IMPROVING THE QUALITY OF OUTPATIENT SERVICES IN NHS HOSPITALS -SOME POLICY CONSIDERATIONS

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Introduction

In recent years, successive British governments have applied themselves to the task of improving the quality and efficiency of the public services in the UK. One particular strand of policy has been to 'privatise' or at least to 'market test' a range of services, on the assumption that a private sector philosophy is better able to deliver the quality of services that the public demands. Another strand of policy, running in parallel with the former, is to publicise various standards in the forms of Charters (e.g. Citizen's Charter, Patient's Charter) and then monitor and publish the performance of public sector bodies in meeting the obligations imposed upon them.

This paper will take one such 'charter' i.e. the Patient's Charter and will examine the way in which one important aspect of it - the waiting time that people spend in outpatient clinics - has been operationalised. After examining some case study material which explores how improvements may have effected, the paper then considers whether the broader objective of the policy (greater efficiency and effectiveness of the Hospital Service) has actually been achieved.

The concern over hospital 'waiting times'

In NHS hospitals, there are approximately 40 million outpatient attendances a year at a cost of some £1.2 billion [1988-89 figures] according to the National Audit Office [1]. About one-fifth of such attendances may be new referrals as a result of referral by a GP. The remainder are due to second or subsequent visits or, more typically, follow-up consultations following a period as an inpatient. The fact remains

that, for many people, the experience of treatment in an outpatient's department is their main experience of the hospital service. When questioned, many patients testify to the excellence of treatment that they have received and are understanding of any shortcomings in the service that they may have experienced. Nonetheless the one consistent feature of dissatisfaction which has been expressed with the outpatient service is the length of waiting time in the outpatient clinic.

Concern over long waiting times in clinics appears to have been a consistent source of dissatisfaction. Evans and Wakeford [2] report that the main criticism of outpatient services was the lengthy waiting time, compounded by an absence of explanation. Nor had the situation improved by the 1980's. Jones, Leneman and MacLean [3] as a result of their literature search indicate that although satisfaction levels were very high, most discontent was expressed over the length of waiting time and the provision of amenities whilst waiting.

In the 133 clinics surveyed in the National Audit Office sample, it was found that the average waiting time was 30 minutes or less in only 47% of clinics. A comparable finding is reported by Cartwright and Windsor [4] although their data was collected in the Spring of 1989 :

Table 1 : **Waiting times in Clinics- National Sample (1989)**

Time spent waiting	Cumulative Percent	Proportion who found wait un-reasonable
Less than 10 mins	11%	11%	2%
10 mins - < 20 mins	18%	29%	2%
20 mins - < 30 mins	16%	45%	2%
30 mins - < 45 mins	14%	59%	10%
45 mins - < 60 mins	13%	72%	34%
60 mins - < 90 mins	13%	85%	44%
90 mins - <120 mins	9%	94%	61%
120 mins or more	6%	100%	77%
All outpatients	639		23%

Source : Adapted from Cartwright and Windsor (1992):
Outpatients and their Doctors Table 26, p. 59

It is interesting to observe the tolerance expressed by the vast majority of patients for waits of up to half-an-hour, after which time their tolerance understandably diminishes. The '30 minute threshold' was incorporated into 'The Patient's Charter' [5] as a National Charter standard i.e.

> 'you will be given a specific appointment time and be seen within 30 minutes of that time'

The definition of 'waiting time' is defined in 'The Patient's Charter' as the time between an appointment time and the start of the consultation or treatment period. The National Audit Office study actually used three different methods to calculate an average waiting time :

- Time between appointment time and the start of the consultation (43 of 133 clinics)

- Time between arrival time and the start of the consultation (45 of 133 clinics)

- Waiting time estimated periodically throughout the clinic (45 of 133 clinics)

and if we were to use only the first of these definitions, then the proportion of clinics with an average waiting time of 30 minutes or less rises to 58% in the NAO study. Note, however, that this figure relates to the number of clinics rather than the patients who attended them.

Leicester General Hospital - a case study

Leicester General Hospital is a medium to large size teaching hospital located some four miles from the city centre in a suburban location to the East of Leicester. It is one of the three major acute provider units within the Leicestershire District which collectively serve a population of half a million people, including a high concentration of the population of Asian ethnic origin. The hospital has some 700 beds and provides some 100,000 episodes of outpatient care each year. These figures are projected to rise over the next few years.

As soon as 'The Patient's Charter' was published in the Autumn of 1991, Leicester General felt that a more systematic recording of outpatient waiting times was needed. Accordingly, the Department of Quality Assurance together with the

assistance of the author instigated a pilot study the aims of which were to determine a baseline for waiting times and to establish a sound methodological base for further measurement work.

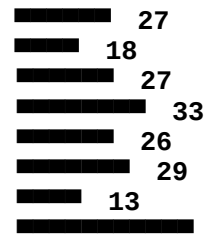
The results of the pilot study (n=220) are indicated below and showed waiting times which, at that time, were considered very much in line with national standards but nonetheless capable of improvement :

Table 2 : Waiting times in Clinics- Leicester General (1991)

Waiting Time Pilot Study [December, 1991]

Value Label	Frequency	Percent	Cum. Percent
Before time	27	12.3	12.3
0 - 10 mins	18	8.2	20.5
11 - 20 mins	27	12.3	32.7
21 - 30 mins	33	15.0	47.7
31 - 40 mins	26	11.8	59.5
41 - 50 mins	29	13.2	72.7
51 - 60 mins	13	5.9	78.6
60 + minutes	47	21.4	100.0
TOTAL	220	100.0	100.0

WAIT_ Waiting Time - 10 minute blocks



Valid Cases 220

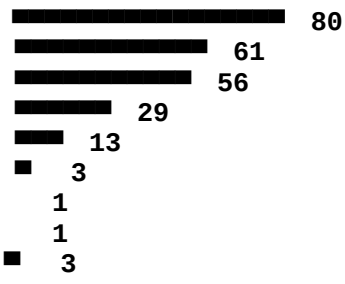
After an intensive program aimed at reaching 'The Patient's Charter' standards, the following sample results were obtained in March, 1993 and this improvement has been maintained, or indeed exceeded, ever since. However, as will be demonstrated later, the global figures given below understate the full extent of the progress made.

Table 3 : Waiting times in Clinics- Leicester General (1993)

Waiting Time - Sample of 31 clinics [March 1993]

Value Label	Frequency	Percent	Cum. Percent
Before time	44	15.1	15.1
0 - 10 mins	80	27.5	42.6
11 - 20 mins	61	21.0	63.6
21 - 30 mins	56	19.2	82.8
31 - 40 mins	29	10.0	92.8
41 - 50 mins	13	4.5	97.3
51 - 60 mins	3	1.0	98.3
61 - 70 mins	1	0.3	98.6
71 - 80 mins	1	0.3	99.0
80 + mins	3	1.0	100.0
TOTAL	291	100.0	

WAIT_ Waiting Time - 10 minute blocks



Valid Cases 291

Measurement and Data Collection

A pilot study indicated that it was crucial to collect succinct yet accurate information from which to derive waiting time statistics. The data was collected by nursing staff for each patient in the clinic in the sample. The importance of accuracy and legibility were stressed and validated data files were then prepared using dBASE III+. The data files were validated by being input twice by each operator and the two resulting files then compared with each other using a checksum program. (The error rates, before correction, were recorded at 1 per 3,000 keystrokes or approximately 1% of all record cards). It was felt very important to ensure that the data had the maximum degree of credibility to forestall any potential criticism of the data when results were presented back to consultants. The data files were then used to prepare statistical reports on a monthly basis. Use was made of a custom-made dBASE program as well as a suite of low-cost survey analysis programs (TURBOSTATS) recently published by the author [6].

The complete system of monitoring and statistical analysis was known by the acronym MOPAL (Monitoring of Out Patient Activity in Leicester) and the methods employed in its utilisation have been more fully detailed elsewhere [7]. The collection of detailed statistical information in order to better plan services is being tried in several outpatient departments. The approach followed at Leicester, although developed independently, bears similarities to that documented by Lal. *et. al.* [8]. A somewhat more complex computer program, QC Wait, developed at the Royal Hallamshire Hospital, Sheffield, has also been shown to more than halve waiting times [9]. A simpler method which concentrates upon synchronising the planned and actual clinic start and finish times is described by Mannion and Pryce- Jones [10]. In this instance, too, providing consultants with charts of the planned v. actual clinic start and end times was the impetus for changes in clinic start times, jointly agreed with clinicians and management.

Measurement Problems

Any attempt to quantify means that the analyst has to make 'operational definitions' and sometimes has to make measurement 'by fiat'. Decisions taken by one analyst, although rational in the light of circumstances prevailing at the time, may not necessarily be taken by another. To indicate some of the problems of measurement problems, four illustrations will be drawn from the case-study.

'Lateness'

What can be said to constitute lateness? A measurement system that records to the minute will classify even a person who is one minute late as 'late' - should such a patient be regarded in the same light as the patient who is 30 minutes late ? Does the Patient's Charter apply to those patients who are late for their appointments, whatever the reason ? In the event, a practical decision was taken to regard as 'late' all those who arrived more than 10 minutes after their appointment time. Those classified as 'late' were liable to have missed their appointment slots in any case but could be statistically removed to give a more clear global picture.

'Ambulance Transport'

Patients being delivered to an outpatient's department by ambulance have little control over their arrival times. An ambulance service, coping with its own logistical and traffic difficulties, could well deliver patients well in advance or later than their stated appointment times. This factor, too, needs to be recorded so that the waiting time calculations can be adjusted if necessary. Similarly, the hospital may well need this monitoring data when negotiating contracts with their 'supplier' ambulance services.

'Consultation time'

Consultation times, particularly if they show marked differences between 'new' and 'continuing' patients, need to be recorded so that future clinics can be planned in the light of past trends. For example, at Leicester one clinic's data revealed that 'new patients' needed to be seen for nearly an hour whilst the average for 'continuing patients' was 17 minutes. But the recording of consultation time could be fraught with difficulties. Patients could be seen by both junior and more senior clinicians, or be seen in several episodes in one 'consultation' as they needed to be sent to other hospital departments for particular investigations and so on.

Average' waiting times

On occasion, patients might arrive 'early' for a consultation and be 'slotted in' to take the place of another 'DNA' (did not attend) patient. In such a case, they would have been seen before their actual consultation time proper. In such a case, should the waiting time be regarded as 0, or be regarded as a negative quantity? If the latter, this could impact upon the *mean* waiting time (although the impact is less heavy if the median were used as a measure).

Output

In any one month, sufficient clinics would be sampled to give a respectable sample size whilst at the same time ensuring that no clinic of any significant size was omitted in a four month period. To avoid the fluctuations associated with small clinics, the data was aggregated for each consultant.

In a typical monthly reporting period, two fortnightly clinics would have been held although for some specialities it was more. Reports were then prepared for each consultant whose clinics had been analysed and the results of the exercise discussed with the individual concerned. This approach almost exactly parallels that described by Ross [11] in which

> 'the key seemed to be to gain the clinicians' understanding and acceptance through presentation of accurate and relevant data'

Various key features of the output were used to take remedial action to improve waiting times in future clinics.

Statistical summary

The statistical summary provides interesting management and clinical information. The median waiting time is calculated and this is likely to give a more accurate 'spot' picture of the average waiting time than a mean. The person with the maximum waiting time is identified so that remedial investigation can be undertaken (and perhaps a letter of apology sent in extreme cases) The statistical summary also provides a 't'-test of differences in waiting time for the 'ambulance' v 'non-ambulance' patients to see if a particular pattern is discernible there. But probably the most useful statistical information of all is the calculation of the average consultation times both

for new and for continuing patients. The sample data revealed that new patients needed a much longer consultation time (as one would expect) of 57 minutes whilst for continuing patients, the average was 17.0 minutes. Armed with this kind of data for each clinic, it should be possible for clinicians and managers to arrive at a schedule of appointments that more fully reflects the pattern of patients in attendance. A sample of some of the outputs in the statistical monitoring is shown in *Appendix 1.*

Implementation

Whilst the provision of good quantitative data is an important prerequisite for the management of organisational change, it is important to stress that it can never be a substitute for effective management. Given the backdrop of the monthly monitoring reports, consultants and management worked as a team, to discover ways in which obstacles to better performance could be removed and better modes of clinic organisation achieved. Of course, there are some significant sources of un-predictability (principally consultants and/or junior doctors being called away to attend to emergencies elsewhere) but over an eight month period the improvements in median waiting times were remarkable.

Given the prominence of health in the current political agenda, it is not a source of surprise that a more aggressive managerialist culture is being imported into the NHS. However, the experience at Leicester tends to reinforce the classic view of the social psychologist, Rensis Likert [12] that a more participative management style generally produces greater involvement of individuals and higher productivity. Put bluntly, an approach which appeared to 'threaten' consultants with an adverse set of reports would not have achieved the desired organisational change. But an approach in which management and consultants worked together to meet the externally imposed standard set by 'The Patient's Charter' effected the improvements needed in a remarkably short space of time. The case study by Wilson [13] lends support to the fact that improvements in the service provided by outpatient departments can be effected by good teamwork amongst the whole clinic staff.

The Leicester case study reinforces the view that the provision of monitoring data by itself does not guarantee the necessary organisational change. In the Leicester case, statistical reports were mulled over by management and consultants working together to remove obstacles to higher performance. Such negotiations

were not always smooth - evidently some consultants reacted adversely to attempts to cast a ruler over their clinic activities. But these were persuaded in time and a culture change was effected by a policy of constant communication between statisticians, management and the consultants themselves. This process was assisted by the data collection techniques used. Great care was taken over the validation of the data input, to ensure there was not a 'GIGO' (Garbage In, Garbage Out) effect. The fact that the data was analysed quickly and in the form of results that were locally accessible helped to ensure data quality and reliability. One of the besetting 'sins' of the NHS is that there appears to be much 'data' generation but insufficient 'information'. When ward staff input data for a variety of control statistics but never see the end results to which such data is put, then there is no incentive to keep data quality high. Indeed, the standard commercial practice of data validation (entering data twice as a check on accuracy and then checking for and resolving inconsistencies) is practically unknown. The Leicester case study demonstrated that staff at all levels can be motivated to record data on their own performance if the results are fed back to them in a reasonably short period of time and improvements can be effected as a result of the monitoring action taken.

Are the measured improvements 'real' ?

The case study revealed that Leicester General had increased the proportion of outpatients seen within 30 minutes of their stated appointment from less than 50% to around 80%. The "NHS Performance Guide" (popularly known as Hospital League Tables) indicates that the national norm in 1994-95 was as high as 88%. [14] So can the public be reassured that the quality of service offered to them by their local hospital has improved as a result?

The principal difficulty for the analyst (although not for his political masters) is the knowledge that there is only a very imperfect relationship between the measure and the reality it purports to describe. It is theoretically possible that the measured quality of service is shown as increasing whilst the actual quality of service is diminishing.

Some logical possibilities are as shown in the following table :

Table 4 : Relationships between indicators of quality and perceptions of the service

Single Indicator	More complete measures of service	Perceptions of the service
Could show an IMPROVEMENT (e.g. 50%->80% patients seen within 30 minutes)	Better overall quality of consultation offered	Better (higher satisfaction score)
		Same (equivalent satisfaction score)
		Worse (lower satisfaction score)
OR NO CHANGE OR	Same overall quality of consultation offered	Better (higher satisfaction score)
		Same (equivalent satisfaction score)
		Worse (lower satisfaction score)
a DETERIORATION (e.g. 80%->50% patients seen within 30 minutes)	Worse overall quality of consultation, offered (e.g. 'rushed')	Better (higher satisfaction score)
		Same (equivalent satisfaction score)
		Worse (lower satisfaction score)

Single measure

This is a 'headline figure' such as an unemployment statistic or an exchange rate. Politicians and Government ministers will not generally be concerned with the niceties of the problems of the operationalisation of performance indicators but will look for a measure that is easy to understand and to advance in public debate as 'proof' of the success of current policy.

If the 'single measure' does not move in the predicted direction, then Ministers may well be briefed with some of the inadequacies of the indicator.

More complete measures of service

These would include several quantitative indicators and probably some qualitative indicators as well. To measure the improvement in the quality of out-patient clinics more completely, we should need to derive measures of the quality of the interaction between patient and consultant. For example, did the patients fully understand what was being communicated to them by clinical staff? Were the consultations without undue regard to time pressures or did the consultant(s) feel a subtle pressure to 'rush' consultations in order to comply with clinic appointment timetables?

Here, it is evident that it is quite possible that the quality of outpatient service has actually declined despite the fact that the 'system norm' seems to have shown some dramatic improvement. Without further more specific investigation, it is hard to reach a conclusion. However, there is ample evidence in other policy spheres which indicates a lack of congruence between an indicator and the reality it is designed to illustrate. One could cite, for example, the fact that successive generations of politicians have argued that educational standards are rising in Britain (measured by the numbers and distribution of grades at GCSE 'Ordinary' level and GCE 'Advanced' level). However, there is now a broad agreement across the political spectrum that the 'real' quality of the output of the British educational system has been declining over the years.

Quantitative indicators are nearly always seized upon because they measure that which is measurable rather than that which is significant. Conversely, the type of qualitative indicators that could be employed to give more rounded pictures are typically regarded with a degree of suspicion. Qualitative data may be seen as being 'soft' rather than 'hard' data (in scientific terms) and suffused with either individual values or political partiality.

However, to derive a complete set of measures of a phenomenon a range of both quantitative and qualitative measures is probably necessary. The qualitative measures may have to be provided by independent 'experts' but this runs counter to the received Whitehall philosophy that experts should be 'on tap but not on top'

Perceptions of the service

Should the members of the public be the ultimate arbiters of the quality of the public services delivered to them ? On the one hand, it is possible to point to the increased emphasis on citizens as the consumers of services rather than the mere recipients. However, as Pollitt [15] observes

> Do 'consumers'(users) understand what is on offer? Are they likely to know what will work best for them, in terms, say, of medical treatments or pedagogic strategies in educational institutions? Are they cognizant of resource constraints, or will they ask for the impossible? What will become of the professional service providers- will they be effectively 'deskilled', deprived of most of their discretion and made slaves of the latest public fad or fashion?

A popular technique to ascertain the public's views of service quality, although much abused, is the 'Consumer Satisfaction Survey'. Although much used in the NHS where they are often perjoratively termed 'Happy Sheets', it is hard to come to a view how we are to arrive at a scientifically respectable survey of consumer satisfaction without recourse to some survey method.

One perennial problem is that badly constructed questionnaires can always elicit the type of responses that managements want to hear. Leaving this problem on one side for the time being, it is still true as indicated in the quote above that consumers may only have the haziest notion of the quality of the service that they are actually receiving. It is not inconceivable that patients could judge the quality of their outpatient experience to be high because they have now more up-to-date magazines through which to browse whilst awaiting their consultation. Conversely, the quality of medical treatment could be increasing but due to the 'revolution of rising expectations' the consumer satisfaction survey could appear to indicate an drop in the overall perceived quality. So the relationship between the consumers' sampled views and the quality of the service that they have experienced may well be a tenuous one.

How may we determine the quality of a service?

The very term 'quality' is now invested with a degree of significance which suggests that the word is more of an 'emblem' than a useful concept with which to guide public services. Five ways of attempting to achieve 'quality', however defined, will now be delineated in order to advance the debate over the nature and

types of performance indicators currently in use. These approaches are not mutually exclusive, however, and are meant to be suggestive rather than definitive.

1. Establish, publish and monitor 'standards of performance'

This is the approach which has been epitomised by the Major administration since 1992. After the Citizen's Charter, there is now a proliferation of other Charters (e.g.Patient's Charter, Parent's Charter) of which probably the more important are those concerned with health and with education. (It is instructive that all the Charters are defined in terms of the individual's rights and obligations rather than the expression of collective rights - hence we have the Patient's Charter but not the Patients' Charter!)

The approach here is to establish (but how?) certain standards and then to publish League Tables by means of which the citizen as consumer can evaluate the performance of locally provided services. It would be an interesting exercise to see whether the provision of such information alters the behaviour or perceptions of members of the public in any discernible way. To many people, the exercise is essentially irrelevant as they little choice but to attend a local hospital or to send their children to a local school. The cynical would no doubt argue that these exercises further empower articulate and vociferous members of the middle classes who probably benefit disproportionately from the public services in the first place. The evidence must remain anecdotal until further research has been conducted.

2. Set up Quality Assurance(QA) units/procedures

One organisational solution to improving the quality of the service provided is to set up intra-institutional and extra- institutional bodies charged with the task of monitoring 'quality'. Again, this approach is most typically to be found in higher education and in the hospital sector where bodies with similar titles ('Quality Assurance Unit') will be found.

Organisations attempt to both produce higher standards of performance and to demonstrate this fact to themselves and to their paymasters by promulgating various

standards and cajoling/threatening subunits of the organisation in order to achieve them. However, as the concern over BS5750 indicates, the provision of a mechanism to attempt to secure a quality product is not the same as actually providing the quality, however measured.

The QA industry itself runs the risk of measuring the quantifiable rather than the significant. So-called 'objective' indicators such as waiting times, treatment rates, examination successes, non-completion rates and the like are recorded, scrutinised and sometimes agonised over but the relationship with that they are attempting to measure often 'glossed over'. It is possible to see multiple 'displacement of goals' so well illustrated in Blau's "*Dynamics of Bureaucracy"* [16] in which over-adherence to the measures employed (statistics of numbers in jobs) could subvert the overall mission of the organisation (to provide a suitable match between vacancies on offer and candidates for employment). So 'the operation was a success but the patient died' may unwittingly become true in a host of publicly provided services in which the measure of the organisations success becomes more important than its fundamental objective.

3. Remove evident sources of dissatisfaction

A once-prevalent theory in industrial sociology was that associated with Hertzberg and his 'Motivation-Hygiene' theory. Succinctly, this stated that job satisfaction could be seen as a resultant of 'satisfiers' (factors conducive to job satisfaction) and 'dissatisfiers' (those factors not conducive). The removal of dissatisfiers did not necessarily increase satisfaction as such but evidently removed sources of discontent. Borrowing this concept and applying it to public services, it could be argued that more attention should be paid to removing those aspects of public service delivery that people find particularly irksome. To some extent, this was true of the 'Outpatients' case-study since previous findings had well documented the fact that long waiting times in clinics were a constant theme of dissatisfaction.

When we couple this argument with the observation from quality control circles that 90% of problems can be attributed to 10% of cases, then it is possible to construct a policy to remove those identified sources of

dissatisfaction. This argument may sound unduly negative - even in the original Herzberg formulation the removal of 'dissatisfiers' does not necessarily increase the amount of satisfaction with the service. But it does remind policy makers that trying to increase the quality of services may well be thwarted if evident sources of dissatisfaction with the services on offer are allowed to fester.

4. Management by 'sample monitoring'

Tom Peters, the management 'guru' has advocated a policy of Management by Walking Around i.e. those charged with responsibilities should attempt to experience the realities of the organisations they manage by 'walking around' them. Although this idea sounds incredibly trite, it does form the basis of some quality control mechanisms within both the public and the private sectors. Hotels and restaurants are aware of the 'one bad meal' effect and are aware of the fact that one of their customers could be the anonymous inspector from a rating agency or a Hotel guide. In the public sector, too, Her Majesty's Inspectors of schools were encouraged to gather sense impressions of the schools that in theory they could visit unannounced. The independent Inspectorate of Prisons can perform a similar service for penal establishments.

One has to counterpose two ways in one could judge the quality of a public service. On the one hand, there is the 'bureaucratic filter' in which, through a series of monitoring statistics, it is possible to gain an overview of the 'health' of a service. On the other hand, we have the less scientific but in many ways more intuitive approach in which services are monitored as they experienced by typical members of the public. The two approaches parallel a dilemma well known to methodologists. The 'scientific approach' relying upon statistical data may score highly on representativeness but loses out on the reality of the service as experienced by clients ('ecological validity'). But the alternative approach, relying heavily upon sample experiential monitoring, may be criticised for over- generalising from one or two, possibly unrepresentative, instances.

There is no reason why these two approaches should not be combined and when they are, the results may be highly unpredictable. After the publication of 'Hospital League tables' journalists descended upon some of the hospitals officially rated as not meeting the required standards of service but found that members of the public treated by those hospitals seemed as satisfied as patients treated elsewhere.

5. Using customer satisfaction surveys

Reference has already been made to the fact that customer satisfaction surveys are capable of manipulation (either deliberately or through poor design). The sampling methods are often poor and the quality of the data suspect. Nonetheless, there is no reason, in principle, why survey methods cannot be refined by the use of more focused interviewing, to help to derive some indicators of quality.

There is some evidence that surveys can act as 'window dressing' and as an apparent attempt to consult the users of services without taking the results very seriously. The key to using customer satisfaction surveys could well be to place them in the hands of 'independent' consultants such as local universities rather than in the hands of local management themselves. In this way, there should be better control over the standards of sampling, treatments of non-response, quality of questionnaire construction and so on.

One of the problems of using a survey method to determine satisfaction is that of expense. If a survey is to be conducted according to normal scientific rigour, then recourse has to be had to methods of random sampling rather than quota sampling and the respectability of the results has to be bought at a price. The 'quick and dirty' types of survey do not cost so much to conduct, but neither do they command much respect. The providers of the service could be resentful of the amount of money spent on the monitoring function which could be better diverted to improving the quality of the service they themselves administer.

Evaluation of different approaches to quality maintenance

The thrust of recent British policy has concentrated on the first of these approaches and recent pronouncements have indicated that 'league tables are here to stay' But the 'league tables' will always have such a multiplicity of measurement problems that the comparability that they attempt to demonstrate is constantly jeopardised.

The case of the recently published 'Hospital League Tables' is a case in point. The Audit Commission attempted to achieve comparability in the data by refusing to grade with a star those aspects of service in which the data collection standards failed to achieve certain minimum standards. Immediately after the publication of the results, several anomalies came to light. Some hospitals who were upgrading computing facilities chose not to present data rather than presenting incomplete data and so received 'bad marks'. Another hospital's waiting times were made apparently worse because the Audit Commission insisted that an extra 2 minutes should be added to the average waiting time, this being the time taken from patients walking from the front door of the hospital to the reception desks of their clinics. Given also the management imperative to 'get as many stars as possible' then various data were undoubtedly selectively reported or 'bent' so as to present apparently favourable outcomes.

It could be argued that any of the alternative approaches outlined above might have generated better quality control mechanisms than the 'league table' approach. But from the viewpoint of the political machine, there are no 'headline figures' to report and the results are less easy to communicate in a populist fashion. The 'league table' approach to the monitoring of the quality of public services can be interpreted more as an instrument of crude political control than a genuine desire to report on the quality of services offered to the public. However, so far 'league tables' have been greeted with a certain amount of indifference by the public who prefer to accept the evidence of their own experiences rather than the more dubious public comparisons with which they are being bombarded.

The provision of 'league table data' may also be seen as providing the market with more information with which consumers can 'shop around'. If desirable goods (such as high quality hospitals, schools) are scarce then a rationing or allocation system is inevitable. The provision of data, crude though it may be, is one way of trying to discern the debates over 'who gets what?' Put crudely, local catchment areas are liable to be the prime beneficiaries of such quality public services but the provision of more information may well enable more powerful social groups to claim access to such services. For example, popular 'high quality' schools should, in theory, be allowed to expand, whilst 'poorer quality' schools should wither on the vine. The full implications of these policies have not been modelled or even worked out in practice. But it is not difficult to conceive of a situation where overall quality declines as 'popular' services have to deal with uncontrolled expansion whilst 'less popular' services attempt to manage with a declining resource base.

The 'league table' approach conflates measurement and control of quality issues with the distributional questions of 'who gets what?'. A lurking suspicion must remain that the distributional questions are of more importance that issues of quality 'per se'. The fundamental issue of the measurement of the quality of public services cannot be addressed without much more sensitive monitoring and measurement than has been witnessed recently.

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Appendix 1

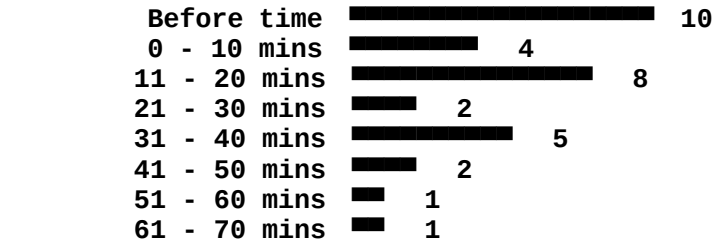
Table 5 : Statistical summary form (Leicester General)

```
Consultant: CONSUL_X  Month : AUG  [ File: CONSUL_X.AU!]
=======================================================

Labels [ID] of patients arriving 10 + minutes late
--------------------------------------------------

Record#  date       id
     1  05/08/92 266326
    32  12/08/92 569204
    33  12/08/92 187460

    N=   3   [ 9.1% ]

Arrival and appointment times for ambulance patients
----------------------------------------------------

Record#  date       id arrival appoint  mins_early
     1  05/08/92 366428   10.05   10.45        40
     2  05/08/92 183372   10.20   10.00       -20
     3  05/08/92 741546    9.55   11.15        80
     4  05/08/92 210234    9.55   10.00         5
     9  05/08/92 867648   10.00   10.00         0
    20  12/08/92  25770    9.45   10.00        15
    21  12/08/92 413674    9.55    9.30       -25
    22  12/08/92 143965   10.15   11.30        75
    23  12/08/92 448066   10.15   10.30        15
    24  12/08/92 492293   10.36   10.45         9
    29  12/08/92 384848    9.40    9.00       -40
    30  12/08/92  55437   10.14   10.00       -14
    31  12/08/92 466791    9.50   10.45        55
    32  12/08/92 269914    9.35    9.15       -20

Average arrival time BEFORE appointment   + 12.5 mins
    N=  14   [ 42.4% ]

Statistical summary
-------------------

Number of consultations          :  33
Number of split consultations    :   2  [6.1% of total]
Mean  waiting time (ALL)         :  11.8 mins
Median waiting time (ALL)        :  15.0 mins
Maximum      [id 467548]         :  70   mins
Minimum                          : -60   mins
Mean waiting time (ambulance)    :  12.6 mins
Mean waiting time (non ambulance):  11.1 mins

T-Test of differences in waiting times =  0.141
[ NOT significant at 5% level ]

Mean consultation time [ALL]       : 23.1 mins
Mean consultation time [New]       : 57.4 mins   N=  5
                                        [  15.2% ]
Mean consultation time [Continuing] : 17.0 mins   N= 28
                                        [  84.8% ]
```

Table 6 : Sample Report form (1) - Leicester General

WAITING TIMES Complete data set CONSUL_X.AU1

Value label	Frequency	Percent	Cum. Percent
Before time	10	30.3	30.3
0 - 10 mins	4	12.1	42.4
11 - 20 mins	8	24.2	66.7
21 - 30 mins	2	6.1	72.7
31 - 40 mins	5	15.2	87.9
41 - 50 mins	2	6.1	93.9
51 - 60 mins	1	3.0	97.0
61 - 70 mins	1	3.0	100.0
TOTAL	33	100.0	

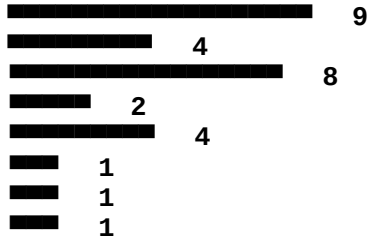


Valid cases 33

Table 7 : Sample Report form (2) - Leicester General

WAITING TIMES NON-DELAYED patients only CONSUL_X.AU8

Value label	Frequency	Percent	Cum. Percent
Before time	9	30.0	30.0
0 - 10 mins	4	13.3	43.3
11 - 20 mins	8	26.7	70.0
21 - 30 mins	2	6.7	76.7
31 - 40 mins	4	13.3	90.0
41 - 50 mins	1	3.3	93.3
51 - 60 mins	1	3.3	96.7
61 - 70 mins	1	3.3	100.0
TOTAL	30	100.0	100.0



Valid cases 30