positivist science. The former observes the present. The latter, however, also tries to use knowledge of the past to interpret the present and, moreover, to conceptualize a more desirable future (Susman and Evered, 1978).

The epistemological and ontological stance of action research has important implications for research methods and characteristics. It is a process of critical inquiry, with an orientation towards social practice and involving a continuous process of reflective learning (Argyris et al., 1985). For this purpose, it requires the researcher to immerse him/herself in everyday settings, gathering qualitative data based on the subjective accounts of participants. Questions and problems are taken from the local context; descriptions and theories are built up as a result of close collaboration between

researcher and participants and are tested within the local situation (Gregory et al., 1994; Walsh, 1995).

Compared to the positivist approach, PAR involves a more conscious 'problematizing' of an action or practice, more planned and deliberate involvement of those who could or should be involved in the inquiry process; more care in documenting and recording action and opinions in detail and in ways which are accessible to other relevant parties; more 'self – sceptical' (Wadsworth, 1998) and more willingness to change and reflect on actions as part of the research process. Action researchers recognize the practical and ethical implications of the values driving their inquiry and the actions that follow from it. This means more conscious and explicitly acknowledged decisions about the questions to be raised, the people to be included, the phenomena to be observed, the interpretations adopted and the actions taken, and consideration of the effect of including some alternatives and excluding others. In this respect it fits well within the CST framework of this research. The way these requirements were met in this research will be explained in subsequent sections of this chapter, and reflected in the presentation of outcomes and reflections in the chapters that follow.

5.4.1. The action element of PAR

All research involves taking action in relation to an existing situation, and all research has consequences for those involved. Even a decision not to change course as a result of the understandings and impressions gained from the research is still a form of action. Most PAR, however, sets out with an explicit agenda of change and empowerment, motivated by a situation that those affected perceive as unsatisfactory and which they seek to alter. Movement towards improvement involves a creative and imaginative leap from the actual to the possible – from what is the case now, to what could be the case in a desirable future.

Such transformation is not conceptualized in terms of predictive theory (if X, then Y). Rather, PAR recognizes and welcomes the potential of human actors to select and implement or to subvert theories and predictions. It is concerned with exploring possibilities, rather than predicting cause and effect (Wadsworth, 1998).

5.4.2. The participation element of PAR

Action research has been described as “the way groups of people can organise the conditions under which they can learn from their own experiences and make this experience accessible to others” (McTaggart, 1991)

Various parties are involved as ‘participants’ in any research, but the question is, who participates, how much, and in what ways, and how far is their participation taken into account. Conceptually, three broad categories of participants can be identified: the researcher, the critical reference group (the group that has the “problem” the research seeks to resolve) and other stakeholders who might benefit from better information about the situation, such as policy makers and service providers. What distinguishes PAR from ‘old paradigm’ social research is greater participation and closer interaction of all the parties and, indeed, a blurring of the distinction between them (Wadsworth, 1998).

Conventionally, researchers participate the most, since they choose the research questions and methods, and interpret the findings. However, in the pursuit of ‘objectivity’, they may fail to make explicit their values, experiences and ideas. This may in itself cause distortion, however, as other participants may not fully understand the nature and purpose of the research. A more participating researcher would be more transparent about why they are interested in the research, and their relationship to the critical reference group, as discussed in relation to the research paradigm (Section 5.2). The various ways in which this was achieved are discussed in subsequent sections on

the conduct of the various phases of the research, and on validity and reliability, and on the research ethics.

The critical reference group is the group that, traditionally, participates least in the research, even though they are the intended beneficiaries; they are 'researched for' rather than researching; the 'done to' rather than the 'does'. Greater involvement of the critical reference group, however, is likely to lead to greater relevance of the inquiry to their needs and concerns, more effective research design, greater meaningfulness of the information obtained, more relevant and effective action, and greater commitment to implementation, monitoring and reflection on the new actions. In this research, the critical reference group can be considered to be HMHTT service users and their carers. As explained elsewhere in this chapter, they were involved in every aspect of the research, from identifying other stakeholders (section 5.5) through the data gathering and debate (section 5.6 and 5.7) to verification of interim and final reports (section 5.8.).

Other stakeholders often participate only at the beginning of the research (as commissioning agents or providers of funds) or at the end (as recipients of a report). Their involvement as participants during the research process, however, has several advantages. It allows their interests to be made explicit and their 'realities' to be understood; it involves them in the same learning process as other participants, so they are more likely to understand and accept the final report; and it helps them to see the practical consequences of a set of findings or recommendations. Service providers, in particular, benefit from the opportunity to make a closer link between their theory and practice. This is most valuable when the participation is "organised around the interests of the critical reference group driven by a critical reference group perspective" (Wadsworth, 1998). In this research, these stakeholders were involved in several ways: as participants in individual interviews (Section 5.6), through a Delphi – like exercise (Adler and Ziglio, 1996) as a means of engagement with service users in the second

(workshop) phase of the research (section 5.7), and as recipients of various presentations and progress reports as set out in the research contract on which ethical approval was based (section 5.9.).

5.4.3. Dilemmas and limitations

The choice of action research as a methodology is not without its problems. The research is subject to a variety of philosophical, social and practical dilemmas (Gill and Johnson, 1997). For example, the researcher's conceptualization of the research problem and context, and his selection and implementation of a research strategy, will be governed by his code of ethics, and philosophical assumptions regarding human behaviours and the nature of knowledge – and these in turn will be influenced by previous social conditioning. There will be political issues, such as the nature of power relations among the participants; and practical considerations, such as resource constraints (Gill and Johnson, 1997). Such issues, however, arise in any research. What is important is to be critically aware of them, and their possible impact, and this is the benefit of using CST as an overarching framework, as explained earlier, in section 5.3.

Perhaps the greatest concern regarding action research is that the learning it produces is narrow, situational and bound by context, in contrast to the universality claimed by positivist science (Susman and Evered, 1978). Social settings cannot be replicated exactly, and this raises the question whether the research outcome would be applicable elsewhere.

This does not undermine the value of PAR for this project, since the research is concerned with developing an interpretive understanding of what is occurring, on my own part as researcher, and on the part of the participants. The aim is to enable them to interpret the world in a way that is locally relevant and applicable to them – not to arrive at some ultimate, universal 'truth' about the health service.

Warmington (1980), however, suggests that whilst the direct results of action research may be context – specific, it can generate improved understanding about the investigation of complex realities, which is generally applicable. In this way, the contingent nature of learning from action research is reconciled with the demand that research leads to generalisable new “truths”.

5.5. Participants

This section addresses the target populations for the research, conceived in terms of identification of stakeholders, and the recruitment procedures employed.

5.5.1. Identification of stakeholders

Because of the unmanageable size of potential populations in the NHS as a whole, and even in any individual region, and the different interests and concerns that may prevail in different areas of care, making a comprehensive investigation impracticable, it has been decided to focus on a single area of health care. The selected area is mental health. This is not to privilege this group at the expense of others, but to confine the study within workable limits so that health professionals, administrators, and service users, can be reasonably represented. The learning generated by this project may be used and adopted by other groups to address their own concerns.

An advantage of focusing on mental health is that HMHTT has an active Research and Development (R&D) unit, which is running a User Centred Research Programme (UCRP). The programme, a partnership between seven NHS Trusts (Tees and North East Yorkshire NHS Trust, Hull and East Riding Committee Health NHS Trust, Doncaster and South Humber Health Care NHS Trust, South West Yorkshire Mental Health NHS Trust, County Durham and Darlington Priority services, Leeds Mental Health Teaching Trust and Newcastle, North Tyneside and Northumberland Mental Health NHS Trust), three universities (University of Sheffield, Leeds Metropolitan University and The University of Hull) and three research teams (Impact

Research Team, Trailblazers Research Team and Direct Impact Research Team), scrutinises, promotes, commissions and advises on research by service users and carers into mental health and various aspects of health services.

The present research constituted a project within the UCRP, in which I took the role of facilitator. In order to recruit participants, it was necessary first to identify the critical reference group and relevant stakeholder groups. In this respect, useful guidance was obtained from Critical Systems Heuristics (Ulrich, 1983), which aims to support a systematic process of boundary critique. With this in mind, CSH offers a framework of boundary concepts which translate into twelve critical boundary questions (Ulrich, 1987, 1996, 2000). Some of the boundary categories are abstract, for example, “purpose” or “expertise”, but four of them relate to the categories of persons involved in or affected by the issues under investigation. These questions ask who are the system’s clients (as a source of motivation for the system); decision – makers (as a source of power); professionals (as source of knowledge) and witnesses (as source of legitimation). Reflecting on these questions, together with the literature reviewed in Chapter Two and Three, I took as the critical reference group and clients of the system, service users, that is past and present patients of HMHTT. The justification for this is that the literature on trust in a health care context consistently identifies the “problem” as an absence or erosion of trust in the system, on the part of service users (Harrison et al., 2003; Checkland et al., 2004). Moreover, service users are source of motivation for the system, in the sense that the purpose of the NHS and its divisions, such as HMHTT, is to provide health care for service users.

Once participants from this group had been recruited as described in section 5.5.2, I involved them in identifying the other stakeholders, namely, the decision makers, professionals and witnesses. We jointly identified the following categories:

Decision – Makers:

- Senior managers located in various departments or functional areas within Humber Mental Health

Professionals:

- Front line practitioners (Doctors, Psychiatrists and Nurses)
- Back line practitioners (Managers, Researchers, Clinical Governors, and Administrators).

Witnesses:

- Informal carers, that is, parents, partners or others who have an on – going role in supporting a client of the system.
- Members from the Public and Patients Involvement (PPI) Forum.

It should be noted that boundary judgement is inevitably somewhat subjective and it would be possible to draw boundaries differently and identify other stakeholders. For example the government could be regarded as a source of motivation and / or power, since it provides funds and sets the regulatory environment in which health care is provided (for example through legislation such as the Data Protection Act 1998). As another example, any member of society is potentially a “witness” to the way health care is delivered. The identification made here is, therefore, not a comprehensive selection of everyone who could conceivably have any interest in health care, but of those stakeholders perceived by service users as relevant to HMHTT and their concerns and experience in particular.

5.5.2. Recruitment of participants

UCRP – HMHTT has a database of service users. Initially, therefore, postal invitations to participants were sent to all addresses stored in the HMHTT database, as a quick and cost – effective way of communicating with a large number of potential respondents. However, this brought no response at all.

In the light of later discussion, it seems that a major factor in the lack of response was lack of trust in research, based on previous experience that ‘nothing changes’.

I was prepared for this eventuality, as I realised that it might be difficult for people to commit themselves to a relationship with an unknown researcher, especially on such a sensitive subject as trust. I was therefore ready to adopt an alternative strategy. This was consistent with my use of creative holism, as a practical aspect of CST, to choose the approaches and techniques best suited to the prevailing circumstances. Moreover, one of the advantages of phenomenological research is the flexibility to adapt to circumstances. Such adaptation is consistent with Mintzberg’s (1978) concept of emerging strategy (see figure 5.3).

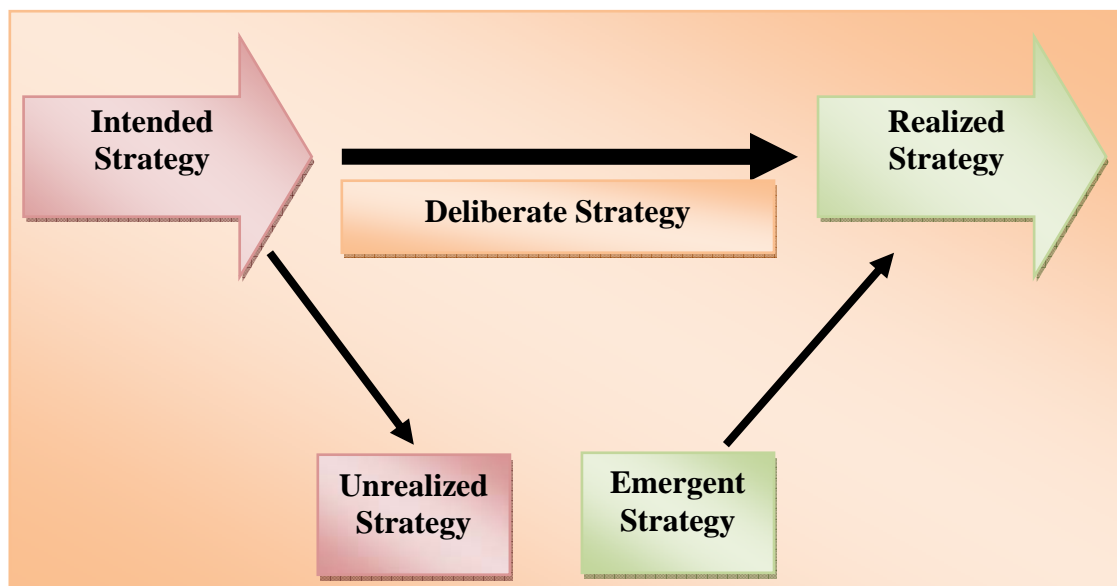


Figure: 5.3. Mintzberg’s emergent strategy

I attended meetings of various groups within HMHTT; such as MOSOS (Monitoring Our Services Our Selves) and the Social Inclusion group, as well as a meeting of Rethink, in order to introduce myself and explain the aims of the research and its expected outcomes.

Rethink is the operating name of the National Schizophrenia Fellowship. For more than 30 years, the organization has been working with informal carers for people

with mental health problems. Its activities include conducting research, providing support groups, and providing services such as respite care, advocacy, carer support, education and training. The meeting attended was a meeting of a local support group.

By attending these meetings and approaching potential participants in person, I was able to gain the interest and “knowledge – based” trust (see Chapter Three) of a small number of service providers, users and carers who agreed to take part in the research. With the commitment of those participants secured, other relevant stakeholders were identified and recruited, both through formal invitation from myself and through a process of ‘snowball sampling’ (a form of non – probability (i.e. non – random) sampling in which members of the initial sample are asked to suggest others who may have relevant knowledge and interest. The people so recruited, in turn, suggest others, so that the sample grows, similarly to the way a snowball, rolled along the ground, becomes larger as it picks up more snow). By this means, 14 clients, 3 (out of 4) decision makers, 6 professionals and 5 witnesses were recruited, all from the Humber region.

I entered the research with no pre – assumption about the number of participants to be included, beyond the fact that the time – consuming nature of semi – structured interviewing and qualitative analysis would place some constraint on the feasible number. Morse (1994) suggests that in phenomenological inquiry, as few as six participants may be sampled, but this would not have provided a sufficient spread of roles and interests for an organisation as large and complex as HMHTT. Bearing in mind the stakeholder groups identified, it was agreed with the initial participants that around 20-25 participants would provide a reasonable spread of opinion.

5.6. Phase One: Interviews “Finding Out”

5.6.1. Interview schedule: The semi – structured interview

Semi-structured interviews were used to obtain information from members of the various stakeholder groups identified in section 5.5, in order in order to understand their perspectives on trust, communication and quality in the service provided by HMHTT (as individuals and as groups), Semi – structured interviews are one of three main types of interview described by writers on research methods, the others being structured and unstructured. The structured interview, where the questions and the order in which they are asked are determined ahead of time, may increase the reliability of the interview, but it does not allow an in – depth discussion with the interviewee, because the interviewee has limited opportunity to express his/her opinions (Kvale, 1996). This would be inconsistent with CST’s espoused commitment to empowerment and, in particular, the aspiration in this research to adopt forms of communication that are, as far as possible, undistorted by power relations.

The unstructured interview is time – consuming and requires considerable expertise to conduct. It can be a challenge for the interviewer to keep the discussion focused on the issues of concern to the research (Bell, 1993).

The semi – structured interview lies between these extremes and uses techniques from both. Questions are normally specified, but the interviewer retains freedom to probe beyond the answers (May, 1997). This type of interview gave me as a researcher the chance to explore more deeply the issues under investigation by interacting with interviewees, as suggested by Kumar (1999).

Qualitative research interviews have several advantages, being highly flexible and capable of being used almost anywhere. They can produce data of great depth, the purpose being “to gather descriptions of the life-world of the interviewee with respect to interpretation of the described phenomena” (Kvale, 1983:174). In other words “to see

the research topic from the perspective of the interviewee and to understand how and why he or she comes to have this particular perspective” (King, 1994:14).

Qualitative interviews vary in focus – from a broad focus on the individual’s whole life-world, as seen in ethnographic research (Fetterman, 1989) to a narrower focus on particular topics and how they are perceived and understood by interviewees. The interviews in the present research were of the latter kind, aiming to explore the questions raised earlier in relation to trust, relational quality and communication in the HMHTT. A key feature is the relationship between interviewer and interviewee. There can be no such thing as a “relationship – free” interview. The relationship is part of the process. The interviewee is not a “subject”, but a “participant”, actively shaping the course of the interview, rather than passively responding to pre-set questions.

Questions focused on how participants described and made sense of particular elements of their lives- the primary concern was not to quantify experience. The researcher tried therefore, not to frame questions in a way that reflected his/her own presuppositions/biases (King, 1994).

An interview guide was created to provide a starting point and references for the interviews. The guide was not a formal schedule of questions to be used word-for-word. Rather, a list of topics was prepared that I expected to cover. King (1994) suggests that topics can be drawn from three sources:

- Relevant literature
- Interviewer’s personal knowledge/experiences
- Informal preliminary explorations

Questions and issues derived from all these sources have already been identified in section 5.3. However, I retained flexibility to modify the guide through use, e.g. adding new topics to reflect emergent issues, dropping any topic that proved incomprehensible

to participants or failed to elicit relevant responses (for a copy of the guide see Appendix 2).

5.6.2. Procedures: Carrying out the interviews

The interviews were carried out between October 2005 and October 2006. Permission to use tape – recording was obtained before beginning each interview. This offers the advantage of leaving the researcher free to concentrate on the topic and dynamics of the interview. It also enables non – verbal clues such as pauses and tone of voice to be preserved for future reference, which can aid the process of interpretation (Kvale, 1996). At the beginning of each interview, I explained the nature and purpose of the research in order to establish a relationship with the interviewee. Also following King's (1994) advice, care was taken to

- Avoid 'multiple questions' (i.e. including several separate issues in one question).
- Avoid leading questions /where the researcher imposes his own perceptions on the interviewee); in other words, not cue the interviewee that a certain type of reply is expected.
- Avoid ending on a difficult or painful topic.

My role was that of a mediator, who directed the interview under flexible conditions, probing for further information when I considered it necessary (Merriam, 1988).

The interviews with service users, carers and professionals, which varied in length from 40 minutes to 1 ½ hours, took place in participants' homes, Trust Headquarters meeting rooms, or other locations, according to the participants' convenience and preference. With senior managers, however, it proved necessary to revise my procedures, as they all insisted that, due to the heavy demands of their roles in the Trust, they could not spare time for an interview of the type I had planned; three were willing to see me, but only for a few minutes. I felt that this was preferable to their

being excluded from the research, and therefore devised a short, structured interview of just a few questions, that focused on the main points from the semi – structured interviews (see Appendix 3). These interviews were conducted in the offices of the senior managers concerned, and were recorded, with their permission. Each of these interviews took about 15 minutes.

5.6.3. Data analysis

Phase One of the research generated a large volume of qualitative data for analysis – a process of data reduction and interpretation.

There are four main types of qualitative data analysis:

- 1) Quasi – statistical – this kind turns textual data into quantitative data – e.g. content analysis (Weber, 1985). The analyst selects a suitable unit of measurement (single words, phrases or themes) and then categorises each unit found. Collis and Hyssey (2003) describe content analysis as a method of converting text to numerical variables in order to apply quantitative analysis, e.g. frequencies. Berelson's (1952) original definition of content analysis was “a research technique for the objective, systematic and quantitative description of the manifest context of communication (p18). Berelson's phrase, “manifest content” implies that content is inherent in messages, waiting to be described for what it is. It neglects the possibility of sources and receivers having different interpretations and restricts content to what is common to all these accounts (Krippendorff, 2004). Krippendorff (1980, cited in Krippendorff, 2004:xiii) criticised content analysis for its “shallow counting game, motivated by a journalistic fascination with numbers and a narrow conception of science in which quantitative measurement provides the only evidence that counts”. Content analysis understood in the quasi – statistical sense should not be used to answer questions which are essentially qualitative, because it is based on a positivist ontology and epistemology which conflict with the philosophical

underpinnings of qualitative inquiry (see section 5.2). There is a danger that large amounts of data may be omitted in the early stages, to record only words / phrases of interest to the researcher, even though these could be important for deeper understanding. Consequently, “its conclusions can often be trite” (Silverman, 2001:123).

More recently, however, the conception of content analysis has broadened to include several qualitative approaches which take content to “emerge in the process of a researcher analysing a text relative to given context (Krippendorff, 2004:19). Examples include discourse analysis, rhetorical analysis, conversation analysis and ethnographic content analysis. Content analysis as understood in this broader conceptualization is an ‘editing’ approach (see point 3, below) rather than a quasi – statistical one.

- 2) The template approach – text is analysed through the use of a guide or codebook (Crabtree and Miller, 1992) consisting of a number of relevant categories or themes. It is like content analysis, except that a) the guide is revised, perhaps many times, in light of the textual data; b) the pattern of themes that emerges is interpreted qualitatively, not statistically.
- 3) Editing – the researcher approaches the text like an editor, “searching for meaningful segments, cutting, pasting and rearranging until the reduced summary reveals the interpretive truth of the text” (Crabtree and Miller, 1992:20). The best - known example is grounded theory (Glaser and Strauss, 1967; Strauss, 1987), although various editing methods are described in the literature under the term, qualitative content analysis. Collis and Hyssey’s (2003) general analytical procedure is an example, as is Hancock’s (1998) ten – step protocol – discussed in more detail later in this section. The editing approach has its roots in the phenomenological tradition in which the researcher ‘brackets’ (sets to one side) his

or her own preconceptions about the phenomenon being studied, and seeks to understand the experiences of individual life-world (see section 5.2). Therefore, recognising and making explicit ones own preconceptions is an essential step in phenomenological analysis.

- 4) Immersion/crystallization – Researchers immerse themselves in the research subject over a prolonged period of time and produce an account of their findings through analytical reflection and intuitive crystallization of meaning. This requires immersion in the subject at every possible level. Qualitative interviewing would be only one strand.

From the above, an editing approach appeared most suitable to this research. A quasi – statistical approach would conflict with the ontology and epistemology of the research paradigm; a template approach was not feasible because no relevant guide or codebook existed and, even if one was found or could be created by the researcher, this could distort analysis as it would inevitably reflect prior assumptions. Immersion was not feasible, due to time constraints and the sensitive and confidential nature of health interactions which limited the amount and kinds of access that could be negotiated.

Qualitative analysis is both a science and art. The scientific dimension lies in the need to maintain and to keep the analysis grounded in the data. The ‘art’ lies in the creative naming of categories, posing of questions and extraction of an integrated, meaningful scheme from a large volume of raw data (Strauss and Corbin, 1998). There are two basic parts to qualitative analysis: mechanical and interpretive. The former involves physically organizing and classifying the data into meaningful segments, while the latter involves coding the data into analytically useful subdivisions and looking for patterns, in order to draw substantive conclusions (Knodel, 1993).

The process of transcription, data reduction and analysis proceeded alongside data collection. As Miles and Huberman (1994) point out, in the ‘life cycle’ of

qualitative research, data collection and analysis are spread throughout a study. They suggest that interim analysis allows modification of the ongoing data collection process to reflect developing understanding of the setting, thereby heightening the internal validity of the study, that is the extent to which the findings accurately reflect the reality of the situation (see section 5.8 for further discussion of validity issues).

As a first step, each interview was given a simple code designation, beginning SU (for Service Users), CA (for Carers), PR (for Professionals) and D (for Decision – makers), followed by a series number (01, 02 and so on). These were used in writing up, in order to provide meaningful context, i.e. the relevant stakeholder group, while preserving the anonymity of interviewees.

Analysis began with reading through the transcripts and listening again to the tape – recordings of the interviews, in order to note ‘paralinguistic’ information such as nuances of speech, tone of voice, hesitation. This also offered an opportunity to correct any mistakes in transcription (King, 1994). A sample of extracts from interview transcripts is provided in Appendix 4.

The next stage was the actual ‘editing’. In carrying out this process, a 10 – step protocol described by Hancock (1998) was adopted. Although she describes her procedure simply as ‘content analysis’, this term could be misleading. What she describes is not the quasi – statistical approach of traditional content analysis but a recursive process of coding, categorization and constant comparison until a point of saturation is reached and a pattern, or ‘big picture’ emerges – the essential features of grounded theory. Her approach was adopted because, while retaining the necessary recursiveness and rigorous comparison, it is practical and clearly articulated. The procedure, in brief, is as follows:

1. Read through a transcript briefly, noting apparently interesting or relevant information.

2. Look through these notes and list the different types of information.
3. Categorise each item in a way that describes what it is about, generating as many new categories as seem to be needed.
4. Look for possible relationships between categories. Several of the original ``minor`` categories may be grouped into a new ``major`` category.
5. Compare and contrast the categories. In the light of the emerging picture, would some items fit better in a different category?
6. Repeat these steps with other transcripts, generating new categories as necessary, until a point is reached where all relevant and interesting information can be fitted into existing categories, i.e. saturation.
7. Review the content of each category in turn, to check whether all the extracts do in fact fit that category.
8. Check that all items of data are in the right category and that each category is appropriately named.
9. Look at the range of categories to see if any of them seem to be linked – they may constitute a major theme.
10. Return to the original transcripts and look again at data that was previously excluded because it did not appear relevant. Consider, in the light of the categories developed, whether any of that data should be included.

Some writers suggest that the mechanical part of the analysis can be greatly facilitated by using a software package, which enables the analyst to code textual data files into analytic categories. Segments of the text associated with a particular code can be then sorted and retrieved. This facility enables all statements relating to a particular topic to be assembled for the analyst to study. According to Miles and Huberman (1994), three-quarters of qualitative researches use computer software packages. A number of such packages exist to facilitate qualitative analysis, e.g. THE

ETHNOGRAPH, NUD*IST, QualPro, Word Match, TAP and Word Cruncher. These differ as to the mode of the operation and the facilities offered. Ethnograph, for example, allows data to be input using a word processor. Codes are assigned and recorded onto memoranda to enable constitution of conceptual frameworks (Easterby-Smith et al., 2002). NUD*IST is more advanced; it can store memoranda until data are acted upon and the memoranda to be searched along with the rest of the data. The coding system can be displayed visually in a hierarchical tree structure system. Still more sophisticated is Atlas-ti, developed specifically for grounded theory. It has the capacity to create conceptual diagrams which show relationships between data, thus facilitating selection of appropriate quotes that support the theoretical analysis (Easterby-Smith et al., 2002)

The most important advantage of using computers for content analysis is their ability to process large volumes of data at high speed (Krippendorff, 2004). Another advantage is their ability to process textual material (understood in terms of character strings) reliably.

On the other hand, there are disadvantages in using computer – assisted data analysis. Learning the relevant software can be a lengthy, time – consuming process. Computer analysis poses a temptation to quantify findings, contrary to the intention of the qualitative approach, and it can result in fragmentation of data, because if one chops a large body of text into mutually exclusive text segments (e.g. words), their position in the text are lost, their grammatical functions are no longer recognizable, the relations between segments are lost, and dialogical distinctions, for example, between questions and answers, are obliterated (Krippendorff, 2004) There is also a problem of decontextualization. Computer analysis, being based on form rather than meaning, can indicate the frequency with which certain words, phrases and combinations appear in a text, but it cannot indicate whether a word is being used with the relevant meaning the

researcher is interested in, in a particular instance. For example is 'trust' affirmed or denied (as in "not trusting")? Does 'care' mean 'act as informal carer' (as in "I care for my disabled husband"), 'show concern' (as in "they don't care about you") or 'like' (as in "I don't care for Dr. X")? Conversely, the same concept or relationship may be expressed by many different verbal forms and grammatical constructions (Lemke, 1998). For example grammatical variations of a word (e.g. bear, bore, born, and borne) or stylistic variations that express the same idea (e.g. empty, unfilled, vacant, and void) would appear as different character strings, at least with the basic word – list types of software (Krippendorf, 2004). Moreover, with relatively small data sets (e.g. fewer than 20 interviews), the investment of time, money and energy needed to acquire and learn the more sophisticated packages may not be justified. According to Easterby-Smith et al. (2002) such data sets may be better understood by manual methods. Above all, critical thinking and deep analysis comes from the researcher, not software (Coffey and Atkinson, 1996). In the light of these considerations, it was eventually decided not to use computer software in the analysis.

In developing and naming codes and categories, a variety of approaches has been adopted. In some cases, category labels were suggested by the literature. For example, the labels, Tangibles, Reliability, Assurance, Responsiveness and Empathy were derived from the generic dimensions of quality described in the quality literature (for example, Parasuraman and Zeithaml, 1988) – see Chapter Two. Consistency, Benevolence and Openness were suggested by the Trust literature (Chapter Three). Adopting pre – existing category names has a number of benefits: it provides a starting framework which facilitates and speeds the analysis; the labels are defined in the literature, facilitating consistency of interpretation and understanding; the categories so labelled provide ready points of comparison with other studies. At the same time, care must be taken to reflect accurately and sensitively the nature of the present data, without

forcing it to fit preconceived categories. Thus, although the literature – derived category labels were a useful starting point, they were only applied to the extent that they appeared a valid representation of the data. I retained the freedom to drop or modify any categories that proved not to be useful, and to add others as needed to reflect emergent issues.

In other cases, labels used were my own creation, based on reflection on the data. For example, the interview transcripts contained a number of references to obstacles to communication. Among these, several interviewees mentioned the use of jargon (Interviewee # SU 02); one referred to difficulty understanding her GP's foreign accent (Interviewee# SU 01); another mentioned that information leaflets could pose problems for users whose first language was not English (Interviewee# PR 02). Initially, these were labelled as three separate categories. During the data reduction process, however, they were all combined into a single category, which I labelled "Intelligibility". Similarly, comments related to venue of meetings, timing, computer access and literacy were all thought to reflect the broad construct, "accessibility".

Examples of labels I have used to denote themes and issues identified in the data, and the way I have grouped them, can be seen in Appendix 5.

5.7. Phase Two: Group Workshops

The group meetings were the second stage in a process which began by exploring, through in-depth individual interviews, HMHTT stakeholders' perceptions around the issue of trust in the NHS. The data from that stage revealed a lack of trust, related to perceptions of quality shortfalls and communication difficulties. The purpose of the group meetings was to bring together participants from different stakeholder groups, in order to verify the stage 1 data, and facilitate a process of engagement in which participants could develop understanding of each others' perspectives and

implement a methodology aiming to facilitate factors identified as conducive to trust, and remove barriers.

5.7.1. Rationale

There were several reasons why I considered the workshops appropriate and necessary. The first had to do with research validity. In qualitative research, an important validation strategy is “member checks” (Guba and Lincoln, 1989), whereby feedback is solicited from informants as to categories and themes developed in data analysis (Creswell, 1994). Such involvement also helps to empower the participants and give them ownership of the research. Such feedback could, of course, be obtained on an individual basis. However, each participant in the interviews responded largely from a single perspective – as decision makers, professional, clients or witnesses. Whilst verification of these individual contributions was important, it was also necessary, since these perspectives were to be combined into an overall picture, to verify my interpretation of the meaning of the whole. By presenting this in a group context, participants would be better able to understand and, if they wished, challenge my interpretation of relevant themes and the connections between them.

Engagement between stakeholders was also important in the light of the focus, in both the trust and quality literature, on interaction. In the trust literature (see Chapter Three), trust is partly a function of cognitive knowledge of others’ attributes, values and so on, developed through experience. In the quality literature (see Chapter Two), Walsh (1995) highlights the importance of dialogue between stakeholders as a means of closing the “quality gap”. Other writers, too (e.g. Parasuraman et al., 1988) have ascribed quality gaps to mismatches between consumers’ needs and providers’ products, between intended standards and actual procedures, and others, all of which imply communication failures. Communication problems between different stakeholder groups were also identified as an issue in phase one. Engagement between stakeholders,

which the workshops were intended to facilitate, was thus justified theoretically and by the emerging empirical findings, as a desirable contribution to understanding and trust.

Workshops were also a way of satisfying the participation required both by action research, and by my understanding of CST. It allowed all participants' interests to be made explicit and involved them all in the same learning process.

5.7.2. Outcomes

The expected outcomes of the workshops were:

- Verification of a cognitive map showing the themes and issues raised by respondents in stage 1, and their connection to each other and to trust.
- Recognition of the factors facilitating and impeding trust
- Suggestions (generated by participants) for action to improve facilitating factors and remove (or at least reduce) barriers.

5.7.3. Choice of methods for workshops

The number of participants in a workshop was planned to be no less than 6 and no more than 12, in order to generate a satisfactory level of dialogue; this was suggested by various other researchers, who have conducted studies in the NHS, based on their experience, and also by participants in phase one of this study. The plan, therefore, was to have three groups of eight participants.

As indicated in section 5.3, for the action / implementation phase, I had originally envisaged using TSI. However, the overarching framework of critical systems thinking encourages and facilitates critically reflective consideration of the choice and use of alternative methodologies. Such reflection suggested that TSI was not the most appropriate approach. The SOSM provides a useful starting point for identifying the methodologies available and thinking about their appropriateness in particular contexts. At this point, a question arose, whether the choice of a method for structuring debate and thinking about change should be made by myself as researcher alone, or jointly with

the participants. While the latter would be in keeping with the participatory, empowering orientation of CST, it raised practical problems. It was not the purpose of this study to teach the participants about a wide range of systems methodologies, and it would be difficult to do so within the time available and would make heavy demands on the participants. If it is not possible for all participants to have sufficient knowledge of the range of choices available, the value of a joint decision becomes questionable. There was also the potential difficulty that different groups could make different choices. In the circumstances, the only feasible option was for me to propose a methodology. However, this was based on careful critical reflection, with my assumptions and reasons for choosing the selected methodology made explicit to the participants and open to challenge.

On the basis of the information obtained in stage 1, together with reflection on systems methodologies, SSM appeared to be the most suitable candidate. It embodies an interpretivist approach in which multiple perceptions are acknowledged and explored, and values made explicit. This makes it a useful approach for pluralist problem contexts, or “problematic situations” as Checkland and Scholes (1990) and Checkland and Poulter (2006) prefer to call them. Phase One revealed a problematic situation, rather than a problem. It was problematic because there were areas of mistrust and dissatisfaction among participants, but too many different ideas, interests and factors to identify a specific problem. Health service users, providers and administrators had differing perceptions and priorities – indeed, several interviewees pointed to the existence of conflicting interests (as I will demonstrate and discuss in Chapter Six). The situation was also complex, in the sense that phase one’s findings indicated a large number of relevant interconnected themes and issues. Complexity, too, is addressed by SSM. Other features of SSM that made it suitable to the current situation are that it provides a way of structuring dialogue, and it is learning – oriented.

Admittedly, critics of SSM suggest that it downplays conflict and doubt whether genuinely participative debate is possible, because of power inequalities. It does not account for distorted communication, they claim, and the distortion means that the results tend to favour the powerful.

Checkland and Scholes (1990) and Checkland and Poulter (2006), however, argue that learning outcomes cannot be predicted and that in principle SSM must be capable of producing radical/emancipatory change, as well as regulatory change. Again, it seems that what is important is for the researcher to be open and honest, with himself and with participants, about the limitations of the approach, and to strive to minimize their effect by promoting and facilitating the fullest possible involvement of all participants.

5.7.4. Procedures

Participants were drawn from the same sample as in Phase One, subject to their availability and willingness to continue. Six 4 – hour workshops were held in the Centre for Learning of the HMHTT. Attendance of representatives of all stakeholder groups in the same meeting proved difficult, due to both scheduling issues and service users' initial mistrust of and reluctance to meet with service providers. Some service users, moreover, although keen to maintain their involvement, had difficulty attending workshops due to their medical conditions or caring responsibilities. These problems were overcome by a process of liaison, similar to the Delphi technique (Adler and Ziglio, 1996), in which issues raised in workshops were fed back by the researcher to other participants (professionals and service providers). Their responses were, in return, fed back to the next workshop.

As noted previously, the workshop activity was structured using SSM. Over a history of more than 30 years of use in a variety of contexts (Checkland and Scholes, 1990) and in the new simplified version for practitioners, teachers and students

(Checkland and Poulter, 2006), SSM has been conceptualized in a number of ways. The version used here (in partial form) was a 7 – step process (Checkland and Scholes, 1990), chosen because it provides a relatively clear and systematic way of structuring debate and was, moreover, familiar to some of the participants. The seven stages are as follows:

Stage 1: The problem situation

Unstructured; a sense of unease felt by individuals leads to the identification of a problematic situation that demands attention.

Participants agreed that this step had been covered by the earlier (interview) phase of the research.

Stage 2: The problem situation

Expressed; information is gathered about relevant structures, process and “climate”, in order to generate a “rich picture” of the situation. The idea is that this highlights significant and contentious aspects in order to stimulate creative understanding.

For this stage, the rich data carried forward into the workshops from the interview phase provided a starting point. This material was extensively debated and expressed in a variety of diagrammatic forms, in order to capture the issues of concern to participants.

Stage 3: Relevant Systems

Stage 3 of SSM calls for the identification and root definition (RD) of some relevant human activity systems that may offer insight into the problematic situation. These are abstract and artificial in nature; they do not necessarily correspond with actual systems existing in the real world, but are described as systems to aid thinking about the way activities are linked and impact on each other. To ensure completeness of the definition, the CATWOE mnemonic is used:

C : Customers –	those who use / benefit from the system
A : Actors –	those who do the activity in the system
T : Transformation –	what the system does
W : Weltanschauung (World view) –	values, beliefs, assumptions
O : Owners –	those who control (have power over the system)
E : Environment –	facilitators and constraints

Stage 4: Conceptual models

Activities (usually around seven), each with a significant verb, structured in a logical sequence, and reflecting the minimum activities needed to achieve the transformation indicated in the root definition.

The idea of conceptual modelling is to produce a description of the actions needed to carry out the transformation and other requirements of the root definition. At this stage, the focus is on what participants think should be in the system, irrespective of whether or not it already exists or how well it is done.

The first step is to produce a list of activities. These are arranged in a diagram which captures contingent relationships among them (shown by the direction of the arrows). The conceptual models produced for the two chosen systems are presented and discussed in the next chapter.

Stage 5: Comparison of 4 with 2, to generate debate about possible change.

In this step, the conceptual models are compared with the real world. For each activity, the questions are asked:

- Does it exist in the real world?
- If so, in what form?
- How well or badly is it done?
- How can we improve?
- What are the alternatives?

In the case of service users and carers, these questions were explored within the workshops.

Ideally, they would be debated in workshops attended by all stakeholder groups together. Since this was impracticable in view of the heavy demands on managers' and decision-makers' time, it was agreed with service users and carers that this stage could be fulfilled in part through the preparation of a report, for feedback. Such a report was produced by service users and carers with my facilitation, and distributed to other stakeholders, with a request for feedback.

Stage 6: Changes

Accommodation among concerned actors over what changes are systematically desirable and feasible in the prevailing context.

Any changes must be both socially desirable and systemically feasible, i.e. possible within the parameters of the root definition, such as resources available and any relevant rules, policies etc. One purpose of the report referred to above was to contribute to step 6 by eliciting from managers and decision – makers, feedback ideas on feasibility of change, for discussion with service users and carers, which took place in a joint workshop.

Stage 7: Action

That alleviates some of the initial unease. Whilst agreement was reached that certain issues and proposal should be pursued, immediate implementation was not possible, due to external factors (see Chapter Six). However, it was agreed to carry forward the issues in question, on the agenda for the coming year, plans for implementation would be subject to the normal decision – making procedures of HMHTT with regard to departmental authorities, timescale and budget so forth.

It is important to recognise that when any action is implemented, it creates a new situation, not a “solution”. SSM is not a “quick fix”, but a framework for structuring

thinking and discussion around an issue, as part of what it is hoped will be taken forward as a continuing process of engagement and dialogue.

5.8. Validity, Reliability and Alternative Quality Criteria

Qualitative researchers have adopted a variety of approaches to the problems of accuracy and generalizability in qualitative research. Some apply the positivist criteria of validity and reliability, but with an attempt at reinterpretation to fit the nature of qualitative research. Others such as Sandberg (2005), argue that the criteria of validity and reliability used for justifying knowledge within the positivist tradition are not in accordance with the ontology and epistemology of approaches that reject the existence of an objective, knowledge reality beyond the human mind. If, as interpretive researchers argue, knowledge is constituted through lived experience of reality, then knowledge produced within this tradition cannot logically be justified based on an objectivist ontology and epistemology (Sandberg, 2005). The quality of a study in each paradigm should be judged by that paradigm's own terms (Healy and Perry, 2000).

Some qualitative researchers, therefore, reflect the distinction between their work and the positivist paradigm by coining new terms such as “trustworthiness” and “authenticity” to capture the kind of verification that is appropriate to qualitative inquiry (Creswell, 1994).

Traditionally, in the positivist paradigm, two types of validity are conceptualized: internal and external. Internal validity concerns the accuracy of the information obtained, and whether it matches reality, while external validity is concerned with the extent to which findings may be generalized beyond the immediate research context (Creswell, 1994). The relationship between the two can be problematic. Excessive preoccupation with internal validity reduces the likelihood that the findings will be externally valid, because it requires effectively stripping away the context, yielding results that are only valid in other contextless situations (Guba and Lincoln,

1989). In qualitative research, however, further problems arise, concerning the appropriateness of these concepts. Guba and Lincoln (1989) argue that the concept of internal validity cannot have meaning as a criterion in a paradigm that rejects a realist ontology.

In explaining their participative approach to the evaluation process (what they call, fourth generation evaluation) they explain that they do not treat evaluation as a “scientific” process, because such an approach would ignore the essentially social, political and value – oriented character of evaluation. The same can be said of this research, which in its data collection phase involves a subjective evaluation by participants of ‘quality’ (including relational quality) in the mental health care service. Like Guba and Lincoln, I take the position that the outcome will not be (and is not intended to be) descriptive of some “true” state of affairs, but will represent “meaningful constructions that individual actors or groups of actors form to ‘make sense’ of the situations in which they find themselves” (Guba and Lincoln, 1989, p8). The findings, therefore, are not “facts” in the absolute, but are created through an interactive process between myself and the participants.

In such a situation, the positivist notion of internal validity needs to be reconceptualized. The issue is not whether the account reflects some ultimate “truth” but how well it reflects the experience and perceptions of the participants (Merriam, 1988; Miles and Huberman, 1994). Thus, internal validity may be better understood in terms of what Guba and Lincoln (1989) call “credibility”. By this criterion, the search is not for correspondence between findings and objective reality, but between “the constructed realities of respondents and the reconstructions attributed to them” (Guba and Lincoln, 1989:237). In other words, how accurately has the researcher represented the perceptions, experiences and beliefs of the participants?

In this research, internal verification, that is, the credibility of the findings as a reflection of the participants' view and experience, is achieved through several strategies, all of which are supported by writers on qualitative methodology (for example, Merriam, 1998; Creswell, 1994; Miles and Huberman, 1994; Guba and Lincoln, 1989). One way of addressing internal validity is the use of triangulation, whereby the researcher looks at the degree of convergence among sources of information, different investigations, or different methods of data collection. In this research, such a procedure was achieved by collection of data from members of several different stakeholder groups: service users, carers, decision – makers (senior managers) and professionals (managers) (the issues involved in identifying stakeholders were discussed in section 5.5). This is not to say that differences of opinion within or between stakeholder groups would invalidate the research; such differences must be accepted as an inevitable part of a ``reality`` that is constructed from the experiences and perceptions of individuals. As will be seen in Chapter 6, it was possible to identify common issues and concerns (for example, different stakeholders agreed that the provision of information was a salient issue, even if they differed in the way they experienced it, or their views on how it should be addressed). Triangulation of information sources, therefore, is not looking for consensus or homogeneity of views; but it is looking for the range of evidence on which the researcher bases a given claim or interpretation and the extent to which any emerging model or ``construction`` of the issues investigated reflects the multiple perspectives of those involved.

Another approach to internal validity is to solicit feedback from informants (also called ``member checks``: Guba and Lincoln, 1989). In this procedure, categories and themes developed in the course of data analysis are taken back to the informants, who are asked whether the conclusions are accurate (Creswell, 1994). Similarly, in this research, validity is strengthened by the involvement of participants in the data analysis.

Each interviewee was shown my summary and interpretation of his or her interview and invited to verify, modify or elaborate on it. A similar process of obtaining feedback from participants was followed at every stage of the research. This provided a safeguard against the introduction of bias by the researcher and increases the degree of confidence that the ideas and meanings emerging from discussion represent as accurately as possible some “truth” as perceived by the participants. The additional engagement of participants beyond the interview process itself was intended also to empower them and increase their ownership of the research.

Member checking gives the respondent an opportunity to correct errors of fact or interpretation, and to offer additional information, especially by allowing them to understand how the situation they have presented is understood by an outsider, it allows a chance for the researcher to summarize, not only for the respondent, but also as a stage in the analysis, and it puts the respondent on record as having agreed that the interviewer “got it right” (Guba and Lincoln, 1989). The recording and careful transcription of interviews meant that in practice, the actual words spoken were not challenged. As will be seen in Chapter Six, however, in the group meetings, some of my understandings and interpretations of the meaning of the information given in earlier interviews were challenged. In such cases, I explained my reasoning and the discrepancies or uncertainties were discussed until a mutual understanding was reached.

Referring data and its interpretation back to participants in this way helps to address the issue of researcher bias. If it is assumed that ‘reality’ is in some sense constructed through the perceptions of social actors, then the researcher is as likely (and, Guba and Lincoln, 1989, note, as entitled) as anyone else to have his own construction. In qualitative research, where the researcher is essentially the instrument of data collection, it is unrealistic to assume that these can be left out of the inquiry.

Rather, they should be acknowledged and the researcher's perceptions and interpretations ``laid on the table`` where they are open to challenge.

In terms of Habermas' (1984b; 1999b;c) theory of communicative action, which underpins much of Critical Systems Thinking (see Chapter Four of this thesis) member checks can be interpreted, therefore, as an opportunity for participants to challenge validity claims made by the researcher. In other words, they can question whether the data presented to them is understandable and ``true`` (in the sense of an accurate representation of what they said and experienced). They can also challenge the researcher's right to express these ideas, and his sincerity in doing so, and the researcher must be able and willing to justify himself to participants on any of these grounds.

It should be noted, however, that Hammersley (1992) questions whether respondent validation should be used as a criterion of research quality. As he points out, to presume that respondents can validate or falsify accounts is to ignore the social character of the relationship between researcher and participants, and to assume that the latter have privileged access to the truth – which is not the case. Participants may not always be fully aware of what has happened to them, or they may feel it is in their interest not to admit certain truths, or to accept falsehoods. Hammersley (1992) warns that the danger of relying on respondent – validation for acceptance of research is that researchers may be tempted to produce bland and /or flattering accounts, as these are more likely to be accepted by participants. This may indeed be the case, and would certainly constitute an argument for not taking participant validation as the only criterion for acceptance. This does not mean, however, that participants should be denied a chance to see and comment on the interpretations they have helped to construct. Rather, it means that multiple criteria of research quality should be used (as is the case in this study) and that the researcher should be critically aware of personal

agendas and vested interests, whatever their origin, in order that these can be made explicit and critiqued in the research.

A further important aspect of the internal validity of the research is the involvement of informants in all phases of the research, consistent with the epistemological assumption of the qualitative paradigm which is based on minimizing the distance between the researcher and the informants (Creswell, 1994).

Prolonged engagement between the researcher and participants facilitates the building of rapport and trust, reducing the risk of misinformation, distortion or presentation of ‘‘fronts’’ (Guba and Lincoln, 1989). This research involves such engagement, beginning with the granting of a ‘‘favourable ethical opinion’’ by the Local Research Ethics Committee (LREC) of Hull and East Riding NHS Trust and the Research & Development which reports to the Clinical Governance department under the Medical Director of the Humber Mental Health NHS Teaching Trust (see section 5.9 for discussion of ethical issues). Such approval was given after extensive scrutiny of my background and research plans, and is itself an indication of trust. The agreement of participants to take part in the research, based on the information provided to them, can be seen as an indication of their recognition of themselves as relevant stakeholders, and also of an initial degree of trust in me as a researcher and the research process. Their continued participation in successive phases of the research can then be viewed as indicative of ongoing trust, since they were free to withdraw at any time. This does not mean that withdrawals necessarily invalidate the research, as participants could have any number of reasons for withdrawing, unrelated to the research itself; for example, a change in family circumstances, or deterioration in health. It does mean, however, that those who continued to participate when they did not need not to do so were making an investment in the research. Moreover, their continued involvement and, hence, ‘prolonged engagement’ with the research contributed to a deepening of trust and

understanding, and increase the likelihood that I was able, accurately and fairly to reflect their perceptions and concerns. Involving the participants from the beginning has helped to give them a sense of ownership of the project; they felt that they were not merely being used as subjects by an unknown researcher, for an academic purpose, but were participants in an initiative to address matters of real concern to them. This process of trust – building has been enhanced by frank discussion of the aims of the research and the possible outcomes; for example, interviewee SU 06 was especially interested in how recommendations would be generated and who would see the final report, matters which we discussed at some length.

So far, the discussion has focused on internal validity or credibility and the strategies employed to ensure faithfulness to the participants' concerns and experiences have been explained. A further question arises, however, regarding the external validity of the research – its generalizability to other contexts. This concept, too, is problematic in qualitative research.

External validity can have little meaning if the ``realities`` uncovered in the research are the product of a particular set of minds, experiences and values. Because the findings are the product of ``human conceptual exchange`` in a particular setting`` (Guba and Lincoln, 1989:9) they may not necessarily help other persons make sense of their settings.

However, as Merriam (1988), among others, points out, the intent of qualitative research is not to generalize findings, but to form a unique interpretation of events, although she suggests that, nevertheless, limited generalizability might be claimed for specific aspects of the research, for example, the categories or themes that emerge from the data analysis.

The qualitative alternative to external validity or generalizability is transferability. Transferability is relative and depends on the extent to which salient

conditions in the context to which transfer is contemplated match those of the original research context. The burden of establishing transferability rests with the receiver, rather than the researcher. The researcher's role, in this respect, is to provide a "thick description" (Geertz, 1973) in order to facilitate judgement by others as to how far the research is applicable to their own contexts. In the present research, every effort was made to satisfy this criterion by careful description of the research context, extensive discussion of concepts employed and their basis in the literature, and a detailed account of the data collection, analysis and intervention procedures.

Thus, in this study as in other qualitative research, the validity or credibility of the constructions that emerge is strengthened by the fact that they are the product of a prolonged process of engagement and negotiation, between participants and researcher. How far these are transferable will depend on the extent to which future potential users recognize and identify with the situations, themes and issues explored.

The concept of reliability applied in quantitative research also proves problematic in qualitative research. Traditionally, reliability is conceived in terms of stability and consistency. This may be stability over time (i.e. that similar result are obtained if the study is replicated) or stability within a measure itself, that is, internal consistency. Neither is really applicable to qualitative research.

According to Stenbacka (2001), since reliability concerns measurement, it has no relevance in qualitative research. In the interpretive / constructivist approach, reliability in the sense of consistency over time is an inappropriate criterion of quality, since these approaches assume not merely that phenomena may change, but indeed, change is central to the development and refinement of interpretations or constructions between researcher and participants (Guba and Lincoln, 1989).

Moreover, according to Morse (1994) the quantitative model of ensuring reliability by using external raters, for example, by asking a second investigator to

record and code a transcript, is not appropriate to qualitative research, because it violates the process of induction. This is because the first investigator has a bank of knowledge derived from other interviews, observations etc, that the second researcher does not have. Moreover, the process of inductive qualitative inquiry frequently depends on insight, and it is unrealistic to expect that another researcher would have the same insight from limited data.

Patton (2001), with regard to the researcher's ability and skill in a qualitative inquiry, argues that reliability is a consequence of the validity in a study. Hence, the measures described above for ensuring validity should demonstrate reliability also. Other researchers, however, propose specific reliability criteria for qualitative research.

As a constructivist parallel to the conventional criterion of reliability, Guba and Lincoln (1989) propose the criterion of dependability. They accept that the research paradigm implies an emergent design characterised by methodological changes and shifts in construction, and these are seen as the hallmark of a maturing inquiry, rather than as threats to dependability. However, such changes need to be recorded and open to scrutiny.

Guba and Lincoln (1989) suggest that dependability can be enhanced through the use of overlapping methods, stepwise replications, and inquiry (dependability) audits. "Inquiry audit" can be used to examine both the process and the product of the research for consistency (Hoepfl, 1997). Such an audit investigates the quality and appropriateness of the research process. It examines the extent to which the research process is established, 'trackable' and 'documentable' – for example, whether the data can all be traced to original sources, and whether the processes by which they were managed and interpreted can be confirmed (Guba and Lincoln, 1989). A similar approach is adopted by Huber and Miles (1994), who suggest two solutions to the problem of reliability in qualitative research: careful retention, in retrievable form, of all

study materials, and a reflexive stance to the conduct of the study, including “regular, ongoing, self – conscious documentation” (Huber and Miles, 1994: 439). Both these approaches were adopted in this study. Care has been taken to retain all materials used: documents from HMHTT; recordings, summaries and transcripts of interviews; field notes; copies of letters and e mails, and so forth. Moreover, I have engaged in constant, critical reflection on the research procedures, interpretations and outcomes, and above all, my own role in the research.

Guba and Lincoln (1989) also suggest that quality control is inherent in the hermeneutic, dialectical process of inquiry. Because data inputs are fed back to the respondents for comment, elaboration or revision, and are, moreover, incorporated into the joint, collaborative reconstruction that emerges, they argue, there is little opportunity for error to go undetected and / or unchallenged.

Sandberg (2005:58) ‘reconceptualizes’ reliability for qualitative research as “interpretive awareness”. He argues that the principal question of reliability concerns the procedures for achieving truthful interpretations. Researchers must demonstrate how they have, throughout the research process, controlled and checked their interpretations of the lived experiences studied, from formulating the research questions, selecting participants, collecting and analysing data, to reporting the result. They must acknowledge and explicitly deal with what Kvale (1996) calls ‘perspectival subjectivity’, that is, the way researchers’ interpretations are influenced by the particular disciplinary, theoretical and methodological perspectives taken in the study. Thus, Sandberg’s (2005) concept of interpretive awareness is consistent with the idea of critical awareness espoused within CST (See Chapter Four). Sandberg (2005) proposes that the phenomenological ‘epoché’ can be used as a strategy to achieve this purpose. ‘Epoché’ implies that researchers should strive to refrain from routinely applying their known theories and prejudices, in order to be open to the lived experiences being

investigated, suspending judgement until sufficient evidence has been obtained. The researcher maintains a “describing orientation” (Sandberg, 2005:60), focusing on describing what constitutes the experience in question, rather than trying to explain why it appears as it does. ‘Epoché’ also requires ‘horizontalization’, which means according equal importance to all aspects of the lived experience.

Hence, reliability was conceived in this research, broadly in terms of integrity in carrying out the research procedures, and openness about my role, values and assumptions, and their impact on the research.

The foregoing approaches to quality evaluation in interpretive or constructivist inquiry, however, are open to criticism on the ground that they focus primarily on method, neglecting outcomes. For this reason, therefore, Guba and Lincoln (1989:245) propose another set of criteria, which they call the “authenticity criteria”, derived directly from the basic assumptions of the paradigm. They are as follows:

Fairness: This refers to the extent to which different values and constructions are solicited, presented, checked and considered in a balanced way. In a situation of value pluralism, it is inevitable that multiple constructions will emerge from stakeholders (in this research, for instance, there were noticeable differences between service providers – managers and senior managers – and service users as well as individual differences within the stakeholder groups). Fairness is achieved by two means. The first is to identify all potential stakeholders and seek out their constructions, and to present these clearly, identifying conflict over claims, concerns and issues. In this study, the process of identifying stakeholders is explained in section 5.5.1 of this chapter, while the identification of conflict is reflected in the discussion of the research outcomes, in Chapter Six. The second technique for ensuring fairness is the open negotiation of recommendations and agendas for action, in circumstances of equality of information, on matters that are known to be relevant, and in accordance with rules to which

stakeholders have assented. This was achieved in the present study by the use, in the second phase of the research, of SSM to structure debate – with the agreement of participants. The identification and definition of systems ensured that negotiation focused on issues identified by stakeholders as relevant, and my liaison role between stakeholder groups facilitated the sharing of information.

The second of the authenticity criteria is “ontological authenticity” (Guba and Lincoln, 1989:248), referring to the extent to which participants (including the researcher) experience improvement, maturation, expansion and elaboration in their constructions. This can be achieved by the provision of examples, cases and other material that help participants to reassess their experience, seeing how it corresponds to differs from the experience of others. In the present study, for example, the phase two workshops provided opportunity for such reassessment.

A related criterion is “educative authenticity” (Guba and Lincoln, 1989: 248), referring to the extent to which the inquiry results in participants’ enhanced understanding of and appreciation for the constructions of others outside their stakeholder group (this does not require, however, that they like or agree with such constructions). The achievement of this criterion can be established by the testimony of participants and by entries in the “audit trail” related to the developing understanding. One advantage, in this study, of using SSM, was the opportunity it afforded for different constructions to be aired and debated among participants, and I took every opportunity to facilitate appreciation of alternative views.

The fourth criterion proposed by Guba and Lincoln (1989:249) is “catalytic authenticity”, referring to the extent to which action is stimulated and facilitated. This criterion is established through testimony of participants attesting to their interest in acting on the research findings and willingness to be involved in doing so; by resolutions resulting from negotiation sessions; and through systematic follow up within

a given time – period, to assess the extent of change resulting from the research. Evidence of decision – making and action emerged at various stages of the research. In an early workshop, for instance, following debate as to the advantages and disadvantages to all parties of a joint meeting between service users and service providers, service users reversed their previous position and decided to seek such a meeting. Another example is the testimony of certain managers, following presentation of a report on the research, that they were interested in acting on it in various ways, and promoting its messages to colleagues.

The final criterion proposed by Guba and Lincoln (1989:250) is “tactical authenticity”, by which they mean the extent to which stakeholders are empowered to act. This can be established by testimony of stakeholders, by follow up to determine which groups actually participate in action, and in what way; and by a judgement (by both participants and researcher) as to the degree of empowerment during the project itself, i.e. whether it was participatory, whether all stakeholders felt they had a significant role in the process, and whether participants gained improved skill in understanding and using power and negotiation.

How far all these criteria were met in practice will be discussed in the concluding chapter of the thesis.

5.9. Ethical Issues

Important ethical issues are involved in any study which deals with the beliefs and values of people. I was therefore meticulous about following ethical principles and avoiding harm to the participants in any way, at every stage from obtaining approval and gaining access to HMHTT, its service users and employees, through conducting the research, to the final report.

The conduct of the study was subject to ethical approval from the Hull and East Riding Local Research Ethics Committee (LREC), through the NHS Central Office for

Research Ethics Committees (COREC), and from the Research & Development Department of Humber Mental Health Teaching NHS Trust (HMHTT) (see Appendix 6). In order to obtain approval, I had to complete various formalities including submission of an initial application with supporting documents; attending a meeting of a fifteen – member review panel; submission of more detailed documents (see below) on aspects of the research questions and procedures, and signing forms indicating my acceptance to be bound by relevant legal requirements such as the Data Protection Act 1998.

HMHTT requires all research to be conducted in accordance with the requirements of the Research Governance Framework and the NHS Intellectual Property Guidance. In undertaking the study, I agreed to comply with “all reporting requirements systems and duties of action” (HMHTT letter of 21/09/05) put in place by the Trust’s information management and data protection policies. Specific responsibilities of my role as outlined within the Research Governance Framework included:

- The study follows the agreed protocol
- Participants should receive appropriate care while involved in the study
- The integrity and confidentiality of all records and data generated by the study will be maintained
- All adverse events must be reported to the Trust
- Any suspected misconduct by anyone involved in the study must be reported

Like any employee working within the NHS, I was bound by a legal duty of confidence to protect personal information obtained during the course of my work. This entailed adherence to a Code of Conduct (HMHTT, 2004:1) in respect to confidentiality and information security. The Code was developed to meet the requirements of:

- The Data Protection Act 1998
- The Human Rights Act 1998
- The Computer Misuse Act 1990
- The Copyright Design and Patents Act
- The Common Law Duty of Confidence

The Code, in its 12 pages and nine sections, sets out the duty of confidence and contains protocols for protection of information in storage, transmission and disposal. It assert service users' right to be informed of how their information is used, and to restrict disclosure or use of information that does not directly contribute to or support the delivery of their care. Unless information is anonymised, explicit consent is required for its use for any purpose other than healthcare. I signed my acceptance to be bound by this code, and was careful to adhere to it throughout the research.

Another ethical issue concerned the recruitment of participants and the conditions on which their agreement to participate was secured. Approaches were made to prospective participants by letter of invitation, with which on information leaflet and informed consent form were enclosed.

The letter of invitation introduced the project, outlined briefly the methods to be used, promised anonymity, and made clear that participation was entirely voluntary. Moreover, participants would be free to withdraw at any time.

The information leaflet provided information on the background of the research and research aims. It was made clear that the study was being undertaken as part of the work for an academic qualification. I explained what would be expected of participants, and that it was intended to audio – tape interviews (with permission) for analysis purposes. The leaflet contained assurance as to the safe storage and confidentiality of data, and procedures for reporting and disposal of the tapes

The informed consent form asked participants, in addition to giving their signature to the document as a whole, to initial four separate boxes, to confirm that they:

- Had read and understood the information leaflet
- Understood that participation was voluntary and that they could withdraw at any time
- Understood the arrangements regarding audio – taping, including that it would not occur without permission and would be stopped at any time on request
- Agreed to take part in the study.

The informed consent form, information sheet and invitation letter, as well as an outline of the recruitment process, and guides as to the questions and issues to be addressed in Phases One and Two, were all scrutinised by the Hull and East Riding Local Research Ethics Committee (LREC) before their favourable ethical opinion (approval) for the research was given.

In addition to the formal and legal requirements imposed by the LREC, I was mindful of my responsibility to the research participants under the general principles of research ethics and the emancipatory agenda of PAR and CST. These governed my relations with participants throughout the course of the research. Every possible effort was made to ensure that participants were comfortable with the research proceedings, and to let them talk, learn and make decisions at their own pace. Careful attention was paid to involving them at every step in the research (as indicated in sections 5.3 on Participatory Action Research and 5.8 on Validity) and to representing them honestly and fairly. I believe (and indeed, feedback from participants indicated) that these measures helped to build mutually respectful and trusting relationships between myself and the participants, which contributed to their willingness to invest time, effort and emotion in the research, and to express themselves freely and candidly.

5.10. Conclusion

The research is a PAR project undertaken within an overarching framework of CST, conducted within Humber Mental Health's User – Centred research programme. Questions and issues derived from the literature focus on issues of trust and communication in the relationship between patients and service providers, the aim being to explore the role of trust in relation to how quality is perceived in HMHTT.

The research consisted of two phases. Phase one, a ‘‘finding out’’ phase, involved semi – structured interviews with members of the stakeholder groups: service users, carers, managers and senior managers, with the aim of finding out their feelings and concerns in relation to trust, communication and quality in the health service. The issues identified were taken forward to phase two, the process of engagement, in which I facilitated a number of workshops. SSM was used to structure creative thinking on issues of concern, notably the identification of facilitators of trust and barriers to trust, and to facilitate participants' thinking on feasible and desirable change.

In the next chapter, the findings from the research will be presented.

Chapter Six

Outcomes

6.1. Introduction

As explained in the previous chapter, in an attempt to explore perceptions of quality and trust in HMHTT services, a Participatory Action Research Project (PAR) was carried out within an overarching framework of Critical Systems Thinking (CST). A modified form of Soft Systems Methodology (SSM) (Checkland and Scholes, 1990; Checkland and Poulter, 2006) was used to structure the process of gathering information and thinking critically and creatively about the issues raised. This chapter reports the outcomes of that process. The chapter is organised around the two phases of ‘finding out’ and ‘engagement’ and, within them the relevant stages of SSM. It begins with the identification and expression of the ‘‘problematic’’ situation, corresponding to stages 1 and 2 in SSM. This section is based on semi-structured, face to face, interviews with service users (SU), informal carers (CA), service providers (PR) and decision makers (DM). It presents participants’ perceptions in relation to Quality, Communication and Trust, in turn, and ends with attempts to model the issues raised in diagram form. The section that follows, based on the workshops held with service users and providers (separately and jointly) deals successively with the selection of relevant systems on which participants wished to focus (stage 3 in SSM); conceptual modelling of those systems (stage 4) and comparison of these ‘‘ideal’’ systems with the status quo as perceived by participants. The chapter ends with an account of progress towards agreeing and implementing change.

6.2. Phase One: Finding Out

This section presents a range of perceptions, opinions and issues raised by participants with regard to the themes of service quality, communication and trust. In

fact, the three strands are interlinked in complex ways, as will be seen later. However, initially, they are presented separately to facilitate clarity and readability. Following presentation of these key themes, reflected in the ``voices`` of the participating stakeholders, attempts to capture participants' perceptions diagrammatically are discussed.

6.2.1. Service quality

An opening question about what service quality meant to participants elicited a variety of responses, which showed that for service users and carers in particular, quality was viewed in very subjective terms. Only one service user referred to the possibility of existence of some sort of objective standard by which quality might be evaluated:

“It means that they have standards to live up to...you have quality assurance there and if it falls below that you can complain and if it goes above that, well, it is better for everybody” (SU 02).

However, she went on to say that there was a difficulty in assessing service quality, because “you do not know what the standard is” (SU 02). Similarly, a carer posed the question, “Does a person know what they may reasonably expect?” (CA 01). Whilst one service user expressed a sense of quality quite simply in terms of outcomes – “you use the service and it makes you better” (SU 04), corresponding with what a service provider called “quality of intervention” (PR 03), other participants acknowledged that this, too, was a difficult criterion to apply, because “outcome is `greyer` in Mental Health than Physical Health” (CA 01).

In the absence of such objective criteria as clear, known standards or a proven “cure”, one service provider resorted to the classic definition of quality as “meeting customer requirements” (PR 01), while a carer, CA 02, expressed a similar idea when

she referred to “giving the patient what they need, when then they it”. But what do service users need?

It is noteworthy that when asked what quality meant to them, or when recounting experiences which led them to perceive quality as satisfactory or not, participants usually said very little about tangibles, and in the few cases where such aspects of service were mentioned, it was to point out experiences of dissatisfaction. In the case of SU 02, for example, perceptions of service quality were influenced by the difficulty and inconvenience of travel:

“... at least you got a service when you got there, but it was the actual inconvenience of having to go so far to get treatment... it was not local, that was the main disadvantage – the fact that you had to travel so many miles to get treatment ... you’re already stressed before you’ve even got there.”

Another service user, who had experience of a number of clinical and acute units, suggested that “the premises are not always conducive to giving that quality” and in particular described

“a warren of a building that is totally inadequate for people with mental health problems. There were corridors all over the place, confusing, there were doors off that were not checked by security, there was no garden for [residents], just a little back yard” (SU 08).

The participant acknowledged that “it was kept clean and tidy”; the problem was simply that the building “just wasn’t built for that sort of thing”.

With these few exceptions, however, service users and carers – and to some extent service providers also – viewed quality of care in terms of the subjective experience of participating in the service, and in particular, the interaction and relationship between the client and service providers – what one participant referred to as the “quality of contact” (PR 03).

A number of comments concerned service users' and carers' feelings of assurance regarding their perceptions of health care staff as competent and well intentioned. SU 05 spoke of the expectation that such staff would have "depth of knowledge", while SU 08, who had "every praise" for the staff, cited as evidence the positive outcome experienced by a young man of his acquaintance, which he attributed to the dedication and skill of NHS staff:

"... three months after ... compared to the view that I saw of him when I went to visit, I could see that service, the NHS side... the service he had had in those few months, the distance he had travelled was wonderful. So I did see the quality there..." (SU08).

On the other hand, there was a suggestion that GPs might not have sufficient training to deal with the range of issues raised by mental health. As one service user expressed it:

"There may be only 20 things that can go wrong with your stomach, but there are a million different things that can go wrong with your brain. I do not think GPs have the training required" (SU 08).

The same respondent gave the example of discussions with two GPs about the possibility that he had post – traumatic stress disorder.

"I mentioned it to my GP, and he,... without saying it, because he was far too polite for that, but he disapproved the suggestion that there was a problem and there was indeed a problem existing like that. I spoke to another GP, who simply admitted that he hadn't had training to diagnose such a thing and that he had to engage, or find or look for a route for me to go down – so he didn't know that route" (SU 08).

This participant's experiences refer to lack of awareness or knowledge in relation to a specific condition. The concern here was that since the GP is the gateway to other health services, a lack of required knowledge on the GP's part may lead to delay

in or lack of referral for appropriate help and support. This was, however, a rare instance of a criticism related to the health professional's knowledge.

Whilst generally seen as competent and well-intentioned, health care staff were, however, the focus of some criticism with regard to their reliability. Three service users, for example, commented on experiences of unreliability in appointment keeping: "The CPN was dreadful – she would make appointments and cancel them" (SU 05). Service users expected health care staff to keep appointments and to be on time, and that any deviations from this principle should be rare, as indicated in the following exchange:

Interviewer : Do you see them [service providers] as reliable?

SU : Depends if they arrive on time. Sometimes they are running late, but you can excuse them if there has been an emergency.

Interviewer : How often?

SU : You could excuse it maybe a couple of times but you would not be able to excuse it if it was happening every time (SU 02).

Another participant described her feelings when she telephoned a service provider in a crisis situation and was promised a call back, which failed to materialize; in fact it was three weeks before she received a response to her appeal for help. She was at pains to point out how this undermined her confidence in the service because, "when people promise and do not deliver, people feel let down" (CA 01).

Service users' concerns in such instances were not confined to the disappointment of an unmet expectation or service product not received; such incidents also had symbolic value as (perceived) reflections of the attitude of the staff concerned towards service users. SU 03 commented that "it does not show respect to the patient" and results in the patient "feeling totally unimportant" (SU 03).

Indeed, it was perhaps this perceived lack of respect that was of more concern than the delay or cancellation itself; consequently, such incidents were more readily forgiven when accompanied by a message of apology, showing courtesy to the patient. This was evident in the case of SU 05, who described, as an example of what he perceived to be service of high quality, his experience with a particular psychologist. His account focused very much on the relational qualities of their association, reflected *inter alia* in the fact that “if delayed, she always sent a message”. It is interesting that such a simple courtesy was considered worthy of special mention.

In fact, the greater part of the comments made by service users and carers with regard to service quality concerned the relationship between themselves and the healthcare practitioners, and focused mainly on two attributes: responsiveness, meaning the willingness to help and provide prompt service, and empathy, encompassing approachability and understanding. In relation to responsiveness, for example, CA 01 cited as an example of good service quality a time when she had raised the problem of her husband’s speech difficulties with his psychiatrist and he took action the same day. In contrast, another participant described what she perceived as a lack of responsiveness to her needs because she did not meet new criteria on crisis intervention:

“Now, when I go to see some doctors, I say I have got problems with my mental health, they listen to what I’ve got to say, and when I finish speaking, they say, “Have you got anything else wrong with you, physically?” They just completely blank the mental health part” (SU 07).

She was under the impression that “because I don’t take medicine and because I am not cutting or swallowing tablets or jumping off the Humber Bridge” she was not allowed to receive mental health services. She went on to recall a catalogue of incidents in which she had sought help from various quarters and been dismissed or passed back and forth between the GP and CMHT. As in the previous case of the participant with

PTSD, she felt the lack of responsiveness to her needs was related to lack of knowledge on the part of doctors.

It was, however, in the area of empathy that the main service shortcomings were reported. When the relationship was successful, it was described in simple, non – specific terms: “We just clicked” (SU 03), whereas failure to “recogniz[e] the person, not the illness” (SU 03) was reported at greater length, with illustrative examples. One interviewee, for example, discussed a confrontation with staff in hospital over her refusal to take medication until the nature of the medication and its possible side effects had been explained to her. Up until this point no explanation or information on her condition or the drug had been communicated to her and so in her distrust, through the lack of communication, she had stopped taking the medication. Her criticism was that she was not treated as a reasoning being – “not realising that there was a reason why I had not taken the medication” (SU 01). Another service user criticised the failure of staff to take interest in her painting (through which she expressed her feelings and concerns) as a “wasted opportunity” (SU 05).

It was interesting to note, moreover, that behaviours that were no doubt intended to convey responsiveness and empathy to patients could be interpreted very differently by the patients themselves. One such example was that of SU 04, who recalled an occasion when he had discussed his depression with his CPN, and the latter talked about how he had faced the same situation. Rather than being perceived as a demonstration of empathy, this was seen as a failure to recognize the patient’s situation and feelings: “He tended to talk more about his problems than mine” (SU 04). The CPN had failed to recognize and validate the uniqueness of the individual’s experience and to give him the personal attention he felt he needed. Another example cited was the practice of saying, “If you want me, come and find me” – leaving the patient to knock on a closed door and

face an office full of people. While perhaps intended to indicate a willingness to be available, this behaviour demonstrated a failure to understand how intimidating this was for the patient, for whom “it creates a barrier” (SU 05).

There were, moreover, indications that the intangible dimensions of service quality, such as responsiveness and empathy, often impact on the tangible aspects. A service provider raised the issue that people with mental illness often do not get physical needs met (for example they do not get screened for diabetes) because it is difficult for them to face a surgery full of people (PR 02). Similarly, a service user / carer (SU 02) who spoke about getting dental care for her daughter with learning difficulties reported that the tangible aspect (treatment) was good, but there were problems with the intangibles, responsiveness and empathy, which made it difficult to get what she needed.

Sometimes, however, empathy could come from unexpected sources, as in the case of SU 03, who recalled that his belief in the possibility of recovery had been sparked, not by a health care practitioner, but by a cleaner who spent time engaging with him as a fellow human-being, showing “compassionate ordinariness”.

A number of service users highlighted the importance of “doctors [and other practitioners] that listen to you” (SU 04) or expressed frustration that “they do not listen” (SU 06). However, comments also revealed the close connection between empathy and responsiveness; empathy was of little value unless combined with action; as one service user clearly expressed: “They listened but did nothing about it... I wanted more than just an ear” (SU 05). Indeed, an appropriate level of responsiveness could rectify the situation when a failure of empathy occurred. A service provider (PR 03) recalled a complaint concerning the use of third party information in a case conference. The complainant had been attending a meeting with a relative, at which disclosures

were made about the relative's previous behaviour, which she had known nothing about, and which had implications for her. She was very distressed, not only by the disclosure itself, but by what she saw as the arrogance of the professionals and their lack of thought for her feelings. The Patient Advice Liaison Service's (PALS) action in response demonstrates the importance of responsiveness. They involved the complainant, over several months, in working to put together a protocol to get people to think about what they were doing and avoid recurrence of such a situation. The woman felt ``included`` and ``listened to``, while the practitioner was pleased that "we had made the partnership" and "we had valued this person's opinion". In this way, responsive action restored the relationship between users and provider. In this respect, the interviewee noted, it was also important that PALS had ``made good`` and ``reported back`` so the woman could see "we were doing what she had asked us to do".

In contrast to the predominantly relationship focused view of quality taken by service users and carers, decision makers were much more concerned with strategic (cost-effectiveness) and normative (standards-related) perspectives. For example DM 01 indicated that one of the service priorities was service improvement, seen in terms of labour productivity, cost saving, and how to design and reconfigure the service to achieve these goals:

"We need to look at how services can be modernised – not reduced, but provided more efficiently at less cost. For example, when beds are closed, it is linked with more home care, which people prefer. When we make savings, the resources are available for investment in other areas of patient care" (DM 01).

DM 02 expressed a similar focus: "I emphasise the need to improve service and save money – they are not necessarily mutually exclusive". His discourse was "achieving financial targets", ensuring that the service was provided "within the resources available" which were "not only inadequate but diminishing".

This resource, cost-efficiency based approach was challenged, however, by the pressure to achieve health care standards, which changed from time to time. “We have to reassure ourselves, the board and the health Care Commission that we are meeting those standards” (DM 01).

Thus, a clash of agendas could be perceived, between service delivery and cost saving, in which it might be suggested that the latter might colour perceptions of the former, as in the idea of linking “major savings” to service development by “moving service closer to the community” (DM 02). The third decision-maker interviewed, in contrast, more directly expressed concerns with the service users’ needs, reporting aims of effective service provision “based on users’ needs” and of “engaging with users about their experience of services – what they value and what needs to change” (DM 03). She shared with service users the rhetoric of responsiveness; however, she acknowledged that with a large client base (“there’s a quantitative issue – the number of people and the time scale”) it was not always easy to meet service users’ needs and expectations, especially as these are so varied: “I listen to the needs of users, but the difficulty is that users and needs are diverse. So some people whose needs are not met may think they are not listened to” (DM 03).

Service providers found themselves in a similar position, caught between a relational view of quality and conflicting demands of environmental pressure and strategic imperatives. All the service providers interviewed emphasized the importance of provider – user relationships as a key element in their conception of service quality. PR 01 described it as “pivotal” and “crucial”, and emphasized the necessity of “creating a dialogue” which is “necessary in order for people to articulate their needs”. PR 04, a CPN, argued that “you get real quality when there is proper interaction”. This was not necessarily easily or instantly achieved, especially when “I have to do things that you

may not like or want” and she had to “try and use my understanding of what’s happening to them” to “engage properly with that person”. For this service provider, “quality...is all about how I negotiate that relationship with that service user” (PR 04). Service providers acknowledged, however, the relationship – building is time consuming and time is in short supply, so often, “people are not getting what they really need, they get part of it” (PR 01).

A further difficulty is “confusing, competing demands” (PR 01). The service is caught between different needs and interests of multiple stakeholders. For example, people who commission services may have different ideas from patients and “we cannot provide anything we are not commissioned to provide” (PR 03). PR 02 admitted that what is important to users may be completely different from practitioners’ assumptions and “a lot of outcomes are our outcomes”, because “organisations are structured around management structures etc...they have a vested interest in their own survival” (PR 02). Not only do different stakeholder groups have different interests, but there are many different interests, even within one group and “with two-and-a-half thousand users in our service it would be very difficult to have an individual, tailor-made service” (PR 02). Consequently, a disproportionate time is spent on “a few people with great needs” (PR 01).

The conflict of interests was well illustrated by PR 04, who discussed at some length the rationale for and impact of the normative approach to quality, “We have to be able to demonstrate [quality] so we have standards ensuring safety, dignity, confidentiality” but felt the focus on “performance and outcomes” had led to an “almost artificially constructed sense of, we have quality because we have all these mechanisms...it’s a false quality almost”. In the view of this participant, the mechanisms of clinical governance and performance review were “so far removed from

what's actually happening in practice., from what's really going on in the terms or units" that it resulted in "unrealistic and unobtainable" goals and objectives, and bureaucratic documentation processes that "actually get in the way and serve to give nurses, you know, like, a reason not to be with people". The nurse recognized that there are "broader political pressures" such as policy and legislation to be adhered to, but asserted that relationships with service users had to some degree been lost in the process and there was a "need to get back to a more fundamental aspect which is much more about attitudes and values" – exactly the message that service users seemed to be trying to convey.

6.2.2. Communication

A strong theme throughout the interviews was the importance (and in many cases, perceived unsatisfactory nature) of communication, with regard in particular to information flows between practitioners and service users. The need for information, expressed by service users and carers, was closely related to the idea of participation – interviewees wanted to be able to make informed judgements, to be proactive, to participate in and understand care. The kind of information wanted concerned choices in treatment and care (if there are any), immediate prospects and possible outcomes. In the view of carers, such information should be given "not just to the service user but to the people around them (CA 01). In practice, however, many participants felt that these needs were not being met. According to one service provider, complaints to PALS are mostly about poor communication and lack of information (PR 03). When asked how well the doctors explained her schizophrenic son's condition and treatment, one carer replied, "I do not think they ever have. I have had to find out from books, myself" (CA 01). Another carer commented on the worries carers have the first time their relative is hospitalized:

“Carers will be – because there’s been no discussion, the first time going into hospital – [they’re afraid] they are going to be discharged with no follow-up, not being aware of the care plan approach or anything. Nobody sits and explains that there will be these [services] put in place for your loved one, and so they just think that they will be discharged and history will repeat itself” (CA 03).

For a spouse or parent who has suffered the distress of witnessing the illness of a loved one, and trying to cope with the psychological and behavioural consequences, this is clearly a source of great anxiety which could be allayed by “basic general information” (CA 03).

At the same time, a service user acknowledged that there was a dilemma in relation to information provision, as sometimes too much information could be as much a source of worry as too little. When asked if she felt she was given enough information about her medication, she replied:

“Well, how much is enough? The fact that they tell you it does you good and you realize it is doing you good, that’s all the information you need. You don’t need to delve into what it actually does to your body and what side effects, because if you read all of that, you would say ‘forget it’” (SU 02).

This suggests that information needs may be something to be negotiated with the individual, according to the type of information in question, and the individual circumstances.

In addition to the issue of what information should or should not be communicated, issues were raised regarding the mechanisms (channels and formats) of communication. Communication might be written (e.g. letters, e-mail, leaflets and brochures), oral (face to face or by telephone) or visual (e.g. posters). A number of participants mentioned more than one of these channels, and the various degrees of success or attendant problems experienced with them. Service providers, for example,

highlighted the difficulties that might be faced in providing information through visual or written means. PR 03, for example pointed out that information might be displayed in a poster or notice in a waiting room, but may not be noticed, understood or remembered; a number of complaints had arisen from information being displayed in this way, rather than imparted directly. Another service provider (PR 02) noted the problems that could arise with written materials, for example, for people who had difficulty with reading.

There were also comments related to the mechanisms available to service users and carers, if they wished to communicate with service providers. For example in a crisis CA 02 reported that she found the telephone to be a vital communication link. “I can talk to doctor A – or I can ring the CPN Outreach team or one of the other carers”.

However, other participants found the telephone a problematic medium. This could be because certain people were not readily accessible by phone. “Normally you cannot speak to the doctor” (SU 04), or because of their ineligibility for certain services. As an example of the latter, SU 07 emphasized the importance of instant telephone contact: “I thought this was a very good thing, they did have a 24-hour, if you are in the system, you get a Care Plan and you have got numbers you can ring”. However, she went on to explain that because she was the victim of “a gap in the service”, she was no longer eligible. “I used to value ringing the Social Services helpline, but because I don’t receive services I cannot do it” (SU 07). For a time, an alternative had been a crisis line operated by the mental health charity, MIND, but “because of the government directive on crisis intervention, the MIND line has also gone” (SU 07).

The same service user, who also had mobility difficulties, and who found face to face contact difficult because of poor short term memory and a tendency to become distressed when asked direct questions (she attributed both to having been the victim of

an attack some years previously) made effective use of written communication to make some of her needs known.

“What I did in one of the doctors’ once, cos I lived in a village and it cost too much [to travel], I used to do it by post, I used to write a letter and they would write back... I can’t cope with getting physical medicine so...if I’d go to the doctor and hand in a prescription I sent a stamped addressed envelope so I did not have to keep going backwards and forwards” (SU 07).

Participants raised a range of contextual factors grouped under the categories of accessibility and intangibility, which impact on communication. For example, access to information may be constrained by factors such as difficulty of travelling to meetings. A common theme was that a significant factor in accessibility of communication is the personal attributes of the service users; several interviewees emphasized the role played by confidence and assertiveness. For example, CA 01 commented, “I have the confidence to ask”, but suggested others may “not be confident enough to push for what they need”. This may be a personality trait – “I’m a shy person” (SU 04) or a result of the illness itself: “I lost all confidence to knock on the [CPN’s] door” (SU 03). As a result, “they [people with mental illness] do not have the ability to be assertive enough” (CA 01). SU 02 similarly felt the ability to be assertive was important: “You felt as if you had to pick at them to get the answers you were requiring”. However, another service user indicated how much easier it might be to adopt a passive stance, because “I don’t wish – and I think many people with mental health problems feel the same – they do not want to be a burden and don’t want to offload their problems” (SU 08). Moreover, they may find discussing their problems embarrassing or painful: “Ex-servicemen don’t want to talk about why they are not sleeping well” (SU 08). The problem in such cases, as acknowledged by a CPN, was that people who were unable or unwilling to be assertive could be overlooked:

“There are a group of people who are very assertive, but there are a number of people who will sit very passively, and I think sometimes we overlook them. I can’t say that I knew that person understood why they were here, or what treatment they were getting...” (PR 04).

Other impediments to accessibility of information and support appeared to be institutional / systemic. SU 05 commented that “you have to fit into the system”, while SU 03 elaborated that “people had routines, protocols, procedures, that superseded my need to communicate”. The same participant noted that to some extent, the degree of engagement possible depended on the willingness and creativity of the service provider. For example, one nurse manager had set up a system of meetings between patient and key worker, three times a day for five days. This “meant someone had to communicate with you” and “showed that systems can be created” to facilitate this, but “when she left, that initiative failed” (SU 03). An example of the way systemic procedures could unintentionally constrain access to communication and support was the loss of open access to “605” (an abbreviated reference to the address of a unit in Hull which used to provide a drop-in service); lamented by SU 02:

SU : It used to be where people could meet and talk and feel as if ...it’s not like that now – you have to have an appointment there – you can’t just walk in and have a cup of tea and natter – that’s lost.

Interviewer : That is lost?

SU : Yes

Interviewer : And it was good?

SU : Yes, it was when you were feeling down, and you had nobody to talk to, you could talk to other service user or talk to the staff. You could just pop in and say ‘I’m feeling a bit down today’. You had somebody there who would make you feel better.

As this example shows, service users' communication needs were not confined to – and did not always warrant – formal appointments. A few moments of empathetic informal communication might help them through a difficult time, but such communication was needed immediately, when the fear or depression was being experienced. The appointment system, however well intentioned, was perceived in practice to cut service users off from a valued source of help.

Moreover, even when access to service providers was gained in physical terms, and information was offered, communication could be impeded by lack of intelligibility. For example, SU 01 indicated that she had difficulty understanding her doctor's foreign accent. CA 01 & CA 02 both commented on the use of medical jargon and the latter suggested, "I don't think the doctors would expect you to say 'I do not understand- can you explain?'". PR 04, however, indicated that she was "quite careful and considerate about the language that I use". When in a professional meeting, she could "use jargon ... sort of, like, psychiatric-speak" but she thought that in other contexts she had developed "the ability... to mirror the sort of language people use towards me" (PR 04).

Although this service provider, like the others interviewed, spoke of sincere efforts to communicate effectively with service users and to understand their needs, there was a strong feeling among service users and carers of inequality in the relationship. Some service users felt 'excluded' (SU 02), 'put down' (CA 01) or 'treated disrespectfully' (SU 01). CA 01 remarked that "consultants are very, very, very powerful" and described a feeling of "utter helplessness" when encountering service providers, as well as instances of service providers being put under pressure – for example to exclude carers: "You do not want your father involved, do you?". Such imbalance of power in the relationship was not confined to consultants, but extended to all service providers, because not only did they have control of information and

treatment, but they had the power to withdraw their service entirely, as one service user argued:

“We can’t argue with a GP. We can put a point over, but everyone is fearful of losing the trust of the GP and losing even your position in the surgery and [they] strike, you off and say ‘We don’t want you’ ... so I think people are frightened to challenge their GP, because of the possible consequences” (SU 08).

One of the service providers interviewed acknowledged this imbalance of power – the fact that, for example, inpatients are totally dependent on nurses for everything and that for an individual who is “powerless to get a couple of paracetamols or towels out of the cupboard” there is “a real sense of profound helplessness and powerlessness” (PR 04). She accepted that sometimes the exercise of power relations was “beyond negotiation almost”, for example when a patient became psychotic or paranoid and intervention was necessary to ensure their safety. However, she suggested that “the way that you use language, the way that you use communication” can significantly affect how disempowered the person feels.

Whilst some service users felt excluded or weak in the relationship with service providers, carers felt particularly marginalized, because of their status. CA 02, for example, reported an instance where her son had been released from the hospital (where he had spent six months having been detained under the “sectioning” procedure) but she was not informed of his release. A service provider, PR 02, admitted that carers are not involved as much as they could be in care planning, even though they are often more aware of the service users’ needs. In this respect, confidentiality rules, intended to protect the patient, can “get in the way” and people are “confused about what they can and cannot divulge” (PR 02). However, as a carer CA 01 pointed out, the rules do not apply equally to formal and informal carers. If a service user does not want his /her (informal) carer involved, they will not be given information; but a formal carer, such as

a care home manager, will automatically be informed, without needing the patient's consent. Thus, communication with carers depends on their paid/unpaid status, rather than the actual kind and level of care and support provided.

Some providers, for their part, described a number of ways in which they had tried to improve communication with service users. PR 02 referred to patient involvement in quality initiatives (which can be seen as an interface between Quality and Communication). PR 03 mentioned several ways in which he could meet service users to ascertain their needs: through established user groups, through work with individuals, through work on a unit (he spent about 10 per cent of his time on a unit), through visits to carers' groups, and through the National Patient Survey. PR 04 had experience of patient questionnaires (such as exit questionnaires on discharge), suggestions boxes, and patients' councils. However, none of these initiatives appeared to have been as successful as might have been hoped. According to PR 02, attempts to involve patients in quality initiatives had met with low response and participation had dwindled. Similarly, PR 04 commented with regard to the various initiatives she had mentioned,

“It gets the momentum going and then it tails off and it gets neglected and suddenly we're not doing that anymore...we have a bright idea and then it tails off”

Similarly, PR 06 said “the NHS is brilliant in innovation but is terrible in sustainability”.

One possible reason for the limited success of such initiatives is that they are “driven by our agenda” (PR 04). Another is that the service user population is not stable; as users' condition improves, they want to move on and not stay involved in user groups, patients' councils and the like (PR 03). This idea was borne out by a service user, SU 02, who had been involved as both service user and carer. She had attended

many public meetings and had been a committee member at “605”, mentioned earlier, but had subsequently “stopped all my voluntary [work] and more or less tried to move out of mental health and have a normal sort of life”.

Some providers admitted, however, that there were a number of institutional constraints on the various efforts to understand service users’ needs, communicate better and improve service quality – structures, mechanisms and procedures which might facilitate or impede communication and related action. These included time: people want “quick results” but solutions need a “long-term relationship” and a “period of learning” (PR 01); the competing demands on practitioners – “nurses being preoccupied with things in the office” (PR 04); and finance (for example PR 03 said there had been no increase in budget since before 2000). PR 01 suggested that another obstacle was the “very process – driven” institutional culture. The same participant pointed also to lack of opportunity for some service users to communicate because of the “colonization” of “privileged points of access” by professionals and by certain other users; in other words, contrary to service users’ view, the problem was not a simple case of one – sided communication, dominated by professionals, but also of the nature of the Trust and the existence of a “very loud, vociferous lobby” who can “drive the Trust” (PR 01).

A final interesting point raised by service providers, with regard to communication at the individual level, was the “reserve of practitioners” and the suggestion that their failure to be open in communication might sometimes be at least partly a defence against exploitation (PR 01) or personal distress and emotional exhaustion (PR 04):

“You get people who...keep coming back to you, making various requests...or wanting to engage in long discussions about what is going on and if you are exposed to that over a 7-hour shift or sometimes a 12-hour shift, it becomes too much, too overwhelming. Or similarly if somebody is

very self – destructive, and talking and describing and behaving in a way that is harrowing, that sort of exposure can make you want to back off...you desensitise yourself and you distance yourself ...sometimes participants can be very personally threatening or offensive”.

In such cases, the personal needs of service providers as individuals clearly conflicted with expectations of their role as practitioners – a conflict which might be invisible to service users, who would see only its consequences, as a perceived absence of engagement and empathy.

Whilst service users, carers, and service providers all spoke of issues surrounding communication between patients or carers and practitioners, a rather different perspective was put forward by decision – makers, who discussed communication within the Trust itself, that is, between themselves and colleagues or subordinates. DM 01 and DM 02 spoke of internal communications and the need for information system improvement. DM 03 explained relationships with others in the organisation chart, for example meetings, reporting structures and divisional boards. In these discussions, the focus was on the way the decision-makers could provide leadership and support teamwork on projects. Only DM 03 referred to mechanisms for communication with clients and expressed a clear wish for service users to have significant input into quality initiatives.

Thus, for communication, as for quality, there was a general perception among stakeholders that it was important, but it meant different things to different people, and involved a complex array of interacting issues. These confusions, constraints and competing agendas were reflected in perceptions of trust, discussed next.

6.2.3. Trust

Service users acknowledged the importance of trust in their dealings with HMHTT: “Trust is paramount” (SU 03); “It plays a very major role” (SU 05); “I have to feel I can trust them” (SU 04). One service user expressed the dependence in the relationship, which made trust a key issue: “When you are ill, you put your life in their hands” (SU 05).

Perhaps for this reason, some service users were prepared to take trust for granted, assuming that trustworthiness is inherent in particular roles: “A doctor is a doctor. You are supposed to trust a doctor. They are supposed to know how to treat you” (SU 03). This service user had, he said, never thought about trust. Yet, despite expressing a generalized assumption of trust, he admitted that in interaction with medical personnel, he did not feel comfortable or confident, but “apprehensive”. Other service users more explicitly linked their feelings of trust – or lack of trust – to their experiences of health services (not necessarily confined to those provided by HMHTT). One asserted,

“I have absolutely no trust in the NHS in absolutely no form, as I have seen so many things go wrong, right across the spectrum...I think doctors are so short of time...so I don’t think he gets to a true diagnosis when you go in...when we go into doctors’ surgeries, we are at risk to ourselves” (SU 08).

Whilst one service user indicated that the willingness to trust was to some extent a personal attribute – “I am quite a trusting person. I would say, er, or maybe I am just too naïve...” (SU 03) – most referred to specific characteristics and behaviours that they expected from health care providers in order to trust them. The most frequently mentioned was competence; service users needed to feel assured that professionals had the required skills and knowledge to treat them effectively. For example, one participant

expressed the need for practitioners to have “good, sound and appropriate knowledge and education” (SU 05).

Other responses clustered around the integrity or benevolence of the practitioner – the feeling that he/she had the service user’s best interest at heart and would act accordingly. Evidence of such integrity could take a variety of forms. For example, practitioners should respect patient confidentiality: “Not to take [what the patient has confided] beyond the interview” (SU 03). They should be “kind” (SU 05). One service user saw a practitioner’s integrity demonstrated in the professionalism with which he had treated her, regardless of his personal feelings towards her:

“When I read my notes, I found out one of my former doctors didn’t actually like me but he never showed it and I thought that was very good professionalism, so that’s a form of trust – you can trust a doctor who hates your guts!” (SU 07).

The same participant also related her feelings of trust to the quality of time and attention given to her by practitioners, and cited instances of where this had been lacking:

“I think often it’s non-verbal behaviours, if they look at you – eye contact, and also if they look at their watches a lot of the time and that – I’ve known some doctors and CPNs I’ve been with, and they are actually catching up with their notes while... you don’t feel you are getting quality time because they are not giving you their full attention, so, erm, they need to give to give you their full attention, not to be sidetracked into doing other things. I think that conveys a very bad practice” (SU 07).

One service user thought that practitioners’ integrity was undermined by commercial imperatives:

“I don’t trust doctors necessarily to give the correct medicine out, as I believe it may have been affected by commercial reasons to give that medicine out, so what I would like to see, to give

my trust to doctors, is sufficient resources for the doctor to give me the drug that he wants to prescribe me, not the one that he can afford” (SU 08).

This service user admitted that he had no firm evidence for his fear that some doctors might be swayed by commercial considerations, but expressed concern that the presentations made to doctors by medical representatives from pharmaceutical firms, “giving their stuff away” must “rub off” and affect clinical judgement. In his view, adequate resourcing would remove such pressure, enabling service users to feel assured that the practitioner was motivated by no concerns other than benevolent interest in the best outcome for the patient.

Such concerns raise the issue of the values by which health care practitioners operate, particularly those in power who set the tone of the service. As one service user indicated:

“Trust depends on the values of those in charge of the organisation...if they do not tally...I would not want to put my trust in that organisation (SU 05).

Another theme running through service users’ stories was the reciprocal relationship between trust and communication; lack of trust was seen as an obstacle to open communication, while at the same time, poor communication resulted in lack of trust. This was illustrated particularly well by SU 02, in her account of her struggle to obtain help for her daughter. At one point in our conversation, she characterized trust as an input to and facilitator of the relationship with health service providers:

“...you can’t be open with them if you don’t trust them. And you feel they may be laughing at you, or think you are silly or naïve or, you know, you just don’t know what they think” (SU 02).

She went on to express her feeling that communication between herself and doctors had been distorted by their attitude towards her as a woman – “They treated me

differently, they didn't tell me the truth so I had to try and get it out of them". The result, she claimed, was that "all that created this imbalance with doctors and trust". In this instance, the feeling that information was being withheld from her and that communication was not open caused this woman's trust in service providers to be eroded. A turning point, however, was reached when she became an active participant in the system through involvement in the user-led research programme:

"I did begin to trust the system when I was beginning to do my Trailblazers and (inaudible). We learned how they worked and get to trust them a bit more" (SU 02).

The final theme in service users' comments in relation to trust concerned the relationship between trust in individuals and trust in the system. The two were shown to be closely connected, in the sense that experience with individuals reflects on systems. As SU 01 explained, perceptions of service quality and, hence, trust in the system that provides the service, are formed by accumulation of experiences with individuals. These can vary because "with any provision, you are going to get rotten apples and you are going to get good ones" (SU 01). At the same time it is easier to trust individuals than the system, because of the personal relationship that can be built; a number of participants described trusting relationships with individual doctors and CPNs who had proved supportive over time (a number of examples have already been cited in the sections on quality and communication). Nevertheless, it was recognized by some service users that the system impacts on the behaviour of individuals (as in the scenario envisaged by SU 08, whereby care may be affected by resource constraints). As SU 05 asserted, "If the system does not support these workers, it all goes pear-shaped".

Carers, as "witnesses" of the service provided by HMHTT, expressed similar views to service users, as regards the attributes which induced them (or would induce them) to trust service providers. CA 01 focused on reliability and described how trust

was eroded when a promised phone call was not received. She noted that service providers might inadvertently sow the seeds of mistrust by making promises that cannot be fulfilled: “You have to be careful what you offer, because reality intervenes”. Moreover, she noted that a mental patient may have different perceptions and responses from other people, so that it is easy to arouse in them expectations that are unintended by the service provider. “Saying ‘Hi’ is fine, but saying ‘How are you?’ and then walking past is not”. This is because it is interpreted as an invitation to discuss the patient’s concerns, feelings and problem – an ‘invitation’ that appears to be promptly withdrawn when the practitioner walks past. The patient feels let down and mistrusts the practitioner’s sincerity.

For CA 02, trust depended on the practitioner doing “the best” for her schizophrenic son. Her idea of “the best” seemed to combine the notions of benevolent support-“the CPNs and nursing staff have always been very helpful and I trust them” and competence: “if he had had the right treatment...”

The same carer added an interesting idea to the debate on trust in individuals, versus trust in the system – interesting because it was contrary to the trend of service users’ response. Whereas service users generally appeared to show more trust in individual practitioners with whom they had a rapport, than the system, CA 02 claimed to trust the system more than individuals. Her trust in the system arose from the experience that “when things have gone wrong, I have been able to approach someone”. In other words, the wider system offered alternative viewpoints, safeguards, mechanisms for complaint and for obtaining redress. In contrast to this were situations in which she felt certain individuals had misdiagnosed or failed to help her son. Thus, it seems that good or bad experiences with individuals may reduce feelings of trust or

mistrust, but the extent to which these colour perceptions of the system as a whole is influenced by other factors, including the way the system itself responds to problems.

For service providers (professionals), as for service users and carers, trust is of crucial importance; indeed, it was described as “inherent in quality” (PR 04). Whilst one saw the ability to trust as an individual propensity – “some people are unable or willing to trust” (PR 03), for most it was generated as an outcome of the relationship between themselves and service users. Attention was drawn to the importance of respect, especially for mental patients who tend to have low self-esteem, fear being “talked down to” and are very sensitive to “inadvertent signals” (PR 01). Consistency was considered important – “You must not say one thing and then later say something different” (PR 01), as was reliability: “I have to prove that I will do what I say, that I am reliable” (PR 02). This, in turn, was related to the ability to be realistic in order to avoid raising unreasonable expectations. As PR 04 indicated,

“I think one of the things that undermine my justification of people is when they’re, you know, they have these pie in the sky ideas, that bear no relationship, you know, to what could realistically happen”.

However, PR 01 pointed to an assumption among service users (as he perceived) that HMHTT is not trustworthy, not reliable.

Whilst many of the issues raised in the interviews with service users and carers did indeed support the view that there were feelings of mistrust in individuals and/or the system, it was interesting to hear the acknowledgement by PR 04 that practitioners, similarly, may experience mistrust of service users:

“I think that sometimes as nurses, and that includes myself, we become very distrustful of people without any sort of justification. We will start to see...there is always that mentality...that everybody will always take, even if somebody is

ill, what are they trying to get from you?” (PR 04)

Distrust may occur because trust has been abused in the past: “Their past experience caused deep mistrust and if that happens I have to live with it” (PR 03). It may also be the effect of the image of the system or organisation: “Simply because I work for the NHS, I cannot be competent in some people’s eyes” (PR 03).

There was a recognition among practitioners that trust cannot be assumed, but has to be earned – “It’s something that has to be worked at” (PR 04). However, when people have been let down in the past, it becomes difficult to earn their trust. As PR 03 suggested, negative past experiences can create a barrier or resistance to trust that may be almost impossible for an individual practitioner to overcome:

“There are some users and carers who, it does not matter what I do, how I do it, for how long I do it, it would be almost heresy for them to trust me”

In his view, the key to building or restoring trust is engagement; however, he rated the current level of engagement in HMHTT as only C+.

His colleague, PR 04, also described the kind of open, honest engagement she considered paramount of building trusting relationships:

“...to be honest about...the fact you are a human being too, so there are many different levels on which ...or ways in which you can...you can be truthfully and honest and open. That will help, hopefully, which will encourage people to sort of know who you are, and get a sense of your, like, your ability and a sense of your genuine concern to be with them in whatever they are going through” (PR 04).

She suggested, however, that systemic pressures might undermine the good intentions of individuals, causing them to “become prevented and distorted in the context of the whole organisation”. This could be due to the need to “develop a survival

mechanism” in order “to keep their position or to hold their status”, to “fit in and not rock the boat”. In her view, the people who command trust are those who “have retained that individual integrity or that sense of clarity”, who still have a “sense of their own values and beliefs” (PR 04).

Decision Makers had comparatively little to say on the subject of trust, although DM 01 asserted the need for people to trust in the changes currently underway in HMHTT: “We want people to trust that foundation status will benefit patients and give opportunities for staff”. As this comment shows, for decision-makers, the concern was not only the trust of service users, but also that service providers should trust management and the initiatives they were implementing. According to DM 02, the extent to which this was actually achieved was variable, and he attributed problems to mismatches of expectations which happen when “communication is lacking or you do not get all the right people involved” (DM 02). In the view of DM 03, the problem was more that “sometimes we are not honest enough with people about what we can and cannot do”.

The solution to mistrust, in the view of all decision – makers, was communication. However, it was notable that DM 01 and DM 03, whose concerns appeared to be more strategic than those of DM 02, spoke only in terms of internal communication, in order to enhance the level of “working together” (DM 02). Thus, in relation to trust, similarly to quality and communication, decision – makers had rather different perspectives from other stakeholder groups.

The foregoing discussion has reported various perceptions and concerns expressed by service users, carers, service providers and decision-makers in relation to service quality, communication and trust. Trust and Quality were spoken of in very similar terms, focusing largely on the relationship between service user and provider

and the need for reliability, consistency, responsiveness and empathy. Communication appeared to be central to the formation of both trusting relationships and perception of service quality, but was sometimes impeded by issues of accessibility and intelligibility.

The interviews were validated at the individual level by referring transcripts / summaries to the participants concerned.

In the following sub-sections attempts to model diagrammatically the relationships among the issues discussed will be presented, based on my own interpretation of the interview data followed by the outcomes of discussion in workshops with service users and carers.

6.2.4. Modelling

The individual interviews resulted in the construction of a provisional ‘‘rich picture’’ (Checkland and Sholes, 1990; Checkland and Poulter, 2006) intended to capture the perceptions of trust, quality and communication, the relationships between them, and related factors, as experienced by stakeholders (see Figure 6.1). The process began with the provisional arrangement of notes, each containing a proposed theme or relationship (Appendix 7, Figure 1). This in turn led to a rough diagram, which was discussed with stakeholders (Appendix 7, Figure 2).

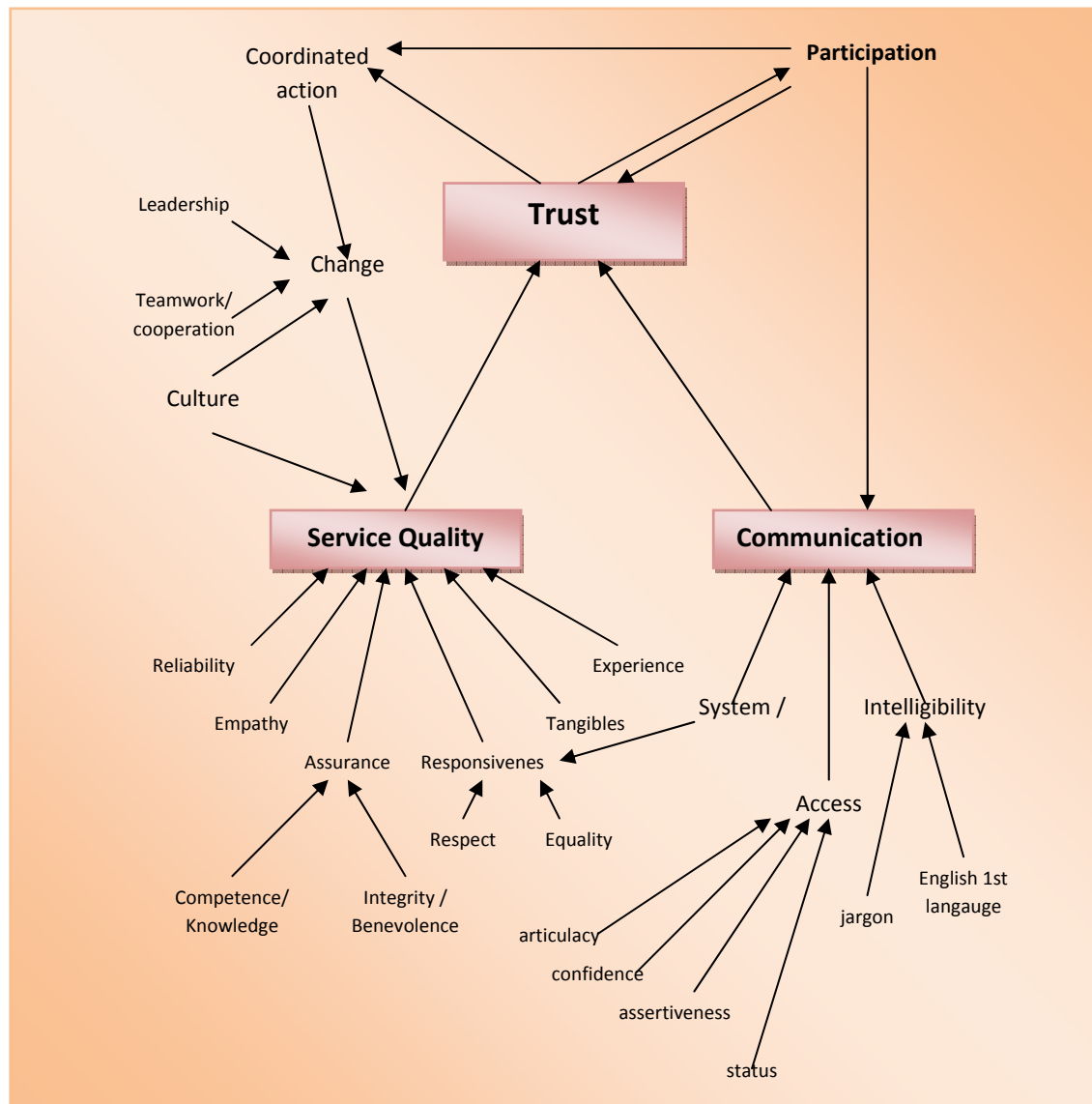


Figure: 6.1. Outcome of “Finding Out” interviews

The arrows in the diagram represent directions of influences and inputs. These are not cause and effect relationships (causation is more complex and may include factors other than those represented in the diagram) but they show that factors were perceived and spoken of by participants as connected in the ways shown. Trust emerges in the figure, largely as influenced by service quality and communication, each of which in turn had several antecedents, which could (via impacts on quality and communication) constitute facilitators or barriers to trust.

The cognitive map represented my understanding of the wider picture based on the sum of all the interviews and informed (e.g. in the choice of terminology) by the literature. This map could potentially satisfy the ‘rich picture’ aspect of SSM. However, it had first to be validated by participants because

- In line with the ‘critical’ orientation of the research, the researcher’s words understandings and claims must be open to challenge by participants.
- Participants need to arrive at and adopt an agreed picture of the status quo, in order to decide priorities for issues to address (i.e. choice of relevant systems, in SSM terms) to move forward.

On being shown the cognitive map, participants had the opportunity to seek clarification or explanation about any aspect of the map – e.g. to check the meaning of a particular term, or ask why certain entities were shown as connected. Reference was made to the phase one interviews in order to provide the necessary explanations. If they wished, the participants were encouraged to add further comments, elaborations or retractions.

Initial discussion with service users, of the picture derived from the individual interviews substantiated the issues identified, but aroused heated debate as to the relationships between them. They wanted to make clear that trust was central to them and had difficulty understanding that the initial diagram shown in Figure 6.1 represented structural relationships and did not imply any hierarchy of importance. In an attempt to make their feelings clear, they produced three further models (Figure 6.2). The original diagrams from this stage can be seen in Appendix 7, Figures 3, 4 and 5.

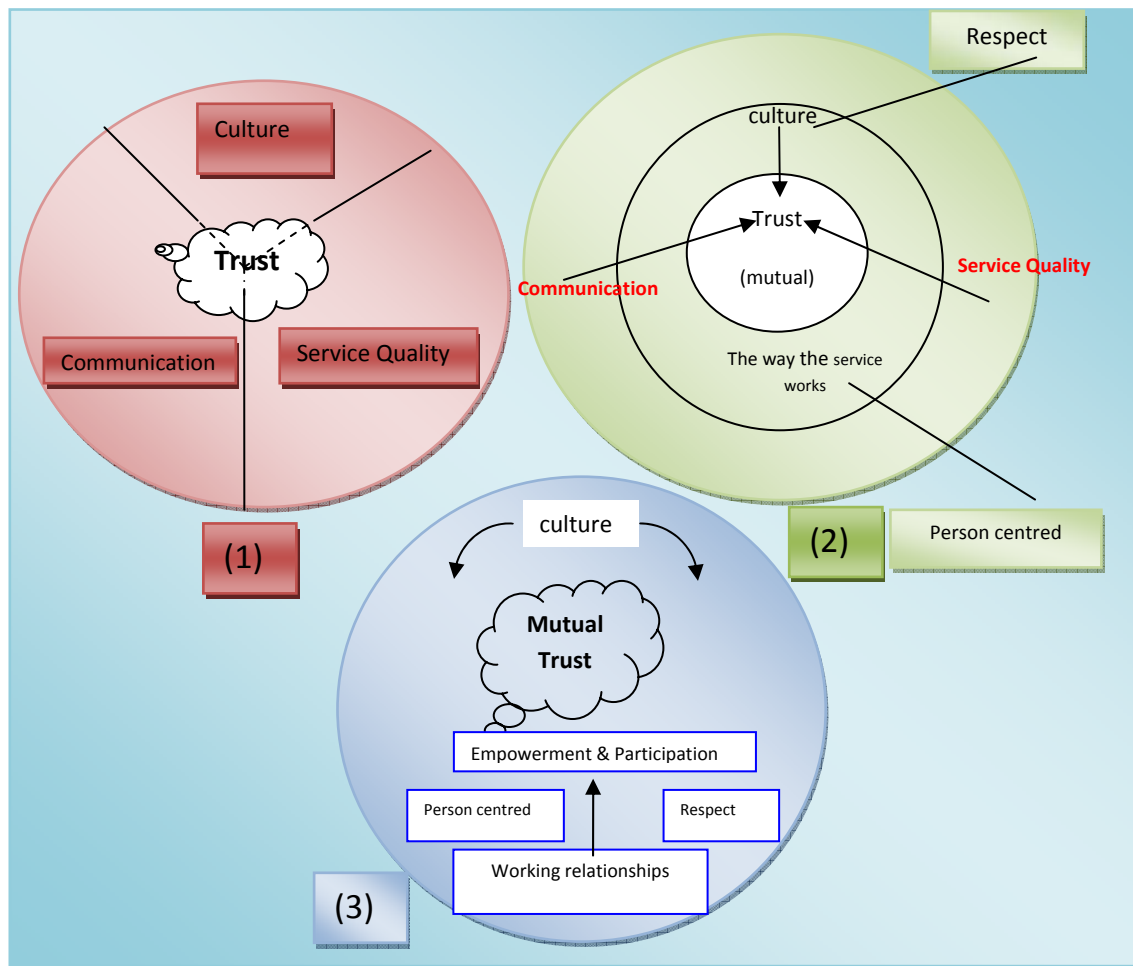


Figure: 6.2. Three Conceptualisations of trust

Interestingly, it can be seen that in the third diagram, quality, as such, is not mentioned at all; it has been subsumed into the broad area of a culture characterised by respectful, empowering, participative working relationships between service users and providers.

A dominant theme in the expression of the “problematic situation”¹ as perceived by service users was their deep mistrust of service providers and decision – makers. They were afraid of being intimidated and made to feel valueless; of being misunderstood; of being patronised; of being confused by jargon and political rhetoric. Moreover, they had little expectation of any beneficial outcome from user involvement

¹ Checkland preferred not to use the word problem as he felt this implied a ‘solution’. SSM does not seek ‘solutions’, but debate and creative thinking leading to accommodation of views and agreement on feasible and desirable change to alleviate ‘unease’. This, in his terminology, constitutes ‘improvement’.

because “it’s happened before; nothing changes”. Indeed, some viewed the idea of consultation or user involvement cynically as an exercise in “ticking boxes” and “a chance for them [managers and decision – makers] to practise their arguments” and raised the question, “Is this to address our needs or theirs?”. At the same time, there was a real desire that “they will hear what the problems are”, particularly the emotional impact on service users of the problems they encounter. Service users also wanted to be told service providers’ plans and the reasons for them, to be given choices, to be more than passive recipients.

6.3. Phase Two: Engagement

SSM was introduced to participants as a method for taking their concerns forward, and the overall purpose was explained. It was explained that, individually and jointly, they had already completed the first stage, the building of a ‘rich picture’, represented by the cognitive map they had validated. The next stage was to decide on one or more ‘system’ representing one or more issue targeted for improvement. Discussion was held with participants on how to proceed from this point, in terms of number and timing of meetings etc.

In the case of individuals who were not able to attend the meetings but were still interested to be part of the project, two channels were available to include them:

- I could liaise between these individuals and larger group, by taking the outcome of the meeting to them and obtaining their feedback.
- In the case of members of the executive board (which includes user representatives as well as managers), liaison could be conducted through the meetings of the board.

In this way, every effort was made to secure the maximum participation throughout.

It should be pointed out that at this stage, service users and carers were meeting in the absence of service providers. What had begun as a temporary stratagem due to the difficulty, for service providers, of attending meetings, due to their work schedules, was continued at the insistence of service users, due to their initial mistrust of service providers' motives and their feelings of the intimidation.

In order to enable debate on the issues to take place and to facilitate some level of dialogue, therefore, I undertook to liaise between service users and service providers, representing their constructions of the situation to each other as openly and fairly as possible and to convey their feedback. While my initial feeling was that this was not an entirely satisfactory way of achieving 'dialogue', I came to see that in fact it served a useful purpose by empowering service users to express and clarify their concerns in a less threatening atmosphere until eventually they were able to acknowledge (even if they did not agree with) service providers' constructions.

Meanwhile I encouraged service users and providers to think about the advantages and disadvantages of a potential joint meeting (see Appendix 8) which was eventually agreed on.

In the following paragraphs, I report the concerns and actions pursued during the engagement process, in terms of the stages of SSM.

6.3.1. Stage 3: Relevant systems

Stage 3 of SSM calls for the identification and root definition of some relevant human activity systems that may offer insight into the problematic situation. These are abstract and artificial in nature; they do not necessarily correspond with actual systems existing in the real world, but are described as systems to aid thinking about the way activities are linked and impact on each other. A list of 22 possible systems was

produced by workshop participants (see Appendix 9) of which four: communication, carer involvement, user participation and training were identified by service users and carers as high priority. Due to participants' time and resource constraints, it was mutually agreed to focus on just two systems: communication and carer involvement. Communication was the area considered to be most problematic by participants. Many of the stories they related in the initial interviews had concerned communication failures – situations where information had not been provided, or had been unintelligible, or had not been given in a sensitive, respectful manner, and situations where they felt their concerns were not listened to or understood. Carer involvement was chosen by participants because it was indirectly important to service users, whose first and main source of support was often their carers; and to carers themselves who were anxious for more information to help their relatives who needed care, especially when the service users' condition prevented them expressing their needs or making informed decisions. Each definition is presented and checked against the CATWOE mnemonic, below.

Root Definition 1: The Communication system

A system owned by Humber Mental Health and operated by health service providers to provide good two-way communication between service users / carers and providers in order to facilitate good quality in service delivery and hence, increase trust between the parties within the parameters of the New Dawn² project and the constraints of available resources.

² New Dawn is a patient charter launched in 2002, expressing what service users have a right to expect from mental health services in Hull and East Riding. ND sets standards in the areas of Information / Communication; Facilities / Environment; Standards of Care; Partnership /Respect; Advocacy; Mental Health Law; Involvement Opportunities; Advance Directive /Wishes; Complaints, Concerns, Comments and Complaints and Carers /Supporters.

Table 6.1: CATWOE analysis of Root Definition (RD) 1 - Communication

C	Customers	Service Users / Carers and “general public”
A	Actors – those who do the activity in the system	Service Providers (Trust employees)/ Service users and Carers
T	Transformation – what the system does	From non – shared information to shared information
W	Weltanschauung – World views (Values, beliefs, assumption)	<ul style="list-style-type: none"> ➤ Trust is related to quality. ➤ Enhancing communication will improve quality and, hence, trust. ➤ Trust lies beyond quality ➤ Good communication is an ethical requirement – duty - of professional practice
O	Owners – those who control / have power over the system	Humber Mental Health (SP) and Commissioners and those with individual responsibility to communicate – the actors
E	Environment – facilitators and constraints	<p>Attitudes from workers of Humber Mental Health towards Service users and Carers.</p> <p>New Dawn project context.</p> <p>Resources.</p>

Root Definition 2: Carer involvement system

A system within Humber Mental Health, whereby service providers recognize the role played by informal carers and promote their understanding of and involvement in the care of their spouse / relative / friend, with relevant information and support, within the constraints of relevant legislation, ethics policy and the patients’ wishes, in order to enhance their cooperation with and contribution to patient care and hence to optimal outcomes.

Table 6.2: CATWOE analysis of Root Definition (RD) 2 – Carer involvement

C	Customers	Informal carers
A	Actors – those who do the activity in the system	Service Providers, Users and informal carers.
T	Transformation – what the system does	➤ From lack of information and support for carers to more information and support
W	Weltanschauung – World view (Values, beliefs, assumptions)	<ul style="list-style-type: none"> ➤ Informal carers play an important role in supporting patients and complementing the efforts of the service providers. ➤ Such a role can best be played if carers are as fully informed as possible about the conditions and treatment of the patient they help and care for. ➤ Informal carers need practical and emotional support. ➤ Issues related to the conditions of the illness and its impact on the carers / family
O	Owners – those who control / have power over the system	Humber Mental Health, Service providers, patients, informal carers, commissioners
E	Environment – facilitators and constraints	Legislation, e.g. Data Protection Act Ethics policy on service users' confidentiality, Service users' wishes.

6.3.2. Stage 4: Conceptual models

The idea of conceptual modelling is to produce a description of the actions needed to carry out the transformation and other requirements of the root definition. At this stage, the focus is on what participants think should be in the system, irrespective of whether or not it already exists or how well it is done.

The first step is to produce a list of activities. These are arranged in a diagram which captures contingent relationships among them (shown by the direction of the

arrows). The conceptual models produced for the two systems, Communication and Carer Involvement are shown in figures 6.3 and 6.4 respectively.

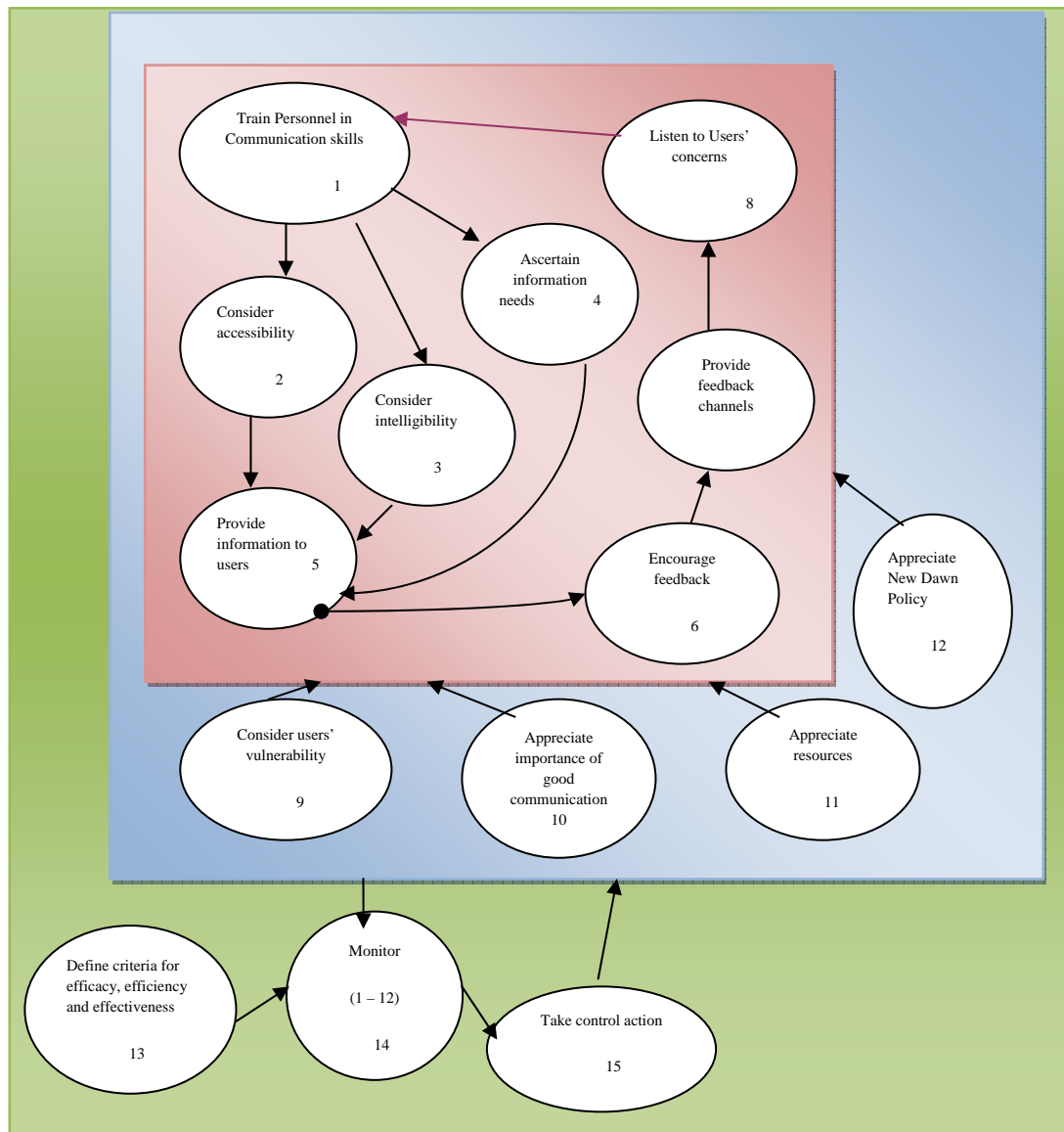


Figure: 6.3. Conceptual model of communication system

In Figure 3, the inner (red) box groups a set of activities linked in a communication cycle (1 – 8). The starting point is ‘training personnel in communication skills’ which should sensitize service providers to service users’ needs, consequently influencing their attitudes and practice in communicating information and enabling users to give feedback. Knowledge of users’ concerns (gained via activities 6&7) should feed back into development of training, as shown by the direction of the arrow from activity 8 back to activity 1. Thus, the activities are linked in a cycle, not a linear

process. What is intended is not a 'one – time` solution, but an ongoing process of engagement and learning. Activities 9 – 12 come outside this set but impact on the cycle of 1 – 8 as a whole. Similarly activities 13 – 15 are applied to the whole system made up of 1 – 12, all the activities, and all the links, and enclosing 1 – 12 in the outer, blue box is intended to show this. This is important because a concern was raised by some participants that CNST and performance indicators monitor only outcomes, whereas what is needed is to monitor the whole process.

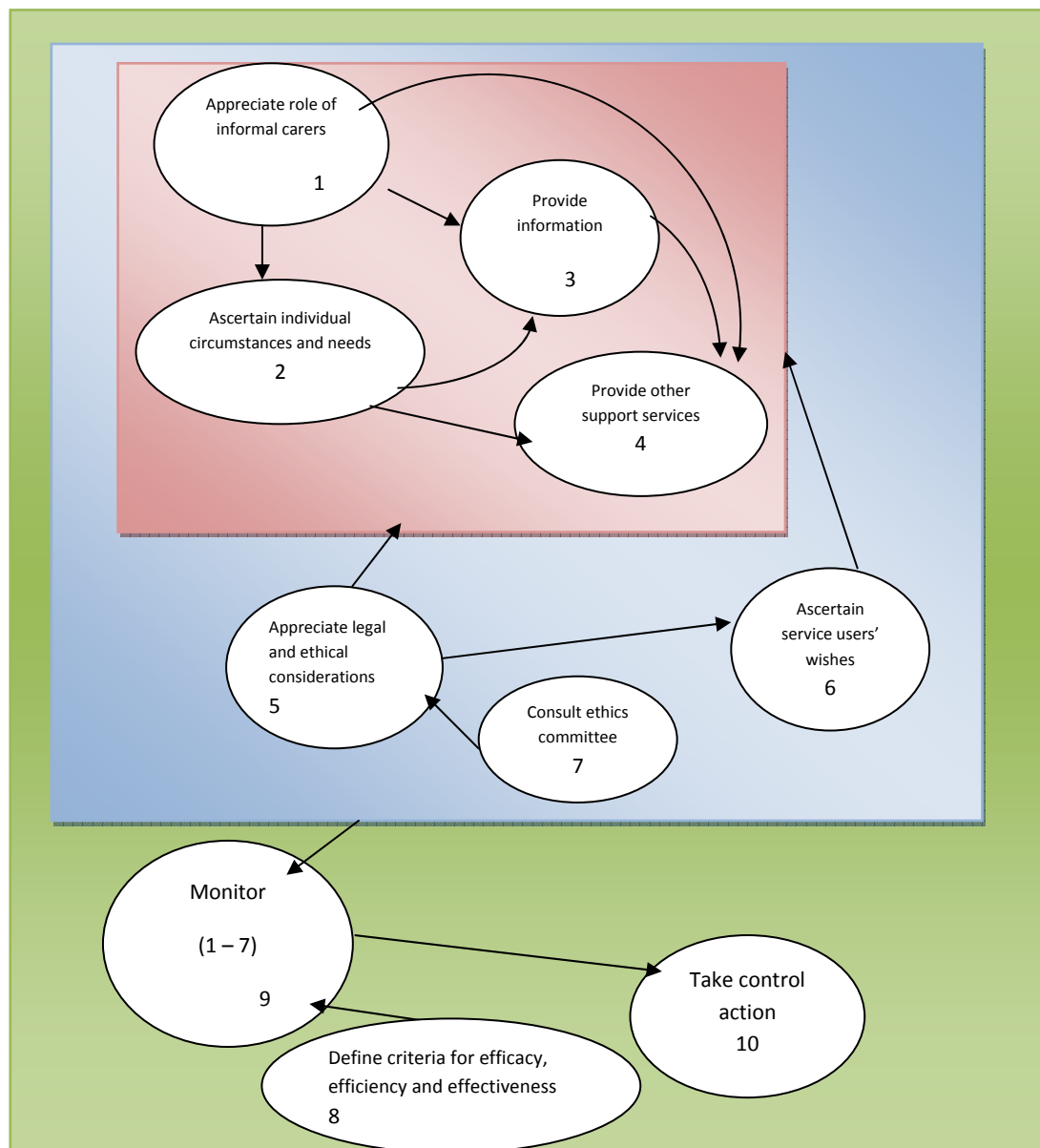


Figure: 6.4. Conceptual model of carer involvement systems

Figure 6.4, similarly, shows a core set of activities, labelled 1 – 4, contained in the inner red box. These activities, however, are contingent on other activities, labelled 5, 6 and 7. Thus, activities 1 – 7 make up the wider system, denoted by the outer, blue box. This system, like the one in Figure 6.3, is subject to the monitoring and control process denoted as activities 8, 9 and 10.

Two points relevant to both models should be explained:

- 1) The numbers do not represent the order of the activities (activities linked in a system do not have a linear sequence), nor do they indicate any ordering of importance. They are just a matter of convenience so we can say “activity 5” or “activities 1 – 8” without repeating lists of names.
- 2) Each model is a minimum set of activities. Any activity can be expanded into a new system at a different level of recursion. For example “provide information” could be expanded into a separate sub-system which might include as one of activities, for example, “produce leaflet”. This activity in turn could be expanded to include activities such as “Check plain English criteria”, “select layout”, and so on. For the purpose of this project, however, we are concerned simply with the two basic models.

6.3.3. Stage 5 Comparison

In this stage, the conceptual models are compared with the real world. For each activity, the questions are asked:

- Does it exist in the real world?
- If so, in what form?
- How well or badly is it done?

- How can we improve?
- What are the alternatives?

Service users and carers attending the workshops embarked on such comparison by applying the models to “New Dawn” (ND). It seemed that in practice, ND did not meet its own standards. For example, ND highlights service users’ right to information and the importance of communication, but service users did not always know about ND itself. It was claimed that because ND was not widely disseminated, there was a lack of staff implementation and widespread lack of awareness of its standards by service users. Where it was disseminated, a different problem arose, of perceptions that the standards were not applied. The issue here seemed to be that staff saw the ND standards as aspirational, whereas service users and carers saw them as policy. Thus, there were differences in views, expectations and interests. Moreover, service users and carers felt their inputs about desirable service quality were missing. Such concerns highlight that effective two – way communication is essential for the success of any quality initiative, and lack of it is a barrier to trust.

Ideally, these issues would be debated in workshops attended by all stakeholder groups together. Since this was impracticable in view of the heavy demands on managers’ and decision-makers’ time, it was agreed with service users that this stage could be fulfilled in part through the preparation of a report, for feedback. In contrast to the service users’ perspective, one informal managerial response to the model was to focus solely on the first of SSM’s questions, “Does the activity exist?” and to conclude that all the activities were already in place, all performance indicators were being met, therefore there was no problem.

This conflict of perspectives again highlights communication issues. Did service users and carers not know about some of the activities, because they had not been told

about them? Or do managers assume that once a standard has been set or a policy formulated, everything else falls into place? Clearly, it is not so simple. As one participant, PR 02, commented, implementation requires, first, interpreting what is to be done; second, having the necessary resources available and third, ensuring that staff actually follow through in the care they give. Difficulties may arise at any of these points – consistent with the ‘quality gap’ thinking (Zeithaml and Bitner, 2003), discussed in Chapter Three.

Another participant, PR 06, thought that the problem is not that standards exist but are not met (as the ‘gap’ model might suggest, and as service users suggested with regard to New Dawn, for example). In his view, standards are being met but, as he questioned, “Who sets the standards?”. If performance indicators are met, but service users are still dissatisfied, we have to ask, what are the performance indicators? How are they measured? Are they measuring the right things (i.e. the things that matter to users)? If not, why not?

One obvious difficulty with CNST, for example, is that it measures only process; evaluating outcome is more difficult. To quote a common cry among service users, “It is not what is done, it is how it’s done”. The activities in the model might exist, in some form. It was still necessary to ask, however, how are they done? Could they be done better? What are the alternatives?

6.4. Agreeing and Implementing Change

In the foregoing stages, stakeholders had entered into a situation of engagement, and embarked on the process of comparison between the “ideal” systems conceptualized, and their perceptions of how the communication and carer involvement systems operated in the real world. Participants acknowledged that they had acquired a better appreciation of each others’ perspectives and concerns, and expressed a

willingness to continue the process of engagement and of working on the issues raised. This would involve their participation in two further SSM stages; Stage 6: Identify and Agree on Changes, and Stage 7: Implementation.

It is significant that by this point, service users and carers had, through the process of engagement, sufficiently appreciated service providers' position, that they were willing to participate in a joint meeting, at which proposals for change were discussed.

Any changes must be both socially desirable and systemically feasible, i.e. possible within the parameters of the root definition, such as resources available and any relevant rules, policies etc.

The learning generated from this project, and the process of engagement begun, did in fact result in proposals for feasible change which were, in a broad sense, accepted by all stakeholder groups as socially desirable. It was agreed that plans for implementation would be deferred to the planning and budgeting procedures for the following year, given the current constraints imposed by external factors, including the proposal of the forthcoming shift to Foundation Trust (FT) status. However, interest was shown in the possible implications of the research for development of the bid for FT. Moreover, the research was drawn to the attention of the lead for culture change in HMHTT. Whilst it was disappointing not to see implementation of proposed change, I had achieved my main aim of seeing participants agree on things to be done, understanding others' viewpoints and recognizing their constraints.

6.5. Conclusion

This chapter has presented the outcomes of a two-phase Participatory Action Research Project carried out in HMHTT. The project began with a process of “finding out” the perceptions of service users, carers, service providers and decision-makers, around issues of service quality, communication and trust. The second phase, “engagement”, involved workshops during which participants embarked on thinking critically and creatively about the issues raised, identifying relevant systems on which they wished to focus with a view of generating ideas for change.

In relation to service quality, service users and carers said very little about tangibles, but often perceived intangible aspects of service delivery as unsatisfactory, particularly with regard to talk of responsiveness and empathy. Decision – makers took more strategic (cost- effectiveness) and normative (standards-related) approaches, while service providers found themselves caught between a relational view of quality and conflicting environmental pressures.

Great importance was attached to communication between service users and providers, as the basis for informed judgements and productive relationships, but like quality, communication was seen to be complex and hindered by a variety of confusions, constraints and competing agendas. Issues were raised, for example, regarding accessibility and intelligibility of communication, and the perceived exclusion of carers in particular.

Participants asserted that trust was crucial to relationships between service users and providers, and the need for trust was clearly related to a sense of the dependence of the former on the latter, which consequent risk and vulnerability. Trust was seen to depend to some extent on individual propensity, but mainly on the reliability, consistency and integrity of the service provider. Experiences accumulated over time

resulted in participants building trust (or in some cases, distrust) in particular individuals, but this might or might not translate into trust in ‘the system’, which many participants saw as operating in a way that constrained individual behaviour and undermined trust. For service users and carers in particular, service quality was inseparable from trust.

In the ‘Engagement’ phase of the research, participants identified communication, carer involvement, user participation, and training as priorities, and decide to focus on the first two of these issues. Through a process of discussion, facilitated by Delphi – like referral and feedback (see Chapter Five), service users, carers and providers separately and jointly produced root definitions and conceptual models of “ideal” systems of communication and carer involvement, within the parameters of the ‘New Dawn’ project. Service users and providers engaged in a process of comparison between the “ideal” and perceived “reality”. Preliminary indications were that activities in the models were perceived by managers as existing in reality, but perceived by service users as performed unsatisfactorily. The project ended with service providers expressing commitment to continuing the process of engagement and pursuing the issues raised by the project.

In the following chapter, the outcomes of the project will be discussed in relation to the research questions and relevant literature, critical reflections on the project experience will be presented, and the contributions of the research to theory and practice, will be highlighted.

Chapter Seven

Discussion and Conclusion

7.1. Introduction

The previous chapter has presented the outcomes of the two – phase PAR project in HMHTT, to explore the role of trust in the way quality is perceived. In this chapter I will discuss those outcomes in the light of the literature, offer reflections on the research process, and highlight the contributions of the research.

The chapter is divided into eight sections. The first three of these address the research questions related to service quality, communication and trust, in turn, setting the findings and outcomes in the context of relevant theory and previous empirical work. This is followed by a critical reflection on the methodology and conduct of the research, including my role as researcher and the extent to which the authenticity criteria discussed in Chapter Five (section 5.8.) were met. Contributions of the research to theory, to practice and to methodology are highlighted, and the limitations of the study are acknowledged. Suggestions for further research and a postscript conclude the thesis.

7.2. Questions Related to Quality

The main question posed in relation to quality was: *How do stakeholders currently perceive quality in the service provided by HMHTT?* This question was addressed through three sub-questions, which will be examined in turn.

7.2.1. What does quality mean to the participants?

As noted in Chapter Two, quality in health care is a difficult construct to measure or evaluate, because health itself is a complex condition which can be affected by many variables. It was noticeable in this study that actual health outcomes such as “cure” played little or no part in participants’ attributions of service quality. Efficacy of treatment, one of Donabedian’s (2003) quality criteria, may be more measurable in other aspects of health care, but in mental health in particular, it is a “grey” area (as one service provider pointed out) and in any case “cure” cannot be guaranteed (Press, 2006). Perhaps for this reason, the majority of participants – but particularly service users – focused on what they, like Press (2006), thought should be guaranteed, that is, care. For service users and carers especially, service quality was a subjective concept, a relativistic judgement (Holbrook and Corfman, 1985) of perceived quality (Zeithaml et al., 1990) focused predominantly on aspects of the relationship between service users and providers. This supports the view that in the absence of expertise needed to evaluate ‘technical quality’, health service users concentrate on functional quality (Grönroos, 1982; Rust and Oliver, 1994; Kang and Fames, 2004).

Stakeholders’ conceptions of quality encompassed elements consistent with previous typologies of service quality dimensions, both general (e.g. SERVQUAL: Parasuraman et al., 1985) and health – related (Maxwell, 1992; Donabedian, 2003). Service users and carers wanted to feel assured of the competence of service providers, and to be treated with respect and consideration; similar notions of service quality have been expressed in previous studies in health service contexts, for example Baeze and Calnan (1995) and Hart (1999), and correspond to the ‘Assurance’ dimension of SERVQUAL. In addition, quality was perceived in terms of willingness to help (Responsiveness, in

SERVQUAL) and approachability, listening, providing information, and understanding (all covered in the SERVQUAL category of Empathy). All these dimensions can be related to Maxwell (1992) and Donabedian's (2003) idea of 'Acceptability', which focuses not on what is done, or on outcomes, but the way the service is performed, and the extent to which it conforms with prevailing expectations, norms and values. As one service user expressed it, "It's not what is done, but how it's done" that matters or is problematic. These process-related aspects of service quality, experienced through interaction, whether in individual transactions or in the enactment of long-term relationships, dominated the perceptions of quality expressed by participants. This preoccupation was reflected not only in the Phase One interviews, but also in the Phase Two engagement, in which the service areas prioritized for debate and potential change were communication and carer involvement, both essentially concerned with relationships between stakeholders, both as individuals and as interest groups.

7.2.2. Do different stakeholder groups agree in their perceptions of quality?

The interview responses revealed that decision-makers saw quality in rather different terms than service users and carers, while service providers were caught between the contrasting and to some extent competing agendas of these two groups. Service users focused very much on what has been identified as functional quality (Grönroos, 1982). This view is concerned with the manner of the service provision, as reflected in factors such as the competence, helpfulness and understanding shown by those who deliver the service. Such factors, it has been suggested, can be encompassed in Donabedian's (2003) category of 'Acceptability'. In contrast, decision-makers appeared to focus more on strategic and normative quality. Strategic quality, with its concern for balancing outcomes against cost,

can be said to correspond to the dimensions of optimality and efficiency suggested by Donabedian (2003). Such a perspective recalls the traditional view of quality inspired by “gurus” such as Deming (1986), as does the decision-makers’ emphasis on the role of leadership and management explanation. Decision-makers’ other focus was normative, concerned with standards. Attribution theory suggests that conformity to standards should induce perceptions of trust and excellent quality. However, as suggested in Chapters One and Two, a difficulty with this approach is that a focus on standards or performance indicators may prioritize limited measurable goals at the expense of others which may be of equal or even greater importance to service users (Ludbrook and Gordon, 1999; Lally and Thomson, 1999). That this may indeed be the case is suggested, not only by the concerns expressed in interviews, but also by attitudes towards the New Dawn charter, and also by some managerial feedback to the system models produced in the Phase Two engagement process. Managers perceived that the “ideal” activities already exist, because related performance indicators are met, whereas service users and carers were clearly dissatisfied with the selected areas of communication and carer involvement, perceiving them as priorities for change. Based on such differences the questions arise whether standards are in fact met, or whether the “right” (from service users’ perspective) standards are set at the outset. In fact, one decision-maker appeared to recognize this dilemma in her diplomatic answer to the question whether she was happy with the level of service quality: “The service meets the requirements of the Department of Health – but you can always improve quality” (DM 03).

Meanwhile, service providers, as noted above, revealed some conflict between their recognition of the importance of building empathic, responsive relationships with service

users, and awareness of the strategic and normative imperatives imposed by external factors, including resource constraints and the regulatory environment.

The findings confirm the suggestion of Ovretveit (1994) that there exist different perspectives on quality: client quality, professional quality and management quality. However, they challenge his implication of a simple correspondence between certain perspectives and stakeholder groups. Decision-makers in this study predictably showed concern with “management quality” (efficient and productive use of resources within constraints set by higher authorities) but also with aspects of “professional quality” (whether the service meets needs as defined by professional providers and referrers). Service providers displayed a broad perspective that encompassed both these categories and “client quality” (what clients and carers want). It can be expected that service providers’ and decision-makers’ perspectives on quality may vary over time, according to change in the structure of the service, the political environment and so on. They may also differ at any given time according to the roles of individual incumbents within the service; some differences of emphasis were noted, for example, between the three decision-makers. Thus, although differences of perceptions were noted among stakeholders, these do not necessarily display such a simple function / role correspondence as indicated by Ovretveit (1994). Nevertheless, the differences are sufficient to support the need for critical consideration of whose perspectives, values and purposes are being privileged when quality standards are set or change is proposed.

7.2.3. How far is participants' ideal of quality met in practice?

According to Parasuraman et al. (1988) evaluation of quality is formed on the basis of comparisons between perceived performance and prior normative expectations, that is, ideas of what “should” happen. There was evidence that the participants in this study made such comparisons in forming their judgements of service quality. Whilst there were instances where participants found the outcome of such comparisons satisfactory, citing examples of a rapid and effective response to a crisis or complaint, or of personnel who were particularly approachable, supportive and understanding, in many cases, service quality was perceived to fall short of the ideal. The few references to tangibles were to highlight deficiencies (such as poor ward cleaning) and inconvenience (long journey). Suggestions were made that doctors are inadequately trained in some areas, such as PTSD, resulting in misdiagnosis or inability to suggest an appropriate treatment plan. Failures of reliability, particularly with regard to appointment-keeping, were frequently mentioned. However, the dimension most frequently portrayed as falling below expectation was empathy; service users and carers complained of being treated disrespectfully, “put – down”, excluded, not listened to, not understood. Whilst empathy could come from unexpected sources, such as a cleaner or receptionist, too often, service users and carers felt service providers failed to recognize the uniqueness of their feelings and give an appropriate personal response. Given that empathy was the main focus of these groups' idea of quality, the perceived failures in this area support the view of Sanderson (1987, cited in Walsh, 1995) that where agendas conflict, it is usually the consumer's values that are ignored.

Such ‘quality gaps’ or discrepancies between expected or ideal service and the perceived quality of the service received (Gap One) can occur as a result of managerial gaps (misunderstanding of customers’ needs and wants, or failure to set appropriate standards) or deficiencies in front-line service delivery (standards not met or ‘over-promising’ beyond what can realistically be delivered – Parasuraman et al., 1985). Given the differences of perspectives on quality among the four stakeholder groups, it is possible that some of the perceptions of service deficiencies may reflect ‘Gap Two’, the gap between management perceptions of the public’s expectations and the public’s actual needs and desires. The difficulty here, however, is that in mental health services, there is no homogeneous “public”, but a huge number of individuals with diverse needs which cannot all be met, so there will always be some who feel let down or not listened to, as service providers indicated.

Other sources of dissatisfaction, or attributions of low quality could be related to absence of standards, or failure to meet the standard set. In fact, the interviews gave little indication that quality expectations and comparisons were based on standards, because people do not know “what the standard is” or what one may “reasonably expect”. However, in the Phase Two engagement process, when participants were debating the “New Dawn” patient charter, their expressions of dissatisfaction implied a “Gap Three”, where standards are in place but not met. A problem uncovered by debate was that service users and carers took to be “policy” (and therefore standards giving rise to certain expectations) what service providers viewed as “aspirations”. In this respect the quality gap may actually be a “Gap Four”, where the organisation communicates an over-optimistic picture of what it will deliver, raising expectations that cannot be met in practice.

The discussion of the first research question highlights the importance of information exchange and relationship building, of open debate on needs and values, and of realism, honesty, and accuracy regarding standards, policies and principles for perceptions of service quality. All these themes raise issues of communication, as the key to expressing, challenging and negotiating perceptions of quality. This is the subject of the second research question, discussed next.

7.3. Questions Related to Communication

The main question posed in relation to communication was: *How do stakeholders in the HMHTT communicate?* The findings in Chapter Six revealed that there are various forms and channels of communication between stakeholders: visual, oral, and written; posters, telephone, face-to-face meeting, leaflets, letters, and e-mail. Their feelings about communication and obstacles to effective communication will be discussed.

7.3.1. How do they feel about the quality of communication?

All stakeholder groups asserted the importance of communication, both in interviews and in the workshops. It has been suggested elsewhere that communication is the medium through which knowledge is gained, leading to cognitive trust, and empathy is shared, leading to effective trust. It was one of the original dimensions later subsumed within Empathy in the SERVQUAL model of service quality (Parasuraman et al., 1985; 1988). Indeed, a study by Bowers et al. (1996) based on focus groups suggested that incorporation within the Empathy dimension “hid” communication and belied its importance. Such a view is supported in this study, in which the significance attached by stakeholders to communication warranted its being regarded as a major issue in its own right. Particular importance was attached to information provision, as the means by which

service users and carers would be enabled to participate in the health care system. Williams (2007) called for healthcare providers to treat patients and their families as partners in healthcare, and the provision of information to service users and carers was seen as central to this relationship.

7.3.2. Are there obstacles to effective communication?

The findings in Chapter Six showed that effective communication between stakeholder groups may be impeded by a variety of personal and institutional constraints, consistent with previous literature. Access to information may be impeded by practical difficulties such as lack of mobility, or lack of telephone or e-mail facilities. Equally, it may be constrained by difficulties in decoding or comprehension. Etchells (2003) drew attention to communication problems caused by a cultural and linguistic gaps between service providers and users. The former are highly educated, possessed of specialized knowledge, and familiar with jargon and technical terms. Some service users may be poorly educated, with limited vocabulary. In this study, the service users who participated, as a self selected group of volunteers involved in the PPI, were probably more educated, aware and articulate than many, but some acknowledged that, for example, jargon could be confusing. Service providers may not always be aware of the bewilderment and fear that may underlie a service user's apparently calm response to information, or of the effort and care needed to communicate well. Spencer (2003) highlights prevailing "myths" that communication skills are natural, innate and personality linked, so they cannot or need not be taught. However, he asserts the importance of health service providers being trained in communication skills such as conveying information clearly, extracting patient information effectively, and conveying empathy.

Other impediments to effective communication are institutional. For example, institutional processes and structures may leave little time and opportunity for learning and relationship building. Etchells (2003) suggests that this is an outcome of the shift towards practice – based relationships, rather than continuity of care by a single practitioner. As this study showed, systemic factors like the change from ‘drop-in’ to appointment might also be perceived in some cases to impede access to communication of the kind and at the time needed by the service user. Institutional cultures can impede effective communication in a variety of ways, through “routines, protocols, procedures” that impeded engagement, competing demands on practitioners, financial constraints and a very “process-driven” culture. Such factors appear to have resulted in the failure of a number of initiatives for communication and participation beyond the dyadic relationship between the individual service user and service provider. These institutional pressures recall Sztompka’s (1999) identification of “culture” (meaning norms and values in a particular society) as one of the factors that can impede or facilitate trust – with which communication is closely linked. A possible explanation of, for example, the failure to sustain initiatives may be found in Flood’s (1993) suggestion, related to the VSM, that excessive interference by the controller weakens the validity of the system, bearing in mind the disparity of power perceived to exist between stakeholders, and the potential of power relations to disturb dialogue. Such disturbance, highlighted by Habermas (1981a, b; 1984a; 1987; 1999b, c), was similarly observed by Gregory et al. (1994) and Walsh (1995) in the Trent Quality Initiative (see Chapter Two). Even when power relations as such were not highlighted, we saw in the experience of service users and providers that communication could be distorted by the difference in expectations and interpretations between them, resulting in quality gaps.

The existence of such obstacles to effective communication, as perceived by stakeholders, had implications not only for perceptions of service quality, but also for the conferring or withholding of trust. The research questions related to trust will be discussed next.

7.4. Questions Related to Trust

The main question posed in relation to trust was: *What does trust mean to stakeholders in the HMHTT?* This research question was addressed through sub-questions, concerning cognitive, affective and behavioural dimensions of trust, the importance attached to trust, and the extent to which different stakeholder groups agree in the meanings they attached to trust. In addition, the issue of trust in individuals versus trust in the system was explored.

7.4.1. Cognitive trust: Do service users see providers as competent, reliable, etc?

Cognitive trust, also called knowledge-based trust (Shapiro et al., 1992) is a judgement based on what is known about an individual or organisation (Kasperson et al., 1999). The interview data suggested that to some extent, service users made attributions of trust based on perceptions of service providers' competence, reliability and so on. Service providers recognized this, indicating the need to earn trust by demonstrating reliability. In general, perceptions of competence and good intentions were favourable. However, this was not necessarily translated into trust; indeed, at the start of Phase Two of the research (engagement), service users' trust in service providers was very low. This supports the view of Tinsley (1996) that capability is not in itself a guarantee of trust. However, as Mayer et al. (1996a) argued, depending on the situation, capability may be separable from antecedents of trust or may act with them in a cumulative manner. The latter appeared to

be the case in this study, both in the grouping of factors presented as conducive to trust (see section 6.2. and 7.4.6.) and in the way trust was increased during the process of engagement (see section 6.3. and 7.4.8.).

7.4.2. Affective trust: How do service users / carers feel in interaction with service providers?

Affective trust, also called identification-based trust (Shapiro et al., 1992; Lewicki and Bunker, 1996) is an emotional response to the other party, which is independent of information about their capabilities and intentions. Service users and carers participating in this study expressed low levels of interactive trust: “intimidated”, “helpless”, “valueless”, “patronized” and “confused” were some of the expressions used to describe individuals’ feelings when interacting with, say, GPs, consultants or CPNs. These responses are closely related to the empathy dimension of service quality discussed previously. As noted by Kasper et al., (1999), affective trust may play a strong role in relations among family or ‘in-group’ members, but they suggest that it may be less important, in relations outside the ‘in-group’, than cognitive and behavioural trust. However, the findings of this study show that for service users and carers, this dimension of trust is at least as important; and possibly more so than cognitive and behavioural trust; they expected and needed empathy – in a sense, to feel part of an ‘in-group’ with service providers.

Service providers showed some recognition of this, when they highlighted the vulnerability and sensitivity of mental health patients. Moreover, one particularly open and self-reflective service provider showed that affective trust (or mistrust) could also be an issue for service providers, when she admitted sometimes suspecting the motives of service users, who made demands on her, without necessarily having “evidence” related to the individual concerned. Such feelings appeared to be generated by an accumulation of past

experiences with other cases; in other words, cognitive mistrust aroused by members of a group (such as patients) could be generalized to feelings of affective mistrust towards others. This admission supports the claim by Parkhe and Miller (2000) that the suspicion that disruption of expectations is likely to be generalized to other exchanges leads to distrust.

7.4.3. Behavioural trust: How do service users' / carers' perceptions and feelings influence their behaviour?

Behavioural trust is concerned with how expectations as to others' behaviour influence the behaviour of the individual who trusts or mistrust (Kasperson et al., 1992; Covello, 1992). Decision – makers wanted and needed behavioural trust from both service users and service providers; in the former case, to encourage cooperation with the service provided, and in the latter to enhance the level of “working together”. Such behaviours, it was suggested, would be secured by effective communication to “convince” stakeholders that ongoing and proposed changes would bring benefits and opportunities for them.

In the case of service users and carers, the behavioural responses to feelings of mistrust had varying impacts on behaviour. There were isolated instances where mistrust had resulted in non-compliance with treatment (refusing to take medication until an explanation of its purpose and effects was given) or changing doctors, but in other cases, service users complied with treatment, kept appointments and so on. This was not necessarily because they were more trusting, but because of feelings of fear, powerlessness and lack of choice, reflecting Wynne's (1996) view that lack of dissent may simply be a function of the social reality of dependency.

Whereas mistrust did not necessarily have a clear impact on behaviour towards treatment, it did influence willingness to participate in dialogue, as reflected in service

users' and carers' initial objections to meeting with service providers. Such a response is consistent with the sociological view that trust is important for cooperation and collaboration (Cvetkovich and Löfstedt, 1999,); Misztal, 1996) and facilitates interaction in organisations (Meyerson et al., 1996). Since, in a context of diversity, public dialogue is needed to clarify different perceptions, needs and priorities (Williams and Matheny, 1998) a level of trust that promotes such dialogue is crucial. The second phase of this research, then, can be seen as an expression of behavioural trust, in that participants had to take the risk of trusting, to some degree, at least the engagement process (if not other individuals or the system) in order to commit to it. At the same time, it can be seen as bringing about some increase in behavioural trust when service users changed their stance towards service providers.

7.4.4. How important is trust to stakeholders?

All stakeholder groups saw trust as of the utmost importance (one service user said it was “paramount”), albeit perhaps for different reasons. Whilst, as indicated previously, decision-makers attached importance to trust for strategic reasons related to the viability of HMHTT's plans and programmes, for service users, trust was linked to risk and dependency – “you put your life in their hands”. In this sense, trust can be equated to a need for security (one of the components of Assurance in the SERVQUAL model of service quality proposed by Parasuraman et al., 1985). Service users' need for trust in a situation of risk and dependency is consistent with Misztal's (1996) argument that trust allows responsibility for managing risk to be relinquished to others. Service users and carers need to do so, because of the great asymmetry of power within the NHS, between service users and service providers. The latter have specialized knowledge that the former lack. Service users and carers must therefore to some extent relinquish behavioural and

decision control to service providers, in exchange for cognitive control – the belief that their health condition or that of their loved one will be controlled (Cvetkovich and Löfstedt, 1999).

7.4.5. Do different stakeholder groups agree in the meanings they attach to trust?

As this issue has been touched on in answer to previous questions, a brief summary will suffice here.

There was a high level of agreement among stakeholder groups in their perceptions and opinions related to trust, although there were some differences of emphasis, particularly for decision-makers. All groups agreed on the paramount importance of trust, in relating it to the satisfaction of expectations, and in viewing it as a prerequisite for collaboration and partnership – service users also saw it as an outcome of partnership. All agreed that trust requires effective communication; however, two of the three decision-makers focused mainly on internal communication, that is, with service providers, as an aspect of securing support for change, rather than on communication with service users. Service users, carers and service providers agreed in seeing trust as inherent in and almost synonymous with quality, as developed through and expressed in the relationships between the parties, and as rooted in mutual respect. Whilst it would be unwise and possibly unjust to suggest that decision-makers did not have these perspectives, they were not among the meanings they chose to express. This can be explained in terms of the claim that different kinds of trust may prevail or be valued in varying degrees according to the social context (Kasperson et al., 1999).

7.4.5.1. Trust in individuals versus trust in the system

Participants' attributions of trust or mistrust supported the idea of a distinction between trust in individual (inter-personal or micro-level trust) and trust in a system

(macro-level trust) – or what Putnam (1993) called personal and social trust. With the exception of one carer, participants found it easier to trust individuals than to trust the system. This may to some extent, as Beck (1986) and Giddens (1991) suggested, be related to changes in social values and a decline in deference to authority, but the evidence from participants provided more support for the view that the difference is related to interpersonal contact and relationship building. Trust in a system lacks the mutuality that characterizes individual trust and enables trust to be sustained and grow (Putnam, 1993). Moreover, because of the greater distance involved, and the relative facelessness of systems, it is difficult to acquire the detailed and accurate knowledge on which cognitive trust could be based.

The exception to the general rule, a carer who expressed greater trust in the system than in individuals, can in part be seen as an example of calculus-based trust; she trusted the system because there was recourse to be had when problems arose. At the same time, however, she spoke of individuals who had been supportive and helpful; her trust in the system was also in part the outcome of an accumulation of experiences with individuals whom she presumably saw as in some sense representing the system. In contrast, she mistrusted certain individuals or categories of individuals (specifically, consultants) on the basis of previous experiences, and saw their betrayals as individual rather than systemic. It may be that, just as a more personal relationship can, when things go well, does it induce greater trust, so, when things go badly, can it induce greater mistrust, because the dependence and the feeling of being let down are greater. In either case, the problem with individual trust, as participants' experiences indicated, is that membership of stakeholder groups changes. Thus, a change in the personnel holding particular roles may lead to changes in the level of trust (Tinsley, 1996).

7.4.6. What factors are conducive to trust?

The research findings support the view of Checkland et al. (2004) that in the NHS, trust is based on individual experiences and the interpersonal aspects of care. Several of the factors found to be conducive to trust correspond to existing typologies such as that of Mishra (1996). They included competence and reliability, including knowledge-based trust (Shapiro et al., 1992) and benevolence – for example kindness, time and attention, doing the “best”, inducing transference – based trust (Lewicki and Bunker, 1996). Another important factor is integrity / professionalism. This may, for example, be demonstrated in unbiased response (Renn and Levine, 1991), as in the case of a service user who respected and trusted a doctor who had treated her without betraying his personal disliking. It also includes confidentiality. A service provider, for example, reported a complaint involving perceived misuse of personal information. Such concerns are consistent with Bies and Tripps’ (1996) finding that breach of confidence is one of the ‘honour violations’ that were among their three main categories of the causes of mistrust. Similarity of values between the individual and the organisation was a trust factor mentioned by one participant, consistent with Earle and Cvetkovich’s (1995) Salient Values Similarity Theory, and with previous empirical findings, for example Sitkin and Roth (1993) and Kramer and Tyler (1996).

Taking further the idea that factors found to be conducive to trust are largely relational, a group of comments, as well as the experience of the phase two workshops, highlighted issues around communication, participation and open engagement. Openness, one of Mishra’s (1996) trust factors – highlighted also by Peters et al, (1997) - can be seen as a prerequisite for the other two. Communication (if it is open and undistorted) should increase trust because it enables acquisition of knowledge, conducive to cognitive trust, and

it affords opportunities for developing and displaying empathy, conducive to emotional trust (Kasperson et al., 1999). Participation – in debate and decision-making – is a precursor to social trust (Putnam, 1993). Hence, trust is, as pointed out by Wekselberg (1996) affected by broader organisational processes and structures which may promote or inhibit participation.

The role of standards as factors conducive to trust was rather ambiguous. Sitkin and Bies (1994) view the legalisation of organisational activity which standards reflect as a substitute for interpersonal trust. They can be considered as a basis for calculus – based (Lewicki and Bunker, 1996) or deterrence-based (Shapiro et al., 1992) trust, in the sense that they offer certain safeguards, and the possibility of sanctions or redress if they are not met. However, first, the standards must be disseminated, and there was evidence in the workshops that in relation to New Dawn, for example, this was not the case; nor was their status (normative or aspirational) clear and agreed between stakeholder groups. There remains, too, the question whether the standards are the right ones, reflecting what service users actually want, value and need. Checkland et al. (2004) criticize over-reliance on standards as reflecting a shift away from accountability based on professionalism and reflective practice, and the danger of this was apparent in indications that some service providers and decision-makers perceived that the ‘wants’ incorporated by service users in their ideal system proposal already existed and performance indicators were being met, so there was no problem. Standards can be a factor in promoting trust – if they are debated and agreed in a way which reflects service users’ needs – but standards that draw attention away from those needs, or that are perceived to be unmet, may actually undermine trust.

7.4.7. What factors are barriers to trust?

A number of factors were identified, that were perceived, to varying degrees, to act as barriers to trust. One of these was the operation of financial pressures. This could affect trust by imposing imperatives other than clinical efficacy on treatment decisions (as suggested by one service user), by the effects of staff shortages, and so on. Similarly, Taylor-Gooby and Hestie (2003) identified increasing pressure on NHS budgets as a cause of erosion of public trust in healthcare, while Calnan and Sanford (2004), in a survey in England and Wales, found cost-cutting to be a major factor in distrust at the macro level.

A second factor was the organisational image of HMHTT, created in some service users' and carers' perceptions as a result of negative past experiences. Shore (2007) notes the importance of 'brand image' in attracting or impeding trust, and an unfavourable image can be seen as contributing to social mistrust (Breyer, 1983). Such an image arises when there are suspicions that unsatisfactory experiences are likely to be generalized to other exchanges (Parkhe and Miller, 2000). In line with the asymmetry principle, when trust is lost in this way, it is not easily restored: mistrust is self-perpetuated by inhibiting relationships, and by colouring perceptions and interpretations of subsequent experiences (Slovic, 1999; Kramer, 1996). Thus, "trust is gained incrementally but lost catastrophically" (Innes, 2003a:17).

One reason for unfavourable perceptions of the organisation which are barriers to trust can be unrealistic and consequently unmet expectations on the part of service users. These may be raised inadvertently, for example by aspirational statements that service users perceive as normative – as revealed in this study with reference to New Dawn, and as recognized by some service providers and decision-makers. The mechanism is similar to the creation of the quality gaps (Parasuraman et al., 1985) discussed previously. As

Berwick (2007:49) asserts, “Quality and trust are first cousins” and “results build trust”. Thus, when the expected results do not materialize, trust is eroded.

The main barrier to trust, however, identified in the interviews and prioritized for debate and action in the workshops, is poor communication. Williams (2007), too, found inadequate communication between patients and doctors to be a source of mistrust. Patients want, for example, to understand treatment alternatives and feel free to express their preferences. However, even if information is provided, patients may have difficulty understanding it, due to the cultural and linguistic gap between patient and doctor (Etchells, 2003). For this reason, clinicians should “encourage their patients to ask questions and make sure they understand the answers” (Williams, 2007: 75). More than this, they should show empathy and openness. Failures of communication not only deprive both service user and service provider of information which may be important to the efficacy of the therapeutic relationship, but also leave service users feeling let down and disrespected. Not only, then, is their trust eroded but, as noted above, they are inhibited from further engagement and involvement as partners in health care.

7.4.8. What action can be taken to facilitate the supporting factors and reduce the barriers to trust?

The research promoted action to facilitate trust-supporting factors and reduce barriers, at three levels: through the research process itself, which facilitated engagement among stakeholders with different perceptions, concerns and experiences; by the agreement to prioritize two systems for debate and the generation of proposals for change; and (through the first two) by contributing as a stimulus towards subsequent ongoing discussion and programmes within HMHTT.

Given that communication had been identified, both as a potential contributor and, more often, a barrier to trust, the research process can itself be regarded as an action to facilitate meaningful communication between and among stakeholder groups. As Powell (1996) argues, trust is developed through learning, experience and communication. The project provided an opportunity to work towards such conditions in a spirit of cooperative inquiry and interaction. It relied on the mutual belief that participants in the interaction shared common goals and would participate in action towards them (Wekselberg, 1996). The engagement process in this study helped the participants to understand each others' viewpoints and the constraints and limitations faced by other groups. The eventual agreement of service users to meet with service providers can be regarded as a success for the inquiry process, and a step towards removing barriers to trust.

Further action to facilitate trust – building factors and reduce barriers was undertaken through the identification of 22 possible relevant systems, the prioritization of four, and the focus in the workshops on communication and carer involvement systems, identified by the participants as their main priorities. The importance of those issues to service users and carers is in line with previous research in the region; in the Let's Talk Report (Walsh and Knapp, 2006) communication – related issues of service culture and Involvement (including carers) were two of the emerging themes and appeared in the top five issues in terms of agreement among participants in that event. Spencer (2003) similarly shows work on improving communication to be a significant step towards enhancing trust.

By the end of the project, as noted earlier, although no further action had been implemented, due to external factors, agreement had been reached to place issues raised on the agenda for the next year's budget and subsequent follow up shows progress in the area

of communication through several initiatives. The opportunity remains for participants to continue the engagement process to address others of the issues listed in Appendix 9.

7.5. Critical Reflections

A PAR project should be a learning process for the researcher and participants. In this section, my aim is to reflect critically on the experience of the project, in order to demonstrate my enhanced understanding of the research process and my own role. I also consider how far I succeeded in meeting the authenticity criteria for interpretive / constructivist research, discussed in Chapter Five.

7.5.1. My role as researcher

During the course of the research, I experienced an ongoing process of learning about research technique and about the impact of my role as a researcher. I entered HMHTT as an “outsider”, meaning that I was not a member of the system, in any capacity. Such a perspective could be said to promote objectivity and scientific detachment, leading to more ‘authentic’ knowledge – but this view reflects a somewhat positivist view, not in keeping with the interpretive stance of this research. Conversely, an “insider” role may be expected to afford empathy with and understanding of the research participants, which generates special insight. The insider – outsider debate is also linked to the issue of power and knowledge the various parties in a research relationship have or are perceived to have, with possible implications for access to information. At the beginning of the research, my “outsider” status set me at something of disadvantage. The situation was not helped by the fact that although LREC and R&D in HMHTT approved the research, and I was appointed as honorary researcher in accordance with NHS, no internal announcement was made, so

many people did not know who I was, or why I was there. Some participants were initially unsure how they should view me and what my motivation was for undertaking the research. Meanwhile, as an “outsider” I began with limited prior knowledge of the working of the system, the status and roles of individuals, and the “jargon” used by participants. My task was in a sense to become an “insider”, gaining acceptance and understanding through a process of honest engagement with participants over time.

The challenges of the researcher’s role were reflected, for example, in the interviewing process. Through interacting with the respondents, playing back recordings, making notes and reflecting critically on my performance after each interview, I became more aware of the need to adapt the interview schedule flexibly to the individual interviewee (for example a particular question might be more relevant to one stakeholder group than another; or a question may be rendered redundant by an interviewee’s disclosures in response to previous questions). I learned to think about difficult concepts like ‘quality’, ‘interactions’ and perceptions in order to find ways of making my questions easier to understand and responding to questions from participants. I also recognized the difficulty of using prompts and probes effectively – sometimes I used them too quickly so that the interviewee did not have time to reflect on and formulate his / her answer to the original questions. I was also wary of the risk that they might lead or confuse the interviewee. In encouraging interviewees to communicate and seeking to build rapport, I was sometimes tempted to make self – disclosures, but at the same time had to be careful not to ‘lead’ participants by ‘feeding’ them ideas that seemed important to me or imposing my own interpretation on what they had said. This raises the question whether there can ever be undistorted dialogue in an interview, since in an effort to avoid distorting the

interviewee's disclosures, the researcher must to some degree suppress his own presentation of self. It is a delicate balance. Whilst I recognize that I made mistakes, my technique as an interviewer was constantly being refined and improved.

Critical reflection on my role continued throughout Phase Two of the research, in which I facilitated workshops intended to give participants a voice and empower them to identify and act on issues of importance to them. I have already discussed, in Chapter Five, section 5.2., some difficulties related to the researcher's role, that arise in the constructivist and critical paradigms, and I experienced these at first hand. One such issue is the extent to which I risked 'forcing' my interpretations on participants, for example when I attempted to produce a conceptual model of the relationships between quality, communication and trust, based on the Phase One interviews. In so doing, I had to recognize the extent to which the outcomes reflected my own understandings and purposes, and set these aside to enable participants to develop their own, very different models. Whereas my cognitive-based model reflected my interest in the structural relationships among the factors shown and their "systemic" nature, service users and carers modelled the issues in a more affective way, reflecting the emotional meaning of trust to them in their dealings with HMHTT. It was not that my model misrepresented what participants had said in interview, but it did not meet their needs at the time. They needed to assert the overarching importance to them of trust, which coloured their perceptions of the whole system, before they were ready to think more analytically about how specific aspects of the health care system in HMHTT "should" look.

Another issue arose with respect to my proposal of Soft Systems Methodology (SSM) to structure debate, as discussed in section 5.7.3. In making such a proposal, I could

be accused of privileging my own knowledge and perceptions over those of participants, adopting the “transformative” (Giroux, 1988) role of the “expert”. At the same time, it was not feasible that participants could, in the time available, acquire sufficient understanding of a range of methodologies to make an informed choice among them. In this case, I had to be open with the participants about my thinking and the implications of any decision made. There were other occasions, too, when my role as researcher necessitated that I play a relatively dominant part in the proceedings; for example in compiling the report for HMHTT. However, at every step, decisions were made jointly with participants. The final proposal and actions were not instigated by me, based on some prior assumption as to what transformation was needed (Guba and Lincoln, 1994) but were generated as participants formed and acted on their emerging reconstructions.

7.5.1. The authenticity of the research

Throughout the research process, I strove to meet the authenticity criteria for interpretive or constructivist inquiry proposed by Guba and Lincoln (1989). I have already explained how I sought to identify potential stakeholders (section 5.5.) and seek out their constructions (section 5.6.) and in Chapter Six I attempted to present these clearly, identifying conflicts. I have also described how, through structured debated combined with a Delphi-like liaison process, open negotiation was facilitated, on issues identified by participants as relevant to them, in accordance with procedures agreed by them, and with information sharing between groups. In these ways, the criterion of fairness was satisfied.

The second criterion is ontological authenticity, referring to the extent to which participants - including the researcher, experience improvement, maturation, expansion and

elaboration in their constructions, for example by providing opportunities for comparison of one's own experience with that of others. In this project, service users and carers, in a series of workshops, had opportunities to share ideas and experiences, and to learn from each other. At the same time, my liaison enabled an exchange between service users and providers. During this process, participants did indeed experience a broadening of their constructions of such notions as 'quality' and 'trust' and were encouraged to reconsider the advantages and disadvantages of joint meetings – resulting in a change of heart by service users, who had originally adopted a “them and us” stance in which service providers were not to be trusted. Meanwhile, I too experienced development and expansion in my ideas, as in the instance described in the previous section, where I not only developed a more elaborate understanding of the nature of trust and quality and interconnection between them, but also was made more sensitive to the affective dimension of these issues by exposure to participants' experiences.

The above criterion appears closely related to the third criterion, educative authenticity, which refers to the extent to which participants gain enhanced understanding of others' constructions. Through the airing of alternative views in this study, for example, service users and carers began to appreciate the thinking of service providers and the extent to which it was affected by the constraints under which they were operating. This does not mean that they necessarily liked or agreed with aspects of service providers' decisions, but they gained a better understanding of why those decisions had been made, for example, cost implications, the regulatory environment, other causes and issues that competed for time and resources. Similarly, service providers gained a better understanding of how aspects of service provision were perceived by service users and carers, and why service

which might have seemed satisfactory to providers might be less enthusiastically welcomed by service users; for example why an open invitation to “come and find me” was challenging rather than supportive for a vulnerable patient, or that service users saw “New Dawn” standards as normative rather than aspirational.

The fourth criterion, catalytic authenticity, is the extent to which action is stimulated and facilitated. In this project, actions of various kinds were stimulated and facilitated throughout, from the active involvement of participants in the engagement process, through the eventual bringing together of the service user and provider groups, to the agreement to put communication and carer involvement issues on HMHTT’s agenda. At this stage, the possibility for action in the sense of implementation of agreed changes was limited, due to external constraints. We were mid-way through the Trust’s financial year, and action was therefore constrained by pre-existing commitments. Nevertheless, the acceptance by service providers of the need for action, and their willingness to disseminate the learning of the research to other parties, constituted first steps in the direction of change.

The fifth and final criterion of authenticity is tactical authenticity, the extent to which stakeholders are empowered to act. There is a sense in which it could be argued that users and carers were not empowered to act, in that service providers and decision-makers can always close down dialogue if they so wish, and implementation of change remains subject to the normal authorities and procedures of the Trust. It is doubtful whether, in large public organisations like the NHS, such constraints can be broken down by SSM or any existing methodology. What can be claimed, however, is that service users had an opportunity to voice their needs and concerns, gained skills and confidence in managing

debate and, ultimately, were enabled to exert an influence on decision-making. In that sense, it can be said that they were empowered and to that degree, the criterion of tactical authenticity was met.

7.6. Contributions of the Research

7.6.1. Contribution to theory

The research has provided insight into the relationship between communication, trust, and perceptions of service quality, derived from synthesis and analysis of findings from Phase One of the study, “Finding Out”, thereby contributing to theory in terms of understanding “relational quality”.

Participants’ comments supported various generic dimensions of quality derived from literature, such as the Tangibles, Assurance, Reliability, Responsiveness and Empathy proposed by Parasuraman et al. (1985; 1988), Acceptability and Efficiency (Maxwell, 1992; Donabedian, 2003) and Optimality (Donabedian, 2003). These are predominantly process measures; that is, participants were concerned with ‘how’ rather than ‘what’ in service delivery.

The research points to issues which influence stakeholders in making attributions of good or bad quality and shows these to be to a great extent contingent on, or mediated by, accessible, intelligible, open and honest communication at individual and group level. A strong mutual relationship was observed between trust and quality, to the extent that many participants had difficulty distinguishing them and saw the one as inherent in the other. A holistic, multi-disciplinary approach to trust showed correspondences between dimensions of or approaches to trust and dimensions of quality; for example, between calculus – based

trust and reliability; between knowledge – based trust and assurance, and between transference – based trust and responsiveness and empathy. It was suggested that where transference – based trust is not sufficiently developed (for example, because of absent or distorted communication) this undermines calculus – based trust and knowledge – based trust – challenging the conventional theory that sees the three as arranged in a hierarchy or progressive series. These feelings appear to be associated with perceptions of low quality. This is not to imply a cause – effect relationship between them, or to functionalize trust, but to recognize that they are intimately linked in terms of the meanings these participants gave to their experiences.

7.6.2. Contribution to practice

The research contributes to organisational practice by providing indications of possible routes and mechanisms by which work to build trust and improve communication may facilitate both more favourable subjective perceptions of quality and measures to achieve feasible and desirable change in terms defined by the participants.

The findings indicated that whereas quality initiatives such as performance targets focus on tangibles, service users are actually very concerned about relational quality. In addition to conflicting agendas between stakeholder groups, there was also deep mistrust of service providers and decision-makers on the part of service users and carers, to the extent that for a considerable time, they resisted the idea of a joint meeting. Such scenarios can be a source of the quality gaps discussed by Parasuraman et al. (1985).

Phase Two of the research opened up communication between various stakeholder groups of HMHTT, giving them the opportunity to view issues of concern from each

others' points of view. This was achieved by applying a modified form of SSM to structure debate and thinking about changes. Service users and carers were empowered by initially engaging them in meetings apart from service providers, which encouraged them to tell their stories and find their "voices". Emotional and practical constraints on joint meetings between service users and providers were addressed through a Delphi – like liaison process and through the preparation of a report, validated by service users and carers, and distributed to all participants for feedback. In this way, participants who had difficulty attending meetings due to illness or pressure of other commitments, for example, were kept engaged in the process of exploring and debating issues and concerns and enabled to contribute. Moreover, eventually, service users and carers began to appreciate the feedback from service providers, to the extent that they eventually felt able to agree to a joint meeting.

The process of communication and trust-building facilitated decision-making and proposals for action to address two issues that have been highly contentious in the HMHTT context, namely, communication and carer involvement. Moreover, it generated learning about ways of structuring and managing debate that can be taken forward to identify and address other problematic situations. It is not claimed that the research provided "solutions" to 'Trust' or 'Quality' – nor was this the intention. However, it initiated what it is hoped will be a continuing process of engagement and dialogue, in a spirit of good will, towards feasible and desirable outcomes for HMHTT and its stakeholders. Moreover, the techniques used here may prove of interest and value to other departments and organisations, subject to their assessments of transferability based on the information provided.

7.6.3. Contribution to methodology

This project adopted CST as a framework for conceptualizing and working towards trust and subsequently addressing quality issues in HMHTT. A review of selected strands of CST literature identified a number of thematic links with various strands of the trust literature. However, a criticism was raised, that although the basic principles of CST implicitly raises issues of trust there is a lack of explicit guidance on ways of recognizing and addressing these issues. One contribution of this work, therefore, was to assert the need for incorporation into CST of an explicit recognition of trust issues, and to suggest some ways in which this might be done-as an explicit aim of critical awareness, as an explicit focus of boundary judgement, and by taking account of cognitive and affective, as well as behavioural dimensions of problem contexts. In this study, an attempt was made not only to understand trust as a construct, but also to build a trust dimension in CST, by explicitly recognizing mistrust and facilitating a process of engagement through which mistrust might be reduced.

An important part was played in this process by the use of a Delphi-Like liaison process as a modification of SSM. Whereas it might be assumed, theoretically, that communicative action required direct dialogue between stakeholders, I recognized that initially, the prevailing level of mistrust was too great to make such a dialogue possible. Service users felt intimidated by service providers, mistrusted their motives, and set out from an entrenched position that there could be nothing to be gained from dialogue. By holding separate meetings initially, service users and carers, as the more vulnerable and less trustful stakeholder groups, found the confidence to voice their concerns, challenge each others' perceptions and priorities, and clarify their aims, in a way they would have been

unable or unwilling to do in the presence of service providers. Meanwhile, my liaison between the groups sustained their interest and engagement in the process, enabled them to present their constructions to each other by a mechanism which reduced threat and conflict, and eventually allowed trust in me and in the research process to be extended to some degree to other participants. In this way, the inequality of power between the stakeholder groups was to some extent moderated, and the path was paved for more direct dialogue.

I do not claim that this is the only way of addressing trust issues within CST. However, I offer it as one illustration of the value of addressing trust explicitly and as an encouragement to other researchers to explore ways in which creative holism can be employed to build trust between researcher and participants, and between stakeholders involved in a critical systemic intervention. Such efforts, I suggest, would strengthen the critical reflection and pluralist dimensions of CST and thereby enhance its ability to contribute to improvement in human life.

7.7. Limitations

Like any research, this project was subject to limitations of scope and methods, which have implications for the interpretation of its outcomes. The following are some limitations faced in this research.

The scope of this research was confined to HMHTT and reflect the views of participants based on their involvement and experience with HMHTT. Although some participants made reference to experience with GPs and other aspects of health services, these too were discussed largely as they affected or were affected by the participants' relationship with HMHTT. The issues identified in relation to trust, communication and

service quality in this research, therefore, cannot be generalized to other segments of health services, such as medical, surgical, accident and emergency, maternity and so on. However, other departments, patient bodies, etc, could if they wished, apply similar methods to identify and address issues of concern to them, based on their assessment of transferability to their contexts.

Another limitation concerns the research sample. For a project of this kind, it would have been extremely costly to obtain representative samples, and indeed, probably not possible, considering the wide range of mental health service stakeholders, the vulnerability of many service users, and the instability of the population (some will end their involvement with the service, through change of job, change of address, change in care arrangements etc, or even death; meanwhile new users will be referred to the service and new staff appointed). The service users and carers who participated can be regarded as self – selecting volunteers representing a constituency of interest. Their perceptions and experiences may not necessarily be typical of the whole population served by the Trust, but they illustrate concerns and opinions among relevant communities that can be explored further.

The research was confined to the perceptions, opinions and reported experiences of the participants. No objective evaluation of quality was carried out.

There was also a limitation in the scope of the workshop activity. The engagement phase of the research was focused on two participant-selected “relevant systems” in the context of the New Dawn initiative. As indicated in Chapter Six, these were but a sample of a much longer list of possible systems (see Appendix 9) generated by participants.

However, the PhD constraints, in terms of the overall research period and the limited time availability of the participants, precluded work on the other suggested systems.

7.8. Suggestions for Further Research

There are a number of ways in which research could build on the contributions of this work. Some suggestions are offered here.

This research was carried out within HMHTT as part of the NHS. It is not clear how far some of the issues raised were related to the nature of mental health services specifically or health service in general, and how far they reflected issues specific to the size, structure and culture of the NHS. It would be interesting, therefore, to carry out similar studies in other health contexts – not only other departments, but also other providers (such as private clinics). This may help to identify different environmental and cultural factors from those prevailing in the current study, and to examine their impact on trust and quality perceptions, thereby further deepening understanding of trust and quality.

One interesting area to develop would be in relation to trust in CST. This study offered a critique of the lack of explicit attention to trust (although it was acknowledged that implicit connections run through CST) and suggested ways in which a more explicit trust dimension might be developed. Empirical work is now needed to generalize and test these ideas for particular methodologies. Such research would make valuable contributions, both to trust and systems thinking and practices.

Another area where work is needed concerns the issues of participation and representation. Like others before it, this project faced some difficulties in recruiting participants and securing their full involvement, due to prior levels of mistrust, and a

variety of practical and institutional constraints. One strategy for dealing with these issues – a modified SSM incorporating a Delphi-like liaison – has been adopted in this study with a degree of success. Nevertheless, there is scope for further projects to propose and test other ways of dealing with the participation issue.

7.9. Concluding Remarks and Postscript

This project, undertaken in a spirit of co-operative inquiry, has been a challenging, stimulating, emotional, sometimes highly-charged learning experience, which has greatly enriched my understanding of the complex interrelationships between trust, communication, and perceptions of service quality. It was encouraging and rewarding to see signs of new understanding among participants, and a willingness to take the issues explored forward, in proposals for change.

Since leaving HMHTT, I have sustained my interest in the research and the organisation, and have followed up what HMHTT is doing in these areas – for example, by reading documents and maintaining contact with all research participants. I have seen that carer involvement and communication issues have been taken onto the Trust's agenda, and new initiatives are underway. I cannot claim that these developments are entirely due to or solely informed by this project. However, if the research has made some contribution towards carrying the trust and quality agendas forward by facilitating understanding and collaboration, it has achieved a worthwhile aim.

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Appendices

Appendix 1 / One – Web-search

Table 1: Literature Search: Key Words and Outcomes

Database	Keyword(s)	Hit(s)
ABI / INFORM	Authenticity	23
	Confidence	380
	Creditworthiness	9
	Faith	256
	Faithfulness	0
	Genuineness	1
	Honest	57
	Honesty	58
	Integrity	298
	Reliability	523
	Reliance	202
	Rely on	296
	Risk	4878
	Sincere	6
	Sincerity	4
	Trust	978
	Trustworthiness	5
	Quality	4806
	Quality Health Service	354
	Critical Quality	3
	Trust and Quality	44
	Trust, Quality and Risk	2
	Trust and Risk	62

Web-Search: ABI/Inform

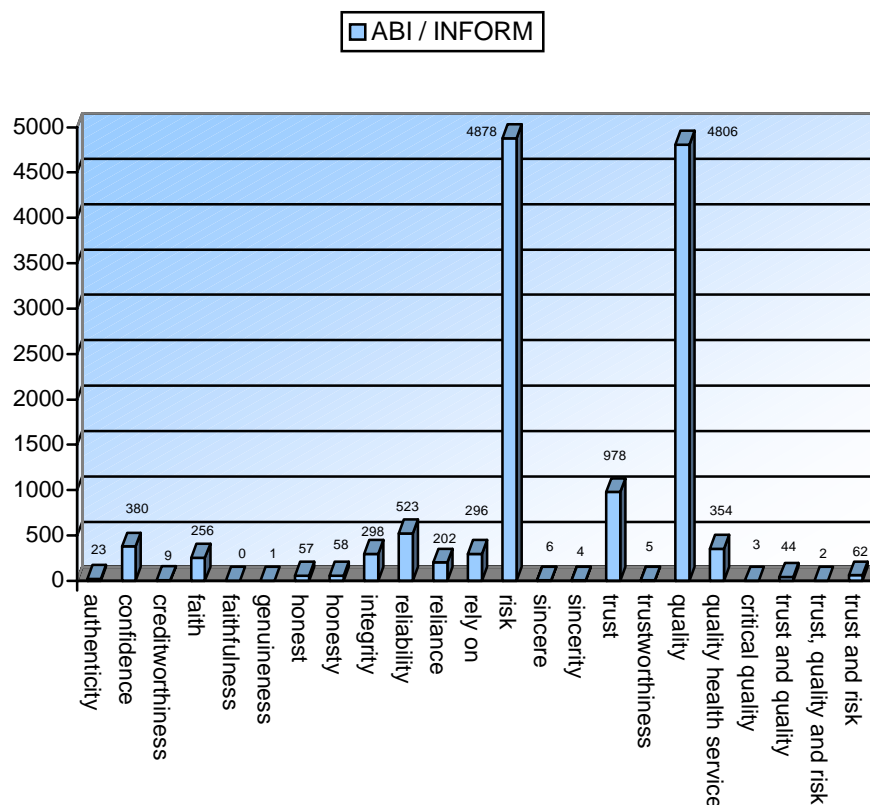


Figure 1: Literature Search: Key Words and Outcomes

Table 2: Literature Search: Key Words and Outcomes

Database	Keyword(s)	Hit(s)
ASSIANet	Authenticity	13
	Confidence	120
	Creditworthiness	0
	Faith	2
	Faithfulness	0
	Genuineness	5
	Honest	0
	Honesty	29
	Integrity	38
	Reliability	200
	Reliance	5
	Rely on	0
	Risk	200
	Sincere	0
	Sincerity	3
	Trust	197
	Trustworthiness	4
	Quality	200
	Quality Health Service	0
	Critical Quality	0
	Trust and Quality	6
	Trust, Quality and Risk	0
	Trust and Risk	5

Web-Search: ASSIANet

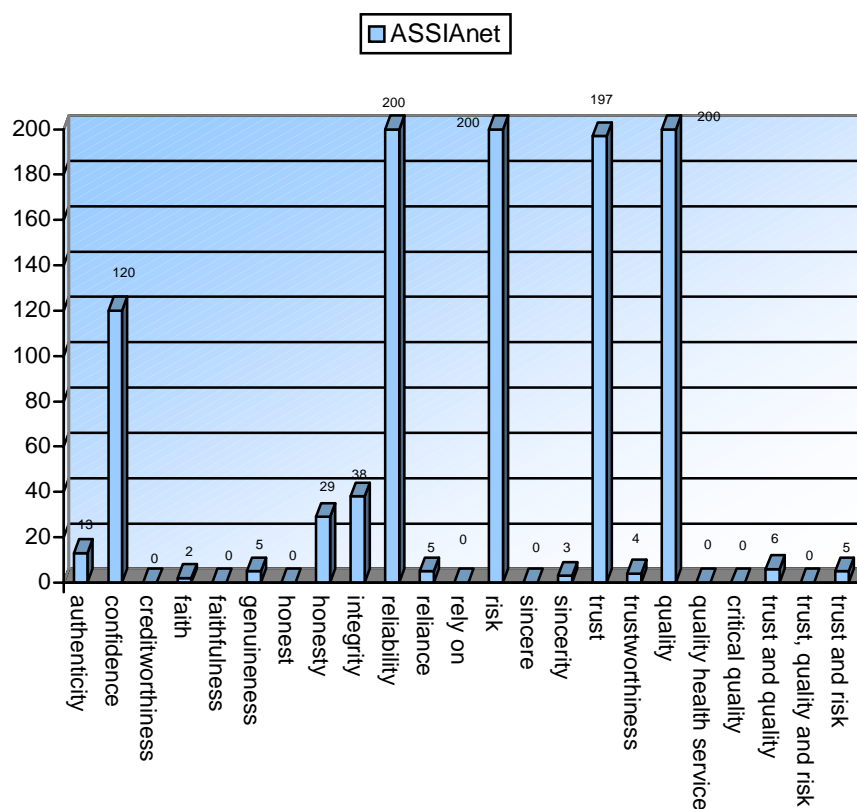


Figure 2: Literature Search: Key Words and Outcomes

Table 3: Literature Search: Key Words and Outcomes

Database	Keyword(s)	Hit(s)
BIBSYS	Authenticity	108
	Confidence	181
	Creditworthiness	2
	Faith	1242
	Faithfulness	7
	Genuineness	1
	Honest	57
	Honesty	10
	Integrity	246
	Reliability	1184
	Reliance	68
	Rely on	4
	Risk	2622
	Sincere	12
	Sincerity	13
	Trust	399
	Trustworthiness	4
	Quality	4433
	Quality Health Service	7
	Critical Quality	12
	Trust and Quality	0
	Trust, Quality and Risk	0
	Trust and Risk	0

Web-Search: BIBSYS

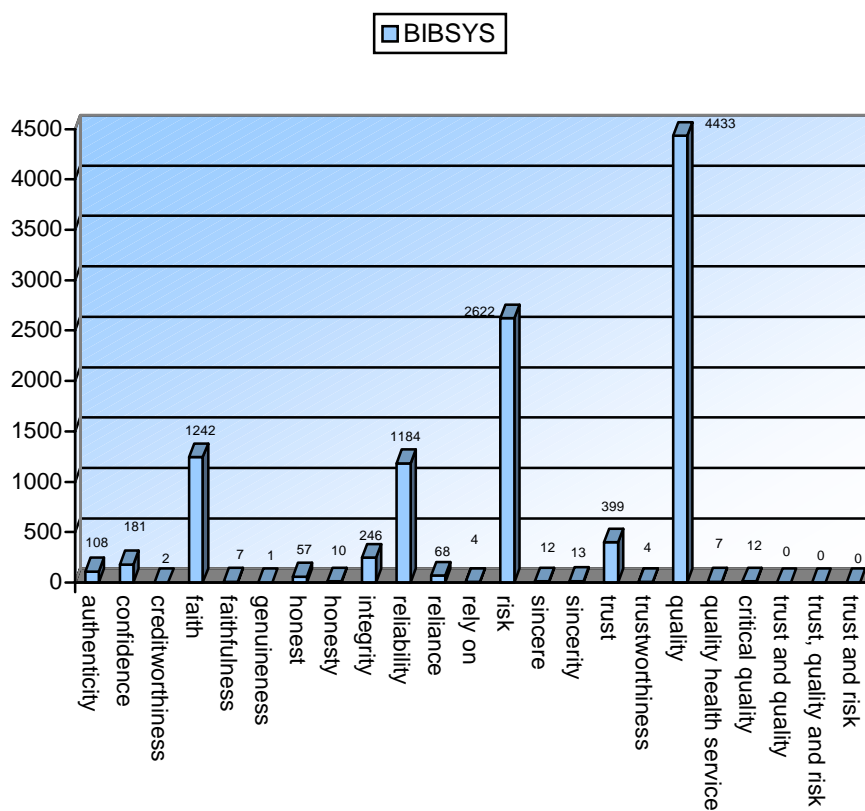


Figure 3: Literature Search: Key Words and Outcomes

Table 4: Literature Search: Key Words and Outcomes

Database	Keyword(s)	Hit(s)
biz/ed	Authenticity	2
	Confidence	4
	Creditworthiness	0
	Faith	1
	Faithfulness	0
	Genuineness	0
	Honest	1
	Honesty	0
	Integrity	8
	Reliability	3
	Reliance	0
	Rely on	0
	Risk	64
	Sincere	0
	Sincerity	0
	Trust	33
	Trustworthiness	0
	Quality	120
	Quality Health Service	1
	Critical Quality	1
	Trust and Quality	0
	Trust, Quality and Risk	0
	Trust and Risk	2

Web-Search: biz/ed

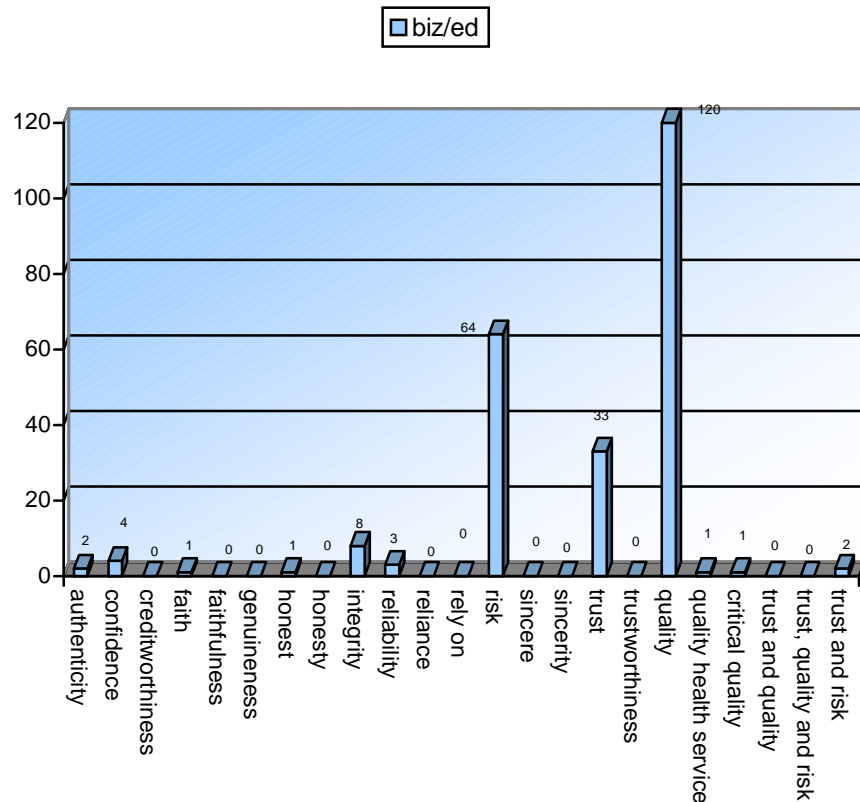


Figure 4: Literature Search: Key Words and Outcomes

Table 5: Literature Search: Key Words and Outcomes

Database	Keyword(s)	Hit(s)
CINAHL	Authenticity	0
	Confidence	38
	Creditworthiness	0
	Faith	4
	Faithfulness	0
	Genuineness	0
	Honest	0
	Honesty	3
	Integrity	5
	Reliability	34
	Reliance	1
	Rely on	1
	Risk	421
	Sincere	0
	Sincerity	0
	Trust	15
	Trustworthiness	0
	Quality	751
	Quality Health Service	0
	Critical Quality	0
	Trust and Quality	0
	Trust, Quality and Risk	0
	Trust and Risk	0

Web-Search: CINAHL

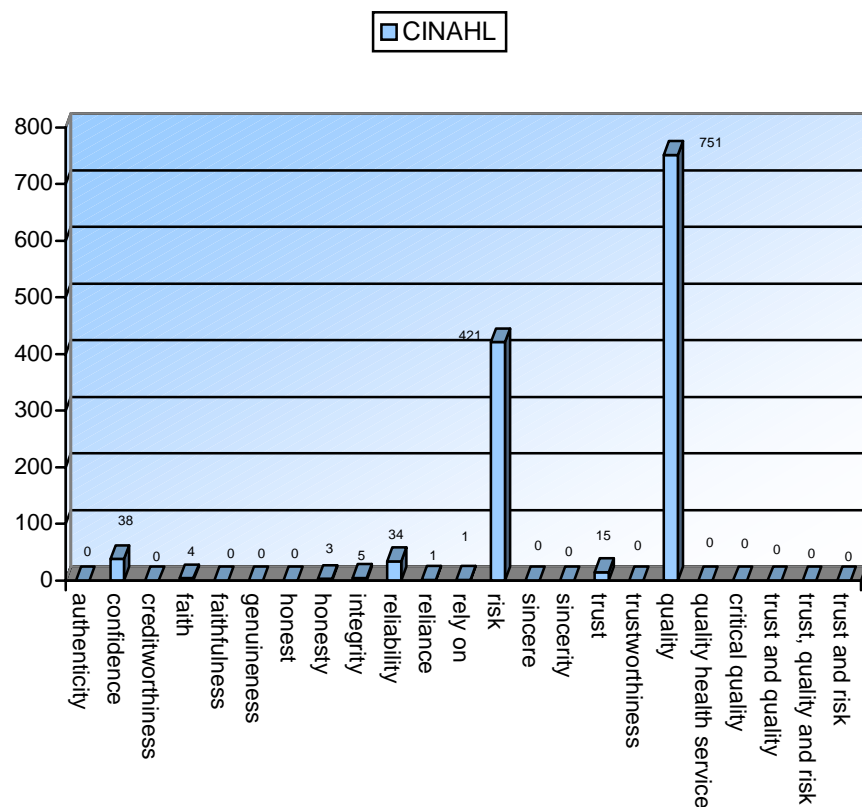


Figure 5: Literature Search: Key Words and Outcomes

Table 6: Literature Search: Key Words and Outcomes

Database	Keyword(s)	Hit(s)
Cochrane	Authenticity	0
	Confidence	865
	Creditworthiness	0
	Faith	4
	Faithfulness	0
	Genuineness	0
	Honest	3
	Honesty	2
	Integrity	31
	Reliability	175
	Reliance	25
	Rely on	38
	Risk	938
	Sincere	1
	Sincerity	1
	Trust	174
	Trustworthiness	0
	Quality	1137
	Quality Health Service	356
	Critical Quality	282
	Trust and Quality	174
	Trust, Quality and Risk	146
	Trust and Risk	146

Web-Search: Cochrane

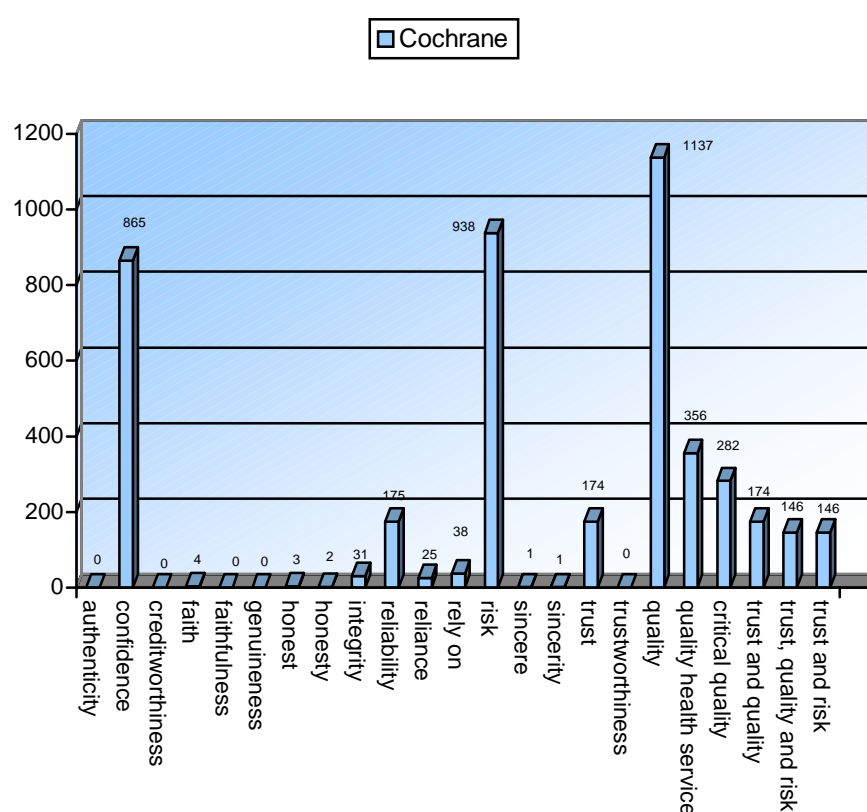


Figure 6: Literature Search: Key Words and Outcomes

Table 7: Literature Search: Key Words and Outcomes

Database	Keyword(s)	Hit(s)
COPAC	Authenticity	651
	Confidence	1515
	Creditworthiness	34
	Faith	18255
	Faithfulness	119
	Genuineness	92
	Honest	1113
	Honesty	324
	Integrity	860
	Reliability	2240
	Reliance	380
	Rely on	20
	Risk	10328
	Sincere	379
	Sincerity	241
	Trust	13481
	Trustworthiness	27
	Quality	21056
	Quality Health Service	91
	Critical Quality	43
	Trust and Quality	19
	Trust, Quality and Risk	0
	Trust and Risk	11

Web-Search: COPAC

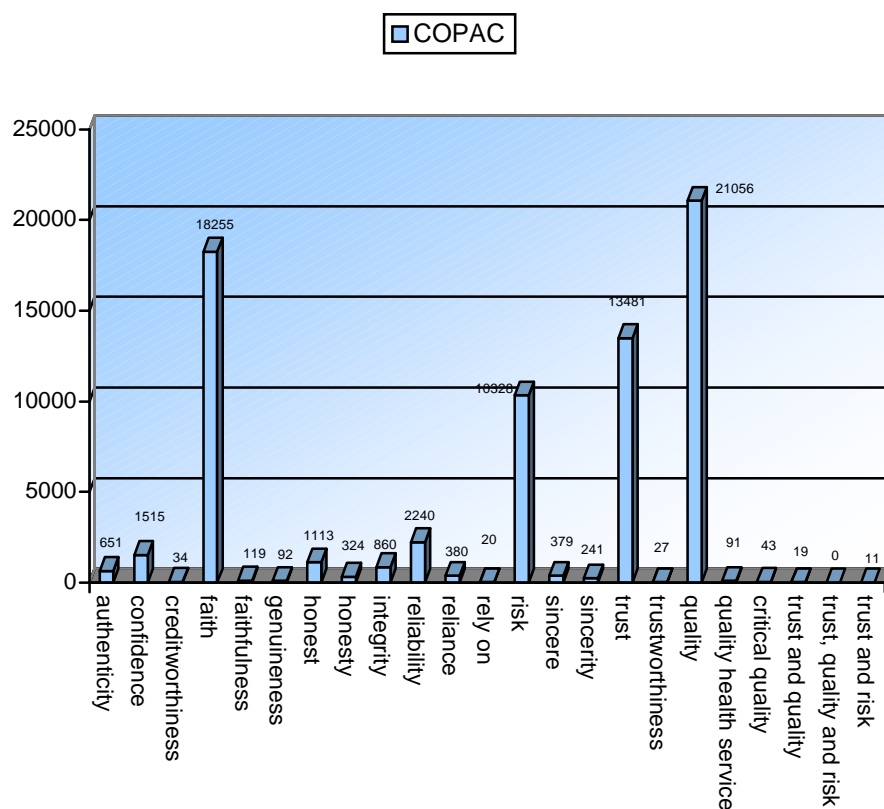


Figure7. Literature Search: Key Words and Outcomes

Table 8: Literature Search: Key Words and Outcomes

Database	Keyword(s)	Hit(s)
EBESCO: Academic Search Elite	Authenticity	240
	Confidence	4835
	Creditworthiness	14
	Faith	576
	Faithfulness	15
	Genuineness	13
	Honest	106
	Honesty	66
	Integrity	2425
	Reliability	3976
	Reliance	557
	Rely on	1335
	Risk	10000
	Sincere	37
	Sincerity	26
	Trust	49988
	Trustworthiness	49
	Quality	10000
	Quality Health Service	0
	Critical Quality	2
	Trust and Quality	244
	Trust, Quality and Risk	16
	Trust and Risk	284

Web-Search: EBESCO: Academic Search Elite

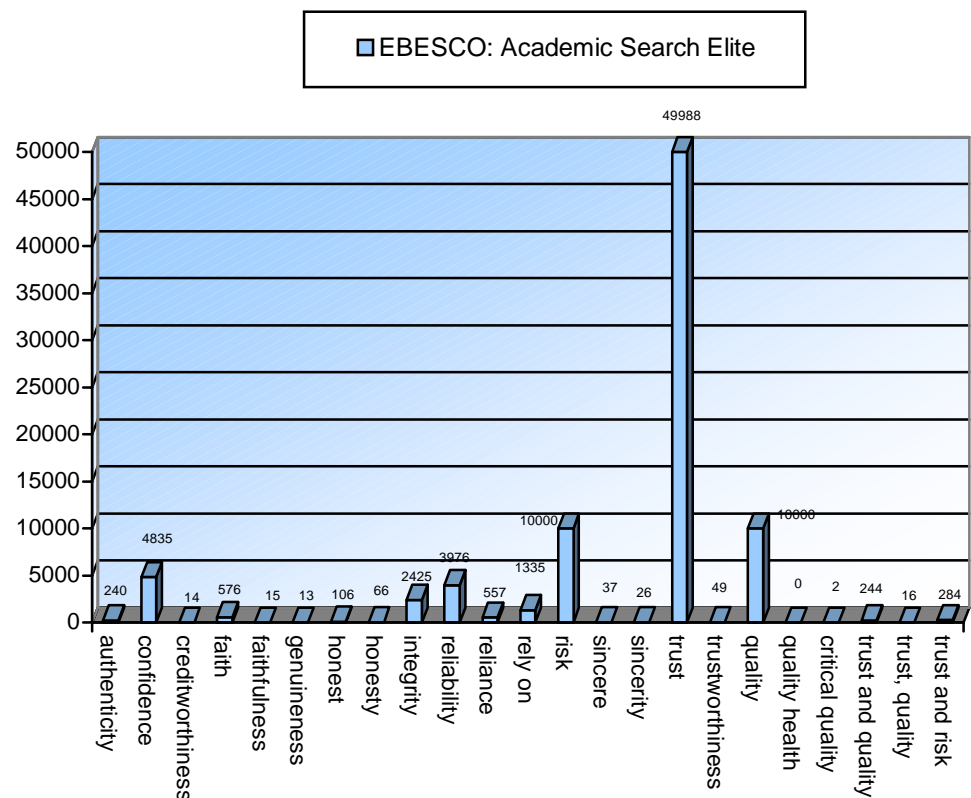


Figure 8: Literature Search: Key Words and Outcomes

Table 9: Literature Search: Key Words and Outcomes

Database	Keyword(s)	Hit(s)
Medline	Authenticity	291
	Confidence	32286
	Creditworthiness	1
	Faith	435
	Faithfulness	18
	Genuineness	18
	Honest	202
	Honesty	147
	Integrity	11970
	Reliability	14133
	Reliance	1484
	Rely on	3796
	Risk	176292
	Sincere	49
	Sincerity	22
	Trust	1999
	Trustworthiness	74
	Quality	67048
	Quality Health Service	8
	Critical Quality	20
	Trust and Quality	241
	Trust, Quality and Risk	15
	Trust and Risk	190

Web-Search: Medline

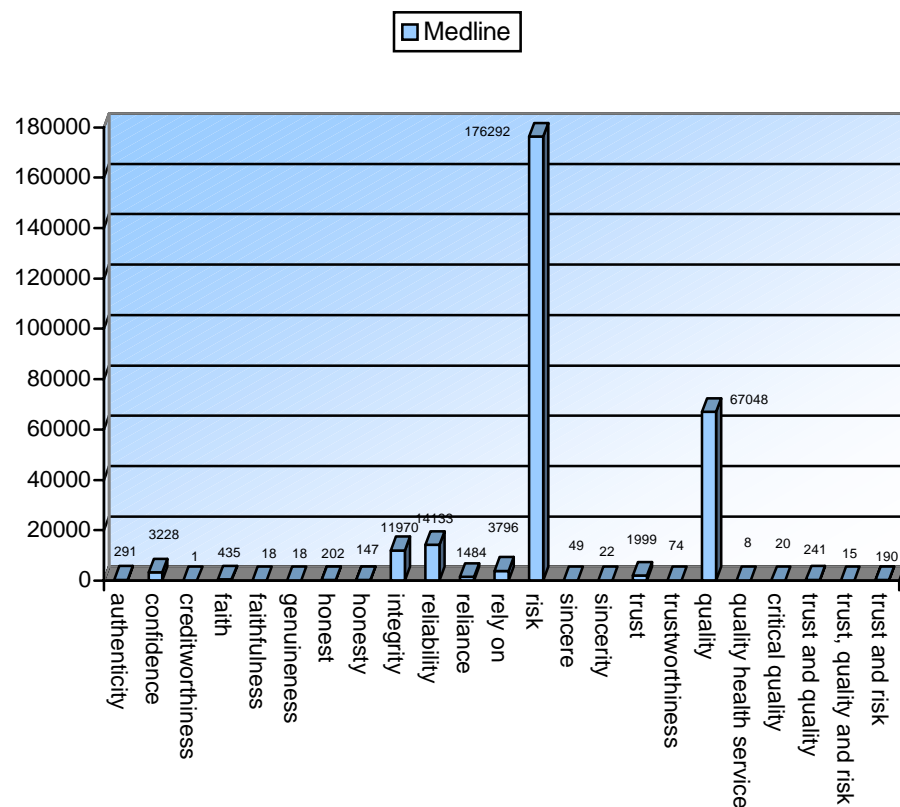


Figure 9: Literature Search: Key Words and Outcomes

Table 10: Literature Search: Key Words and Outcomes

Database	Keyword(s)	Hit(s)
Philosophers Index	Authenticity	573
	Confidence	257
	Creditworthiness	1
	Faith	3809
	Faithfulness	42
	Genuineness	23
	Honest	120
	Honesty	147
	Integrity	622
	Reliability	298
	Reliance	364
	Rely on	351
	Risk	800
	Sincere	68
	Sincerity	90
	Trust	529
	Trustworthiness	59
	Quality	1827
	Quality Health Service	0
	Critical Quality	1
	Trust and Quality	10
	Trust, Quality and Risk	0
	Trust and Risk	3

Web-Search: Philosophers Index

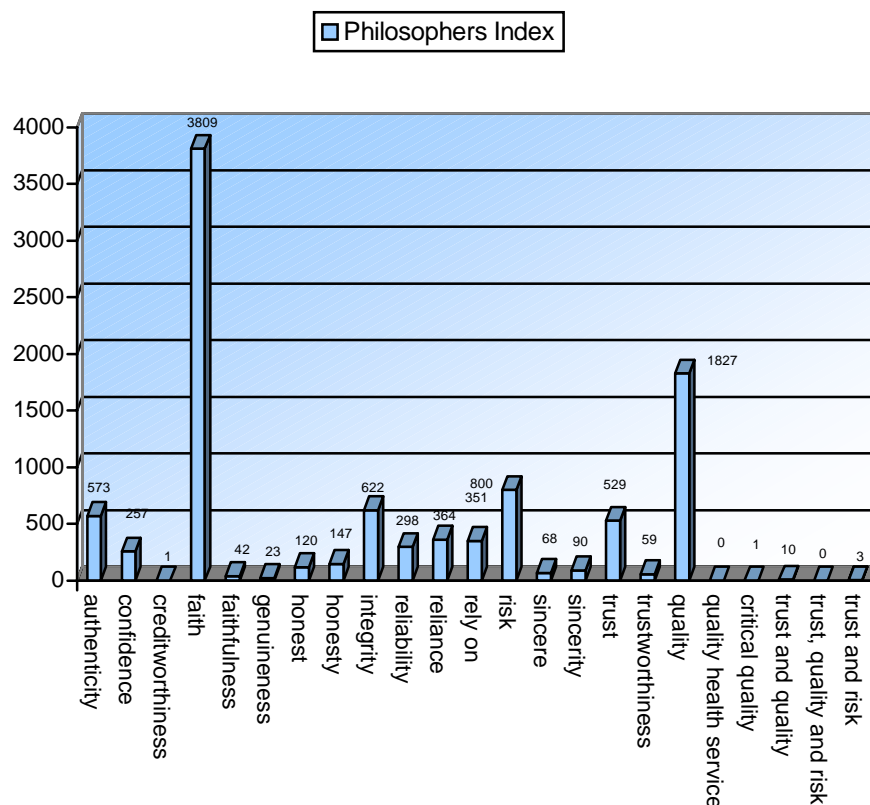


Figure 10: Literature Search: Key Words and Outcomes

Table 11: Literature Search: Key Words and Outcomes

Database	Keyword(s)	Hit(s)
PsycINFO	Authenticity	356
	Confidence	157
	Creditworthiness	13
	Faith	443
	Faithfulness	11
	Genuineness	1
	Honest	50
	Honesty	59
	Integrity	205
	Reliability	232
	Reliance	214
	Rely on	233
	Risk	4560
	Sincere	17
	Sincerity	12
	Trust	1100
	Trustworthiness	17
	Quality	2819
	Quality Health Service	0
	Critical Quality	0
	Trust and Quality	0
	Trust, Quality and Risk	0
	Trust and Risk	1

Web-Search: PsycINFO

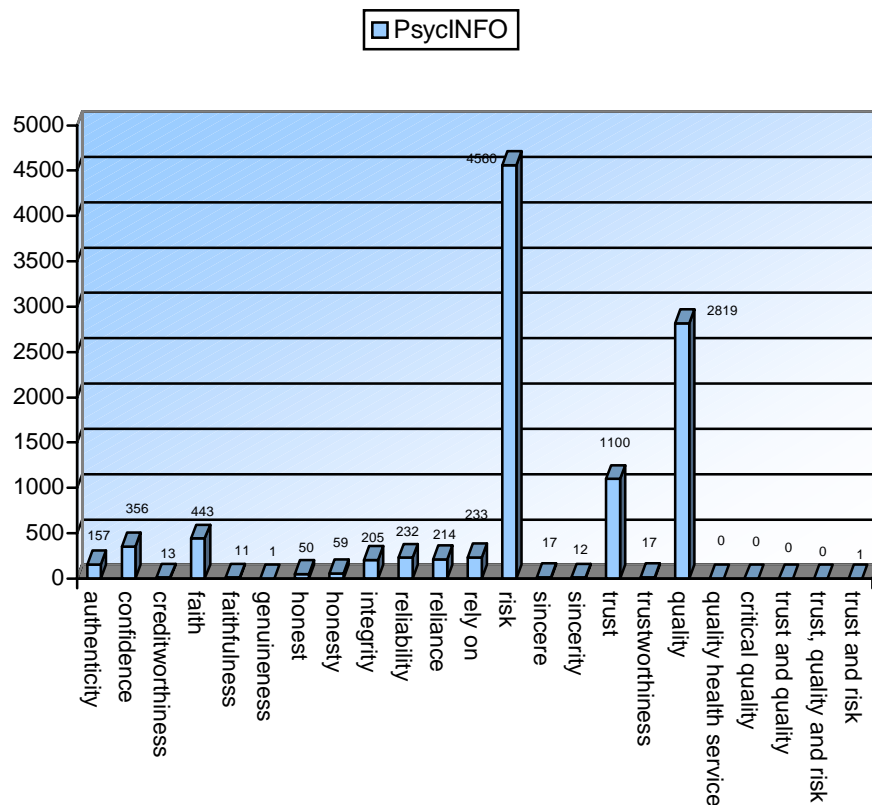


Figure 11: Literature Search: Key Words and Outcomes

Table 12: Literature Search: Key Words and Outcomes

Database	Keyword(s)	Hit(s)
SOSIG	Authenticity	4
	Confidence	24
	Creditworthiness	0
	Faith	36
	Faithfulness	0
	Genuineness	0
	Honest	5
	Honesty	3
	Integrity	21
	Reliability	9
	Reliance	7
	Rely on	0
	Risk	177
	Sincere	0
	Sincerity	0
	Trust	161
	Trustworthiness	2
	Quality	429
	Quality Health Service	71
	Critical Quality	0
	Trust and Quality	6
	Trust, Quality and Risk	0
	Trust and Risk	2

Web-Search: SOSIG

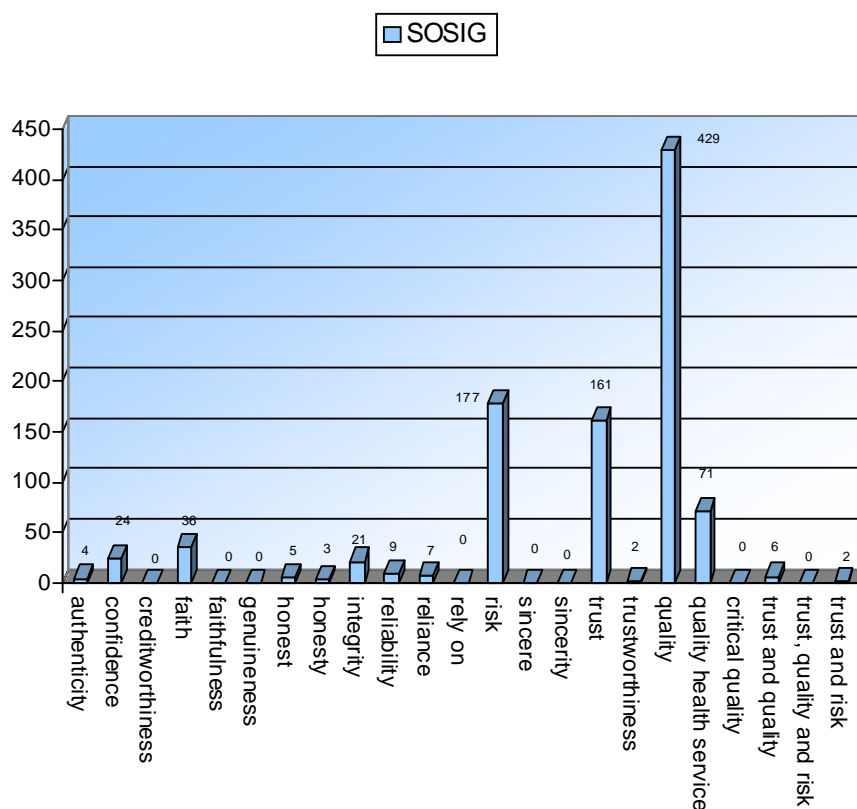


Figure 12: Literature Search: Key Words and Outcomes

Appendix 2

Interview Guide for SU, CA and PR

Trust and Communication in Health Service: “User Centred Research and Development (R & D)”

Project Reference Number: 05/Q1104/07

Phase One Topic Guide

The overall research questions, concerning the role of trust in relational quality, will be answered by the researcher based on analysis and synthesis of findings in relation to three main areas: Quality, Communication and Trust.

It should be noted that what follows is not a detailed schedule to be followed verbatim. Key questions (**shown in Bold**) will be posed in broad terms, so as not to constrain participants' responses. Possible prompts, probes and subsidiary or follow up questions are indicated. However, the essence of these semi – structured interviews is the retention of a degree of flexibility in order to keep the discussion within participants' frame of reference and to follow up the points they raise

Topic Area One: Quality

What does ‘quality’ in the NHS mean to you as a (service user/ practitioners/ administrator)¹?

Or in other words, what are you looking for to get from / deliver through the NHS that would give you the feeling of a quality service?

Can you give an example of anything you have experienced that particularly made you feel you were getting/ giving a high quality service?

What especially pleased you about this?

Can you tell me about any instance where you saw the service quality as less than you think it should be?

What particularly upset/disappointed you?

If the idea of ‘relationship’ has not already been raised by the participants in relation to the above:

To what extent do you think your relationship with (service users/ practitioners/ administrators) has a bearing on the quality of the service? In what way?

How happy are you with the relationship?

What do you like/ dislike about it?

¹ Terms to be used as appropriate.

Topic Area Two: Communication

What opportunities are there for you as a (service user/ practitioner/ administrator) to communicate with (service users/ practitioners/ administrators) in the NHS?

e.g. in the GP surgery
in hospital outpatient departments and clinics
on hospital wards
any other channels

These might be, for example, related to:

Treatment for a specific condition
Lifestyle advice / preventive medicine
Policy decision
Complaints
Administrative – scheduling appointments etc.

Further probes / prompts

face to face
written
telephone
suggestion box
through another person
committees
etc.

How would you describe communication between you and (service user/ practitioner/ administrator)?

How happy are you with it? Why?

For service users

How well do you think the doctor / nurse listens to your concerns?
How well does the doctor explain your condition or treatment?
Do you feel you can ask questions if you need to?

For practitioners

To what extent do you think patients listen to and understand the information and advice you give them?
How can you tell?
Is there any way of following up patient understanding?
How can you, as a practitioner, gain an understanding of patients' and relatives' concerns and worries?

For all participants

Are there any factors that you think hinder effective communication between you and (service user/ practitioner/ administrator)? What are they? How do they affect you?

e.g. time constraint
access
specialist terminology
differences of interests (conflicting agendas)

Topic Area Three: Trust

What part does trust play in your relationship with (service user/ practitioner/ administrator)?

e.g.
Do patients see practitioners as competent, reliable etc?

How do patients feel in interaction with doctors?
(Comfortable? Confident? Afraid?)

How do their perceptions and feelings influence their behaviour?
(e.g. Do they keep appointments? Comply with treatment?)

What do participants expect from others in the NHS (service user/ practitioner/ administrator) in order to trust them?

Do they think those conditions are satisfied?

Is there a difference between trusting an individual (e.g. ones G.P, a colleague) and trusting the system as a whole?

Appendix 3

Structured Interview Guide for Decision-Makers

Trust and Communication in Health Service: “User Centred Research and Development (R & D)”

Project Reference Number: 05/Q1104/07

1. Can you briefly explain to me your role in HMHTT?
2. What would you say are your main aims?
3. What are the current priorities of the Trust?
4. Can you tell me about any obstacles you face in achieving these aims?
5. Can you change any of these?
6. Is there a clash of agendas?
7. Is trust an issue?
8. How can service be improved?

Appendix 4

Sample Extracts from interview transcripts

SU 02

I will start about quality and what does this word mean to you?

I: It means the best, the finest quality. Or a standard.

Y: And what does quality in the NHS mean to you as a service user?

I: It means they have standards to live up to.

Y: And what type of standards are you aiming to receive?

I: The highest they can achieve. It is not always achievable, but you have quality assurance here, and if it falls below that you can complain, and if it goes above that, well that is better for everybody.

Y: And this level you are aiming to receive, will you then be satisfied?

I: Yes, if it has not fallen below what you perceive to be the standard guideline.

Y: If I ask you, what are you looking to get from them as a Service User, what would you say?

I: I would say you are aiming to get honestly about your condition and build up a relationship with who ever you are dealing with, who you can be open and honest with them and feel as if you are not being judged.

Y: Who should be honest?

I: Both – the Dr's and the Patients.

Y: Can you tell me of any experiences that made you feel you were getting high quality or low quality service?

I: That's difficult to pin point because I don't know what the standard.

Y: Yes, you mentioned that earlier. Standard, and the question will be automatically be raised “what does standard mean”?

I: You cannot judge anything if you don’t know what the standard is.

Y: Do you know about the standard of quality?

I: No.

Y: Why?

I: I don’t know – it has never come up.

Y: Have you tried to ask about this type of quality? What is the standard? Have you tried to be acknowledged about this? Asked who manages this? Asked your GP?

I: I’ve been to the PCT and tried to find out what they were doing and stuff like that.

Y: You’ve been there?

I: Yes. They sent me a <I’ll show you> I got one in the post today.

Y: So you have taken the initiative to ask about the standard of quality that everybody should receive.

I: Yes, we worked on (as service users) about making standards for the New Dawn. So, I actually worked on that. So I know that patients are expecting standards, such as watching TV, or making a cup of tea if they wake up during the night and stuff like that.

Y: 605, do you go to 605?

I: I used to go to 605. I was a member of the committee there.

Y: Hmm, I haven’t seen you yesterday.

I: No, I’ve not been on the committee for a while.

Y: Are you intending to go again?

I: I don't think so.

Y: Why?

I: Because I had my breakdown a couple of years back, another breakdown, and I felt as if it was time for me, myself and my family, rather than take on too much else, so I stopped doing all my voluntary, and more or less tries to move out of mental health and have a normal sort of life, so I am now working in a cyber café in the community.

Y: How would you describe the service which is delivered by 605?

I: I think it's.....at the moment I don't really know what has happened to it. It used to be where people could meet and talk and feel as if...it's not like that now – you have to have an appointment there – you can't just walk in and have a cup of tea and a natter –that's lost.

Y: That's lost?

I: Yes.

Y: And was it good?

I: Yes, it was good when you were feeling down, and you had nobody to talk to, you could talk to other service users or talk to the staff. You could just pop in and say “ I am feeling a bit down today”. You had somebody there who would make you feel better, and you would leave there and feel a lot better.

Y: Have they replaced that service by any other, such as a help line?

I: I don't know – I have been out of it for the last two years so I don't really know what is going on now. I don't know if the standard has changed, or got better or worse!

Y: We come now to the trust issue, and what part does trust play in your relationship with the practitioners and service providers?

I: It plays a big part, because you can't be open and honest with them if you do not trust them. And you feel they may be laughing at you, or think you are silly or naïve or, you know, you just don't know what they think!

Y: Do you see practitioners as competent?

I: Yes. Some of them but not all of them.

Y: Not all of them?

I: Not all of them.

Y: Do you see them as reliable?

I: Depends if they arrive on time, Sometimes they are running late, but you can excuse them if there has been an emergency.

Y: How often?

I: You could excuse it maybe a couple of times, but you wouldn't be able to excuse it if it was happening every time.

Y: How often do you see them?

I: Not often. I only see them once every six months.

Y: Every six months, you can excuse them a couple of times, that means, well, ok!

How do you feel interacting with Dr's?

I: This goes right back. I did have a problem with Dr's when I was still with my daughter because she had health problems right back from being a baby and I felt at that stage, that had my husband come with me we would have got to the root of the problem much

sooner. Because I was a woman, they treated me differently, as they didn't tell me the truth so I had to try and get it out of them. All that created this imbalance with Dr's and trust, because you felt as if you had to pick at them to get the answers that you were requiring.

Y: Treating you differently because you were a woman. Had that something to do with trust or inequalities dealing with gender?

I: It was a trust issue from my point of view – it might have been gender inequalities from their point of view.

Y: How do your perceptions and feelings and influence your behaviour?

I: Well, hopefully I have got over the initial, even though it still upset's me today. But that what was going on at the time, and especially when you had a child that was ill at the same time.

Y: Can you give me examples?

I: No, I am getting more confused about it. I am going back as if I am going back in my mind as if it is happening...it upsets ...it was as if you had to be strong for your child's sake, cause you had to get all the information you could, because you had to report back to your husband and family what the Dr's were saying, so you felt under a lot of pressure to get it right.

Y: Does that affect your behaviour with keeping appointments?

I: No.

Y: So, do you keep appointments with Dr's?

I: Yes. Although they did say when I went to hospital last time I missed an appointment in January 2004, but I don't remember it...

Y: Is there any difference to you, between trusting an individual and trusting the system as a whole?

I: Well, the system has let me down as a whole so many times – that's not just the medical, that's also the educational side and the Social Services. I felt as if I was battling them all at one stage. But I feel as if I have got through that and I have started to trust them again, until you hear something, and you think why is this still happening to people? It might have been one of your complaints and it is still happening today.

Y: And to you?

I: I've moved on. I still had dealings with social workers for my daughters sake, but I feel as if I have moved forward. I don't feel as if I am in a goldfish bowl any more. At one stage I felt as if I was in a goldfish bowl and every body was looking in on my life and wanting bits of me – my opinion and my outlook on life.

Y: What happened to make you change your mind that you should trust the system, or do you trust the system now?

I: It's what's going on in the system now. I did begin to trust the system when I was beginning to do my Trailblazers and <inaudible>. We learned how they worked and got to trust them a bit more.

Y: So you think, at the time you have been encouraged to express your opinion and experience, you start to trust the system again. Does that mean if you hadn't been offered this offer, you still would not trust the system?

I: I would still have big gaping holes where I didn't trust them because they had let me down so often.

Y: How often do you feel you have been let down?

I: Over the years, through education and special educational needs and things for my daughter – quite a lot, because we had to fight for everything.

Y: And you have just said that you still see this happening to people?

I: Yes.

Y: What do you feel about that?

I: Well, that angers me because I want to do something and try and help them get through what I have been through.

SU 07

Y: How do you communicate with them?

I: I, because a lot of my memory and I find direct questions difficult, I am presented d something, I have found out that they can read me more quickly than I can say it, because I know I digress, it's a bad habit. So, ...inaudible.....also, I can't receive a service. One of my problems, I thought this was a very good thing, they did have a 24 hour, was that if you are in the system, you get a Care Plan, and you have got numbers you can ring, there was a 24 hour, for some reason, I used to go into crisis between 11 and 4 – I don't know why, something inherent in the brain that triggers it off, it's very difficult as I hadn't anybody to speak...

Y: There is no access number you can ring, or..

I: There used to be the MIND Line, it was a charity one.

Y: A charity?

I: Yes, Hull and East Yorkshire MIND – Very forward thinking, they had a Crisis House.

Y: Is it relating to the NHS?

I: No, it isn't – that the point. The NHS depends a lot on the Voluntary Sector. A lot of the social skills that Social Services used to do that aren't there anymore.

Y: I think there is an emergency number..

I: But you are not allowed to use it if you do not have a Care Plan, and I don't have a Care Plan because I can't, I don't receive services, it goes round and round and round.....

Y: If you are, for example, feeling that you are totally unwell? What do you do? What should you do?

I: I can either die, or stay in the room because I can't get one anymore

Y: Can't you even ring 999? And say you are seeking for help? I am feeling unwell?

I: Where I live, I've got a lifeline – an emergency one, there is a warden and she says she feels very disempowered because her job, if one of the residents is ill, is to call for help, and when I am ill, there is no-one to contact because no-one can help. She finds that frightening as well, so I just have to deal with it and hope I get better. So, I think the NHS is unhealthy, and there is no helpline...

SU 08

Y: Okay, let's start now with my questions, and about quality, and what does quality in the NHS mean to you as a service user or carer?

I: Quality, to me, is the way they look after people with mental health problems. Whether they have a decent quality of life and whether they are accepted with dignity when they approach the service for help and whilst they are using the service. They to me are the quality I expect them to deliver.

Y: Can you give me an example of anything that you have experienced which made you think you were getting a high quality service?

I: Yes, as a Chair of the PPI, I inspect, and I hate the word inspect – I call them visit, units in Hull, clinical and acute units. In almost every case, the dedication of the staff strikes me as high quality, not always the premises are conducive to give that quality, but the staff, I have got every praise for, and they do give a quality service as much as they are given the chance to do.

Y: What especially pleased you about this?

I: Last year there was a court case for a private home in Hull, where they got prosecuted – one or two of them were jailed I believe, for abusing people with mental health problems, One of the youngsters that was in that home moved into town to <Inaudible> and I saw this young man, and three months after I saw him on TV, and even from the TV view I had of him, compared to the view that I saw of him when I went to visit, I could see that the service, the NHS side, not the private side, the service he had had in those few months, is, the distance he had travelled was wonderful. So I did see the quality there as opposed to private.

.....

I: I have personally spent 15 years or more suffering from post traumatic combat stress, and this was not picked up by the GP's, all the GP's I spoke to, and in was actually someone within this group, mental health action group, that suggested that I was tested for combat stress, and he was a layman I felt, and still feel GP's are either not aware, or don't believe it – post traumatic stress. They have no training or not sufficient training either to diagnose it, or to help people with it.

Y: You raise two different dimensions – either they are not aware of it or they don't believe it. Two different things.

I: And I've experienced both.

Y: You've experienced both?

I: Yes.

Y: Can you tell me how?

I: Yep, when it was suggested that I had PTSD, and I mentioned it to my GP, and he...without saying it, because he was far too polite for that, but he proved the suggestion that there was a problem and there was indeed a problem existing like that. I spoke to another GP, who simply admitted that he hadn't had training to diagnose such a thing and that he had to engage, or find, or look for a route for me to go down – so he didn't know that route.

Y: What did he do then?

I: Well as it happens, I had to follow two routes at the same time, my GP and the service, and it was the service which told the GP that I had a problem, so he did not need to go

further then because he had been more or less told by a psychiatrist from the service side that I was diagnosed, in his opinion with stress conditions.

Y: Why didn't he refer you to a specialist? Why did he leave you to do that by yourself?

I: He didn't actually leave me to do that by myself. What he did say was "I will need to look at the route we need to send you down". He didn't know of any specialist. He could send me back to a psychiatrist, which he has already done. Because he could see on my papers that I had already seen and spoken to a psychiatrist on two occasions, and the psychiatrist hadn't picked that up.

Y: Who funds the sessions, the GP?

I: Yes. If it's a private surgery who does their own funding.

Y: So, at the end of the day, it depends on the GP and the resources he has?

I: Yes, again, we are back to the GP I suppose.

Y: And if he does not have the resources, does that mean you do not get the treatment?

I: Yes, it does mean that. It means you are getting poor treatment, and less treatment.

Y: And how well does your DR explain your condition and treatment?

I: My DR doesn't seem to..I think I am such a strong willed person, and people looking at me can't believe I have got a problem and I am sure that is the same with my DR. I spend more time with my Dr speaking to him about his <inaudible> opinion and his daughter's and so on, than my problems, and that is my fault, not the Dr's because I don't not wish, and I think many people with mental health problems feel the same – they do not want to be a burden and don't want to offload their problems so that might be some of the reasons why

I was not diagnosed correctly and earlier. Ex Servicemen do not want to talk why they are not sleeping well.

Y: Are there any factors which you think hinder effective communication between you and your practitioner?

I: Factors are resources and time.

Y: Any other factors?

I: Training.

Y: Training?

I: Training. For mental health people, mental health is such a vast spectrum of, er you know...there maybe only 20 things that can go wrong with your stomach, but there are a million different things that can go wrong with your brain. I don't think GP's have the training that is required, I don't know, but I do know lack of training is a hindrance. One thing that I do think is positive about this is that in Hull, I don't know if it is done anywhere else, we have now got Community Health Nurses who reach out to people at the GP stage, so therefore they are not necessarily, psychiatrists or CPN's, and therefore they are getting people before they fall off their perch. They are seeing people who are off work and can help – it might not be necessarily, ..it might be a social or housing problem, and these people can now go across the divide. So we are getting a bit more joined up.

Y: How do service users access that?

I: By the GP's.

Y: But what about time? Is there enough time to talk about this with your GP?

I: I don't think so.

Y: What about accessibility to the GP? Is it easy to arrange an appointment?

I: No.

Y: Why?

I: The problem is we have fallen open, they won't book an appointment for two or three days, we had to book an appointment for that day! It was ludicrous! So, what my GP, I am not sure as I have not been for a few months and get a repeat prescription.

Y: But my GP is from 9 – 11.

I: So yours doesn't have an appointment system – you just go in?

Y: You just go in.

I: Well, we don't at ours – it's just an appointment system.

Y: Has the system been changed? Or is it different from one GP to another?

I: It's different from one GP to another.

Y: Is this something that is designed from the bigger system?

I: I think it is – everything is changing. I don't know if it is bad, but again, it's down to resources.

PR04

Y: Okay, we will be focusing more on your role as a nurse and the NHS and let me start by asking you what does quality and the NHS mean to you? As a nurse?

I: That's a really interesting question. Over the years there has been an increase and burdensome performance review agenda which supposedly about quality but I would question whether it is really about real quality. We have had various ways of looking at that by going right back to quality, indicative, setting standards, using audits, the instructions from Clinical Governance. I am not sure I could go back and know what is real quality and my perspective is that it is inherent within and the relationships we have with our service users and the way we can work collectively with them to try to improve their <not "lot" in life>, but certainly alleviate and support their stressful times. What I think about a mental health nurse we do that is unique and distinct talk a lot about care – what does care mean? That's a nebulous concept in the way that quality is, but one of the quotes I came across was the translation's of the work of Robert Percy – "The Art of Motorcycle Maintenance". It's a trippy, hippy book from the sixties, He talks about quality being about interaction between, in this instance, a mechanic and a motorbike, and then you get real quality when there is proper interaction and communication between what exists and I think there are parallels between my role as a nurse, talking about performance indicators and when I get it right.

Y: What are you meaning them to deliver in the NHS which makes a quality service?

I: We have to be able to demonstrate so we have standards ensuring safety, dignity, confidentiality. I think for me, what I should be doing as a nurse, is it's about making

nursing focusing on what I think it does best, which is the relationships we have with our service users, to make sure we get that right, and that we are hearing them and that we are responding to what their needs are, or what they are asking us for, and I think we have lost a lot of that. We have it in our structure, in our framework, in our policies, but we have lost sight of that. I think we need to get back to a more fundamental aspect which is much more about attitudes and values and not so much more about performance and outcomes. It's about getting the right values and attitudes, and then almost naturally you will have respect for, and humble, compassionate and concerns for the people you work for

Y: Can you give me an example of anything you have experienced that particularly made you feel you were giving high quality service?

I: I have spent most of my career working in acute inpatient services. For many of the people who have come into services, have been, or a significant proportion will have been detained under the Mental Health Act. They won't have wanted to be there. They won't have wanted to...take medication, be detained in one place, so you get people who are very frightened angry, very scared, very distrusting, and for me when I have done my job best is to make a judgement about when I need to step over that line and make decisions on their behalf which they maybe extremely unhappy about and that's involved some extreme things in terms of what I have done to people, such as restraining them, I've given them medication by injection against their wishes, I've stopped them from leaving, but when I've been through that process with somebody, and have managed to maintain a relationship with them, have the ability to make decisions in their own best interests has returned, has managed to keep some sort of contact of the process that

allows us to look at what went on and why there were in that situation, and why I had to make that judgement. And to have a relationship with that person. It's quite remarkable. When you look at the situations you get, I've had to give medication to somebody who though I was telling them they were a new born baby, I've had to fight with somebody who was so troubled with she thought she had springs in her head, she felt compelled to jump in front of a train, I've worked with people who thought I was an alien or a terrorist and had to intervene and that can be expely unpleasant for all concerned, but three days later, you say come and have a cup of tea, and talk to them about it and if I then encounter them further down the line, and they become well again, there is that level of recognition, even though things have been difficult, you can still preserve some sense of care and if I have to do things that you may not like or want, I will try my hardest to recognise within that, that I need to have humility and respect for you. I try to get it right.

Y: How you negotiate that relationship with the service users...OK...well,,,How do you act in this negotiation?

I: How do I act?

Y: Yes. As a practitioner and the service users. Do you act dominantly, do you use your power, or you, simply to negate power to the other users, because one of the common's are, you always hear, that practitioners have all the power, and we don't have any kind of power. We only get what will be offered to us. We don't get what we want.

I: Erm, er, I think er, to a large extent, that is very true. I mean, I think that there are some things that are erm, beyond negotiation almost. If somebody comes in, to hospital, under the Mental Health Act, and they are acutely disturbed as a consequence of some sort of

change in their mental functions, and they are sat here, <inaudible> and they become psychotic or paranoid, or whatever, and that then starts, erm, er, erm, and that culminates in behavoir which is dangerous, it, it puts me beyond the ability to negotiate, fully with the mind, gonna, sort of you know, gonna take control and ensure of their safety. But how I do that,.....how I use that power, I can use that in a really aggressive way: you've got this medication, I don't care, you can have it the hard way, you can have it the easy way, but you are going to have it....which would be...a much less.....erm.....or I can say.....I'm not really sure what is happening to you at the moment but I can see that it is distressing, I can see that it is causing difficulty for you, that you, you know, don't feel safe within yourself, I'm really worried about where that might lead you. I'm really worried that like, er, you're struggling to make sense of what is happening to you, an, and at the moment, you like, that I feel that, I need to do something to help you to help you got some of that control back andi know that you may not be happy about that, but I, I, I, I, I , bit I am really concerned that you are becoming overwhelmed with everything that is going on, it, it, it's hard so you know..so that, so that the way you, the way that you use language, the way that you use communication, can, can, you know, the same situation can have very different angles in terms of *how* disempowered, you know somebody is going to be disempowered, they are going to be, you know, stop <inaudible> but how they, sort of experience of it maybe different depending on how you sort of like, the thing that I think that,we're very neglect for was is the little things, it's like, you like, erm, we don't, er, we make the decisions about whether the kitchen is locked, you know, when the television goes off, erm, you know, when somebody can get some fresh are , and it's those things that I think that it would be so

much easier to relinquish our power over. <inaudible> In my point of view, if somebody comes to the office door, then I will try as far as possible, if somebody says I want a towel, I won't say "yeah yeah in five minutes and forget about it", I will try and respond, and I don't always get it right, you know, I can sometimes, you know, I, I, I'll fob people off, if you like as well, but I think it's, it's being, there are some things that are, are....well there are a lot less facility for negotiation, you know things about medication, to taming people, erm but behind that, there are all sorts of simple things, that actually just really compound erm, and make you sort of like...that sense of power is more profound for somebody I think.

Appendix 5

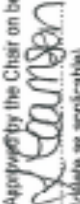
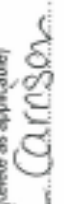
Examples of category labels used in data analysis

Main Area	Category	Sub-category
Quality	Tangibles	Treatment, Screening, facilities,
	Reliability	
	Assurance	Competence, Safety Knowledge Training
	Responsiveness	answering, involving, action, remedy
	Empathy	Values, Respect, Understanding Listening
Communication	Accessibility	Location / venue, Procedures, Status, Timing, Transport, Computer access, literacy, Exclusion
	Intelligibility	Accent, 2 nd language, jargon
	Information needs	
	Format	Written. Oral, Visual
	Channels	Face to face, Posters, electronic, letters, leaflets / brochures
Trust	Competence	Knowledge, skill
	Benevolence	
	Consistency	
Influences	Culture	
	Finance	
	Time	
	Conflicting interests	
	Individual characteristics	Education,

		experience, propensity, assertiveness, confidence
	Power relation	
	Image	
	Supervision	

Appendix 6_ Ethical approval

Hull and East Riding Local Research Ethics Committee (LREC)

Hull & East Riding Local Research Ethics Committee					
LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION					
For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.					
REC reference number:	03/02/104/107	Issue number:	1	Date of issue:	12 September 2005
Chief Investigator:	Mr Yasser Eid				
Full title of study:	Trust and Communication in Health Service – User-centered Research & Development				
This study was given a favourable ethical opinion by Hull & East Riding Local Research Ethics Committee on 05 September 2005. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.					
Principal Investigator	Post	Research site	Site assessor	Date of favourable opinion for this site	Notes ^(N)
Yasser Eid		HIMHT NHS Trust	Hull & East Riding Local Research Ethics Committee	05/09/2005	
Approved by the Chair on behalf of the REC:  (delete as applicable) (Signature of Chair/Administrator)  (Name)					

Appendix 7

Modelling the interview data



Figure 1: Provisional arrangement of themes and categories

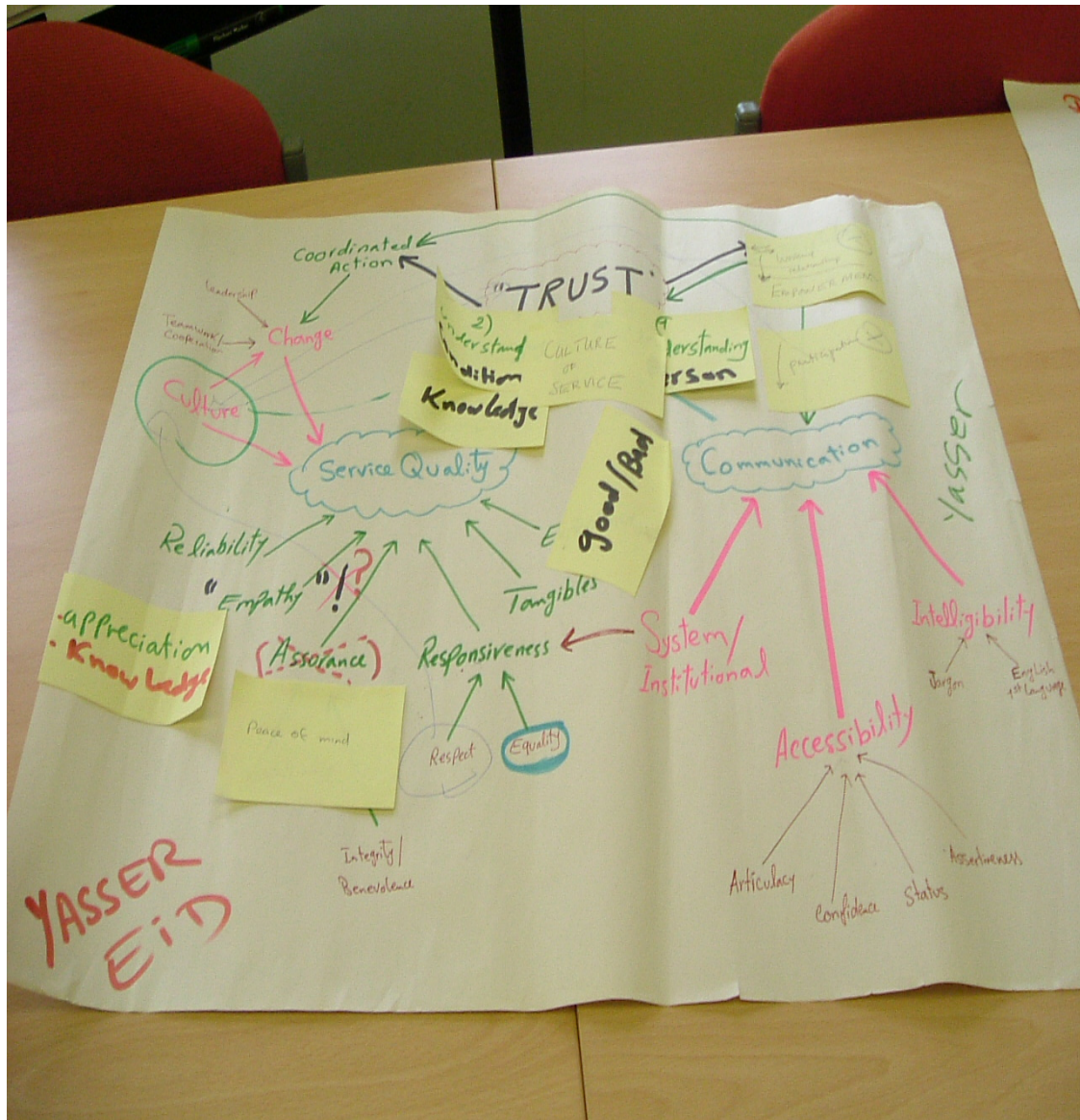


Figure 2: Developing the conceptual model



Figure 3: Service users' / carers' model (1)

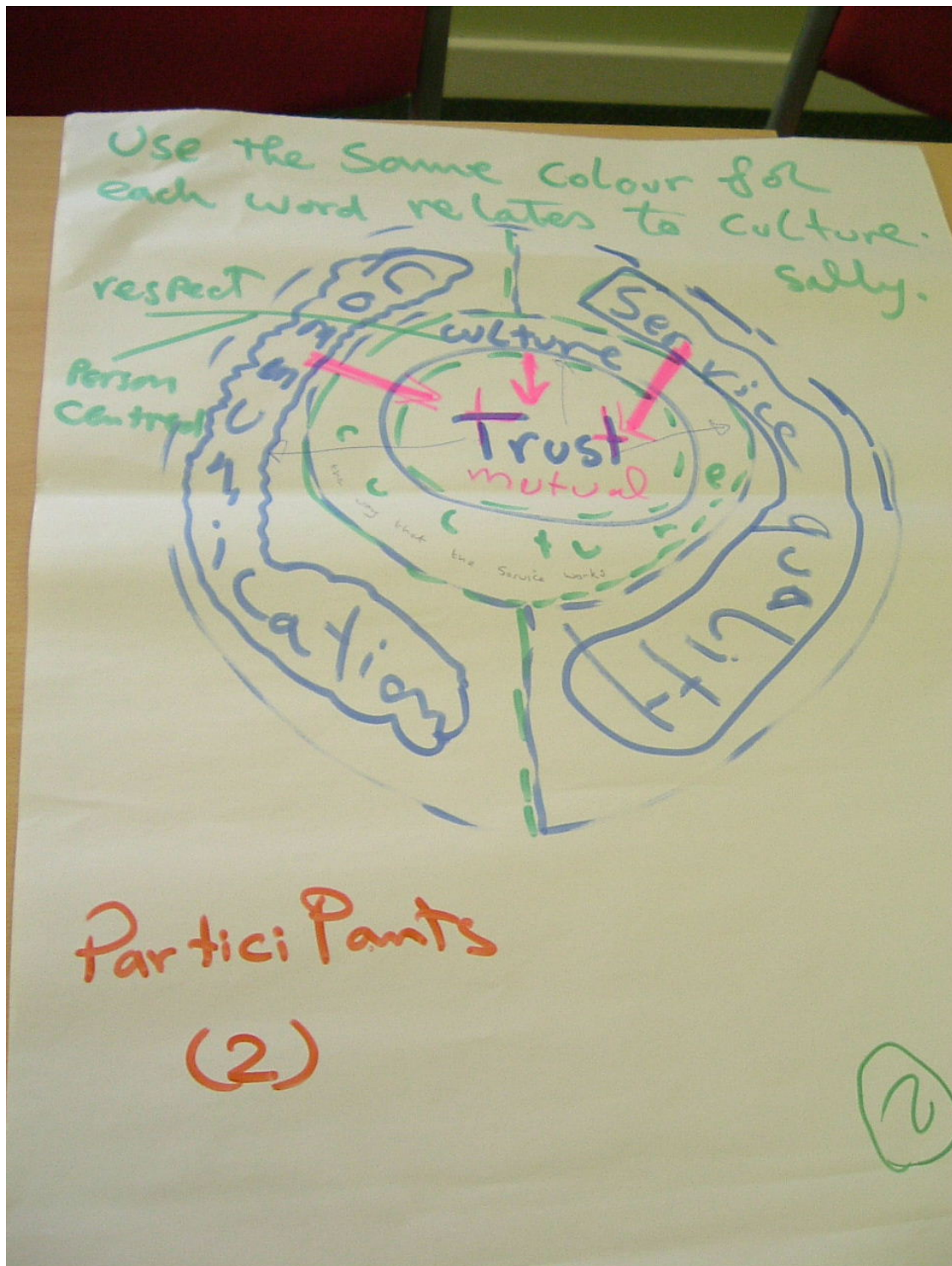


Figure 4: Service users' / carers' model (2)



Figure 5: Service users' / carers' model (3)

Appendix 8

Advantages and Disadvantages of Joint Meeting between SU/CA and PR

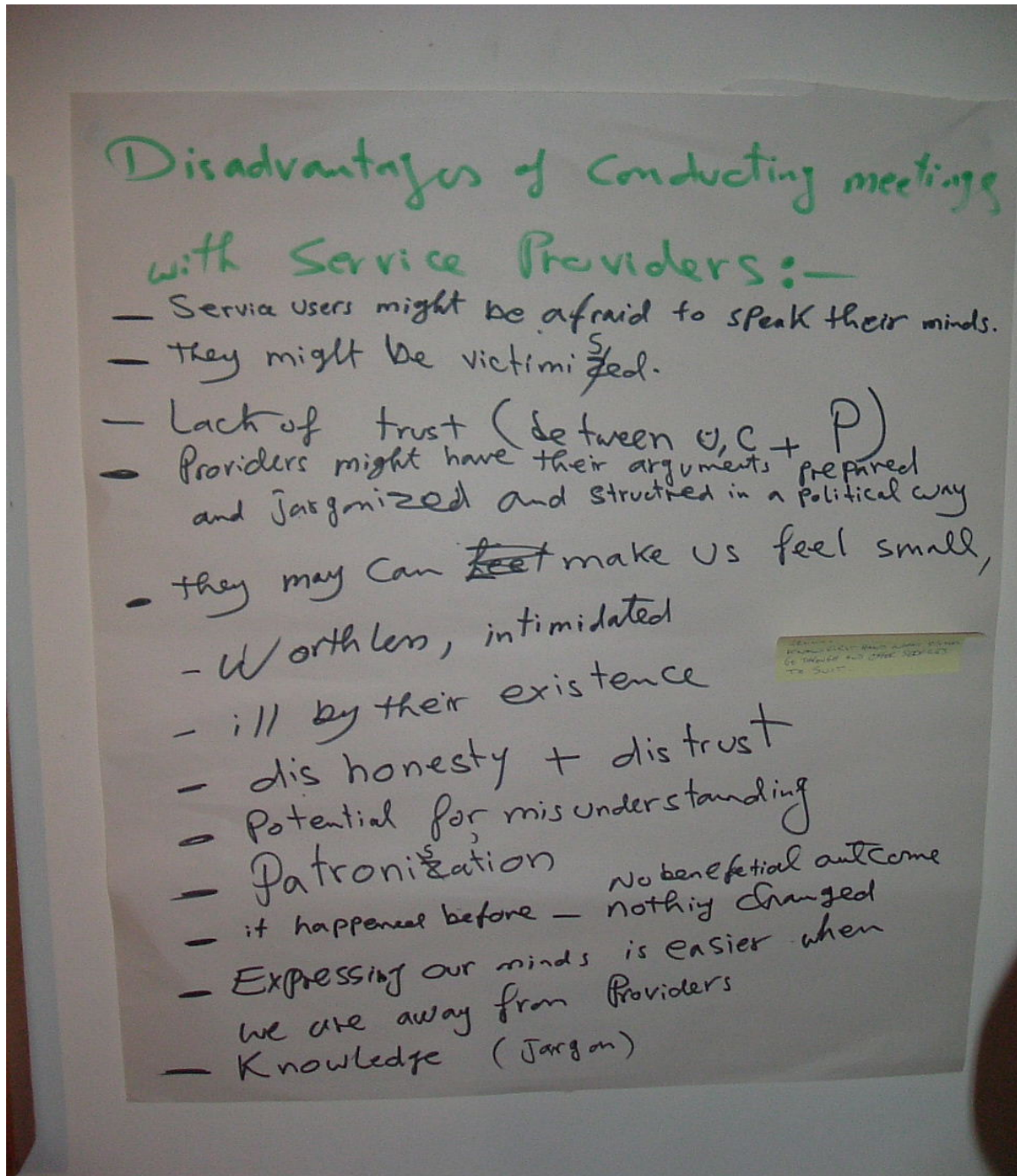


Figure 8.1. Disadvantages to SU from SU perspective

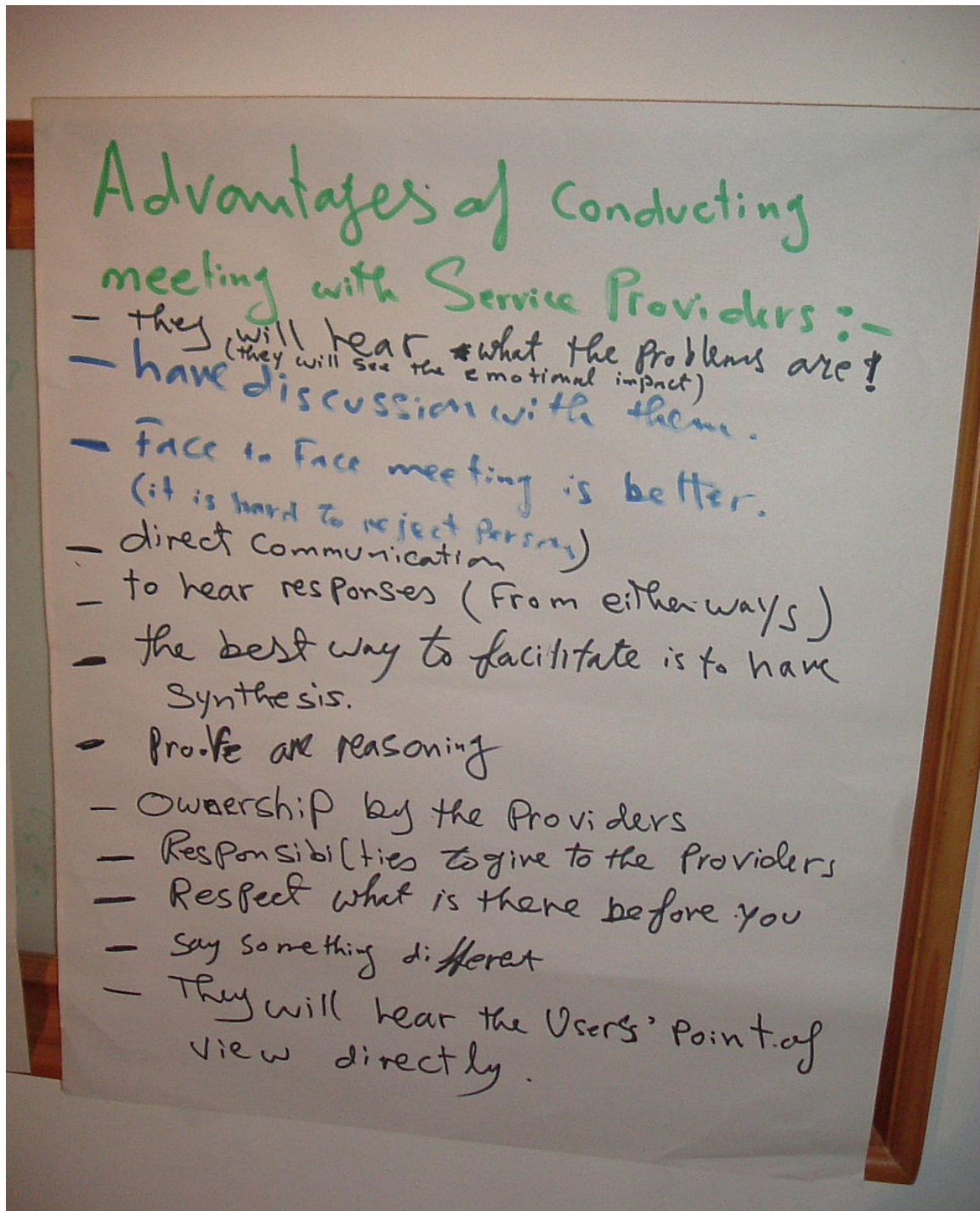


Figure 8.2. Advantages to SU from SU perspective

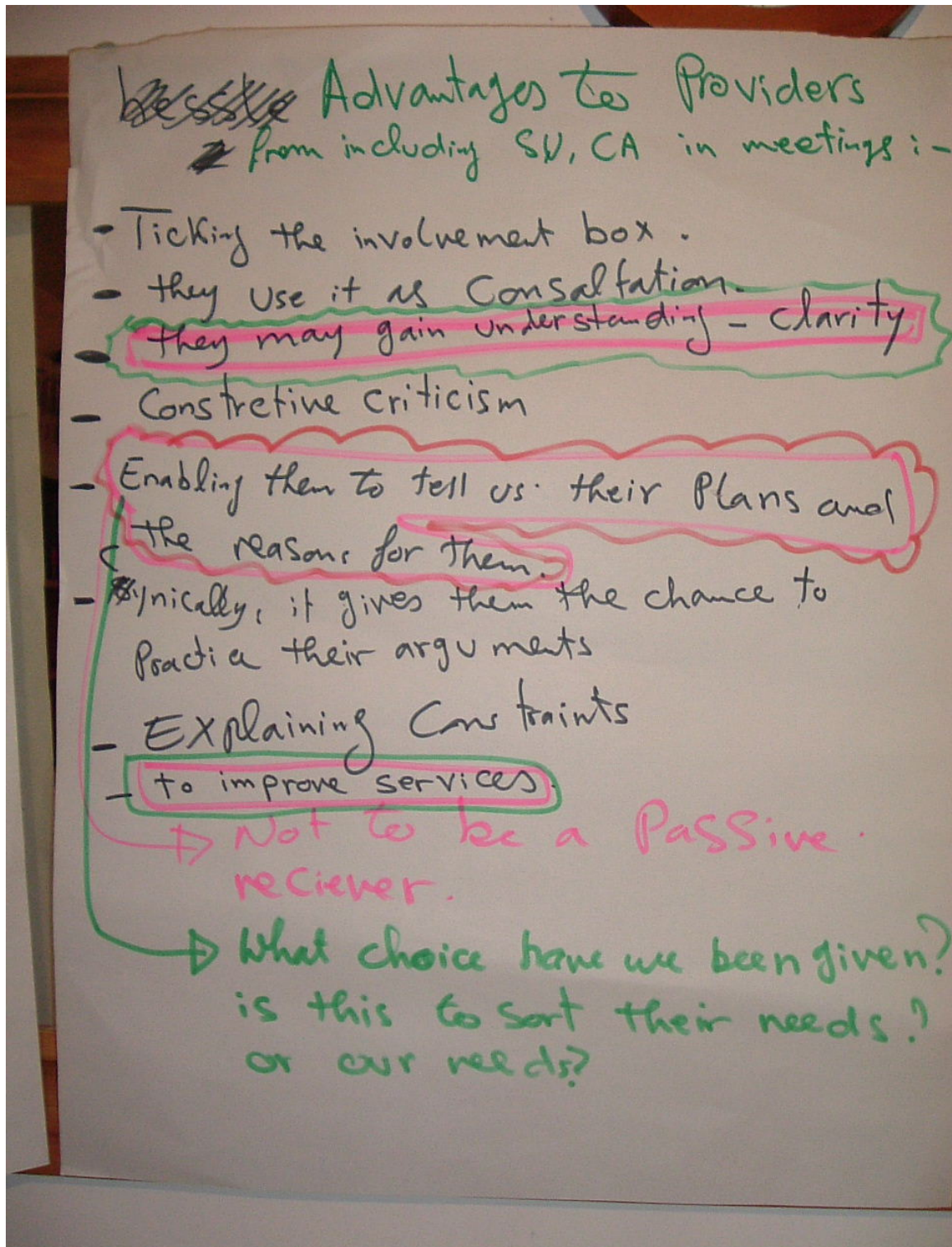


Figure 8.3. Advantages to PR from SU perspective

Appendix 8

Advantages and Disadvantages of Joint Meeting

a) (Expressed of 2nd group meeting by Service users and Carers)

Advantages to Users

- They will hear what the problems are (as they will see the emotional impact)
- Have a discussion with them
- Face to face meeting is better (it is hard to reject a person whereas you can simply reject a report or keep it away)
- Direct communication
- To hear responses (from either ways)
- The best way to facilitate is to have synthesis
- Prove are reasoning
- Ownership by the providers (when they decide to change / improve the service)
- Responsibilities to give to the providers
- Respect what is there before you say something is different
- They will here the users' point of view directly

Disadvantages to Users

- Service users might be afraid to speak their minds
- They might be victimised
- Lack of trust between users and providers
- Providers might have their arguments prepared and jargonised and structured in a political way
- They may make us feel small
- Worthless and intimidated
- Feeling ill by their existence
- Dishonesty and distrust
- Potential for misunderstanding
- Patronisation
- It happened before : No beneficial outcomes , nothing changed
- Expressing our minds is easier when we are away from providers
- Knowledge (jargon)
- The top management of the TRUST should all be people that suffer from mental illness, then they would know first hand what service users go through and offer services to suit.

Advantages to Providers

- Ticking involvement box
- They use it as consultation
- Cynically: it gives them the chance to practice their arguments
- Explaining constraints
- Constructive criticism
- They may gain understanding – clarity
- To improve services
- Enabling them to tell us their plans and the reason for them
 - Not to be a passive receiver
 - But what choice have we been given?
 - Is this to sort theirs needs? Or our needs

b) Providers perspective (Expressed in interview with PR 01)

Advantages to users:

- They can, if they choose, hear what providers have to say.
- Have a discussion with them
- It can help users understand what providers can or cannot do (but only if certain conditions are fulfilled).
- Service users can seek clarification of facts, terminology & meanings, legal and ethical position and of honest intention (again only under certain conditions).
- It is possible to get personal commitments to action.
- The words spoken come from the users themselves – no one else is presuming they know best. As in learning disabilities: nothing about us without us.

Disadvantages to users

- Meetings can be intimidating.
- The meeting might lead to conflict and distress for at least some participants because expectations of participants are not being addressed.
- Most meetings are organised very poorly and lead inherently to conflict where there are some individuals who are seeking confrontation – there are number of these in the service user community. The meetings are often set up in a committee style which itself is adversarial. There is a failure to use approaches like Open Space and if these are used they are constrained. It is as if there is a lack of trust at Board level in the ability of service users AND staff to talk about important things in a useful way!
- The high degree of conflict in meetings leads to the same few thick skinned participants remaining while more sensitive others will not participate – adversarial meetings discriminate against the interests of a majority.
- Providers are political in that their mission is to deliver policy – their customers are also politicians. Policy requirements and local needs are often in conflict and this leads to tension in meetings.
- Nothing changes much – so both patients and staff are sceptical even cynical about these meetings. Again Directors need to be convincing in rewarding patient and public involvement.
- Service users who do go to meetings have axes to grind, believe that they are “experts” in their own condition and in what will help. This is doomed because often they are not experts in their own condition, someone else can see things they cannot, and they are not typical of the community – no matter what the anecdotes say. Instead patient and public involvement is skewed by powerful political interests both amongst service users and in the Trust.

Advantages to providers

- Its required by law at certain times.
- It helps the Trust say it has consulted – even if the consultees were unrepresentative.
- It is good for public relations.
- There is little other benefit to the Trust as things stand. They wanted to make patient and public involvement simply a function of the Governors and membership of the Foundation trust (but this status has been delayed due to financial problems).

Appendix 9

List of some possible relevant systems

Communication systems

Resource allocation system

Carer involvement system

Ethics system

Treatment delivery system

Complaints – handling system

User participation system

Leadership system

Cross – discipline cooperation (teamwork) system

Quality audit system

Training system

Patient record system

Appointment system

Managing change system

Crisis / emergency response system

Public relation system

Organisation learning system

Patient welcoming system (1st point of contact)

Governance system (Quality & Risk)

Information system (in the sense of MIS)

Performance management system

Standard – setting system

***Red = High priority**

***Blue = Example proposed by the researcher to enable the users to understand how it works**