A qualitative exploration of the role frontline health workers play in defining the quality of services provided to women experiencing an early miscarriage

Allison Farnworth

Doctor of Philosophy

Institute of Cellular Medicine

May 2017

Abstract

It is proposed that frontline health care workers in the English National Health Service (NHS) should have an important role in managing the quality of the services they deliver. Formal NHS quality management processes are structured in a highly rationalised way and the extent to which frontline workers have agency to apply their own knowledge to address suboptimal care practices is not well understood.

This study explores how frontline NHS workers manage the quality of services offered to women experiencing an early miscarriage using qualitative semi-structured interview data collected from 34 frontline health care workers and managers from three hospitals in the North East of England. Secondary thematic data analysis, informed by micro-organisational theories, was used to explore the role of frontline health care workers in managing the quality of their services.

This secondary analysis identified three key themes in the data; (1) the link between the quality gap and the difficulties associated with delivering humane and individualised care, (2) the role of collective understandings in defining the parameters of acceptable versus ideal quality of care, and (3) the use of discretionary practices to manipulate quality of care.

These findings suggest that management of health care quality is complex and characterised by bureaucratic constraints that support narratives of powerlessness and compromise amongst NHS workers. Structures that privilege rational models of organisational management pose a significant challenge to the delivery of relational aspects of care. This study contributes to the evidence base by providing insight into the unseen discretionary practices frontline workers engage in to improve quality of care whilst also maintaining organisational functionality. These practices, based on collective beliefs about the parameters of “acceptable” quality of care, are paradoxical; they can improve quality for individual patients but they also support the structures that create quality shortfalls in the first place.

The findings of this study offer a model of optimal care for early pregnancy loss that could be used as a framework on which to base quality improvement activities in this area. They also offer a unique insight into the issues that may result in suboptimal care practices perpetuating in the NHS, especially in relation to the delivery of humane and relational aspects of health care; this finding has implications for frontline clinicians, managers, educationalists and policymakers alike.

Dedicated to Isaac

“There are darknesses in life and there are lights, and you are one of the lights, the light of all lights” (Bram Stoker)

Acknowledgements

My first thanks are due to all the staff who gave their time and shared their thoughts and experiences to contribute to this study. These were often not easy stories to share and I feel very privileged that they were shared with me.

Next I wish to acknowledge and thank my supervisors, Professor Stephen Robson and Dr Ruth Graham. Your unwavering support and mentorship for me in all aspects of my career is deeply appreciated.

To all of my family, but most especially to Wayne and Isaac, who have lived through every high and low of this PhD, and lost so much of my time to it.

To all of my colleagues in the Reproductive Health Research Team, past and present, who have always offered words of support, but most especially to Dr Cath McParlin and Dr Vikki Snaith who are the very best of people; I'm so glad to have shared our PhD journeys together (even if I did come in last!).

The primary study from which data for this thesis was obtained was funded via a Knowledge Transfer Partnership between Newcastle University and The Newcastle upon Tyne Hospitals NHS Foundation Trust. It was funded jointly by the Technology Strategy Board, the Department of Health, The Newcastle upon Tyne Hospitals NHS Foundation Trust, and the Economic and Social Research Council. Many thanks for supporting me and the project, and for allowing me to take the data further.

Sincere thanks are also due to the Iolanthe Midwifery Trust who assisted me in the completion of this work by awarding me an Iolanthe Midwives Award in 2010 and a Midwifery Research Fellowship in 2015.

Last but not least, my most important thanks go to my parents Kathleen and Terry Farnworth who have showered me with love and support every day of my life.

Table of Contents

List of Tables

List of Figures

Abbreviations

AEPU	Association of Early Pregnancy Units
EPAU	Early Pregnancy Assessment Unit
ERPC	Evacuation of Retained Products of Conception
KTP	Knowledge Transfer Partnership
NICE	National Institute of Health and Care Excellence
NHS	National Health Service
NMC	The Nursing and Midwifery Council
PCC	Patient Centred Care
PM	Performance Management
QA	Quality Assurance
QI	Quality Improvements
QOC	Quality of Care
QM	Quality Management
RCOG	Royal College of Obstetricians and Gynaecologists
SLB	Street Level Bureaucracy
UKCRN	United Kingdom Clinical Research Network

Introduction

> "The first inquiry report stated that it should be patients – not numbers – which counted. That remains the view of this Inquiry. The demands for financial control, corporate governance, commissioning and regulatory systems are understandable and in many cases necessary, but it is not the system itself which will ensure that the patient is put first day in and day out. It is the people working in the health service and those charged with developing healthcare policy that need to ensure that is the case" (Francis, 2013; p83)

This quote is taken from the second inquiry into the health care services delivered within a National Health Service (NHS) organisation in Mid Staffordshire, England. The initial inquiry described poor standards in the quality of health care within that organisation. During the second inquiry the role that frontline[1] health care workers played in delivering and maintaining poor quality health care was highlighted; it was noted that many such workers tolerated standards of care that they themselves considered to be substandard, and that those who had raised concerns had not had their concerns addressed adequately by their immediate superiors. Furthermore, the report described a significant disconnect between the most senior staff in the Trust and those who were delivering care, such that the former were ignorant of the impact of board level decisions on patient care. As the quote implies, Francis considered that frontline health care staff have an integral part to play in securing the delivery of high quality services that acknowledge individual patient needs.

This was not the first time that the important role frontline NHS health care workers play in managing quality of care had been suggested; the report "*High Quality Care for All*" (Department of Health, 2008) focused heavily on the potential inherent in supporting frontline health care workers to use their unique knowledge, developed through their frequent interactions with service users, to identify and address aspects of care within which quality could be improved. This is reflected in pledges to, for example:

---

[1] In this thesis, "frontline" health care workers refers to all health care staff, professional and non-professional, who are involved in the direct delivery of services to those accessing NHS services.

> "Actively engage all staff in decisions that affect them and the services they provide, individually and through representatives. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families" (Department of Health, 2008; p71).

Whilst the benefits of capitalising on this "*untapped resource*" (The Nuffield Trust, 2011) have been outlined, the extent to which such aspirations are realised for frontline health care workers in the NHS is questionable. The inquiries conducted at Mid Staffordshire (Francis, 2010; Francis, 2013), as well as public inquiries conducted in other organisations providing health and social care in England (Flynn, 2012; Kirkup, 2015), have repeatedly described situations in which frontline staff have been found to be complicit in maintaining poor standards of care, either by their actions, or their tolerance of poor standards. The inquiries have often implicated organisational factors (e.g. culture, priorities, the nature of the relationship between senior and frontline staff) in influencing the actions and inactions of NHS workers.

> "The focus of the system resulted in a number of organisations failing to place quality of care and patients at the heart of their work. Finances and targets were often given priority without considering the impact on the quality of care. This was not helped by a general lack of effective engagement with patients and the public, and failure to place clinicians and other healthcare professionals at the heart of decision-making" (Francis, 2013; p65).

This thesis investigates this issue from the perspective of the frontline NHS health care worker. It explores the ways in which such workers conceptualise, and make judgements about, the adequacy of QOC in the services they deliver. Furthermore it explores the ways in which such workers respond to services that they consider being of suboptimal quality. The research uses a case study design focusing on the health care offered to women experiencing an early miscarriage. The literature review thus provides a critical review of two distinct bodies of existing research; that relating to management of quality of care in the National Health Service (NHS) and that relating to early miscarriage.

Chapter one provides a review of the evidence relating to quality of care in the NHS. It describes the ways in which quality is conceptualised and the formal tools used to manage quality in the contemporary NHS. It explores the role of frontline workers in defending and improving quality of care, and outlines some of the ways that NHS organisations have sought to engage their frontline workforce in quality management activities. Finally, it considers the informal processes that might impact on the ability of frontline staff to engage. The literature on all of these topics is extensive and it would not be possible to present a comprehensive analysis of each in detail within the limits of this thesis; a critical overview of some of the background issues relevant to the subject matter of this thesis is therefore presented.

Chapter two gives a review of the evidence base relating to early miscarriage and, more specifically, the health care provided to women experiencing such a reproductive loss. The case is made that this health care context presents a useful case study on which to base a study of frontline worker engagement in quality management, due to longstanding evidence of dissatisfaction about quality of care amongst both patients and staff.

Chapter three provides details of the qualitative methodology underpinning the empirical research that is the subject of the thesis, alongside the methods used to collect, manage and analyse the data. It justifies the use of secondary data analysis and provides details of the primary study from which the data was taken. It then outlines why a social constructionist framework was chosen and explains the micro-organisational theories that underpin the interpretation of the findings. It outlines how this framework can help us to understand why gaps might emerge between the care patients wish to receive and that which they actually receive, and explores the position frontline health care workers occupy in relation to such quality shortfalls.

Chapters four to six present the three major themes that emerged from the data; “Recognising the Gaps”, “Negotiation, Compromise and Acceptable Quality of Care”, and “Managing Quality Gaps at the Frontline”. Overall these themes are housed under an overarching narrative of “Minding the Quality Gaps”. The analysis discusses the issues of concern regarding QOC from the point of view of frontline interviewees and the extent to which they feel that they are expected to compromise on their aspirations regarding QOC. It also describes the differing strategies frontline workers describe employing to respond to perceived instances of suboptimal QOC.

Chapter seven views these themes through the lens of micro-organisational theory and considers the implications for frontline NHS workers, the organisations in which they operate, and for women seeking health care for an early miscarriage. It argues that early miscarriage represents a particular type of health care that may be chronically disadvantaged within rationalised models of health care management and delivery. It also suggests that frontline health care workers may exert agency in ways that simultaneously improve quality of care and also contribute to the circumstances that lead to longstanding quality shortfalls in this health care context.

Finally, Chapter eight presents a conclusion and implications for clinical practice. It also explains the limitations of this study and outlines areas for future investigation.

Chapter 1 Review of Literature on Frontline Engagement in Quality Improvement in the National Health Service

1.1 Quality of Care in the NHS

The NHS was introduced in 1948 with the aim of providing a comprehensive and publicly funded health care system to the people of Great Britain (Rivett, 1998). Subsequently, the scope and demand for services provided by the NHS has grown exponentially and the service has been subject to numerous reviews and restructures (Ham, 2009). Currently the NHS in England includes 154 acute health care trusts, 56 mental health trusts, 37 community providers, and 10 ambulance trusts (The NHS Confederation, 2016). Maintaining quality of care has remained high on the NHS agenda, as evidenced by its inclusion in the NHS constitution:

> "Principle 3. The NHS aspires to the highest standards of excellence and professionalism in the provision of high quality care that is safe, effective and focused on patient experience … Respect, dignity, compassion and care should be at the core of how patients and staff are treated." (Department of Health, 2015; p3)

Whilst policy and literature suggests a broad agreement that high quality of care (QOC) should be a key component of services offered by NHS organisations, there is far less consensus about what "*high quality care*" actually means. There is a substantial literature discussing issues such as how quality in health care is defined (Donabedian, 2005), the level of quality which should be aspired to in a publicly funded health care system (Ham and Robert, 2003), and how quality can be monitored and evaluated (Gillespie *et al.*, 2004; Currie *et al.*, 2005; Dixon-Woods *et al.*, 2012; Liberati *et al.*, 2015). External displays of quality and accountability have been described to be important for professionals in terms of maintaining identity and retaining autonomy and public trust (Wells, 1997; Schofield, 2001; Clarke, 2005; Elston, 2009; Busuioc and Lodge, 2016). Health care organisations may also rely on evidence of quality in order to retain reputation and, in some instances, income (e.g. through the CQUIN[2] scheme (Department of Health, 2008; p42; Kristensen *et al.*, 2013)).

The literature presents multiple, sometimes competing, perspectives on the nature of quality in health care. This may not be surprising given that those who have a stake in the quality of services offered by NHS organisations come from a variety of backgrounds, with differing experiences and motivations. Stakeholder groups include (but are not limited to) service users, potential service users, tax payers, health care professionals, health care managers, health care commissioners, service user representatives, health care researchers, informal carers, public health specialists, health care support workers, government ministers, accountants and local councils.

The literature supports the idea that some perspectives on QOC are more influential than others. The Evidence Based Medicine/Care movement, for example, proposes that high quality care is that which is consistent with high quality research evidence (Sackett, 1997); the introduction of the National Institute of Health and Care Excellence (NICE) [3] reflects the importance that the evidence based approach to defining quality has gained within the NHS. NHS organisations have legal obligations in relation to some NICE outputs (i.e. NHS Trusts are legally obliged to provide treatments and drugs recommended via the Technology Appraisal programme), whereas other guidance remains optional but well used throughout NHS organisations (e.g. NICE Quality Standards and recommendations for practice (The National Institute of Health and Care Excellence, 2013)). Whilst the Evidence Based Medicine movement has been widely accepted within the NHS at a policy level, it has also been criticised for having a positivist ethos that subordinates other forms of knowledge (e.g. professional judgement, individual patient preferences and values, and tacit knowledge developed within communities of health care professionals (Gabbay and le May, 2004; Greenhalgh, 2009; Hajjaj *et al.*, 2010; Greenhalgh *et al.*, 2014; Wieringa and Greenhalgh,

---

[2] The Commissioning for Quality and Innovation (CQUIN) scheme was introduced into the NHS in 2009. The scheme links organisational income to quality improvements by including specific requirements in commissioning contracts

[3] The National Institute for Health and Care Excellence was created in 1999 (originally the National Institute for Clinical Excellence). Its original aim was to *"ensure that the most clinically and cost effective drugs and treatments were made available widely on the NHS in England and Wales"*. NICE considers the knowledge used to produce guidelines and advice to exist in a hierarchy, with that gained from well-designed experimental research studies to be more valid than other forms of evidence (e.g. personal experience or anecdote) https://www.nice.org.uk/about/who-we-are/history-of-nice

2015)). It has also been suggested that the use of evidence based guidelines can constrain professional autonomy and lead to lack of critical thinking on the part of health care professionals (Bail *et al.*, 2009; Greenhalgh *et al.*, 2014).

Anyone seeking to improve quality within NHS services has thus to do so within an arena where the very concept of quality is ill defined and open to challenge from a number of other, potentially conflicting and competing, viewpoints (Aij *et al.*, 2013). Furthermore, some of these viewpoints may be particularly powerful and therefore difficult to argue against. This chapter is concerned with QOC in the NHS and, in particular, the power that one particular group of stakeholders (frontline NHS workers) have to assert their views about QOC and translate those views into quality improvements.

1.1.1 Formal Mechanisms of Quality Management in the NHS

In the early decades of the NHS, responsibility for the quality and effectiveness of health care largely lay with clinicians, and more especially with medical staff who broadly controlled the definition, management, and evaluation of care quality (Turner and Samson, 1995). This was driven by a belief that experiential clinical knowledge was required to adequately judge the appropriateness and quality of clinical practices. Structured methods of quality evaluation existed (e.g. medical audit), but they were generally generated and administered from within the professions (Turner and Samson, 1995). Donabedian (2005) describes the role of central government in health care in these first decades of the NHS as being more aligned to issues of cost containment than of quality.

Since the 1980s, a number of factors have challenged this arrangement. These included a far greater emphasis on controlling public expenditure generally alongside narratives of national fiscal crises (Clarke, 2005; Ham, 2009), and concerns about inequality and regional variation in access to care and the outcomes of care in the NHS (Rivett, 1998). Some authors also describe a concomitant societal shift away from cultures of deference to authority, and towards scepticism and cynicism of those in positions of power (Checkland *et al.*, 2004; Clarke, 2005; Elston, 2009). In the NHS, this was heightened by highly publicised cases of health care workers acting improperly (e.g. senior surgeons at the Bristol Royal Infirmary who engaged, unchallenged, in harmful care practices over a sustained period (The Bristol Royal Infirmary Inquiry, 2001)). Put simply, the notion that frontline clinicians could be left to manage issues of care quality unchecked was no longer accepted.

> “What was lacking was any real system whereby any organisation took responsibility for what a lay person would describe as ‘keeping an eye on things’…. No one was doing it. We cannot say that the external system for assuring and monitoring the quality of care was inadequate. There was, in truth, no such system” (The Bristol Royal Infirmary Inquiry, 2001; p6)

More systematic and comprehensive external mechanisms of quality assurance (QA) were thus considered desirable, however the decentralisation of NHS organisations precluded direct governmental control (Clarke, 2005). This led to the development of systems of *“arm’s length control”* (Clarke, 2005; p214) which manifested as an increase in the number of external agencies involved in monitoring and evaluating the quality of the services offered within the NHS; this includes government departments (e.g. the treasury, the Department of Health), and independent agencies and regulators (e.g. The King’s Fund, The Healthcare Commission, the Care Quality Commission, the National Institute of Health and Care Excellence) (Ham, 2009, p. 246). Clinical governance became a statutory duty for health authorities and health care trusts (Clarke, 2005). The introduction a quasi-market system for the commissioning and delivery of health care services led to an increase in the use of performance management (PM) mechanisms, allowing organisations and services to benchmark and compare. Examples of the range of quality measurement used within the context of health care are shown in Table 1-1.

Category of Measurement	**Example of tool/methodology**
Organisational quality management programmes	International Organisation for Standardisation (ISO) 9000, European Foundation for Quality Management model (EFQM)
Systems for obtaining patients' views	Patient surveys, Patient participation (e.g. in design of protocols, development of standards)
Patient Safety Systems	Risk management programmes, Adverse event reporting, Drug safety management
Audit and internal assessment of clinical standards	Performance reviews of clinical staff Internal audit
Clinical and practice guidelines	Use of Standard Operating Protocols (SOPs), Hospital-wide guidelines, Ward or condition specific guidelines
Performance indictors and measurements	Collection and use of performance data
External assessment	Assessment by accreditation or certification institutes. Patient organisations, Government Inspection body

Table 1-1. Methods of measuring quality of health care in 389 European hospitals (Lombarts *et al.*, 2009)

The introduction of the New Public Management (NPM) in the 1980s resulted in increased scrutiny in, and control over, the work of health care professionals by managers (Clarke, 1998; Elston, 2009; Ham, 2009). The introduction of NPM has been criticised for de-professionalising health and social care staff and reducing their autonomy over their own practice, suppressing their views about care, and creating a web of overlapping priorities which such professionals have described as a diversion from clinical or service user focused aspects of care (Martin *et al.*, 2004; Clarke, 2005; Elston, 2009; Waring and Bishop, 2010; Dixon-Woods *et al.*, 2014; Cockerham, 2015).

> "nurses reported lack of real control over the majority of factors that affected everyday standards of nursing practice, and believed that their professional autonomy was not only unacknowledged, but displaced by inappropriately close control over their work by management" (Attree, 2005; p392)

Alongside PM and QA processes, many Quality Improvement (QI) methodologies were also introduced into the NHS (Nicolay *et al.*, 2012). The aim of such methods is to structure the planning, implementation and evaluation of improvement activities, sometimes across multiple organisations. Examples of formal QI programmes described in the literature include Total Quality Management, Lean Thinking/Lean Management (Dickson *et al.*, 2009; Kim *et al.*, 2009; Aij *et al.*, 2013; Lawal *et al.*, 2014), and the Productive Ward: Making Time to Care (Morrow *et al.*, 2012).

The literature around PM/QA/QI processes (henceforth referred to in this thesis as quality management mechanisms) reveals a number of concerns about their appropriateness and ability to truly impact on quality as experienced at the frontline of care delivery. They have, for example, been criticised for over simplifying complex and multi-faceted concepts (e.g. in measuring concepts such as quality or satisfaction) (Crow *et al.*, 2002; Martin *et al.*, 2015) and also failing to adequately account for the social worlds within which health care is delivered and experienced by health care service users and health care workers (Waring and Bishop, 2010; Dixon-Woods *et al.*, 2014; Hamilton *et al.*, 2014; Simms *et al.*, 2014). Lack of uniformity in both the application of the techniques, and in methods of evaluating them, contributes to difficulties in assessing impact leaving evaluation largely reliant on evidence from discrete case studies (Hood and Dixon, 2015). Evidence of the extent to which health care staff value such processes as mechanisms to improve QOC is also inconsistent (Clarke, 2005; Davies *et al.*, 2007; Price *et al.*, 2007; Parand *et al.*, 2011; Carter *et al.*, 2014; Hamilton *et al.*, 2014) and lower levels of enthusiasm have been reported in frontline staff compared to their managerial counterparts (Parand *et al.*, 2011; Nugus *et al.*, 2012) and in medium-level compared to high-level managers (Freeman and Walshe, 2004).

Reports regarding the success of quality management programmes are variable (Walshe and Freeman, 2002; Groene *et al.*, 2010) but it is clear that the widespread use of these mechanisms in the NHS has not prevented significant failures in quality. Key public inquiries have explicitly criticised agencies designed to monitor quality of care for failing to identify the emergence of very poor care practices in some organisations (Francis, 2010; Francis, 2013; Keogh, 2013; Kirkup, 2015).

1.1.2 Unintended Consequences of Quality Management Mechanisms

Not only have quality management mechanisms failed to prevent instances of poor QOC, in some cases they have been implicated in unintentionally contributing towards poor QOC. These mechanisms have the potential to skew organisational priorities towards achieving a façade of quality (e.g. by meeting externally defined quality standards) at the expense of delivering actual quality (e.g. as experienced by service users and frontline staff; this phenomenon has been observed within and outside the context of the NHS (Goddard *et al.*, 2000; Brodkin, 2008; Dixon-Woods *et al.*, 2012). The wish to maintain an outward appearance of quality may then lead to organisational cultures that suppress open disclosure of concerns about quality of care, reject accountability, and ignore views about quality which differ from those specified by the quality management mechanisms (Khatri *et al.*, 2009).

> "Many of these seemed to be motivated mostly by a need to make displays of compliance, rather than by genuine efforts to make systems safer or of better quality. Much of this activity could be characterised as defensive and reactive. It was a source of frustration throughout organisations; frontline teams complained of "blanket" policies which were seen as "very prescriptive and not concentrated on clinical work"" (Dixon-Woods *et al.*, 2014; p5)

Where frontline staff feel organisationally defined standards of quality are not apposite or achievable, frustration and disinterest has been described (Freeman, 2002), with frontline workers then viewing involvement in quality management mechanisms as time consuming administrative exercises which have limited value and divert them from their real work (Davison *et al.*, 2013). Additionally, the existence of formal departments and processes to manage quality may reduce the sense of accountability individual frontline workers feel in relation to protecting and improving quality, or for quality failures within their organisations (Flynn, 2002; Freeman, 2002; Evans and Harris, 2004).

Where performance management programmes publicly benchmark services, feelings of blame, fear and victimisation have been reported in staff working in services that are rated unfavourably (Attree, 2007; Elston, 2009; Hajjaj *et al.*, 2010; Martin *et al.*, 2014)(Scammel, 2016). This has been implicated in contributing to defensive organisational cultures in which staff are motivated to conceal problems and concerns because of fears about personal or organisational consequences associated with disclosure (Squier *et al.*, 1995; Khatri *et al.*, 2009; Green and Sawyer, 2010; McCann *et al.*, 2015). Such fears are not unfounded; "*whistleblowing*" [4] has been linked to professional and/or organisational ostracisation,

---

[4] "*Whistleblowing is the term used when a worker passes on information concerning wrongdoing. In this guidance, we call that "making a disclosure" or "blowing the whistle". The wrongdoing will typically (although not necessarily) be something they have witnessed at work*". Department for Business Innovation & Skills (2015) *Whistleblowing: Guidance for Employers and Code of Practice*. London: The Stationery Office, ibid.; p1

negative impacts on future career prospects, feelings of guilt and responsibility for any subsequent penalisation incurred by the organisation and/or colleagues, and negative psychological outcomes (Porter, 2009; Iedema *et al.*, 2011; Peters *et al.*, 2011; Snow, 2011; Dyer, 2012).

As well as influencing actions, some argue that governance practices influence the way that frontline practitioners *think* about the concept of quality. Organisational risk management practices, for example, have been described to influence the way in which midwives think about quality in maternity care, with a tendency to shift away from physiological models of birth which emphasise normality and towards more risk focused models (Scamell, 2011).

This literature demonstrates that NHS staff work in an environment where QOC is formally managed using mechanisms that rationalise QOC into a series of measurable outcomes. This way of managing quality has the potential to control QOC management and reduce variation but only in ways that privilege a specific version of QOC (i.e. that which can be measured and that is included in the measurement tool). These mechanisms have the potential to skew organisational priorities and suppress alternate views about quality.

1.2 Engagement of Frontline NHS Staff in Quality Improvement

Having outlined the formal mechanisms used to manage quality in the NHS, this section considers the role of frontline NHS workers in defending and improving quality of care, and the extent to which they engage with the quality agenda (through formal and informal quality management mechanisms).

1.2.1 Justifications for Promoting Frontline Engagement

> “we will empower health professionals. Doctors and nurses must to be able to use their professional judgement about what is right for patients. We will support this by giving frontline staff more control. Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients” (The Department of Health, 2010; p1)

This quote is taken from the foreword to the 2010 white paper "*Equity and excellence: Liberating the NHS*" and demonstrates an interest, at the highest level, in engaging and empowering frontline NHS workers to improve quality of health care (The Department of Health, 2010). Frontline engagement has been linked to positive outcomes for workers and for their employing organisations within health care (Admasachew and Dawson, 2011; Wilkinson *et al.*, 2011; Hewison *et al.*, 2013), and in organisations more widely (Cambra-Fierro *et al.*, 2014; Truss *et al.*, 2014). In terms of improving QOC, frontline workers of all disciplines have a unique knowledge of both the services they provide and the experiences and needs of the clientele they deliver them to (Mackintosh and Sandall, 2010; Roueche and Hewitt, 2012; Dearmon *et al.*, 2013; Raffay, 2014). The input of frontline workers has been suggested to have the potential to allow the development of innovative practices which increase responsiveness and improve service outcomes (Roueche and Hewitt, 2012; Dearmon *et al.*, 2013; Ziviani *et al.*, 2013), improve effectiveness and efficiencies in the delivery of care/services, and improve employee satisfaction and engagement in their work (Dearmon *et al.*, 2013). It has also been suggested that engaged frontline workers have a greater capacity and willingness to engage in future QI activities (Chenven and Copeland, 2013; Dearmon *et al.*, 2013), and that an engaged workforce is associated with improved policy implementation at a local level (Parker *et al.*, 2009; Anand *et al.*, 2012; Ijkema *et al.*, 2014; Schneider *et al.*, 2014). This establishes that frontline workers may have a unique role to play in managing the quality of the services they deliver and that successful engagement can have positive implications for staff, organisations and patients.

1.2.2 The Frontline Workforce of the NHS

In the NHS the frontline workforce includes a variety of personnel, including those with professional clinical qualifications (e.g. medical staff, nurses and midwives, allied health professionals), and those without (e.g. health care support workers, clerical and service support staff). In March 2016, NHS organisations in England employed over 1.1 million staff members, of which around 84% occupied roles involved directly in the frontline delivery of care. This compares with managerial or senior managerial roles that made up 2% and 1% of the workforce respectively (see Figure 1-1) (Health and Social Care Information Centre, 2016)[5].

---

[5] the data does not capture how many staff occupy hybrid roles which encompass clinical and managerial responsibilities, such as ward matrons or clinical directors.

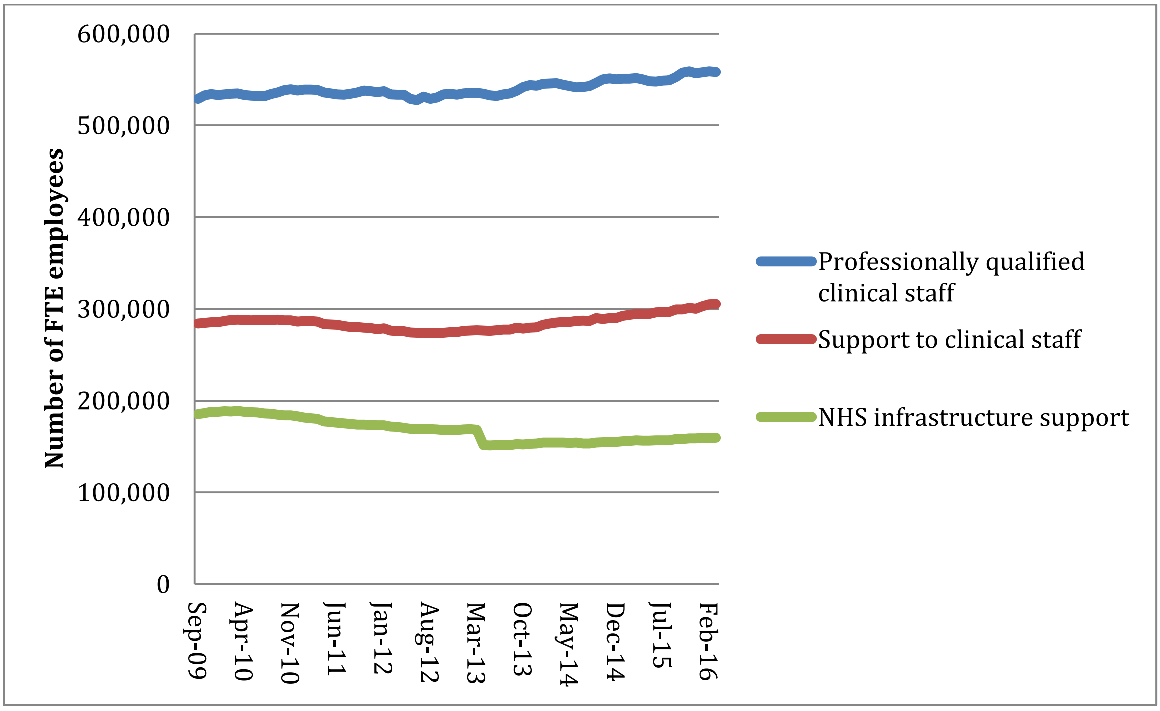


Figure 1-1 Health Care staff types employed by the NHS in March 2016 by Full time Equivalent (Health and Social Care Information Centre, 2016)

Amongst the heterogeneity of roles and responsibilities within the frontline workforce, there is evidence of varying levels of power in terms of how much different staff groups are able to define their role, decide how health care should be delivered, highlight deficiencies and instigate changes to practice (Picker Institute Europe, 2015). This is influenced by factors such the status and hierarchical position of the staff group within the organisation and traditional role boundaries (Traynor *et al.*, 2015). Qualified health care professionals, for example are subject to accountability to their professional bodies, unlike their non-professionally qualified colleagues. Such bodies (e.g. the Royal Colleges, the Nursing and Midwifery Council) often take a position about the components of good quality care (e.g. through the development of guidelines) and state an obligation for professionals to act where they have concerns about QOC.

> "Speaking up on behalf of people in your care and clients is an everyday part of your role, and just as raising genuine concerns represents good practice, "doing nothing" and failing to report concerns is unacceptable". (Nursing and Midwifery Council, 2010; p4)

> "All doctors have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisations in which they work. They must also encourage and support a culture in which staff can raise concerns openly and safely". (The General Medical Council, 2012; p7)

Some differentials in organisational power are long standing (e.g. senior medical staff are described as having, historically, more freedom over their work than other health care professional groups). Others are more dynamic and influenced by organisational, social, legal and political factors (e.g. the development of new roles such as nurse specialists, who can lead health care services which had formerly been controlled by medical staff) (Durgahee, 2003). So, whilst the terminology "*frontline staff engagement*" is used in this thesis, the implication that all frontline staff are equal in terms of their ability to engage in quality management activities, or that they mobilise and function as a cohesive team to improve care is not assumed; indeed "*social and cognitive boundaries*" have been observed to compromise collaborative working across the range of frontline staff (Ferlie *et al.*, 2005).

The literature describes different ways in which frontline NHS workers engage in quality management activities; by aligning to pre-existing formal mechanisms, by engaging with formally developed frontline engagement programmes, and by developing QI strategies at the frontline (i.e. informally and without the involvement of senior staff). The next sections outline this literature in more detail.

1.2.3 Frontline Engagement with Formal Quality Management Activities

There is evidence that frontline NHS workers value the opportunity to contribute towards improving the quality of the services they deliver (Ipsos MORI, 2008). Research focused on frontline health care workers' views regarding their involvement in defending or improving quality largely focuses on their engagement with formal quality management programmes, and on the organisational barriers to disclosure of concerns about QOC (Davies *et al.*, 2007). Other sectors that have explored the concept of frontline engagement include education, social care, and hospitality (all environments where frontline workers have a substantial amount of interaction with the general public).

A key factor influencing the extent of frontline worker engagement appears to be how much it is *imposed* upon them (i.e. a top down approach) as opposed to *instigated* by them (i.e. a bottom-up approach). Relatively simple factors can create barriers; such as failing to provide frontline staff with the time away from their normal duties, or providing the resources and skills to be able adequately engage with quality management mechanisms and to understand how to interpret and deal with the results (Davies *et al.*, 2007; Gerrish *et al.*, 2012; Godfrey *et al.*, 2013; Jeffs *et al.*, 2013; Zallman *et al.*, 2013; Lloyd-Smith *et al.*, 2014; AuYoung *et al.*, 2015).

Top down approaches to quality management have been criticised for failing to adequately involve frontline workers. The more successful approaches to quality management support dialogue with, and support for, staff throughout the organisation, acknowledging the influence of local contexts and allow “shared agendas” on quality to emerge (Powell *et al.*, 2009; Waring and Bishop, 2010; Aij *et al.*, 2013; Davison *et al.*, 2013; Hannan and Celia, 2013; Juma *et al.*, 2014; Sinuff *et al.*, 2015; Timmons *et al.*, 2015). These agendas relate to what quality means, what acceptable standards of quality are (Green and Sawyer, 2010), and which improvements should be pursued (Schneider, English et al. 2014). Such agendas are more likely to convince frontline staff that quality gains outweigh any effort and risks they may incur as a consequence of being involved (Lloyd-Smith *et al.*, 2014; Venance *et al.*, 2014). Additionally, the importance of organisations acknowledging the competing professional, ethical, organisational, and socio-political factors that influence frontline staff has been described (Davies *et al.*, 2007; McAlearney *et al.*, 2011; Cranley *et al.*, 2012; Gerrish *et al.*, 2012; Davison *et al.*, 2013).

Hierarchies that position policy makers and researchers away from those who deliver policies on the frontline are described to be a barrier to developing shared agendas. Middle and senior managers in the NHS have been suggested to be key players in terms of supporting staff to feel able to challenge organisational norms about quality (Davison *et al.*, 2013) and facilitating communication across organisational strata (Gerrish *et al.*, 2012; Othman and Nasurdin, 2013), although the extent to which they have the skills or confidence to deliver on these aspects of their role is unclear (Hewison *et al.*, 2013).

Finally, whilst the literature tends to suggest that frontline workers are an untapped resource in terms of their willingness to engage in projects designed to improve quality of services, research (particularly that conducted in the hospitality sector) suggests that individual frontline employees vary in their capacity and willingness to engage in their work (based on personal attributes such as the extent to which they are committed to meet consumer needs (Karatepe, 2013; Yoo and Arnold, 2014), the extent to which they seek meaning in their work

(Chen *et al.*, 2014) and their prior organisational experiences (e.g. previous experience of involvement in QI activities which had positive impacts (Wittich *et al.*, 2014)).

1.2.4 "Bottom Up" Quality Management Activities

As well as encouraging frontline engagement with formal "*top down*" quality management mechanisms already functioning within NHS organisations, some initiatives to promote "*bottom up*" frontline engagement have been reported. These activities are designed to allow frontline workers to propose their own innovations and to act as a first line of defence against failures in quality. It is important to note that these as strategies are initiated at an organisational level (i.e. with the agreement of senior management), and so they represent a "*top down*" solution to "*bottom up*" involvement.

A key challenge to these strategies is the extent to which the structure of NHS organisations can support such initiatives. Health care workers have repeatedly identified organisational factors as a barrier to them being able to prioritise aspects of care which they consider to represent good quality (Hewa and Hetherington, 1990; Attree, 2005; Ruston, 2006; Hobbs, 2012). Furthermore, a lack of awareness of the organisational mechanisms which would support frontline staff to be able to implement their ideas for improvement has been described (Gilbert *et al.*, 2012; Picker Institute Europe, 2015). Figure 1-2 illustrates information collected during the 2015 NHS staff survey specifically in relation to staff involvement in suggesting, deciding upon and implementing change aimed at improving QOC at a local level. These data suggest that there are significant shortfalls in the extent to which NHS workers feel able to engage in these activities. They also demonstrate differences in response between organisational strata, with those in non-professional frontline roles responding less positively that their professional counterparts, and managerial level staff scoring higher than frontline workers. The surveys do not probe these responses further so the reasons behind these differences are unclear.

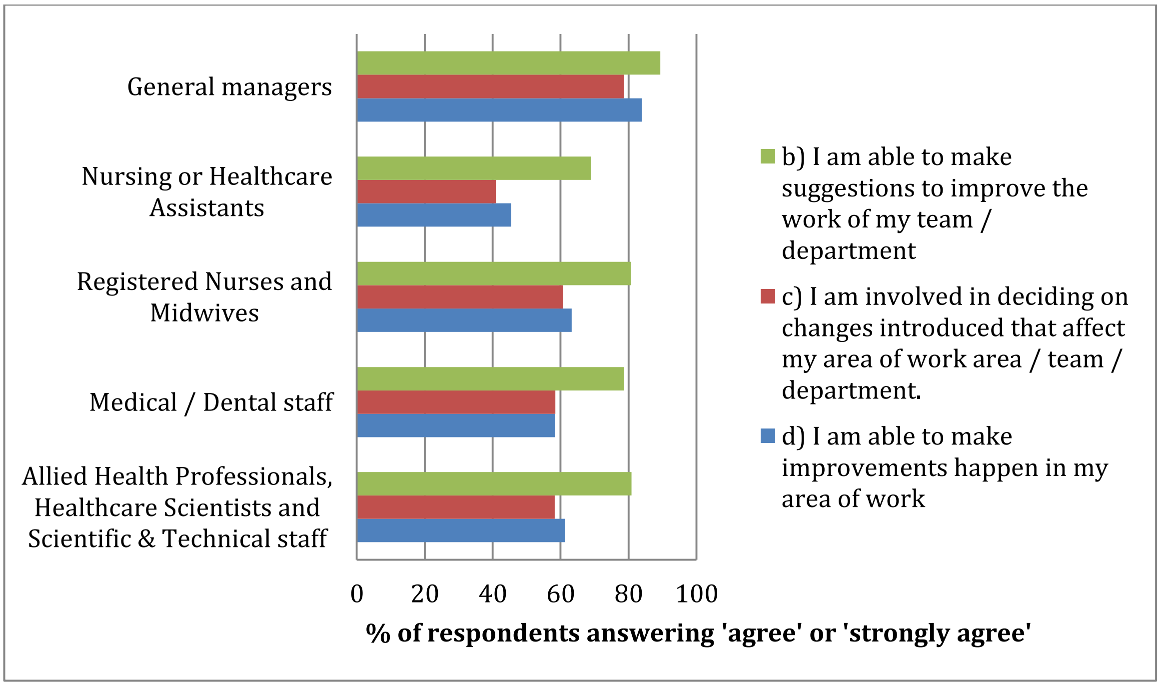


Figure 1-2. Self-Perceived Ability to Suggest and Implement Local Quality Improvement by Staff Type, data extracted from NHS Staff Survey 2015 (Picker Institute Europe, 2015)

Several studies have explored initiatives designed to increase the engagement of frontline healthcare staff in QI; most focus on building capacity and empowering staff through educational programmes or mentorship models (Kellie *et al.*, 2012; Chenven and Copeland, 2013; Matovu *et al.*, 2013; Williams *et al.*, 2014; Dearmon *et al.*, 2015). Other studies have focused on the development of organisational infrastructures that encourage open sharing of ideas for improvement and provide opportunities for frontline staff to interact with senior staff (Cranley *et al.*, 2012) (see Table 1-2).

Type of Strategy	**Context**
Embedding ‘champions’ into local services to provide focused support to frontline staff	Infection control in Canadian health care facilities (Lloyd-Smith *et al.*, 2014); HIV prevention across India (Dallabetta *et al.*, 2014); A delirium prevention campaign in the U.K (Godfrey *et al.*, 2013)
Developing mechanisms that increase the extent to which frontline staff are able to work alongside administrative, research, and managerial staff to assess quality of services and develop strategies to improve it.	Multidisciplinary teams in acute care (Cohen *et al.*, 2010; Harrison *et al.*, 2012; Nugus *et al.*, 2012; Jeffs *et al.*, 2013; Singer *et al.*, 2013; Wright and McSherry, 2013; Gimbel *et al.*, 2014; Moriates *et al.*, 2014; Hechenbleikner *et al.*, 2015); Nursing staff working in a variety of contexts (Kellie *et al.*, 2012; Davison *et al.*, 2013; Dearmon *et al.*, 2013; Jeffs *et al.*, 2013); Managers and frontline workers (Daugherty *et al.*, 2013; Singer *et al.*, 2013); Frontline managers (Gimbel *et al.*, 2014); Multi-agency contexts (e.g. frontline staff, managers, academics) (Grey *et al.*, 2014; Wynn *et al.*, 2014)
Implementation and evaluation strategies which specifically seek to incorporate the views and experiences of frontline workers	Frontline workers across a variety of health care contexts (Chandler *et al.*, 2010; Liu *et al.*, 2013; Ziviani *et al.*, 2013)

Table 1-2. Strategies to Increase Frontline Engagement Opportunities

The research presents mixed evidence on the impact of such initiatives. Many of the studies report positive impacts, with authors suggesting that the initiatives empowered frontline staff (Jeffs *et al.*, 2013), developed their leadership skills (Williams *et al.*, 2014; Dearmon *et al.*, 2015), equipped them to translate their knowledge into improved outcomes for service users (Cranley *et al.*, 2012; Dearmon *et al.*, 2013; Matovu *et al.*, 2013) and resulted in improved efficiencies or service improvements for organisations (Moriates *et al.*, 2014). Interventions were often described as providing a useful framework within which productive conversations between frontline workers and senior managers could be facilitated. Increased job satisfaction was also reported (Jeffs *et al.*, 2013) although frontline engagement activities were often a feature of a larger and more complex programme of QI making it difficult to assess the specific impact of frontline engagement interventions on either staff experience or clinical care (Kellie *et al.*, 2012).

A key criticism of these interventions rests in the fact that, whilst they aim to stimulate frontline staff to engage in a bottom up model of quality management, they are generally still initiated and implemented by those further up the organisational hierarchy; they are aimed at frontline workers rather than being demanded by such workers. Some frontline staff have reported feeling obliged to participate and senior level staff have reported more enthusiasm for, and belief in, the effectiveness of these strategies as compared to the frontline staff at whom the engagement activities were aimed (Singer *et al.*, 2013; Martin *et al.*, 2014). Uncertainty, scepticism and even hostility have been reported amongst some frontline staff with regard to these engagement activities (Nugus *et al.*, 2012). Reasons for this include a lack of belief that organisations were genuinely committed to long term and legitimate consideration of frontline views (Dixon-Woods *et al.*, 2012; Carter *et al.*, 2014). Martin *et al.* (2014), for example, exploring the use of leadership walkarounds[6] found that they were viewed with suspicion by some frontline staff who were concerned it was being used as a form of surveillance. As a consequence some modified the ways in which they described the quality of services to senior staff involved in the walkarounds to avoid blame and punishment thereby defeating the rationale behind the strategy (Martin *et al.*, 2014). Such concerns may not be without foundation; Nugus *et al.* (2012) reporting their ethnographic work, noted

---

[6] A strategy commonly used in British NHS Trusts whereby members of the Trust board visit wards and departments to talk to frontline staff, health service users and carers, with the aim of understanding quality of care at ward level and improving the visibility of senior executives. Walkarounds have been described to be an important tool in improving the safety and quality of health care services Graham, S., Brookey, J. and Steadman, C. (2005) 'Patient safety executive walkarounds', in Henriksen, K., Battles, J.B., Marks, E.S. and Lewin, D.I. (eds.) *Advances in Patient Safety: From Research to Implementation (Volume 4: Programs, Tools, and Products)*. Rockville (MD).

managers withdrawing support for their action research project [7]once negative frontline views were presented to them.

In summary, “bottom up” approaches to frontline NHS worker engagement have been tested and described in the literature. These initiatives are primarily aimed at increasing the capacity for frontline workers to propose and initiate local QI ideas. The literature suggests that, in so far as these approaches remain formal and imposed upon frontline workers (as opposed to emerging from within the frontline workforce), such workers may view them as another part of the formal, top down, quality management culture. They may thus remain sceptical about the motivation behind the initiatives, and the extent to which they might offer frontline workers additional power and autonomy to direct the way their services are delivered.

1.2.5 Frontline Staff and Informal Quality Management Activities

While the literature indicates variable engagement of frontline workers in formal quality management initiatives, the questions remains; what do frontline staff members do in the face of QOC standards they feel could be better (suboptimal QOC) if they feel unable, or unwilling, to engage in formal quality management processes?

There is some evidence that frontline health care workers manage QOC on a day-to-day basis in ways that may not be obvious (or even recognised by the staff themselves). Allen (2014) conducted ethnographic work which described NHS nurses who used their working knowledge of local systems of care delivery to organise work using “*invisible practices which take place under the radar of formal organisational structures*” but which “*are vital to the quality and efficiency of healthcare provision*” (Allen, 2014; p136). Other authors have described the concept of “*invisible practices*” across a variety of health care settings including activities such as resistance and manipulation (Ruston, 2006; Hughes, 2012; Debono *et al.*, 2013; Bloom and White, 2016). These activities appear to operate at a team/ward level, where unspoken rules and shared understandings develop about the best ways to manage and deliver care within the resources available. For some, these practices represent a way to subvert overly rationalised or task based organisational priorities in order to introduce more caring or holistic approaches (Walsh, 2006; Wieringa and Greenhalgh, 2015). Operating in

---

[7] Action research is a type of participatory research “*conducted by participants*” (in the case of health, often by health care practitioners. Action research is described to be “*orientated to making improvements in practices and their settings*” Kemmis, S.E. and McTaggart, R.E. (1988) *The action research planner*. 3rd edn. Victoria, Australia: Deakin University.

these ways requires frontline workers to have some freedom and control over their work, both individually and as groups/teams. These freedoms might be explicit (i.e. they form part of the worker's job description) or implicit (i.e. where working practices are not monitored and freedoms therefore emerge). Cultures which promote frontline autonomy have been described to be associated with an increase in the provision of individualised care (Walsh, 2006; Condon, 2008; Finlay and Sandall, 2009), whereas overly bureaucratic systems have been described as being restrictive and liable to promote obedience rather than creativity and innovation (Bail *et al.*, 2009).

These *"behind the scenes"* activities are of interest because of their potential to provide a route for frontline workers to act to defend and improve QOC in the NHS; though it should be noted that these hidden activities may be used for reasons other than QM (e.g. to minimise workload or to meet organisational targets). Evidence suggests that such activities can represent a powerful influence on the way that health care workers think about QOC, and how far they feel able or willing to propose alternative ideas. Organisational or professional cultures (i.e. not explicit organisational rules, rather implicit understandings about how things are, or should be) have been shown to influence the actions of frontline staff (Bail *et al.*, 2009; Francis, 2013; Zhang *et al.*, 2015). So, whilst on one hand, implicit rules and understandings appear to offer opportunities for frontline workers to influence QOC in ways which may not be immediately obvious, they may also represent a further organisational barrier which encourages compliance with existing views of quality, and stifles alternative concerns or ideas.

This section explores the view that frontline NHS health care workers have a key role in maintaining and potentially improving the quality of the services they deliver. The literature presented offers a view that control over quality has shifted at least some way from frontline health care professionals, to be replaced by formal mechanisms and managerial control, and that this shift has compromised the extent to which frontline NHS workers are willing or able, to instigate change based on their own views about QOC. Formal organisational rules, structures, and mechanisms are presented as entities that have been imposed upon frontline workers, and which have potentially shifted the amount of personal responsibility frontline workers feel for the quality of their services. Workers who feel unhappy about the quality of the services they offer are generally presented as active (engaging with formal QM quality mechanisms, or bypassing them by *"whistleblowing"*) or passive (accepting and continuing to support suboptimal care standards). Passive workers are presented as problematic, and methods to oblige them to disclose concerns, and encourage them to engage in developing ways to improve problems, have been described. Often these focus on ways to reduce organisational barriers to frontline engagement with the implied assumption that they are the key reason why frontline workers do not engage.

1.3 The Distribution of Power in Organisations

A number of social theories focus on the ways in which individuals think and operate when they are part of a larger organisation. These theories offer context to instances where frontline workers in the NHS might accept and continue to support suboptimal standards of care. Importantly, they also help to challenge assumptions that (a) the only barriers to their engagement in improving quality are those that are imposed upon them by their organisation, and (b) those that do not engage in visible forms of action are therefore passive and not contributing to the maintenance or improvement of the quality of their services. Overall the literature presents an argument that any attempt to understand the role of frontline NHS workers in managing the quality of their services must consider the formal and informal power structures that develop at the micro and meso levels of organisations.

1.3.1 Structure and Agency

> “Do individuals act in response to external circumstances as much as mainstream academic sociology tends to assume? Is individual action determined by “culture”, “social structure”, or “mode of production”? Or, do actors act for their own identifiable reasons as the phenomenological, interpretative, and rational-actor schools of the social sciences maintain? These questions point to what Giddens identifies as one of the central problems in contemporary social theory, namely, the relation of agency and structure” (Swartz, 1997; p8).

As a starting point it is useful to consider how individuals relate to, and influence, their societies; the concepts of “*structure*” and “*agency*” are key to exploration of this issue (O'Byrne, 2011). Whilst there is no consensus as to the specific meanings of these terms structures have been described any number of ‘*social fields which exist outside the individual’* (Morrison, 2006; p4) and which consist of *“rules and resources, recursively implicated in the reproduction of social systems”* (Giddens, 2013; p377). Agency has been described as the ability an individual has to “*act*” and to do so *“in a controlled and knowing way”* (O'Byrne, 2011; p227). Those with agency are sometimes referred to as agents.

The development and legitimisation of shared societal understandings has been described by Scott (1987) as "*institutionalisation*". When shared understandings become *"taken for granted as defining the 'way things are' and/or the 'way things are to be done"* (Scott, 1987; p496) these understandings are described to become institutionalised structures. The term 'structure' can be applied to a variety of fields, from macro level (e.g. religion, economic models) to micro level (e.g. individual communities and families (O'Byrne, 2011). They are not always obvious or enshrined in formal rules and laws, but are rather learned through social interaction. They compel individuals to conform and follow their rules because of the anticipated consequences attached to failure to do so, including social exile and withdrawal of resource, support or legitimacy (Scott, 1987).

> "Institutionalization is rooted in conformity – not conformity engendered by sanctions (whether positive or negative), nor conformity resulting from a 'black box' internalization process, but conformity rooted in the taken-for-granted aspects of everyday life. Institutionalization operates to produce common understandings about what is appropriate and, fundamentally, meaningful behaviour" (Zucker, 1983; p5)

As health care workers in the NHS are also members of wider society, any number of institutionalised structures are likely to affect their agency (e.g. norms relating to gender or social class). The unifying feature for all frontline NHS workers is their paid employment within an NHS organisation and so the focus of this thesis is the formal and informal structures that might impact on the agency of individuals working within formal organisations.

The relationship between structure and agency has been conceptualised by different theorists on a spectrum from (a) human agency being absolutely constrained by social structures, to (b) social structures being a consequence of human agency (Layder, 1985). Contemporary theorists have proposed models which describe a more fluid and dynamic interaction between the two, such that the existence of each is dependent on the other (as in the concept of "*duality*" described by Giddens (Reed, 2003), or the "*Theory of Practice*" described by Bourdieu (Bourdieu and Wacquant, 1992; Swartz, 1997)). Structures can then be considered to be both enablers and constrainers of human agency.

> “Structures are ‘rules and resources’ which give meaning to and shape the situations we find ourselves in. By being knowledgeable about these structures, we are able to exercise agency, which means we can find ways of doing things. Agency is impossible without structure, the present impossible without the past, yet structure itself is determined by what people actually do in the present” (O'Byrne, 2011; p208)

Understanding the rules of the structures within which one operates, can confer individuals (or groups of individuals) with the power to act, and their actions then influence those structures (by changing or supporting them). Importantly this may not occur consciously (i.e. individuals may fail to recognise how their actions contribute to the continuation of structures). Interviews with newly qualified health care professionals, for example, has often shown that their socialisation into the workplace requires them to compromise on their beliefs about the nature of high QOC. In order to fit in and be accepted in the workplace (e.g. to gain the trust of existing staff) they learn to assimilate the pre-existing structures that consist of the formal and informal understandings already operating amongst their colleagues. By subordinating their own views about QOC to these “structures”, they lend tacit support to the idea that their own views are less important or practical. Their inactions (i.e. in failing to challenge the status quo or propose an alternative way) and actions (i.e. by delivering care to a standard that they may consider to be suboptimal) thus support and replicate these dominant structures and allow them to retain power (Maben *et al.*, 2006; Hobbs, 2012; Barry *et al.*, 2014).

As discussed earlier in this chapter, the literature has consistently identified meso-level organisational structures that are described to support or suppress frontline NHS staff to engage in QM activities (e.g. the use of formal QM mechanisms and hierarchical organisational models of power distribution); the impact of these on individual agency is explored in section 1.3.2. What is less well understood is the extent to which informal structures which develop at meso or micro level (i.e. within wards and departments, or between colleagues) might present a different, but similarly powerful, influence on the way frontline workers act or believe they can act; this is explored further in section 1.3.3. By considering these two aspects in turn I demonstrate the value in expanding understandings of organisational structures beyond formal and visible organisational practices, by encompassing the informal understandings that might develop between frontline workers. Furthermore, this literature suggests the importance of considering the ways in which the actions (and inactions) of frontline workers might support or subvert the structures within which they occur.

1.3.2 Organisational Structures and Worker Agency

Organisations are social structures within which individuals act collectively to achieve a common goal (Korczynski *et al.*, 2006). Organisations share a number of characteristics (e.g. common goals, shared understandings) but employing organisations have particular features (e.g. economic exchange in return for labour and contractual obligations). Currently, most frontline NHS workers are employed directly by NHS organisations[8] so theories pertaining to formal organisations have the potential to help understand the issue of frontline engagement in quality defence and improvement activities in the NHS.

There are many ways to configure an organisation. Some of the literature describing the limitations NHS structures place on frontline workers has considered the contribution of the bureaucratic model. The term "bureaucracy" is frequently used in a colloquial way, to indicate the presence of unnecessary and inefficient organisational rules; the NHS has publicly been criticised for being overly bureaucratic in both in the popular (Farrar, 2013; Grant, 2015) and professional presses (O'Dowd, 2011; Ford, 2012). Bureaucracy has, however, been conceptualized theoretically by several philosophers; the most prominent being Max Weber (1864-1920).

Weber's bureaucracy describes an organisational model that was conceptualised as the pinnacle of efficiency, rationalisation, and control. Morrison (2006) describes the key features of Weber's "*ideal type*" bureaucracy; they include its highly structured, uniform and impersonal nature, and its focus on careful means-versus-ends calculations that aim to achieve optimal outcomes within the resources available. Bureaucracies involve "*a chain of command which is hierarchically organized*" and bureaucrats have a tendency "*to treat people in terms of 'cases' rather than individuals and remain impersonal in their contacts with the public*" (Morrison, 2006; p383). Bureaucratic models, by their nature, place significant constraints on the agency of workers; individuals are expected to act in accordance to centrally defined rules designated at a strategic level. Whilst this promises optimal equity and efficiency, Weber noted his concern that this left workers in an "*iron cage*", divorced

---

[8] Some healthcare workers may be contracted to provide NHS services whilst being directly employed by another organisation or self-employed, however the majority of individuals delivering frontline NHS services are employed by an NHS Trust Health and Social Care Information Centre (2016) 'NHS Workforce Statistics - March 2015, Provisional Statistics; National Table' 22nd June 2016. 1st July 2016. p. 2. Available at: http://www.hscic.gov.uk/catalogue/PUB20913/nhs-work-stat-mar-2016-nat-hee-tab.xlsx.

from their personal ethics, and reducing their actions to compliance and the performance of mechanistic tasks, leaving them as "*specialists without spirit, sensualists without heart"*(Weber *et al.*, 2001; p124). Bureaucratic models can further restrict individual agency by relying on mechanisms such as functional specialism and means-ends separation; this means that work is broken down into tasks which are managed separately by different workers, thereby reducing the amount of control any one individual can exert over the overall outcome and, in some cases, separating individuals completely from the outcomes of their actions.

Du Gay (2000) outlines a number of criticisms frequently found in the literature pertaining to Weber's bureaucratic model. It has been described as a failed paradigm due to perceptions about its tendency towards the overproduction of rules that hinder flexible working and the ability to respond to uncertainty and change. Its highly rationalist focus has been described to marginalise aspects of life that do not easily fit within that focus (e.g. emotions). These features can have negative impacts on workers who object to the impersonal rules designated within the organisation, but who feel they have no agency to insist on change. For example, health care workers who find themselves supporting aspects of care they feel to be suboptimal have been described as feeling anger, resentment, and loss of self-respect (Jameton, 1984). The bureaucratic model, however, also offers workers ways to deal with this situation by deflecting responsibility for their contributions to services offering suboptimal QOC by allowing them to claim (a) powerlessness and (b) a lack of awareness of how their individual actions might contribute to undesirable outcomes (Adams, 2011). This defence has been observed in several contexts, including cases even where organisational outcomes have been described as ethically outrageous (e.g. workers who enabled the Holocaust (Bauman, 1991; Cohen, 2001; Adams, 2011).

Du Gay (2000) also notes, however, that the bureaucratic model offers some ethically important advantages (e.g. the model emphasises equity and operates to minimise the chances of workers applying their own preferences and prejudices in ways that discriminate against service users and colleagues). Weber also described the ideal type bureaucracy as a theoretical tool, rather than a blueprint, and it is acknowledged that organisations rarely, if ever, exhibit all of the features of bureaucracy comprehensively and consistently (Korczynski *et al.*, 2006). Similarly, it is acknowledged that a literal and complete translation of the bureaucratic model into a real life organisation may be neither desirable nor achievable.

With respect to NHS organisations some features of a classical bureaucracy can be appreciated; for example, in instances where NHS Trusts have been noted to overly focus on the achievement of external markers of quality at the expense of the actual QOC experienced by their patients (Francis, 2013). In some respects, however, NHS organisations deviate from the "ideal type" and a key difference between a traditional bureaucracy and NHS organisations is the professional qualifications and status held by many frontline NHS staff. Organisations which balance bureaucratic and professional features in this way have been described in the literature as "*professional bureaucracies*" (Mintzberg, 1979). Professional bureaucracies, as applied to the health services, were initially described with regards to the medical profession (Turner and Samson, 1995), but the subsequent professionalisation of other health care workers (e.g. nurses, midwives) have extended the concept (Kirkham, 1998).

There is a large body of literature on the role of professionals in society, with sometimes conflicting perspectives on the motivations of professionals and the impacts associated with professionalisation (Turner and Samson, 1995). Regardless of the perspective taken there seems to be broad agreement that professionalisation offers "*material and symbolic*" benefits to workers (Turner and Samson, 1995) including a degree of autonomy for professionals over their practice (Ham, 2009) and regulation from within the profession (The Nursing and Midwifery Council, 2012; General Medical Council, 2013).

The autonomy of frontline health care professionals challenges the concept of the highly constrained bureaucratic frontline worker; instead it suggests that the understandings and responsibilities of professional frontline workers extend beyond those dictated by their employing organisation (Dickinson *et al.*, 2012). This can lead to tension and conflict between professionals and bureaucrats where organisational and professional priorities diverge, and Johnson suggests it is "*not unusual for professionals to resent or resist the 'bureaucracy'"* (Johnson, 2008; p272) by drawing on other sources of authority. It is important to acknowledge that the nature, extent, and purpose of professional autonomy in the health services is contested in the literature, as are the motivations of health care staff to engage in autonomous practice. The medical profession, for example, has been presented as an altruistic group that is "*interested in the wellbeing of patients rather than individual gain*" and will act autonomously accordingly regardless of conflicting organisational demands (Graham, 2006). A number of authors have challenged this assertion; for example, (Freidson, 1988) who described the autonomy of medical professionals as being reliant on their relationship with the State and as being a pre-requisite to their retaining power over other health care workers (e.g. nurses, midwives).

Aside from these macro-level debates, that professional health care workers can be described as resistant implies that they have some amount of agency to assert their individual views about QOC. There is empirical evidence to suggest that, compared to non-professional colleagues this is the case (Peter *et al.*, 2004) but it has also, however, been argued that professionalisation creates yet another structure, laden with formal and informal rules about acceptable ways to think and act (Wells, 1997; Maynard-Moody and Musheno, 2003; Adams, 2011). The nursing and midwifery professions, for example, are often linked to "caring" activities and are thus influenced to operate in ways that maintain their "caring" identity (Reiger and Lane, 2013; McAllister *et al.*, 2014). Additionally, the ways in which health care professionals balance their relationships with both professional and organisational structures is complex. Health care professionals have been described as complicit in prioritising externally defined performance targets, even when they themselves do not consider them to be useful measures of quality, in order to maintain an external appearance of success and professionalism (Elston, 2009; Rozenblum *et al.*, 2013; Martin *et al.*, 2014). Similarly peer pressure has been implicated in deterring health care staff from publicly acknowledging concerns about quality of care (Adams, 2011). Work conducted with frontline workers who have disclosed such concerns reports disapproval and ostracism from both organisational superiors and from professional colleagues (Jackson *et al.*, 2010; Peters *et al.*, 2011).

Models of bureaucracy therefore offer some insight into the formal structures that may support or restrict the agency of frontline health care workers to respond to aspects of health care which they consider to be of suboptimal quality. The relevance of bureaucratic models to the NHS has been further questioned by some since the development of the New Public Management model which introduced competition and consumer choice as a means of replacing, at least theoretically, organisational or professional structures as the main drivers of health care quality (Baggott, 2004). However others have argued that other aspects of the NHS remain within centralised control (e.g. standardization of care via National Service Frameworks, monitoring of standards via the Care Quality Commission, standardised payment for NHS activities via the National Tariff Payment system) meaning that vertical hierarchies continue to co-exist with flattened horizontal forms of organisation (Schofield, 2001; Thompson and Alvesson, 2005).

The literature thus supports the idea that the NHS has developed hybrid organisational structures incorporating features of multiple organisational models (Hoggett, 1996; Thompson and Alvesson, 2005; Courpasson and Clegg, 2006; Olsen, 2006; Exton, 2010). Baker and

Denis (2011) note that the fusion of different organisational models has been mirrored by the development of organisational roles that blur the boundaries between traditionally professional and bureaucratic focused jobs (e.g. health care professionals taking on typically managerial and administrative responsibilities). These roles should, in theory, increase the agency of such workers to influence quality of care by raising their organisational status, but the literature suggests that acknowledging the requirements of both professional and bureaucratic structures is a challenge. In a study based in social care, for example, Evans (2010) suggested that professional identities are wedded to notions of client centredness and care for individuals which has traditionally allowed professionals to deflect responsibility for difficult decisions about the allocation of finite resources towards managers who "don't understand". Hybrid roles challenge these traditional identities and can result in cognitive dissonance for post holders as they attempt to resolve conflicting priorities and loyalties (Clarke, 1998). Conflicts about the rationalisation of care (e.g. balancing the needs of individual patients versus the need to manage groups of patients) have been observed in workers occupying both traditionally professional and bureaucratic roles (Ruston, 2006; Attree, 2007; Evans, 2010), challenging assumptions that frontline health care workers and managers have inherently different priorities or understandings about quality.

The role of non-professional staff working on the frontline of the NHS is slightly different, given the lack of opportunities for membership of an external clinical network. In March 2016, around 31% of staff employed within the NHS in England were described as "*support to clinical staff*". Such workers generally do not hold a professional qualification but they are often intimately involved in the delivery of frontline NHS services (Warr, 2002). Their role is typically placed near the bottom of the organisational hierarchy (e.g. they are paid less and have limited power to define the boundaries of their role) and they are not able to appeal to the additional agency and resource which professional status incurs (Warr, 2002; McCloskey, 2011). McCloskey (2011), exploring the role of non-professional health care workers in Canada, suggests that this places them in a particularly weak position to report concerns or instigate change since they are subordinated by both managers and professional frontline colleagues.

This section has outlined the ways that formal bureaucratic structures may offer an explanation for the reasons why frontline NHS workers may fail to report or address suboptimal care practice of which they are aware (e.g. because, as a frontline worker, they are constrained by the organisational structures that impose a specific view of QOC that may differ to their own). It has also, however, been argued that some frontline NHS workers hold a professional status that confers some power and authority to act.

1.3.3 Informal Organisational Structures

The previous section considered bureaucracy and professionalism as organisational and occupational structures that affect the agency of frontline health care staff. In this section I argue that, beyond these explicit and well-recognised structures, more implicit structures are also present within the social environments where frontline of care delivery occurs (e.g. wards, surgeries, departments) and that these *"street-level"* structures may possess the ability to both constrain and support frontline involvement in QM activity.

There is broad acknowledgement in the literature that, within organisations, formal organisational policy is only one part of the knowledge that informs the day-to-day activities of workers. The development of shared understandings and ideas about the best way to deal with different situations has been observed generally (Zucker, 1983), and in health care organisations specifically (Wieringa and Greenhalgh, 2015). This concept features in a number of theories and concepts (e.g. Bourdieu's description of habitus, the concept of cultural health capital (Shim, 2010)).

Whilst there are differences in these concepts there are key unifying factors. Unlike the rational means-ends calculations described in the bureaucratic model, these street level understandings are generally based on resources such as experience, anecdote, emotion, relationships, and attitudes about how things should be (Marinetto, 2011; Wieringa and Greenhalgh, 2015). Their validity rests in their local acceptance (rather than by attempts to quantify or evaluate using research methods), and they are often not communicated formally (e.g. by formal policy) but by peer-to-peer word of mouth.

> "the variety of designations, nonetheless, all evoke the idea of a set of deeply internalized master dispositions that generate action. They point toward a theory of action that is practical rather than discursive, pre-reflective rather than conscious, embodied a well as cognitive, durable though adaptive, reproductive though generative and inventive, and the product of particular social conditions though transposable to others" (Swartz, 1997; p101)

These underlying structures may be difficult to analyse because they can be unrecognised or unquestioned by those who support them; they may instead be "*taken for granted*" or considered to be “*common sense*” (Zucker, 1983; p443). Alternatively they may contradict explicit organisation policy and therefore be administered and communicated in ways that deliberately shield them from organisational superiors. Theories about these shared understandings suggest that they are powerful and can affect the human agency of workers just as formal organisational structures do (Scott, 1987); in this respect structures are not viewed as being merely imposed but "*perpetuated or transformed by FL staff activities and collective learning*" (Bjerregaard and Klitmoller, 2010; p429).

The role of these understandings in managing quality is poorly understood. They could represent a way in which frontline NHS workers can silently engage in the management of quality within their services as per the examples given in section 1.2.5. In fact, the push to engage frontline workers in quality management in the NHS could, in part be considered an attempt to capitalise on these hidden understandings by encouraging frontline workers to share them and make them explicit (Loyens and Maesschalck, 2010; Wastell *et al.*, 2010).

An underlying assumption of many NHS frontline engagement programmes is that the shared understandings developed at the frontline will always be driven by a wish to protect or improve quality of care, however there is evidence that they can also act to undermine quality of care. At the University Hospitals Morecambe Bay NHS Foundation Trust, accepted, but flawed, understandings were perpetuated within the maternity workforce, leading to negative outcomes for mothers and babies. An investigation suggested that even staff who did not fully agree with these understandings ultimately complied with them, thus they remained accepted and continued unchecked for some time (in fact the public investigation was prompted not by the organisation or its frontline workers, but by “*the efforts of some diligent and courageous families, who persistently refused to accept what they were being told*” (Kirkup, 2015; p5)). In Morecambe Bay there was no suggestion that frontline maternity workers were deliberately attempting to harm those under their care, but rather that they inappropriately pursued a professional belief about what constitutes good quality of care. In this example the actions of frontline workers were supporting a dominant professional understanding (promoting the “normality” of childbirth, a well-accepted ethos within the midwifery profession).

> “midwifery care in the unit became strongly influenced by a small number of dominant individuals whose over-zealous pursuit of the natural childbirth approach led at times to inappropriate and unsafe care” “there were ‘… a couple of senior people who believed that in all sincerity they were processing the agenda as dictated at the time… to uphold normality… there’ve been one or two influential figures who’ve perpetrated that… sort of approach and… there’s nobody challenging….’” (Kirkup, 2015; p13-14)

Frontline workers might also routinely develop shared understandings that support organisational priorities, even if the workers themselves explicitly disagree with those priorities (Deery, 2008). This is a phenomena depicted in the concept of Street Level Bureaucracy described by Lipsky (2010). Lipsky specifically considered the work of frontline workers in public services and suggested that they work under a number of challenging circumstances. Lipsky noted that such frontline workers deviate from those in a typical bureaucracy in so far as they “*have considerable discretion in determining the nature, amount, and quality of benefits and sanction provided by their agencies*”(Lipsky, 2010; p13). This discretion largely results from the complex and unpredictable conditions in which street level bureaucrats have to operate, and the one-to-one nature of their interactions with service users.

Lipsky suggested that “*the helping orientation of street-level bureaucrats is incompatible with their need to judge and control clients for bureaucratic purposes*” (Lipsky, 2010; p73). This leads them to develop “*shortcuts and simplifications*” in the way they deliver services in ways that allow them to control their clients and gain compliance (Lipsky, 2010). These may include making judgements about the deservedness of different clients, influenced by attributes such as personal values or societal stereotypes. It is not suggested that workers are unconcerned with issues of quality or the experiences of their clients, and they may in fact consider their actions to represent a way to secure the best quality possible within the confines of the limited resources available. Where these patterns become routinised they, in effect, become implicit local policies. The discrete actions of street level bureaucrats are often overlooked or tolerated on a discretionary basis by managers, even when they contradict formal organisational policy, because the control of clients and processing of workload is understood to be critical to reaching organisational goals or targets (Evans, 2011; Evans, 2015).

Whilst Lipsky first applied this concept to a social work context, it has subsequently been applied to a number of public service contexts, including health care (Bergen and While, 2005; Condon, 2008; Finlay and Sandall, 2009; Hajjaj *et al.*, 2010). In nursing, for example, Bergen and While's study demonstrated how community nurses reshaped client perceptions of their needs to ensure they matched the resources available to them (Bergen and While, 2005). These strategies remain functional as long as all parties agree to comply with them (Hjorne *et al.*, 2010) but they can also contribute to dysfunctional organisational cultures and this may only become obvious once the nature and impact of these shared understandings are made explicit and scrutinised (McCloskey, 2011).

When considering the role of frontline health care workers, and their role in defending or improving QOC, a key feature of both Weber's and Lipsky's models of bureaucracy is the extent to which they provide a way to understand how frontline NHS staff might reject responsibility for the QOC standards of the services they deliver. In both instances those occupying frontline roles are able to claim to be bound by circumstances they have little control over and to be following orders that they are powerless to refuse. In this way frontline workers are able to publicly denounce an organisational strategy whilst simultaneously supporting it by their discrete actions, allowing them to retain the identities of both a good employee and a caring practitioner. In an organisational environment where health care workers are encouraged to be "*resilient*" and continue to function despite the complex demands health care work places on them, structures that allow workers to deflect responsibility for quality failings may be very useful (Hunter, 2004; Jackson *et al.*, 2007; Wallbank and Robertson, 2013; Hunter and Warren, 2014).

In summary, the literature described in this subsection supports the idea that, alongside formal organisational policies that influence the ways that NHS workers operate, informal policies develop and circulate at the frontline. These informal policies emerge from frontline workers themselves and might be driven by a number of motivations, including the wish to manage QOC and the wish to maintain functionality in the face of difficult working conditions. The importance of these implicit policies is that they offer a way for frontline workers to exert power in the workplace. They also, however, simultaneously have the potential to constrain the agency of individual workers because they are implemented and moderated via peer pressure). Because they operate beyond the radar of formal organisational policy and control their contribution towards quality management remains poorly understood.

1.4 Chapter Summary

This chapter has suggested that quality of care is an important concept in the National Health Service and has outlined a number of formal mechanisms employed in NHS organisations to secure and improve care, and to measure performance in delivering quality. It has been suggested that these mechanisms sometimes have unintended consequences and that they represent a very rational, but potentially superficial, way of measuring the very complex, and frequently contested, concept of quality in health care. The ambition to increase the engagement of frontline NHS workers in the defence and improvement of health care quality has been described; the challenges of achieving this and the reasons such workers may or may not engage in both formal and informal activities has been explored.

Social theories have been used as a lens to view the social and organisational influences that may impact on the ways in which frontline workers in the NHS manage QOC on a day-to-day basis. They suggest that workers are influenced by a complex arrangement of formal and informal structures that can affect how much freedom they realistically have to engage in quality management activities. It also suggests that frontline workers often engage in activities that are not visible or obvious beyond the wards and departments within which they operate, and that these activities may support or disrupt existing organisational priorities (see Figure 1-3). Frontline workers may find engaging in formal QA/QI activities challenging and prefer to rely on shared frontline understandings that allow them to retain the identity of a caring health care worker.

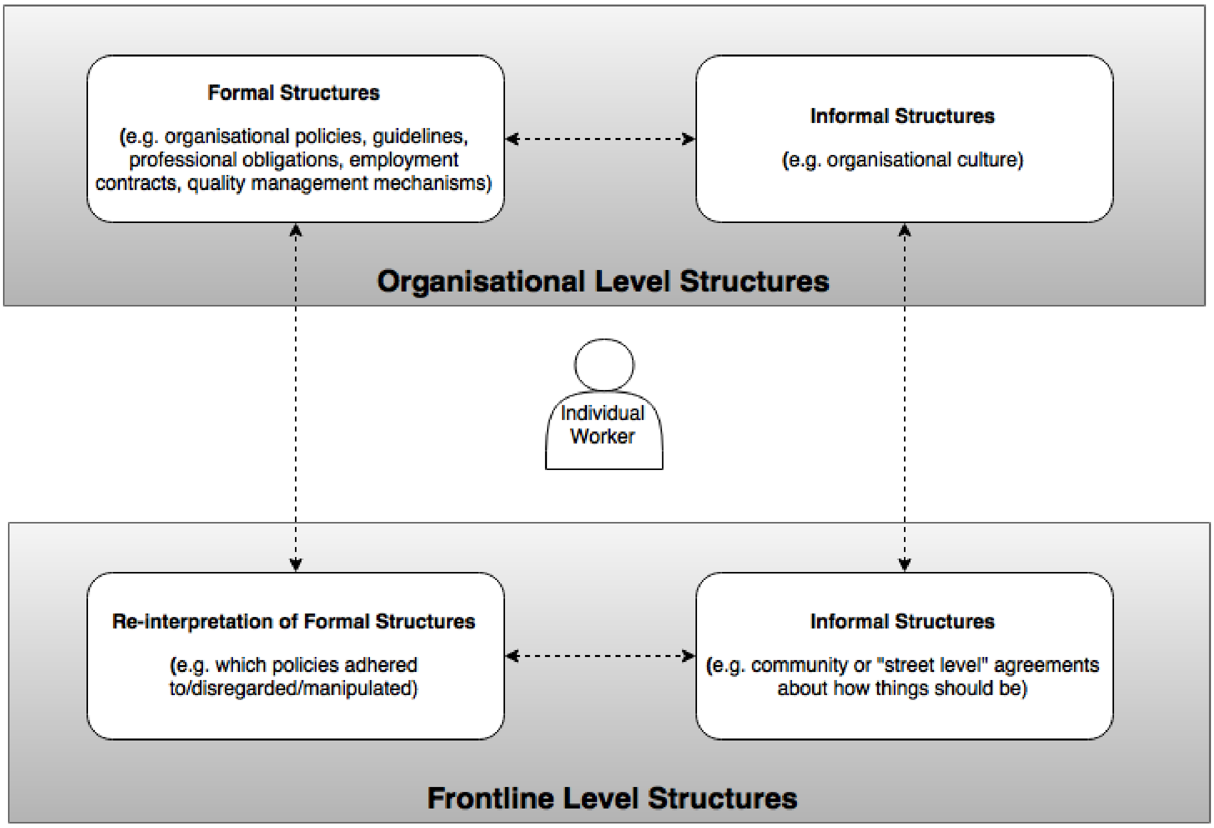


Figure 1-3. Formal and Informal Organisational Structures

Taken together, these literatures suggest that consideration of the ways in which frontline NHS workers react to instances of suboptimal care requires an understanding of both the formal and informal structures that dictate the ways in which frontline workers feel that they can and cannot work. The evidence base exploring the impact of formal structures is reasonably well established, however the informal street level understandings and bureaucracies which develop at the frontline of care delivery are less well understood; e.g. how they develop, how they are understood by frontline staff, and the ways in which they may contribute to improved care (or, conversely, the replication of suboptimal care). Exploring these street level activities offers the opportunity to challenge the image of frontline workers as either passive or active in managing care quality, and to understand the reasons why attempts to engage frontline workers in formal quality management activities are not always successful. It also offers an opportunity to make a valuable new contribution to the evidence base regarding the reasons why and how frontline NHS workers respond to instances of suboptimal care. Exploring this aspect of organisational practice is therefore the focus of this thesis.

Chapter 2 Review of Literature on Early Miscarriage

The previous chapter provided an overview of the concept of quality in health care and the involvement of frontline NHS workers in managing quality. This chapter presents a literature review of the health care services offered to women experiencing a miscarriage. This is offered as an exemplar of a form of health care in which patient, staff, and organisational perceptions of quality vary, and where on-going discordance between patient expectations of care, and their experiences of care, persists.

A search of the evidence base was conducted using the keywords “spontaneous abortion OR miscarriage OR pregnancy loss”, combined with “healthcare OR health care”. Databases searched were MEDLINE, Psychinfo, EMBASE, Cinahl, Pub Med, Scopus and Web of Science. After outlining the definition and impacts of miscarriage, the dominant models of care delivery are explained. Women’s understandings of miscarriage and their views about the health care provided during the miscarriage process are explored. The ways in which quality is managed within the sphere of health care for miscarriage and reasons why gaps between patient expectations and experiences might persist are discussed. Finally, the extents to which frontline health care workers recognise shortcomings in health care for miscarriage is explored.

2.1 Definition and Impact of Miscarriage

2.1.1 Definition of Miscarriage

Miscarriage is defined by the World Health Organisation as “*the spontaneous termination of a pregnancy before the fetus has attained viability, i.e. become capable of extra-uterine life*” (The World Health Organization, 2006; p44). Currently, in the U.K., the spontaneous loss of an intrauterine pregnancy[9] before 24 weeks of gestation is considered to be a miscarriage unless the fetus, once delivered, shows signs of life[10] (*Still-Birth (Definition) Act 1992 c.29* (1992). There are several subcategories of miscarriage that are differentiated by either clinical features, or by the stage of the miscarriage. The features of these subcategories can

---

[9] Different terminology is applied to extra uterine pregnancies (i.e. ectopic pregnancy)

[10] Some deliveries occurring at later gestations (22-24 weeks) result in a livebirth. If such a baby dies shortly after birth, legally this is described as an infant death rather than a miscarriage.

have a significant impact on the treatment choices offered to a woman. Table 2-1 describes different subcategories of miscarriage[11].

Category	**Description**
Spontaneous miscarriage	The miscarriage has commenced without intervention
Complete miscarriage	The miscarriage has completed and the uterus is empty
Anembryonic pregnancy	The pregnancy has formed without a fetus/embryo (or the embryo has demised at a very early stage)
Incomplete miscarriage	A miscarriage has commenced but has not completed
Threatened miscarriage	Symptoms of a potential miscarriage exist but the pregnancy remains intact / viable
Inevitable miscarriage	The pregnancy remains intact but the cervix is open and miscarriage is inevitable
Septic miscarriage	Miscarriage has commenced but remnants of the pregnancy remain in the uterus and are infected
Pregnancy of Unknown Location	Miscarriage occurs before the pregnancy is visible on ultrasound and biochemical markers are the only indication of the pregnancy.
Recurrent Miscarriage	three or more consecutive miscarriages

Table 2-1 Types of Miscarriage

2.1.2 Prevalence of Miscarriage and Health Care Usage

Miscarriage is the most commonly experienced form of pregnancy loss; it is estimated that approximately 20-30% of all conceptions end in a miscarriage (Wilcox *et al.*, 1988) and that up to 25-33% of women will experience at least one miscarriage during their lifetime (Nojomi *et al.*, 2006; Blohm *et al.*, 2008). This is a conservative estimate as many miscarriages will

---

[11] Other types of pregnancy loss < 24 weeks gestation are molar pregnancy and extra uterine pregnancy (including ectopic pregnancy); these conditions have differing physical and management consequences and are not included in this review of the literature.

occur before conception has been recognised, or will complete without health care being sought (Wilcox *et al.*, 1988; Blohm *et al.*, 2008). Additionally, confusion with voluntary termination of pregnancy makes true global estimations of miscarriage complex (Haws *et al.*, 2010). The majority of reported miscarriages occur within the first 13 weeks of pregnancy and are classed as an "*early miscarriage*" (National Institute for Health and Care Excellence, 2012a).

Most women experiencing miscarriage in the U.K. will access healthcare at some point for diagnosis or treatment; in the financial year 2014/15 38,377 women were admitted to an NHS hospital in England as a result of a miscarriage (Health and Social Care Information Centre, 2016). Admissions have been relatively stable over the period that maternity statistics have recorded this information, although there has been a slight drop in numbers since 2010, perhaps reflecting trends across health care to treat early miscarriage on an outpatient basis (see Figure 2-1); a large proportion of the health care is now offered to women on an outpatient basis (in terms of assessment, diagnosis, and treatment). Data relating to outpatient management of miscarriage is not recorded nationally so it is not possible to calculate the total cost of miscarriage related health care to the NHS.

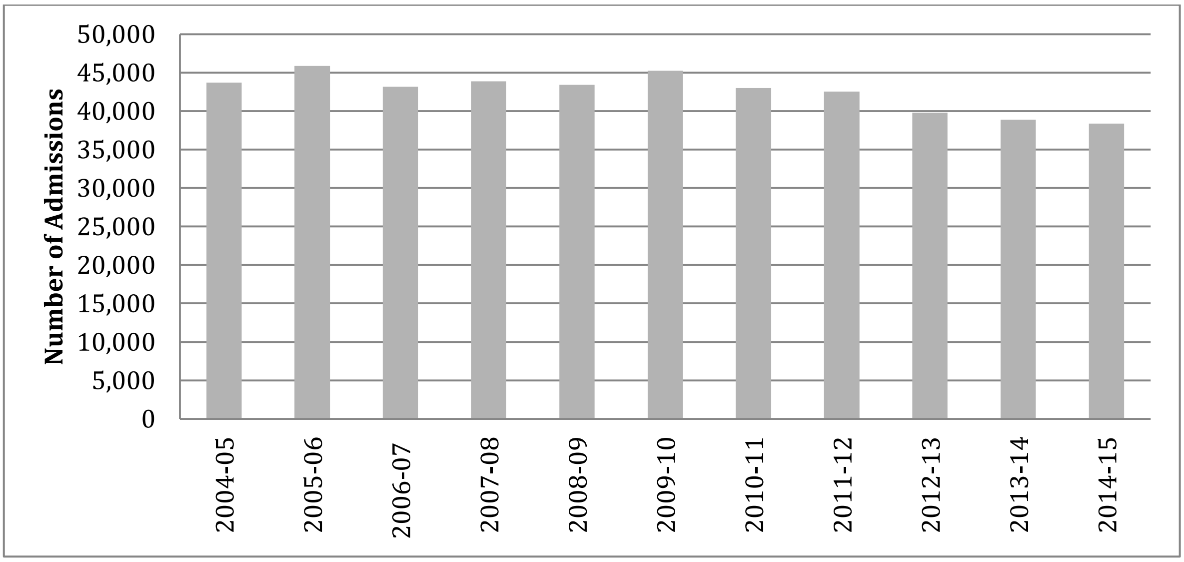


Figure 2-1 Number of Miscarriage Related Hospital Admissions in England, 2004-2015

2.1.3 Aetiology of Miscarriage

It is generally not possible to prevent a miscarriage[12], particularly in the first trimester. Research exploring the reasons why miscarriage occurs have linked it to the high proportion (approximately 60%) of chromosomal or structural anomalies found in miscarried embryos/fetuses (Goddijn and Leschot, 2000); in the majority of cases these anomalies occur spontaneously rather than being inherited from the parents. Higher rates of miscarriage have also been linked to a number of social, medical, physiological, and lifestyle factors (e.g. advancing maternal age (Khalil *et al.*, 2013), maternal smoking (Pineles *et al.*, 2014), maternal obesity (Thanoon *et al.*, 2015), and occupational exposures (Bonde *et al.*, 2013)). The cause(s) of individual miscarriages are generally not investigated so most women experiencing a miscarriage will receive no information about why it happened.

For this reason miscarriage prevention strategies are generally not aimed at a woman at the time of her miscarriage, but rather on the management of any future pregnancies she may have. This has included advising on modifiable lifestyle factors with the aim of improving pre-conceptual health. Women experiencing recurrent miscarriage are often offered further investigation into any medical, physical or genetic factors that may explain the recurrence.

2.1.4 Physical Impacts of Miscarriage

Historically miscarriage has been considered to be physically hazardous and associated with potential maternal morbidity and mortality (Reagan, 2003). Surgical techniques aimed at completing the miscarriage as quickly as possible were therefore developed and adopted widely (Trinder *et al.*, 2006). However contemporary health practices (e.g. improved ultrasound diagnostic techniques) have meant that mortality related to early miscarriage is now rare in the developed world.

In cases of a low risk miscarriage (i.e. in the absence of underlying medical conditions), emergency situations and long-term negative physical outcomes are unusual, however short term adverse outcomes have been reported (e.g. genital tract infection (Chung, Lee et al.

---

[12] Cervical cerclage has been used in cases where cervical weakness has been implicated as the cause of recurrent second trimester miscarriages to try and prevent late miscarriage in a subsequent pregnancy. This involves a stitch being inserted into the cervix during pregnancy. It is a technique which involves a number of risks and so is used very selectively Suhag, A. and Berghella, V. (2014) 'Cervical cerclage', *Clinical Obstetrics and Gynecology*, 57(3), pp. 557-567.

1999, Trinder, Brocklehurst et al. 2006, Sur and Raine-Fenning 2009)). The process of early miscarriage generally involves some unpleasant physical symptoms including vaginal blood loss (Chung *et al.*, 1999; Gracia *et al.*, 2005) and pain (Trinder *et al.*, 2006).

The literature suggests that many women feel unprepared for these aspects of early miscarriage (Moohan *et al.*, 1994; Murphy and Philpin, 2010) and that they may consider some aspects (especially pain and bleeding) to be frightening, or even life threatening (Bansen and Stevens, 1992). Poor information provision from health care professionals has been reported and it has been argued that an increased focus on psychological aspects of miscarriage has led to physical aspects being poorly supported by health care staff (Reagan, 2003; Murphy and Philpin, 2010).

2.1.5 Psychological Impacts of Miscarriage

Interest in the way that miscarriage impacts on a woman's emotional and psychological health is relatively recent (Reagan, 2003), just as it is for other forms of pregnancy and neonatal loss (Moulder, 1998). Miscarriage has been associated with a number of emotional responses such as grief, blame, sadness, feelings of loss and anger. Psychological morbidities have also been described including depression and anxiety disorders, as well as a number of other conditions (obsessive compulsive disorder, generalised anxiety disorder, panic disorder, phobic disorders, post-traumatic stress disorder) (Thapar and Thapar, 1992; Neugebauer *et al.*, 1997; Klier *et al.*, 2000; Brier, 2004; Farren *et al.*, 2016).

Meta analyses of this data are complex due to the wide variation in the use of outcome measures, but published research suggests that miscarriage is associated with increased psychological distress at the time of the event. The majority of women go on to have a normal psychological outcome but, for some, the psychological impact can be prolonged (e.g. groups at higher risk of psychological morbidity include women with a diagnosis of missed miscarriage (Adolfsson *et al.*, 2006), women with a history of mental health problems (Rowlands and Lee, 2010), and women displaying high levels of anxiety or depression in the immediate post miscarriage period (Lok *et al.*, 2010)). This can have long term implications, particular for future reproductive events; some researchers have noted a reduced willingness to undergo another pregnancy (Cordle and Prettyman, 1994), whilst others have reported increased anxiety and health care demands in future pregnancies (Conway and Russell, 2000; Hildingsson *et al.*, 2002; Geller *et al.*, 2004; Woods-Giscombe *et al.*, 2010; Bicking Kinsey *et al.*, 2015).

A small number of studies have highlighted a negative impact on the psychological health and wellbeing of partners of women experiencing miscarriage (Conway and Russell, 2000; Abboud and Liamputtong, 2003; Cumming *et al.*, 2007; Kong *et al.*, 2010a; Peel and Cain, 2012; Van Den Berg *et al.*, 2015). Partners have been described as facing specific challenges, for example, in feeling that they must minimise their own feelings of grief in order to support their partner (Puddifoot and Johnson, 1997; Murphy, 1998; Abboud and Liamputtong, 2003; Hamama-Raz *et al.*, 2010). Healthcare services that are most concerned with physical health naturally focus upon the woman experiencing the miscarriage; acknowledgement and support for partners within healthcare has been described to be variable and largely inadequate (Murphy, 1998; Conway and Russell, 2000).

Studies examining the psychological distress associated with miscarriage generally assume that that psychological outcome is related to the experience of having a miscarriage; however it is important to note that the nature and adequacy of the health care offered to women and their partners potentially represents an important confounding factor. Research conducted by Lasker and Toedter (1994) and Rowlands and Lee (2010), in the U.S. and Australia respectively, demonstrated associations between increased satisfaction with care giver and better psychological outcomes (though it is difficult to ascertain the existence or direction of causation in this relationship).

2.1.6 Emotional Impacts of Miscarriage

The emotions experienced by women during and following miscarriage have been described as analogous to bereavement (Beutel *et al.*, 1995; Conway, 1995; Adolfsson *et al.*, 2004). In common with concepts of bereavement the use of rituals and memorials of early pregnancy loss have been described (Brin, 2004). Some authors have noted that as a bereavement, pregnancy loss is atypical; problematic features include variable personal and societal understandings regarding the ambiguous status of the embryo/fetus (Lee, 2012; Chan and Tam, 2014), feelings of guilt and responsibility for the loss, and the impact pregnancy loss has on a woman’s personal and social identity (Reagan, 2003; Frost *et al.*, 2007; Gerber-Epstein *et al.*, 2009; Murphy and Philpin, 2010). These features have led some to suggest that standardised approaches to supporting women, which routinely utilise standard bereavement support strategies, may fail to account for the complex and individual responses women may have to miscarriage, and the social contexts within which they have to manage those responses (Reagan, 2003; Van Den Akker, 2011).

2.2 Miscarriage and Society

2.2.1 Early versus Later Pregnancy Loss

This thesis is particularly concerned with early miscarriage (i.e. that which occurs in the first 13 weeks of pregnancy). Whilst the distinction between early and late is somewhat arbitrary (i.e. there is little difference between miscarriages occurring at 13 weeks gestation versus at 14 weeks gestation) a number of authors have noted disparities in the ways in which earlier losses are conceptualised within society and dealt with within healthcare.

A key observation is that fetal losses later in pregnancy are often assumed societally to be more traumatic than those lost earlier, thus suggesting a 'hierarchy of grief' (Moulder, 1998; DiMarco *et al.*, 2002; Plagge and Atntick, 2009). This has resulted in health care resource allocation being skewed towards those experiencing a later loss (Moulder, 1998). In fact there is limited support for this simple "*gestational model*" of grief and Moulder (1994) argues that other factors, such as investment in, and attachment to, the pregnancy are more relevant constructs on which to base a framework for understanding prenatal loss.

2.2.2 Societal Understandings of Miscarriage

A number of authors have examined how miscarriage is interpreted and experienced within society. International comparisons have highlighted differences in understandings about miscarriage that are shaped by cultural and contextual factors (e.g. religion, normative beliefs) (Cecil, 1994b; Rice, 2000; Abboud and Liamputtong, 2005; Haws *et al.*, 2010; van der Sijpt, 2010). Additionally, different social groups have been suggested to have specific needs and issues in their experiences of miscarriage (for example same sex couples (Peel and Cain, 2012) or teenagers (Brady *et al.*, 2008)).

A key thread, running through much of this literature, is the idea that miscarriage is a subject that generally is not talked about openly in society (Layne, 1990; Renner *et al.*, 2000; Wojnar *et al.*, 2011; Ross, 2015). So whilst miscarriage is a commonly experienced reproductive event, it remains a marginalised experience for many women (Corbet-Owen and Kruger, 2001; Peel and Cain, 2012). A number of factors potentially contribute to this observation, including its relationship to other socially problematic or taboo issues such as vaginal blood loss (Bolton, 2005; Murphy and Philpin, 2010), atypical bereavement (Renner *et al.*, 2000; Betz and Thorngren, 2006; Murphy and Philpin, 2010), the failure of the individual women or of health care professionals to prevent death of a baby (Littlewood, 1999; Frost *et al.*, 2007;

de Kok *et al.*, 2010), and the ambiguous status of both the "*parent*" and the "*baby*" (Littlewood, 1999; Murphy, 2012).

It has been argued that this contributes to a culture wherein miscarriage is not openly discussed and may, in fact, be actively hidden (Ross, 2015). This limits opportunities for a woman to gain support during and after a miscarriage from (a) her usual sources of social support or (b) other women who have experienced miscarriage. The use of the internet by women experiencing miscarriage has been reported in the literature (Betts *et al.*, 2014; Séjourné *et al.*, 2016); often this involves the use of forums within which women share knowledge, experience and opinion (often anonymously) (e.g. Wiki 2010; Mumsnet 2016). The use of "*virtual memorial*" sites has also been observed (Keane, 2009). Organised support groups have been developed, both physically and online, via national patient advocacy groups, the Miscarriage Association (The Miscarriage Association, 2016) and the Stillbirth and Neonatal Death Charity (SANDS) (Sands - Stillbirth and neonatal death charity, 2016). This suggests that women do have on-going support needs and that they use technology and community based support groups to obtain it (Betts *et al.*, 2014). It also suggests that providing support as part of health care may be particularly important for this patient group, in order to ensure that women receive professional support and up to date, evidence based, advice and information.

2.3 Early Miscarriage and Health Care

2.3.1 Assessment of Early Pregnancy Problems

The health services offered to women during pregnancy and childbirth received increased governmental attention in the 1980's and 90's; the 1993 Changing Childbirth report (Department of Health, 1993) for example, emphasized women's rights to choice, continuity and control thus placing women themselves at the centre of policy changes in maternity care. Despite the large proportion of pregnancies that end in early miscarriage, the subject of early pregnancy loss was largely absent from this debate.

Despite the lack of political impetus to address this area of healthcare, the organisation of care for women experiencing miscarriage has undergone significant changes over the past 20 years. Early Pregnancy Assessment Units (EPAUs), facilities dedicated to the assessment and treatment of early pregnancy problems, began to establish in the 1990s. The impetus for this development was to standardise care, increase efficiency, and reduce unnecessary ward admissions (Bigrigg and Read, 1991; Wren and Craven, 1999) and significant cost reductions have been described (Wren and Craven, 1999; O'Rourke and Wood, 2009). The development of EPAUs also enhanced the role of nursing and midwifery staff within early pregnancy care; in many EPAUs, nurse/midwife specialist roles evolved which involved nurses and midwives taking on skills and tasks that were previously the domain of other health care professionals (i.e. the use of ultrasound to diagnose miscarriage). EPAUs have subsequently been introduced throughout the U.K. and also internationally (Akhter *et al.*, 2007; Edey *et al.*, 2007; Hill, 2009; O'Rourke and Wood, 2009; Tunde-Byass and Cheung, 2009; Rhone *et al.*, 2012; Van Den Berg *et al.*, 2014a; Wendt *et al.*, 2014). They have been described as the "*gold standard*" for organisation of care for women experiencing early pregnancy problems (Edey *et al.*, 2007; O'Rourke and Wood, 2009). Providing an EPAU service is a key recommendation of the National Institute of Health and Care Excellence (NICE) guidelines on the management of ectopic pregnancy and miscarriage (National Institute for Health and Care Excellence, 2012a). Numerous papers describing audits of EPAU services have been published and they generally confirm the organisational benefits of this model of care delivery (Akhter *et al.*, 2007; Rhone *et al.*, 2012; Van den Berg *et al.*, 2014b; Wendt *et al.*, 2014). Improved consumer experience was not the primary motivation behind the development of these units, but units that have sought consumer views generally report positive responses (Rhone *et al.*, 2012; Wendt *et al.*, 2014). Additionally, improved morale amongst EPAU staff members has been described (Wendt *et al.*, 2014).

Whilst EPAUs have become the dominant organisational model for the delivery of care for women experiencing problems in early pregnancy, it is important to note that not all miscarriage related care is delivered through such facilities. Women requiring emergency assessment or treatment are routed through Accident and Emergency departments (Edwards *et al.*, 2016) or through Gynaecology specific emergency assessment services (Bacidore *et al.*, 2009; Warner *et al.*, 2012). Some women receive an unexpected miscarriage diagnosis when they attend for routine ultrasound screening within a maternity department. Additionally, EPAUs are predominately aimed at assessment and diagnosis of miscarriage; where in-patient treatment is required women are often referred to other wards or departments and there is no consensus on the preferred nature of those facilities (i.e. whether women experiencing miscarriage are situated alongside maternity service users, women experiencing other forms of pregnancy loss, or patients undergoing other forms of treatment).

2.3.2 Diagnosis of Miscarriage

Miscarriage is diagnosed using diagnostic imaging (ultrasound) and/or biochemical markers (serum human chorionic gonadotropin (HCG) (National Institute for Health and Care Excellence, 2012a). These techniques are used to confirm the existence of an on-going pregnancy or diagnose a complete/incomplete miscarriage. They are also used to rule out or diagnose extra uterine pregnancies since such pregnancies pose a greater physical threat to the woman and require different forms of treatment (Jhamb, 2013).

Diagnosing a miscarriage is sometimes not a simple process; it often requires more than one attendance at an EPAU before miscarriage can be confirmed which extends the length of time between initial identification of a concern and treatment being offered. Detailed algorithms outlining the timeline for the use of diagnostic techniques are included in the NICE guidelines. There is little evidence regarding women's experiences of this aspect of miscarriage care however Farren *et al.* (2013) suggests that the increasing time intervals between presentation for assessment, diagnosis and treatment, may be associated with increased psychological morbidity.

2.3.3 Treatment Options for Early Miscarriage

Once a miscarriage is diagnosed, treatment is often offered unless the miscarriage is already complete. Treatment options for women experiencing a miscarriage have expanded over the past 15-20 years. Surgical techniques used to dominate but interest in less invasive methods began to emerge in the 1980s and medical and expectant management techniques began to be offered (Nanda *et al.*, 2006; Hemminki *et al.*, 2013). In the U.K. these three main methods of management now appear to be widely, though not universally, available (see Table 2-2). Current guidance[13] suggests that expectant management should be offered as first line management, with medical and surgical management offered if this is unacceptable to a woman (National Institute for Health and Care Excellence, 2012a).

---

[13] The data analysed in this thesis was collected before this guidance was published.

Type of Treatment	Description
Surgical Management	Dilatation and curettage/evacuation, or vacuum aspiration, of the uterus. Often performed under general anaesthetic but more recently some clinicians have offered these procedures under local anaesthetic in community based offices (Dalton *et al.*, 2009).
Medical Management	Oral or vaginal medication is given to hasten the completion of the miscarriage. Generally managed in a hospital environment; more recently outpatient management has been described (whereby the medication is given in the hospital and then the woman returns home to complete the miscarriage).
Expectant Management	No intervention is used and the miscarriage completes naturally. Regular monitoring is offered throughout the process on an outpatient basis.

Table 2-2. Treatment Options for Women Experiencing a Miscarriage

A number of trials examining the safety and efficacy of these three options found them to be largely comparable in terms of safety (Luise *et al.*, 2002b; Blohm *et al.*, 2003; Nanda *et al.*, 2006; Trinder *et al.*, 2006; Harwood and Nansel, 2008; Neilson *et al.*, 2010). There are however some differences such as the length of time to complete the miscarriage, associated pain, and infection rates. Further, some treatment options are more effective in certain situations (for example, expectant management was more likely to be successful in cases of incomplete as opposed to missed miscarriage (Luise *et al.*, 2002a; Nanda *et al.*, 2006)). Surgical treatment has repeatedly been shown to have the highest success rate in terms of completion of the miscarriage, with medical and expectant managements more likely to involve unplanned procedures associated with treatment failure (Niinimaki *et al.*, 2006; Trinder *et al.*, 2006). Surgical treatment has also been suggested to be the most costly treatment (You and Chung, 2005; Niinimaki *et al.*, 2006; Petrou *et al.*, 2006) although this may vary according to the circumstances of the miscarriage (Rausch *et al.*, 2012).

Health economic methodologies have been employed to understand which aspects of available management options are of most value to women experiencing miscarriage. This research has demonstrated variable preferences amongst women, however the treatment benefits most valued were a reduction in the amount of pain experienced and completion of the miscarriage in a way which reduces the possibility of post-miscarriage complications and allows women to return to their normal daily activities as soon as possible (Ryan and Hughes, 1997; Petrou and McIntosh, 2009).

Beyond physical outcomes, exploration of women's experiences and opinions demonstrates that emotions, social norms, and social/cultural contexts also influence how women view treatment options (e.g. whether a woman values "natural" processes over surgical intervention, the amount of social support a woman has, fears a woman may have about seeing the fetus or about having anaesthesia) (Ogden and Maker, 2004; Smith *et al.*, 2006; Olesen *et al.*, 2015). Olesen *et al.* (2015) note that women may not discuss these preferences during consultations with health care professionals. Having choices and engaging in shared decision making practices, where all aspects of a woman's needs and preferences are explored, appears to result in greater patient satisfaction (Wieringa-de Waard *et al.*, 2004; Geller *et al.*, 2010; Wallace *et al.*, 2010).

2.3.4 Care Following a Miscarriage

After treatment has been completed NICE guidelines suggest that adequate information should be offered to women and the option of further care should be given, although the nature of that care is not specified.

> "After an early pregnancy loss, offer the woman the option of a follow-up appointment with a healthcare professional of her choice" (National Institute for Health and Care Excellence, 2012a , p11)

A number of different techniques for providing support after miscarriage have been evaluated including counselling (Swanson, 1999; Neugebauer *et al.*, 2006; Séjourné *et al.*, 2010b; Kong *et al.*, 2014; Johnson and Langford, 2015), psychological debriefing (Lee *et al.*, 1996), web based therapeutic programmes (Kersting *et al.*, 2011; Kersting *et al.*, 2013), and a structured midwifery visit (Adolfsson *et al.*, 2006) . The results of these studies are inconsistent, with some showing a positive impact on psychological outcome and some showing no difference (Swanson, 1999; Adolfsson *et al.*, 2006; Neugebauer *et al.*, 2007; Nikcevic *et al.*, 2007; Murphy *et al.*, 2012). Some have also observed differential results, with the women most affected at baseline being the most likely to derive benefit (Kong *et al.*, 2014). A number of methodological issues make it difficult to draw any meaningful conclusions from the evidence about the most appropriate way to provide post miscarriage support; these include heterogeneity of outcome measures used, unequal levels of treatment compliance and data capture, and the potential for study participation alone to provide positive benefits (thus compromising the extent to which control groups can be considered to have received standard care (Swanson, 1999; Murphy *et al.*, 2012)).

Despite the lack on conclusive evidence supporting positive impacts arising from post-miscarriage follow up (Murphy *et al.*, 2012), research with women has consistently identified a wish to receive more satisfactory post miscarriage care (Cordle and Prettyman, 1994; Lee and Slade, 1996; Paton *et al.*, 1999; Swanson, 1999; Tsartsara and Johnson, 2002; Wong *et al.*, 2003; Simmons *et al.*, 2006; Kong *et al.*, 2010b; Séjourné *et al.*, 2010a; Séjourné *et al.*, 2016). The nature of the desired follow up care, and the needs that it might address are, however, poorly defined. This perhaps provides some explanation as to why evidence regarding the effectiveness of post miscarriage care is inconsistent (i.e. the nature of the follow up, and the outcomes measured to ascertain effectiveness, may not be aligned to patient experience or need).

Another aspect of post miscarriage care relates to the offer of investigations aimed at identifying the cause of the miscarriage and the likelihood of recurrence in future pregnancies. Several studies have demonstrated that women find lack of explanation for their miscarriage to be distressing (Cecil, 1994b; De Jager, 1994; Paton *et al.*, 1999; Evans *et al.*, 2002; Wong *et al.*, 2003; Simmons *et al.*, 2006). Nonetheless national guidance states that investigation into the causes of early miscarriage should only occur after three consecutive miscarriages for pregnancies in the first trimester (Regan *et al.*, 2011). Studies exploring the impact of offering universal investigations show inconsistent results (Nikcevic *et al.*, 1999; Nikcevic, 2003; Nikcevic *et al.*, 2007). Patient uptake for the investigations was very high in all studies; however the results suggest that the benefits of providing such investigations may accrue only to women who can be given a reason for the miscarriage (it is not unusual for investigations to conclude without a definitive cause being identified) (Nikcevic *et al.*, 2007).

2.3.5 Women's Views of Health Care for Miscarriage

Research exploring women's views of treatment options and post miscarriage care has been outlined in the previous sections. In terms of satisfaction with the delivery of health care more generally health care professionals, and the care they provide, have been described as highly influential in shaping women's experiences of miscarriage (Murphy and Merrell, 2009). A number of authors have reported that patient satisfaction is linked to the provision of (a) individualised, rather than generic, care (Corbet-Owen and Kruger, 2001; Rowlands and Lee, 2010; Van Den Akker, 2011; Musters *et al.*, 2013; Radford and Hughes, 2015; Van Den Berg *et al.*, 2015), and (b) care aimed at "patient centred" aspects of health care (this encompasses attributes such as empathy, emotional sensitivity, acknowledgement of loss, communicating effectively, respect, and feeling cared for) (Corbet-Owen and Kruger, 2001; Tsartsara and Johnson, 2002; Gold, 2007; Geller *et al.*, 2010; Rowlands and Lee, 2010; Rhone *et al.*, 2012; Warner *et al.*, 2012; Musters *et al.*, 2013; Radford and Hughes, 2015; Van Den Berg *et al.*, 2015). Organisational models that promote continuity and allow relationship building have been described to be useful in terms of meeting these needs (Corbet-Owen and Kruger, 2001; Tsartsara and Johnson, 2002; Rhone *et al.*, 2012; Musters *et al.*, 2013). It has also been suggested that staff with specialised knowledge of pregnancy and miscarriage (as opposed to general medical or nursing knowledge) may be better equipped to provide early miscarriage care (Edwards *et al.*, 2016).

Despite clear evidence of the importance of emotional and interpersonal aspects of care for women experiencing miscarriage, research with such women persistently suggests that these aspects of health care are often not adequately acknowledged (Cecil, 1994b; De Jager, 1994; Moohan *et al.*, 1994; Moulder, 1994; Conway, 1995; Moulder, 1998; Moulder, 1999; Corbet-Owen and Kruger, 2001; Evans *et al.*, 2002; Tsartsara and Johnson, 2002; Wong *et al.*, 2003; Ogden and Maker, 2004; Simmons *et al.*, 2006; Gold, 2007; Stratton and Lloyd, 2008; Kong *et al.*, 2010a). This observation has been made about pregnancy loss more generally and some have argued that this reflects the inability of health care systems driven by a "*reductionist biomedical discourse*" (van der Sijpt, 2010) to adequately address the social, emotional and psychological complexities of an experience such as pregnancy loss (Moulder, 1998; McCreight, 2005; de Kok *et al.*, 2010; van der Sijpt, 2010; Lee, 2012).

2.4 Formal Quality Management in Early Pregnancy Services

2.4.1 Variability

National guidance regarding the delivery of health care for women experiencing early pregnancy problems has existed for some time; initially this was published by the Royal College of Obstetricians and the Association of Early Pregnancy Units (The Royal College of Obstetricians and Gynaecologists, 2006; The Association of Early Pregnancy Units, 2007). In 2012, the National Institute of Health and Care Excellence published guidelines, alongside quality standards and audit tools (National Institute for Health and Care Excellence, 2012a). Despite this, variability has been observed in practices in the UK, for example in methods used to manage miscarriage (Poddar *et al.*, 2011), in management of pregnancies of unknown location (Basak *et al.*, 2013), and in the provision of memorial services (Levine and Cumming, 2015). Similar variability has been observed in early pregnancy care internationally (Van Den Boogaard *et al.*, 2013; Yap *et al.*, 2014).

The reasons why variability persists have been explored and a number of factors identified including differences in the ways in which staff are trained and supported in their work (Cameron and Penney, 2005), the complexity of guidelines (Van Den Boogaard *et al.*, 2011), differing definitions (Jhamb, 2013), the influence of patient or health care professional preferences (Molnar *et al.*, 2000; Dalton *et al.*, 2010; Van Den Boogaard *et al.*, 2011), and organisational resource availability (Dalton *et al.*, 2009). Some guidelines are vague and non-specific; NICE guidelines, for example, refer to the importance of offering dignity, respect and sensitivity (all terms that are open to interpretation).

> “Treat all women with early pregnancy complications with dignity and respect. Be aware that women will react to complications or the loss of a pregnancy in different ways. Provide all women with information and support in a sensitive manner, taking into account their individual circumstances and emotional response” (National Institute for Health and Care Excellence, 2012a , p10)

Additionally, professionals do not always agree with, or strictly adhere to, guidelines. NICE guidelines have, for example, been criticised for limiting patient choices about treatment and failing to account for individual circumstances (Bourne *et al.*, 2013).

2.4.2 Audit as a Quality Management Tool

Audit is a commonly used tool of quality management, used to identify adherence with evidence-based guidelines with the aim of reducing variation and identifying opportunities for improvement. A number of papers have reported on audits of their early pregnancy services or on the development of audit tools specific to early pregnancy or recurrent miscarriage (Van Den Boogaard *et al.*, 2010). Furthermore the NICE have developed their own audit tools that are publicly available (National Institute for Health and Care Excellence, 2012b).

Quality standards are generally derived from high quality research evidence (Van Den Boogaard *et al.*, 2010; Bonfill *et al.*, 2013). This approach relies on a hierarchy of legitimate knowledge, which privileges quantitative and measurable attributes over other forms of knowing (Greenhalgh and Russell, 2009). The quality indicators described in the literature for miscarriage care are heavily focused on process elements of care and measurable attributes, for example use of diagnostic techniques (Basak *et al.*, 2013), treatment types used (Akhter *et al.*, 2007; Van Den Berg *et al.,* 2014a), waiting times (Akhter *et al.*, 2007), treatment outcomes (Wahba *et al.*, 2015), staff training (Wahba *et al.*, 2015), access to services (e.g. counselling) (Van Den Boogaard *et al.,* 2013), and costs (Van Den Berg *et al.*, 2014a).

Issues relating to patient experience are either omitted or captured by simplified and potentially methodologically flawed methods (e.g. by counting the number of formal complaints made by patients (Wahba *et al.*, 2015)). This inevitably limits the number and types of patient voices contributing to quality assessment, and detracts from difficult to measure aspects of care.

2.5 Health Care Professionals and Miscarriage

> "One of the clearest findings from our analysis was the discrepancy between professional and patient priorities in the aftermath of a miscarriage. Women complained about the circumstances and level of care they received, and reiterated the importance of 'emotional support" (Simmons *et al.*, 2006; p1944)

This quote describes a finding repeated throughout the evidence base; namely that women experience miscarriage as a highly significant event but feel that staff do not view or treat it as such (Cecil, 1994b; Cecil, 1994a; Moulder, 1994; Conway, 1995; Moulder, 1998; Conway and Russell, 2000; Tsartsara and Johnson, 2002; Wong *et al.*, 2003; Stratton and Lloyd, 2008; Kong *et al.*, 2010b). A simple interpretation might be that this "gap" could be a consequence of poor awareness and understanding on the part of staff about the complexity of the situation and the sensitivity desired by women; indeed the NICE guidance on miscarriage suggests staff training as a mechanism to improve quality in this respect.

> "Health care professionals providing care for women with early pregnancy complications in any setting should be aware that early pregnancy complications can cause significant distress for some women and their partners. Healthcare professionals providing care for these women should be given training in how to communicate sensitively and breaking bad news. Non-clinical staff such as receptionists working in settings where early pregnancy care is provided should also be given training on how to communicate sensitively with women experiencing early pregnancy complications". (National Institute for Health and Care Excellence, 2012a , p10)

Literature exploring the views of health care workers involved in the provision of services to women experiencing a miscarriage is sparse; however that which is available challenges the assumption that health care workers lack knowledge or view miscarriage as a low priority event. The evidence suggests widespread appreciation of the need to provide emotional support as part of the health care package (Prettyman and Cordle, 1992; Simpson and Bor, 2001; Murphy and Merrell, 2009; MacConnell *et al.*, 2013; Gergett and Gillen, 2014; Engel and Rempel, 2016). This observation is not universal and, in a study that explored both health care professional and patient views about quality of care in Australia, Evans *et al.* (2002) described discrepancies in the priorities placed on various aspects of care between the two groups. Whilst the patient group prioritised "*a more considerate and sensitive attitude from staff*", the health care professional group suggested that additional staff, provision of counselling, and more privacy were given precedence. It is however, important to consider that whilst this was interpreted by the authors as a discordant priorities, it could also be argued that both groups are identifying the same problem but from different perspectives; if staff have insufficient time to spend with women and are unable to offer them privacy, then this could well be interpreted by their patients as insensitivity and inconsideration.

Whilst the evidence suggests that healthcare workers have a desire to provide emotional support (Fenwick *et al.*, 2007), a number of factors constraining their ability to do so have been described, such that "*how they would like to practice and what was actually possible in their day to day work*" (Murphy and Merrell, 2009) are very different things. These include organisational factors, for example lack of time, an emphasis on task-based aspects of care, or limited ability to instigate organisational change (Wallace *et al.*, 2010; Gergett and Gillen, 2014); in a study of the efficacy of different forms of audit feedback, Cameron *et al.* (2007) noted that being made aware of deficiencies in care, whilst feeling unable to address those gaps, was very frustrating to health care workers.

Another feature compromising the ability of staff to deliver emotional support is the complex, uncertain, and very individual nature of the experience of miscarriage. Betts *et al.* (2012) describe this as requiring staff to engage in a finely tuned balancing act within which they are required to provide reassurance whilst also being realistic about outcomes. This requires complex interactions which acknowledge individual social, psychological, physical and emotional needs, and which are influenced by patients and their families, hospital practices and policies, resource availability, social norms, and the beliefs and skills of individual health care workers (Simpson and Bor, 2001; Van Den Akker, 2011; MacConnell *et al.*, 2013; Gergett and Gillen, 2014). Lack of confidence and training in managing these interactions has been identified as a barrier to providing support (Simpson and Bor, 2001; Gergett and Gillen, 2014; Marko *et al.*, 2015; Engel and Rempel, 2016). Additionally, exposure to miscarriage has been described to be emotionally challenging for health care workers who describe having to control their own emotional involvement and responses in order to maintain a professional persona (Bolton, 2005; McCreight, 2005; Wallbank and Robertson, 2008; Wallbank and Robertson, 2013). Emotional support for staff has been described to be mostly confined to peer-support from colleagues (Fenwick *et al.*, 2007; Wallbank and Robertson, 2008).

Managing these staff to patient interactions has been recognised to be challenging within an institutional setting. Organisational models which provide health care workers a degree of autonomy and discretion allow a more holistic approach to care which can cater to the needs of individual women (Graham *et al.*, 2012; Olesen *et al.*, 2015). Engaging frontline workers in developing services and managing organisational change has similarly been described to allow shared values and understandings about quality of care to develop and be enacted (Darney *et al.*, 2013).

2.6 Future Developments in Early Miscarriage care.

The gradual rise in average maternal age at childbearing may result in an increased incidence of miscarriage (Tromp *et al.*, 2011) and new technologies, such as increasingly sensitive pregnancy tests which bring forward the point of pregnancy diagnosis, are likely to impact on demand for early pregnancy services (Layne, 2006). Women who present with symptoms of miscarriage in the very early stages of pregnancy (< 7 weeks gestation) pose a difficult management dilemma for clinicians (Bottomley *et al.*, 2009); current ultrasound technology is generally not able to confirm either a miscarriage or an on-going pregnancy at this stage, and a diagnosis of pregnancy of unknown location (PUL) or an intrauterine pregnancy of uncertain viability (IPUVI) is made. The most appropriate way to manage such pregnancies has been the source of clinical debate (Bignardi *et al.*, 2008) , but it usually results in multiple hospital visits for women, prolonged periods of uncertainty and, potentially, unnecessary interventions (Bottomley *et al.*, 2009). Advances in ultrasound technology may bring forward the gestation at which miscarriage can be diagnosed (though it may also have a psychological impact on women since some suggest that visualising the fetus can have an impact on both attachment to the pregnancy and emotions in the event of pregnancy loss (Cecil, 1994b; Layne, 2006)). Other methods of predicting miscarriage are currently being investigated (i.e. biochemical markers); this may reduce uncertainty for both women and clinicians (Gevaert *et al.*, 2006; Bignardi *et al.*, 2008; Oates *et al.*, 2013).

2.7 Chapter Summary

This chapter has outlined the evidence base regarding miscarriage. It demonstrates that a large number of women experience this form of pregnancy loss, and that these women frequently access care from the NHS for diagnosis and treatment. In the context of exploring the role of frontline NHS workers in the management of quality, the care offered to women experiencing early miscarriage offers an interesting case study on a number of levels.

Whilst there have been a number of advances in the organisation of care and the physical management of miscarriage, managing the emotional aspects of the experience remains a challenge that health care does not appear to have adequately addressed. On the face of it, the solution to these issues is relatively simple; frontline workers should be educated and trained to act in ways that are sensitive and supportive. However, research conducted with frontline workers presents a more complicated interpretation of the issue with a number of barriers to the provision of care that meets patients’ needs.

The evidence does not suggest that frontline or managerial level workers lack awareness of the importance of emotional aspects of care. Instead it suggests that (a) miscarriage is a highly individualised experience that is shaped by a number of social and cultural factors, and (b) delivering individualised health care to women experiencing miscarriage within a health care system focused on biomedical aspects of care, and evaluated using techno-rational quality management mechanisms, is particularly challenging.

The unique contribution this thesis makes to this evidence base is in its consideration of quality management from the perspective of frontline workers delivering care to women experiencing early miscarriage. It explores the idea that the tacit day-to-day practices of frontline NHS workers may serve to bridge the gaps between organisationally and patient defined notions of quality. It also considers the extents to which these practices may be both constrained by, and contribute to, organisational and societal understandings of miscarriage. As such, the case of early miscarriage offers an opportunity to explore how social science analyses of the social world can be used to shed light on areas of persistent patient and staff dissatisfaction with care.

Chapter 3 Methodology

3.1 Introduction

This chapter introduces the methodology for the study described in this thesis. It begins by outlining the research paradigm and conceptual framework that has guided the development of the research question, the research methods chosen, and the analytic strategy. The study is based on the use of a secondary data set and this is outlined and justified. The collection of the primary data is described and the analytic method used is outlined. Finally limitations and the impact of researcher background and perspective are described.

3.2 Conceptual Framework

3.2.1 Defining the Research Problem

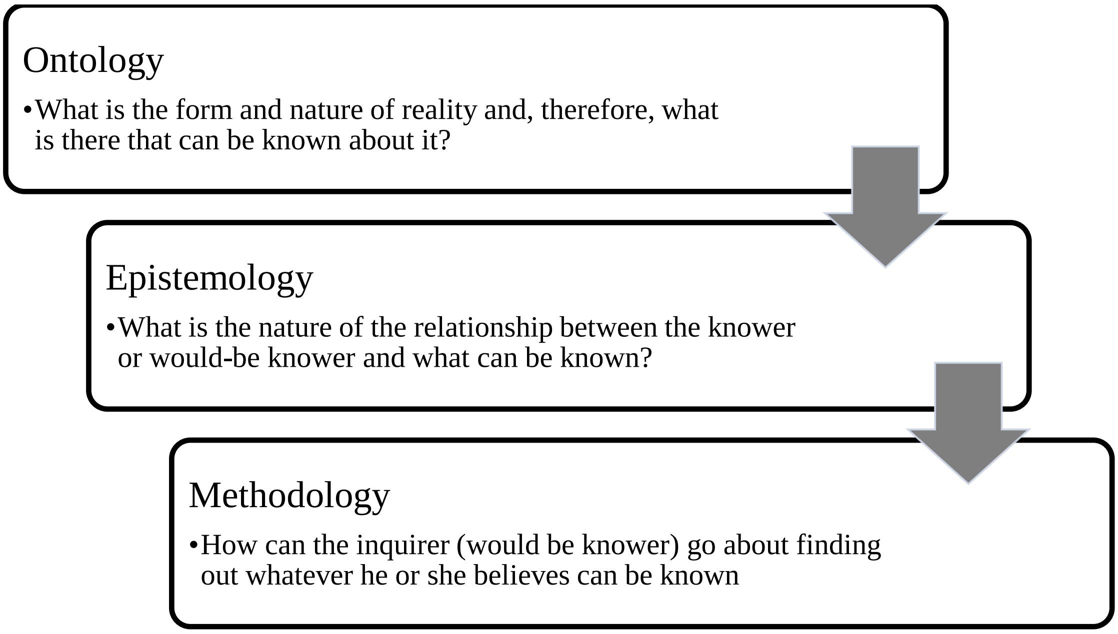
Silverman (2011) notes that many administrative and "*social problems*" (Rubington and Weinberg, 1995) exist in society, but that directly translating such problems into research problems is challenging because of the potential to miss important issues and concepts that contribute to the problems. Social theory offers opportunities to illuminate these issues by providing explanatory concepts which make researchers aware of "*relevant issues, processes, and interpretations that they might not necessarily have identified themselves using an inductive approach*" (Macfarlane and O'Reilly-de Brun, 2012; p1). These interpretations can then offer different ways of thinking about and approaching the "problem" (Reeves *et al.*, 2008).

The literature in chapters one and two have outlined a social (or organisational) problem for the NHS; namely, that its frontline workers are viewed as a resource that can be mobilised to manage and improve quality of care, however (a) the best ways to achieve this are unclear and (b) frontline workers have been observed to knowingly tolerate poor standards of care in a number of settings. Organisational structure (particularly hierarchies) and culture are frequently cited as key barriers to frontline staff acting to improve care. The care offered to women experiencing early pregnancy loss is offered as an exemplar with which to explore these issues in-depth. As outlined in chapter two, early miscarriage is a context in which health care practices persistently fail to meet the expectations and preferences of patients, and where there is evidence that the health care staff involved in the delivery of care are aware of this discrepancy.

Formal programmes aimed at dissolving organisational barriers to improving care within the NHS setting have had limited and variable success but there are implicit assumptions underpinning those programmes. One example of an implicit assumption is that there are common understandings about what is meant by quality of care, that organisational hierarchies are tangible entities which can be dismantled at will, and that empowering frontline health care staff will predictably lead to them acting in ways which improve quality of care for their patients. The next section presents the research paradigm and theoretical concepts that have been used to query these assumptions.

3.2.2 Research Paradigms

Guba and Lincoln describe a research paradigm as "*a basic belief system or worldview that guides the investigator, not only in choices of method, but in ontologically and epistemologically fundamental ways*" (Guba and Lincoln, 1994; p105).   Researchers need to be clear about the paradigm underpinning their research in order to make explicit the assumptions that are made throughout the research process. Paradigms are made up of three key concepts as shown in Figure 3-1. The answers to these questions are pivotal in guiding choices about every stage of the research process (Maxwell, 2012).



Ontology

- What is the form and nature of reality and, therefore, what is there that can be known about it?

Epistemology

- What is the nature of the relationship between the knower or would-be knower and what can be known?

Methodology

- How can the inquirer (would be knower) go about finding out whatever he or she believes can be known

Figure 3-1 The Components of a Research Paradigm. Taken from Guba and Lincoln (1994; p108)

3.2.3 Realism

The research approach utilised for the substantive content in this thesis is guided by relativist ontology. The realist ontology was considered first and rejected because it offered limited scope to explore the multiplicity of views that might be relevant to understand the relationship frontline workers have with the quality of the services they deliver.

Realism proposes "*a real world of objects apart from a human knower"* (Angen, 2000; p380). This paradigm suggests that this "real world" can be revealed by the use of research methodologies which control the influence of value based factors and place the researcher as a *"disinterested scientist"* who aims to establish actual or probable facts about one true reality (Lincoln *et al.*, 2011; Bryman, 2012, p28). Realism is commonly considered to be the dominant paradigm underpinning biomedical research (Maxwell, 2012). The critical realist paradigm is also underpinned by this ontology, but differs in so far as suggesting that a reality exists, but that humans can never "*fully understand what it is or how to get to it because of hidden variables and a lack of absolutes in nature*" (Lincoln *et al.*, 2011; p102).

The exploratory nature of the research question involves consideration of the interplay of a wide range of views, perspectives and values, with no intention of privileging any one as a "true account". It also relates to concepts (quality of care, the roles of various frontline workers in delivering quality, the role of socially created organisational structures) that are not "natural features" of the world with a reality beyond human understandings of the concepts. For these reasons the realist ontology was rejected in favour of an approach that offered more scope for exploring the impacts of a multiplicity of views.

3.2.4 Relativism

Contrary to the realist ontology, relativism proposes the existence of multiple realities which are *"mental constructions, socially and experientially based, local and specific, dependent for their form and content on the persons who hold them*" (Guba, 1990; p27)

Within this paradigm the values and influence of the researcher are explicitly acknowledged; this means that the knowledge produced during such research is viewed in many respects as being a co-creation of both the researcher and of the those providing data (Lincoln *et al.*, 2011; Bryman, 2012). Qualitative methodologies are aligned with this paradigm and the research is generally inductive in nature (i.e. aiming to explain rather than to test hypotheses) (Lincoln *et al.*, 2011; Bryman, 2012).

Criticisms of relativist approaches are often directed towards issues regarding the generalisability and validity of the outcomes (Angen, 2000; Lincoln *et al.*, 2011). These criticisms are a result of the tendency to privilege positivist notions of validity; viewed with this lens the subjective nature of interpretivist research inevitably leads to accusations of lack of rigour or generalisability (Angen, 2000). It has, however, been argued that ideas of validity are inappropriate to research conducted within a relativist ontology (Angen, 2000; Lincoln *et al.*, 2011). Angen (2000) contends that issues of validity in interpretivist research are actually issues of validation, and relate to authenticity and usefulness of the findings. Validation, then, can be secured by ensuring that the research: has practical value, generates new understandings, makes the subjective assumptions of the researcher and the research design explicit, and explains the transformations in understandings which develop as the research progresses (Angen, 2000). Additionally, the inclusion of thick, rich description in the analysis, accompanied by illustrative quotes taken from the data set have been described to be ways to create confidence in the findings (Angen, 2000; Vartanian, 2011).

3.3 Theoretical Framework

3.3.1 Social Constructionism

Having established that the relativist paradigm offered the most appropriate way to approach the issue under investigation in this study, social constructionism was chosen as the specific framework used in the analysis.

The research question described in this thesis focuses on the experiences of frontline NHS staff in terms of the ways in which they understand the concept of quality in health care and act to improve it. As outlined in chapter one, existing literature suggests that frontline workers in the NHS are bound by the organisational structures in which they operate, and that this may result in them supporting health care practices which contradict their own beliefs about acceptable quality of care. Many of the issues involved in this situation revolve around social constructions; for example, an organisational hierarchy is a concept developed by humans and enacted only when the individuals involved in the hierarchy have an understanding of what it is, what it involves, and act accordingly. The same can be said of the concepts of quality in health care and of the role of health care professionals. Accommodating this thinking places this research question within the constructionist paradigm.

> "if the researcher formulates a research question so that the tenuousness of organisation and culture as objective categories is stressed, it is likely that an emphasis will be placed on the active involvement of people in reality construction" (Bryman, 2012, p.; p34)

Constructionism is described by Bryman (2012) as both an ontology and an epistemology that rejects the notion of the existence of objective structures acting upon human agency, and instead emphasises the ways in which humans come to construct their own realities through interaction with, and experience of, the world (Bryman, 2012, p33). In this way the "individual" and "society" exist within an ecosystem, each affecting the other (Burr, 2003). Research guided by a social constructionist approach considers how and why particular concepts and categories come to be accepted in society, the ways in which human interaction supports this, and the implications this has for the ways in which people are treated and the way that they act (Burr, 2003). In this framework, truth is conceptualised as a product of social interactions between people, rather than as an objective fact that awaits discovery by the researcher.

Social constructionism is a well-established social theory that has been more commonly used following the publication of "*The Social Construction of Reality*" (Berger and Luckmann, 1979). It has been applied to numerous contexts, including in relation to health and health care (Bryman, 2012). Understanding how concepts of health and illness can be socially constructed, and the social impacts of those constructions, have been key concerns of medical sociologists for some time (Conrad and Barker, 2010)[14]. By using a constructionist framework, one can look at the fine detail of people's activities without treating social organisation as a purely external force.

Bryman (2012) describes constructionist arguments as existing on a spectrum; from those who reject any notion of an objective reality, to those who acknowledge that in any given situation there are phenomena (e.g. culture) which pre-exist the individuals involved in that situation, and which act as an evolving "*point of reference*" for them. Thus a constructionist

---

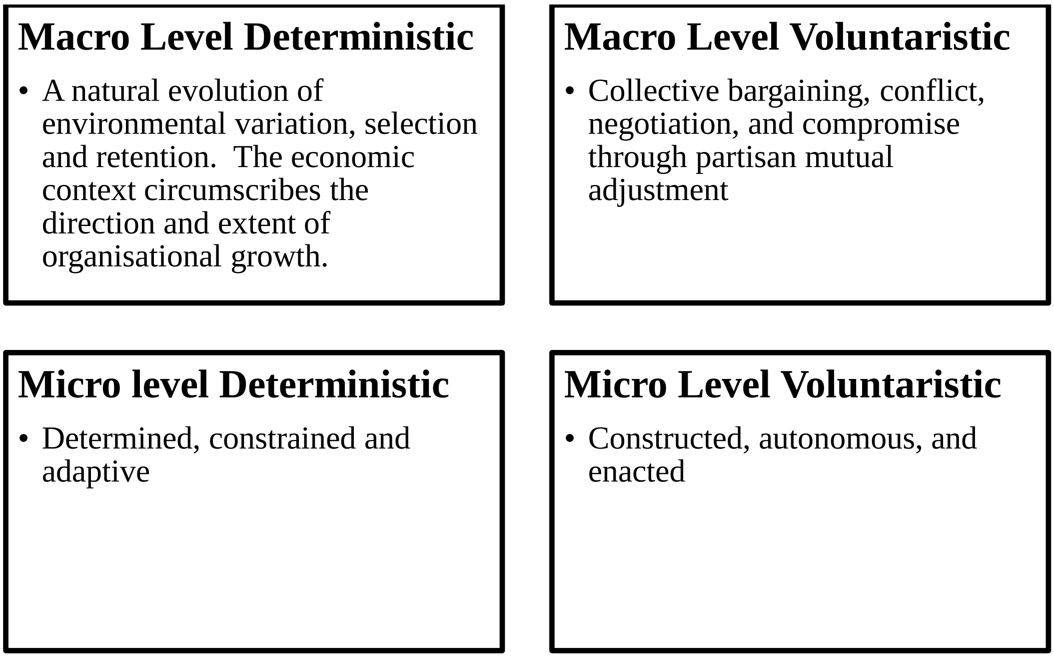
[14] Silverman (2005) for example, describes the way in which death is a social fact (i.e. a change in biological state), but that research has illuminated the ways in which it is also bound by socially constructed definitions about when a person can be considered to have died (e.g. in relation to the point at which resuscitative efforts should be instigated or abandoned, when life support systems can be switched off).

approach is useful in considering the organisational barriers NHS workers describe facing as (a) constructed by the beliefs, interactions and practices of the workers and those around them, and (b) somewhat external since these constructions predate individual workers (e.g. frontline NHS workers enter their roles within a society where hierarchies and bureaucracies are already accepted as a legitimate form of organisation, and where ideas about quality may have already been agreed).

Subjectivity is embraced in this perspective, in so far as the researcher is encouraged to explicitly acknowledge their values and perspectives and the influences they may have on the research process and outputs (Lincoln *et al.*, 2011); this means that the validity of research conducted under this paradigm has been queried (as per the issues relating to relativism outlined in section 3.2.4). This approach has also been subject to some specific criticism in relation to the pragmatic utility of the findings; if there is no objective truth which can be uncovered, and instead an unlimited number of multiple, and sometimes competing, realities then how useful can one perspective be compared to any other? Additionally, if all of the knowledge individuals draw upon to make choices is socially constructed, are any choices free or are human choices and actions simply a product of the societies in which they operate? Burr (2003) notes that these are difficult issues for social constructionists to address and they continue to be debated. Burr also suggests that providing individuals with access to different voices, and different ways of thinking about the nature of their lives, can be empowering and increase their agency to choose from different discourses. Social constructionism is a broad church (Lynch, 1998), and therefore some further theoretical reference points are needed to clarify the way in which social constructionism has been used in this thesis. These reference points are outlined in the next section.

3.3.2 Micro Level Organisational Theories

The context of the research problem in this thesis is in understanding how individuals interact with organisational structures. Astley and Van de Ven (1983) proposed that organisational theory can be viewed from four distinct perspectives depending on whether the theory is aimed at the macro (i.e. systems of organisations or economies) or the micro level (i.e. individual organisations and the subunits and individuals within them), and whether human action is taken to be deterministic (i.e. controlled by exogenous forces) or voluntaristic (i.e. a result of free will). The importance of these distinctions is that problems experienced at one level within an organisation may be viewed and experienced differently at other levels (Astley and Van de Ven, 1983).



Macro Level Deterministic

- A natural evolution of environmental variation, selection and retention. The economic context circumscribes the direction and extent of organisational growth.

Macro Level Voluntaristic

- Collective bargaining, conflict, negotiation, and compromise through partisan mutual adjustment

Micro level Deterministic

- Determined, constrained and adaptive

Micro Level Voluntaristic

- Constructed, autonomous, and enacted

Figure 3-2. Different Perspectives on Organisational Theory. Adapted from Astley and Van de Ven 1983 (Astley and Van de Ven, 1983)

The research question posed in this thesis concerns the understandings that frontline health care workers in the NHS have about their relationship with the organisations in which they work, placing the perspective primarily at the micro-level. Taking a social constructionist approach means that the distinction between deterministic and voluntaristic is less clear; it is possible that frontline workers may simultaneously construct the reality of the structures around them and then be constrained by their beliefs in the reality of those structures. As Burr notes "*if agency and structure are part of one inseparable system, then the effectiveness of human agency is just as real as the determining features of social structure*" (Burr, 2003; p74).

A number of theorists have explored the activities which occur at the micro-level of organisations, and two theories which have particular relevance to the work of frontline employees involved in the delivery of public services are outlined here; the work of Strauss et al on "Negotiated Order" (Strauss *et al.*, 1973) and the work of Lipsky on "Street Level Bureaucracy" (Lipsky, 2010).

3.3.3 Negotiated Order

Strauss *et al.* (1973) used a social constructionist approach to explore the ways in which health care institutions providing psychiatric services come to be organised (Bryman, 2012).

Using data collected from health care workers in the United States, they observed that, beyond the explicit formal rules of the organisation, a system of "*negotiated order*" operated. This involved workers of all levels agreeing and disagreeing, explicitly or implicitly, to act in certain ways via "*clusters of psychiatric thinking and practice, with cluster formations (representing people both inside and outside of psychiatry) shifting in terms of specific issues and problems*" (Schatzman and Strauss, 1966; p12). Implicit and explicit rules were often vague and non-binding (e.g. subject to being forgotten or ignored) and activities such as negotiation, diplomacy, control and compromise all contributed to the maintenance of order. The hospital was therefore considered to be not only a physical location operating under formal organisational rules, but also a construct of the negotiations which took place and shifted every day.

> "one might maintain that no one knows what the hospital 'is' on any given day unless he has a comprehensive grasp of what combination of rules and policies, along with agreements, understandings, pacts, contracts, and other working arrangements, currently obtains. In any pragmatic sense, this is the hospital at the moment: this is its social order" (Strauss *et al.*, 1973; p317)

Order did not happen but was worked at, since all rules were temporal; any changes to the order involved "*renegotiation or reappraisal*" and a decision not to act or change was considered as significant as a decision to change (Strauss *et al.*, 1973). A spectrum of behaviour was implicated in negotiations, from those fully engaged to those who were "*scarcely involved*" in conversations. Factors influencing negotiations included differences observed between professional and non-professional health care workers (particularly in terms of their orientation to patients and other staff), the influence of patients who enter into the negotiation process, and the presence of a "*single, ambiguous goal*" (which was to return patients to the outside in better shape) that provided the symbolic cement which all staff agreed on and which held the organisation together. These negotiated practices become embedded as a structure which operated to "*set the limits and some of the directions of future negotiations*" (Strauss *et al.*, 1973). Importantly, whilst Strauss et al focused on the internal processes which create organisational structures, they also acknowledged the significant impact of larger social structures which set the context for these negotiations (Svensson, 1996).

The concept of negotiated order has been applied to analyse practices in many settings. This includes policing (Wooff, 2015), criminology (McAra and McVie, 2012), environmental control (Fineman, 1998), technology development (Dokko *et al.*, 2012), and education (Medved and Heisler, 2002). Many of the studies have applied the concept of negotiated order to examine specific organisational settings but it has also been applied more widely (e.g. exploring international negotiations (Forster, 2000)). It has been applied to a variety of health care contexts (Svensson, 1996; Evans, 2007; Reeves *et al.*, 2009; Nugus *et al.*, 2010; Miller and Kontos, 2013) and it has been used to explore intra-organisational relationships (e.g. between frontline workers and managers, and between different health care professional groupings (Svensson, 1996; Allen, 1997; Evans, 2007; Reeves *et al.*, 2009; Nugus *et al.*, 2010)). It has also been used to explore the application of a quality management programme (Lean methodology) in health care (Esben Rahbek Gjerdrum and Huniche 2011).

These applications of negotiated order theory, in various contexts, have built upon the original observations of Strauss *et al.* (1973). In terms of health care, the development of, and interplay between, professional roles has been identified as playing an important role in negotiations. Nursing in particular has been noted to have undergone a number of changes with the development of specialist roles and shifting boundaries around allocation of work, with nurses taking on new tasks and responsibilities (which were previously the domain of medical or administrative personnel) and handing over others (e.g. health care workers taking responsibility for tasks which were previously the domain of nurses) (Svensson, 1996). It is argued that this has strengthened their position in terms of negotiating the way in which frontline care is delivered, moving them from a historically subordinate position in relation to medical staff, and into a more collaborative model (Svensson, 1996; Miller and Kontos, 2013). This does not appear to be a universal or comprehensive shift; Reeves *et al.* (2009) and Allen (1997) observed the continued existence of distinct boundaries in interactions between medical and nursing staff which were largely unidirectional (i.e. doctor dictating to nurse) and which Allen (1997) described as "*non negotiated*" practice. This emphasises the importance of context in understanding negotiated practice.

Studies exploring boundaries between health care professional groups are represented in this literature, but the negotiations between frontline workers and managerial level staff are less well understood. A key criticism of the negotiated order model is that, in scrutinising activity at the micro level, it may fail to adequately account for macro level structures and the ways in which they impact, and are impacted, by negotiations on the frontline. Alongside this, the role of health care managers and patients within negotiations has not been well explored (e.g. do these external forces control the boundaries of negotiation, or do they also enter into the negotiation process)(Evans, 2007; Baïada-hirèche *et al.*, 2011). A further criticism is that the term “negotiation” is poorly defined and interpreted differentially within the literature; for example, Miller and Kontos (2013) describe a number of practices which frontline nurses used to maintain order including persuasion, peer emotional support, and coercion. The extent to which these differing strategies can be considered as “negotiation”, or as other forms of social interaction contributing to the maintenance of order, has been questioned (Allen, 1997).

The strength of this theory is in acknowledging the impact of the *“significant ‘hidden mechanisms’”* (Baïada-hirèche *et al.*, 2011) operating within organisations, which result from day to day interactions, and more specifically, negotiations between workers (Reeves *et al.*, 2008). Understanding these mechanisms, and the ways in which they contribute to every day care practices for women experiencing early miscarriage, has the potential to offer new insights into the reasons why care often does not meet patient expectations. It also introduces the notion that frontline staff may have an active role in improving or supporting suboptimal care practices beyond those that are visible to their employing organisation.

3.3.4 Street Level Bureaucracy

Street level bureaucracy (SLB) is another key micro level organisational theory that acknowledges the potential power frontline workers have to influence the care they deliver. Developed by Michael Lipsky, and outlined in detail in his first book on the subject (Lipsky, 1980), it has subsequently been refined by a number of authors, including Lipsky himself (Lipsky, 2010). Originally defined in relation to social work in the United States of America, SLB refers to the working practices of individuals working on the frontline of public service delivery. The defining features of a street level bureaucrat are that they deliver public services and they exercise discretion in their everyday work in order to respond to the unpredictable and complex demands of their clients. Lipsky suggests Street Level Bureaucrats work in challenging conditions (including chronic underfunding in relation to expected outputs, unlimited public demand for the services, limited scope for demands to be taken elsewhere, and “*ambiguous, vague, or even conflicting*” organisational goals (Lipsky, 2010 , p27)).

In order to cope with these conditions, the street level bureaucrat uses his/her discretionary power to act in ways that increase their control over these otherwise impossible situations. These actions can be enacted individually, but some become patterned, structured and systematic, creating a new layer of bureaucracy (Brodkin, 2012); in effect, they *make* policy since these are the policies which guide the services actually experienced by clients (Lipsky, 2010). The SLB model contends that these tacit understandings are primarily motivated by a desire to manage an unrelenting workload by "processing" clients through the system as easily as possible whilst also maintaining and maximising street level autonomy (Lipsky, 2010). The development of shared understandings relating to the nature of clients have also been described (e.g. by categorising some types of client demands or actions as unreasonable) leading to strategies which aim to manage and control the expectations and activities of clients (Wallace and Pease, 2011).

In SLB the relationship frontline workers have with managers is positioned as "*intrinsically conflictual*" (Lipsky, 2010). SLB activities can disrupt the correct implementation of organisational policies and thus attainment of organisational goals, however, the relationship is also mutually dependent; managers rely on street level bureaucrats to deliver services in challenging conditions, and street level bureaucrats rely on managers to grant them discretion and to support their continued employment. This leads to a paradox whereby the actions of street level bureaucrats can conflict with, but ultimately support, organisational objectives:

> "Lower-level participants develop coping mechanisms contrary to an agency's policy but actually basic to its survival. For example, brutality is contrary to police policy, but a certain degree of looking-the-other-way on the part of supervisors may be considered necessary to persuade officers to risk assault" (Lipsky, 2010 , p19)

The SLB model has been applied in a variety of contexts, most notably in social care settings (Evans, 2011; Goldman and Foldy, 2015; Hoybye-Mortensen, 2015; Scourfield, 2015; van den Berk-Clark, 2016) but also in areas such as public administration (Diop-Christensen, 2015; Fuertes and Lindsay, 2015; Nielsen, 2015; Oberg and Bringselius, 2015; Takle, 2015; White *et al.*, 2015; Gjersoe, 2016; Hunter *et al.*, 2016), education (Hupe *et al.*, 2014; Grissom *et al.*, 2015; Henman and Gable, 2015; Timberlake, 2016), and policing (Armenta, 2016). In the context of health care the SLB model has been used to explore street level practices in variety of settings including hospital based care (Hoyle and Grant, 2015; Karadaghi and Willott, 2015; Gaede, 2016) and community based care (Finlay and Sandall, 2009; Gross *et al.*, 2011; Aniteye and Mayhew, 2013). It has been applied to reproductive health care (McCann *et al.*, 2015; Kerpershoek *et al.*, 2016). Similar concepts describing discretionary frontline activities have been reported but not explicitly defined as SLB (e.g. the use of nursing 'workarounds', described as mechanisms which temporarily fix workflow problems (Debono *et al.*, 2013)).

These studies have observed variable levels of discretion being enacted within different organisational and professional contexts. The need to manage workload was evident in a number of studies, confirming Lipsky's assertions (Gross *et al.*, 2011; Debono *et al.*, 2013; van Berkel and Knies, 2016). This was, however, only one factor influencing the use of discretion and a number of other factors have been implicated in the literature (see Figure 3-3).

The structural nature of organisations (i.e. how much the structure explicitly allows frontline autonomy and how policy breaches are dealt with)(Finlay and Sandall, 2009; Bruhn, 2015; Muller *et al.*, 2016; Timberlake, 2016)

The personal ethics and aspirations of individual frontline workers (Bergen and While, 2005; Aniteye and Mayhew, 2013; Debono *et al.*, 2013; Brodkin, 2015)

Personal characteristics of frontline workers (e.g. gender) (Nielsen, 2015)

Promotion of communication, collaboration and negotiation between colleagues (Debono *et al.*, 2013)

Concern for clients (Henman and Gable, 2015), especially in relation to receiving timely and personalized care (Debono *et al.*, 2013)

The amount of accountability workers feel for the outcomes of their work (Goldman and Foldy, 2015)

The wish for job satisfaction (Brodkin, 2015)

The clarity of policy aims and the ability of frontline staff to understand them (Bergen and While, 2005; Debono *et al.*, 2013; Gilson *et al.*, 2014; Hunter *et al.*, 2016)

The extent to which policy aims align to collective understandings of frontline workers (Bergen and While, 2005; Gilson *et al.*, 2014; Van der Aa and van Berkel, 2015) or local management strategies (Wells, 1997)

Operational inadequacies (Debono *et al.*, 2013)

Figure 3-3 Factors described to affect motivation of frontline workers to use discretionary practices

Professionalism is not a key focus of Lipsky's street level bureaucracy model (Evans, 2015) however it has been argued that professional status can have a profound influence on the use of discretion (Evans, 2015; Van der Aa and van Berkel, 2015). This influence has been described to manifest as a willingness to engage in discretionary practices (explicit and tacit) that contradict organisational policies where this allows the delivery of care aligned to professional values. In health care this is typically described in terms of a desire to deliver meaningful care and to meet individual client needs (Wells, 1997; Bergen and While, 2005; Finlay and Sandall, 2009; Saario, 2012; Grant, 2013; Hoyle and Grant, 2015; McCann *et al.*, 2015; Kerpershoek *et al.*, 2016).

The SLB model does not suggest that street level workers have absolute discretion. Organisational structures place constraints on action with discretion operating in the gaps. Middle managers in particular are seen as key mediators in communicating, and attempting to enforce, organisational objectives (Evans, 2015). Some studies have noted professionals to situate managerial priorities as being dichotomous to their professional priorities (the former concerned with efficiency and external displays of quality, the latter concerned with individual client needs and client based notions of quality); ergo, managerial strategies are often viewed as disempowering to professionals and ineffectual, or even deleterious, to the quality of services delivered at the frontline (Wells, 1997; Gilson *et al.*, 2014; Hoyle and Grant, 2015; McCann *et al.*, 2015). The idea of professional and managerial values existing at opposing ends of a spectrum has, however, been challenged (Harrison, 2015) with some authors suggesting that both frontline and managerial level workers exercise discretion, and may even do so collaboratively (Evans, 2010; Evans, 2011). Additionally it has been proposed that managers may have "*a vested interest in not scrutinizing practitioners' implementation of policy too vigorously as a way of deflecting responsibility for its consequences*" (Wells, 1997; p333)

Impacts of street level discretion have been reported variably. Some positive impacts have been described in terms of protecting client rights and providing safer or more meaningful services (Allen, 1997; Finlay and Sandall, 2009; Debono *et al.*, 2013; Hoyle and Grant, 2015). Alternatively, street level deviations from organisational policies has been described to be associated with negative impacts on policy implementation (Wells, 1997; Debono *et al.*, 2013; Bullen and Fisher, 2015), inappropriate outcomes for clients (Gjersoe, 2016), inefficiencies (Gaede, 2016), discriminatory or uneven distribution of care or resource (Karadaghi and Willott, 2015; Ulmestig and Marston, 2015; White *et al.*, 2015; Muller *et al.*, 2016). More broadly, street level practices have been suggested to contribute to the social control of clients and the replication of societal norms[15] (Maynard-Moody and Musheno, 2003; Takle, 2015; Armenta, 2016). It is important to recognise that the tacit ways in which discretionary actions are agreed and enacted means that they are generally not subject to scrutiny or evaluation of their impact meaning that unequal treatment can be administered unchecked.

In summary, models of negotiated order and street level bureaucracy both suggest that beneath the surface of frontline care delivery, a complex network of shared understandings and agreements to act (or not act) exist. They develop as a consequence of human interactions and are constantly subject to the possibility of rejection or renegotiation. Negotiations may involve any number of people within the organisation (e.g. at street level and organisational superiors) and beyond (e.g. patients, professional groups). They are influenced by a number of factors that may or may not be primarily aimed at managing quality (e.g. workload management, beliefs about professionalism, societal norms, political imperatives, resource availability). The agency of individual frontline health care workers is constrained by their beliefs about the formal and informal policies operating across all organisational layers. Most health care workers have some autonomy to exercise discretion in their day to day working practice; either as a formally agreed part of their role, or because their knowledge about their organisation means they are able to recognise opportunities to act in relatively undercover ways. Discretion may be enacted individually, but it can also develop into patterned and shared responses, leading them to become part of the shared street-level policy landscape. Discretion may also operate beyond the frontline with managerial staff colluding with frontline staff to agree variations to organisational policy (or, at least, agree that variations can be made without necessarily knowing the details of those variations).

Any consideration of the contribution frontline NHS workers make to the management of quality in health care therefore needs to consider (a) the formal organisational policies which guide the delivery of services and the management of quality within those services, (b) the

---

[15] For example, work exploring sexual and reproductive health care for teenagers in South Africa found that implementation of policies designed to reduce risk to this client group was uneven. This was driven by structural constraints and the moral position of nurses delivering the care (e.g. whether they thought it appropriate for teenagers to engage in sexual activity). The authors argue that this impacted negatively on the quality of services by increasing risks to those it was designed to help (Muller, A., Rohrs, S., Hoffman-Wanderer, Y. and Moult, K. (2016) '"You have to make a judgment call". - Morals, judgments and the provision of quality sexual and reproductive health services for adolescents in South Africa', Social Science and Medicine, 148, pp. 71-78.

street level policies which operate and the ways in which they reinterpret formal policies into the practices delivered at the frontline, (c) the interplay between formal and informal policy and the implications this has for quality of care. Using this approach offers the opportunity to critically analyse street level practice to gain additional insight into the reasons why "*policy-on-the-page*" and "*policy-in-practice*" in terms of delivering a high quality early miscarriage service may diverge, and why attempts to address this using mechanisms grounded in conventional views of hierarchical control are likely to fail (Brodkin, 2015).

> "By examining how policy is delivered at the 'front lines' of organisations, it brings into view those discretionary practices that systematically shape the policy experience. This is important to accountability as it extends management's capacity to assess dimensions of practice that bear on the content and quality of service delivery and on its distribution" (Brodkin, 2008)

3.3.5 Other Theoretical Constructs Considered

Two other potentially important theoretical models were considered when developing the theoretical framework and a brief explanation of each is provided in this section. This outlines their potential relevance to the research question, and it also explains why these theories were not chosen as the primary focus of the analytical framework used in this thesis.

Emotion work

A large body of literature exists within the sociology of emotions, including within the context of organisational studies. A key theory within that body of knowledge is that of "*Emotional Labour*". This term was first defined by Arlie Hochschild in the 1980s (Hochschild, 1983; Hochschild, 2012) and describes the ways in which individuals modify the expression of their own emotions in their everyday work (paid and unpaid) in order to be effective within their role. Where this happens within the framework of paid employment, this can be thought of as a commodification of emotions. This regulation of emotions requires individuals to "act" in a required way[16]. Acting places a burden on the individual who then has to manage the dissonance associated with displaying one emotion whilst feeling

---

[16] Hochschild's seminal work involved exploring the work of air hostesses who are obliged to appear cheerful and accommodating, even when faced with rude and demanding customers Hochschild, A.R. (2012) *The Managed Heart : commercialization of human feeling*. Updated edn. Berkeley, Calif. ; London: University of California Press.

another. Ultimately it can result in individuals shifting their personal emotions fundamentally to align to that which is required of them in their role; "*deep acting*".

The concept of emotional labour has been described as relevant to the work of health care workers (Mann, 2005). It has been applied to health care professionals who provide health care to women experiencing pregnancy loss generally (Wallbank and Robertson, 2013), and during the first/second trimester specifically (Bolton, 2000; McCreight, 2005). The latter is described by Bolton (2000) as challenging to nurses who suppress their own feelings of distress in order to present "*the detached face of a professional carer, but also to offer authentic caring behaviour to patients in their care*" (Bolton, 2000; p580).

It has been suggested that this improves quality of care for patients (sometimes to the detriment of the individual workers) however it is important to note that the application of emotional labour is not under formal control, therefore the success with which individual workers deliver it is hard to measure. Negative emotional impacts have been described amongst frontline clinicians who feel that they are compelled to support care which they consider to be suboptimal (e.g. "*moral distress*" (Oh and Gastmans, 2015)). The long term impact of health care professionals setting aside their emotions in order to manage workload is also poorly understood, but it could be suggested that persistent "*deep acting*" (Hochschild, 2012) may make frontline workers overly resilient and have a negative impact on the ability of frontline workers to maintain genuine empathy with women experiencing early miscarriage.

Feminist Theory

Feminist theories were considered because a striking feature of health care for early miscarriage is that it involves a predominately female frontline workforce delivering care to an all-female patient population (accepting that male partners may also receive care during a pregnancy loss, however the woman is primary focus of the care provided). Feminism covers a broad spectrum of theories that are concerned with the:

> "exclusion of women – women's voices, women's experiences – from the academic and political debates. They seek to show that, in so far as these debates are dominated by male voices, they necessarily promote male interests and marginalise or subordinate the interests of women" (O'Byrne, 2011; p91)

In relation to this research question, feminist perspectives have been previously applied to (a) studies of pregnancy loss and (b) studies of health care professionals. The former has described early pregnancy loss to be an experience that is shaped by cultural and social forces which subordinate the experiences of women experiencing an early pregnancy loss compared to women experiencing a later pregnancy loss or a live birth (Layne, 2006). A feminist approach is used by Layne (Layne, 2003; Layne, 2006) to identify strategies for improved care for women experiencing early miscarriage which include empowerment and preparation through greater information sharing, provision of choices regarding treatment, and acknowledgement by caregivers of the personal nature of the experience of early miscarriage (Layne, 2006). Feminist perspectives on health care professionals are outlined within a large body of evidence (which is too large to accommodate within this thesis) however an important feature of the literature involves the gendered nature of the health care professions. These studies explore the impacts of nursing and midwifery being historically female dominated professions, in comparison to medicine being a far more established profession, traditionally driven by men. This is described to have had a number of implications, but a particularly relevant one is the proposal that nursing is cast as a "*caring*" profession driven by notions that women have a more natural disposition towards traits such as caring and intuitive thinking (Abbott and Meerabeau, 1998). This contrasts to the techno-rational focus of the medical professional that, it is argued, dominates contemporary health care (Schofield, 2001; Maxwell, 2012; Wolf *et al.*, 2012). This results in both "*caring*" aspects of health care, and intuitive forms of knowledge, being subordinated and de-legitimised in comparison to techno-rational ways of thinking and planning care.

When early miscarriage is viewed through this lens then it would suggest that health care services may naturally fall short of patient expectations because the gaps in care identified by women predominately relate to interpersonal aspects of care (e.g. feeling cared for, have needs anticipated). Medical staff, who have traditionally controlled issues of diagnosis and treatment, may systematically overlook these aspects of health care (e.g. omitting them from formal guidelines or only referring to them in vague ways) and not incorporate them into clinical decision making (Mackintosh and Sandall, 2010). This results in these aspects of health care being considered by both medical and nursing staff as an "add-on", rather than as an integral part, of the service (Bolton, 2000)[17].

---

[17] this interpretation does not mean to imply that all nurses care and that all medical staff do not, or that all nurses are female and all medical staff are male, this is patently incorrect; rather it means that the evolution of health care in the NHS has been driven by gendered understandings of what counts in terms of quality and demands resource use and that the resultant structures impact on all genders.

Theories of emotional labour and feminism have the potential to offer different insights into the factors that may influence the delivery of quality care services to women experiencing early miscarriage; indeed it might be difficult to conduct research in the field without encountering aspects of each. However, the primary focus of the research question in this thesis is on meanings and management of quality in health care and it was important from the outset to choose an analytical framework that could accommodate diverse understandings of QOC. The comparatively narrow focus of Emotional Labour and Feminist theories are therefore not highlighted as strong reference points in the analysis here, but it is nevertheless important to note their potential, and this is reflected in the discussion of the findings.

3.4 Methods

3.4.1 Study Aims and Objectives

This research aims to explore the question:

> How is the quality of health care services offered to women experiencing an early miscarriage conceptualised and managed on a day-to-day basis by frontline staff delivering those services with the NHS in England?

This aim will be met by answering the following sub-questions. Within the context of health care services offered to women experiencing an early pregnancy loss:

a) Which factors influence NHS workers when they assess the adequacy of quality of the services they offer?
b) How do frontline NHS workers describe their responses to instances of suboptimal care quality in terms of actions or inactions?
c) What are the formal and informal mechanisms used by frontline NHS workers to manage the quality of care on the frontline and what provokes their use?
d) What role does organisational hierarchy play in the quality management activities of frontline NHS workers?

3.5 Secondary Data Analysis

3.5.1 The Use of Secondary Data in Research

This research question is addressed using data collected for a different research project. This is known as a secondary data analysis which is "*a research strategy which makes use of pre-existing quantitative data or pre-existing qualitative research data for the purposes of* *investigating new questions or verifying previous studies*" (Heaton, 2004, p16). Initially, secondary analysis was used with quantitative datasets, but in the 1990s interest in its application to qualitative datasets increased and papers describing secondary analyses of qualitative data began to appear in the academic literature (Heaton, 2004). Since then qualitative secondary data analysis has been increasingly employed in academic research.

Secondary data can be sourced in one of three key ways; (a) through formal archives (e.g. NHS National Maternity Statistics are publicly accessible online (Health and Social Care Information Centre, 2015)), (b) through informal data sharing between researchers, and (c) reuse of data by the researcher who originally collected it (Vartanian, 2011; Bryman, 2012). In relation to the primary use of the data, a secondary analysis can explore a new question, re-evaluate the results of the primary research, or it can involve a meta-synthesis of a number of datasets on the same topic (Walsh and Downe, 2005).

3.5.2 Advantages and Disadvantages of Secondary Data Analysis

There are several advantages to re-using qualitative data. Firstly, using a pre-existing data set reduces or eliminates the costs usually expended in collecting data; these costs can be substantial and prohibitive for researchers. In addition to researcher costs, it also reduces burdens to participants since it avoids having to recruit another group of participants; this is particularly valuable where the topic is sensitive or the participants hard to reach (Heaton, 2004). Ethical arguments have also been made regarding the imperative to make best use of the rich datasets qualitative research methods often generate (Bryman, 2012). These advantages are of real benefit to research in sensitive areas such as reproductive loss, where recruitment to studies can be challenging.

Alongside these potential benefits, there are also concerns about the validity of using secondary datasets, and about some of the ethical implications of reusing data. Epistemological concerns include the extent to which data collection has been designed specifically for one purpose and how far the data can be valid for use for a different purpose. This is a challenge where the questions asked in the primary or secondary studies are particularly divergent (or where they are particularly convergent in which case the boundaries between one study and another are difficult to define) (Lincoln *et al.*, 2011). Another concern relates to how much the researcher can know, and become immersed in the data, in cases where they had limited or no involvement in the data collection (Heaton, 2004; Vartanian, 2011; Bryman, 2012). This separation also serves to limit the ability of the researcher to judge the quality of the research in terms of its conduct, the ways in which the data was collected, and contextual factors which may have relevance to the data (e.g. if an interviewee was upset during an interview).

> "Direct engagement in interpretive research brings about a different quality of knowing. This 'participatory knowing' cannot be achieved through the eyes of even the most interested researcher who was not bodily present in the research setting"
> (West and Oldfather, 1995; p456)

Ethical concerns have also been described; particularly in relation to the obligations researchers have to participants. Confidentiality and control of the data are key concerns, particularly if whole rich and detailed data sets, which are difficult to anonymise, are being shared. Researchers using a secondary dataset should be clear that the participant who contributed the data has given consent for an alternate use of the data, or that they have given a second consent for this additional usage.

These issues were considered before beginning this project and are outlined in the following sections. First an outline of the primary data set is provided, followed by a discussion of the suitability of the dataset for this project.

3.6 Primary Study

This section provides an overview of the project for which the data was primarily collected. This gives context, and establishes the validity and suitability of the dataset for secondary analysis. It also establishes the rigour of the primary research and the validity of the data set.

3.6.1 Project Overview

This PhD thesis draws on data collected during a project examining the health care services offered to women experiencing an early miscarriage as defined in the previous chapter. This project was supported by a Knowledge Transfer Partnership (KTP) between the Newcastle upon Tyne Hospitals NHS Foundation Trust and Newcastle University, funded jointly by the Newcastle upon Tyne Hospitals NHS Foundation NHS Foundation Trust, the Department of Health, the Economic and Social Research Council, and the Technology Strategy Board. The stated aim of the primary project was to "*develop, evaluate and embed an interpretive model of engagement with staff and patients for NHS service review, to facilitate the implementation of new local level health service delivery policies*".

The project was conducted in the North East of England and involved the early pregnancy loss services at four different NHS Foundation Trusts. It was a three phase project which covered a process of exploratory research examining the experiences and views of services users and service providers (frontline and managerial), the development and implementation of evidence based and locally appropriate changes to health care, and the evaluation of these changes from the perspective of service users and providers. A summary of the purpose and activities conducted during each phase of the primary study are outlined in Table 3-1.

	Phase 1	Phase 2	Phase 3
Aim	To explore opinions about the content of high quality care for women experiencing an early pregnancy loss from the perspective of patients and health care workers. To explore the role of frontline health care workers in developing and managing the quality of early pregnancy loss services.	(i) To compare self-reported patient satisfaction in each of the participating health care trusts (ii) To feedback the results of phase 1 to frontline workers at the main participating Trust and develop ideas for service improvement.	(i) To describe the experiences of frontline staff involved in the project (ii) To develop a generic toolkit describing the processes of the project for use throughout a Health Care Trust
Method	A qualitative semi-structured interview study	(i) A cross sectional patient survey (ii) Interactive workshops with groups of frontline staff	(i) A qualitative interview study (focus groups and individual interviews) (ii) N/A
Participants	24 Patients with recent experience of health care for an early pregnancy loss +/- (b) their partners, and (c) 41 staff who are involved in the delivery or management of early pregnancy loss health care.	(i) Patients attending any of the four participating hospital trusts for treatment of an early pregnancy loss (i) Frontline health care workers of all disciplines involved with the delivery of early pregnancy loss services at the main participating hospital Trust	(i) A selection of 11 frontline staff involved in the delivery of early pregnancy loss services who participated in phase 2 of the project (ii) N/A
Output	A report detailing the components of a high quality early pregnancy loss service as described by patients and health care workers, and outlining suggested barriers and facilitators to achieving this	(i) A report detailing the results of the patient survey. (ii) A report outlining the outcomes of the workshops with an agreed plan for service improvement	(i) A report detailing the experiences of frontline workers who were involved with the project and recommendations for future work (ii) A toolkit published within the NHS Trust involved in the KTP

Table 3-1 The Three Phases of the Primary Project

The project began in March 2010 and concluded in February 2012; Appendix A shows a project Gantt chart. The focus of the work in this thesis is the data collected in Phase 1, and more specifically on data collected from health care professionals since this provided the richest dataset and the one that aligned best to the research question specified for the secondary analysis. In view of this selection from the data available overall, this section provides more detail about this specific component of the primary project.

3.6.2 Phase 1 Project

Phase 1 Design

The aim of the phase 1 primary project was to explore patient and health care provider perceptions of health care provision for early miscarriage across four study sites in the North East of England. The study design used was a qualitative semi-structured interview study involving (a) patients (+/- their partners) who had recent experience of hospital based health care following a diagnosis of early miscarriage, and (b) hospital based health care practitioners and managers providing care within the early pregnancy loss services offered by four acute Trusts in different geographical areas in the North East of England. These areas were selected purposively to represent diversity in the package of care offered to couples experiencing miscarriage and in the management of their early pregnancy loss services. Key features of each of the participating hospitals are:

> *Hospital A:* Large tertiary referral unit. Early miscarriage diagnostic services delivered in a dedicated standalone unit. In-patient treatment delivered on a gynaecology ward. Most early miscarriage care delivered by specialist nurses, gynaecology nurses, and health care assistants.
>
> *Hospital B*: Small Secondary Care Hospital. Early miscarriage diagnostic services delivered in a clinic run within an antenatal clinic. In-patient treatment delivered on a general surgical ward. Most early miscarriage care delivered by midwives, gynaecology nurses, and general surgical nurses.
>
> *Hospital C*: Large Secondary Care Hospital. Early miscarriage diagnostic services delivered in a unit dedicated to the provision of antenatal care. In-patient treatment delivered on a gynaecology ward. Most early miscarriage care delivered by specialist nurses, gynaecological nurses and health care assistants.

> *Hospital D*: Large tertiary referral unit. Early miscarriage diagnostic services and in-patient treatment delivered in a maternity assessment unit. Nearly miscarriage care delivered by midwives and maternity care assistants.

All hospitals had a lead consultant for early miscarriage care, however in each case the consultant generally provided more of an oversight role than a direct patient care role[18]. Otherwise more junior medical staff (usually foundation level, but sometimes specialist registrar level) were routinely involved in the care of women experiencing early miscarriage however their contact with this patient group was, compared to the nursing/midwifery staff, limited (e.g. they prescribed medication, explained treatments, obtained written consent for procedures). On some issues there was variability in the extent of their involvement (e.g. at hospital D, midwives took consent for medical treatment, whereas the other hospitals allocated this tasks to medical staff).

In total, 41 transcripts from interviews with staff were available to use in the secondary analysis with each of the four hospitals represented in the sample. An overview of the sampling approach and data collection process is provided next, to allow for meaningful discussion about the suitability of the data available for secondary analysis.

Phase 1 Sampling

A purposive sampling strategy was used to recruit health care workers involved in the management or delivery of early miscarriage care. There were no exclusion criteria for the staff participants. Purposive sampling is a non-probability form of sampling in which the researcher strategically targets sampling to ensure that participants have a selection of attributes and characteristics that are of interest to the research question (Bryman, 2012). In this study maximum variation sampling was used with the aim of including as wide a variety of potentially influential characteristics as possible. Features of the sample sought are shown in Table 3-2.

---

[18] Consultants were most likely to become involved in cases where a medical problem developed (e.g. where a woman bled heavily), where there were complicated features to the case (e.g. the woman had complex co-morbidities or had had a number of EPLs), or where a woman had experienced recurrent miscarriage.

Participant Group	Attributes Sought
Health care workers involved in the delivery or management of early miscarriage services	Differing staff groups (e.g. medical, nursing, midwifery) Differing organisational roles (e.g. frontline workers, managers) Specialist and non-specialist roles Male and female*

*where possible, acknowledging that the majority of frontline health care workers in this field are female

Table 3-2. Purposive Sampling Strategy for Staff Participants in the Primary Study

Phase 1 Sample Size

Qualitative research methodologies do not pre-specify an absolute sample size in the way that quantitative research methodologies do. This is because the aim of sampling in a qualitative study is to reach data saturation, rather than to prove or disprove a hypothesis to a predefined statistical level. Sampling thus continues until data saturation reaches "*the point in qualitative research when the issues contained in the data are repetitive of those contained in data collected previously*" (Glaser and Strauss, 1968; Somekh and Lewin, 2011 , p345). It was estimated at the outset of the phase 1 study that thematic data saturation would be reached with up to 10-15 health care staff from each of the participating study sites (i.e. between 40 and 60 across the four sites).

Phase 1 Recruitment

Health care workers were identified via staff lists provided by each of the participating health care Trusts. Frontline health care workers' names were stratified by occupation group (i.e. nurses, midwives, medical staff) then an invitation letter was sent to every other name on the list ensuring every occupation group was represented. Managerial level workers (directors, ward managers, matrons) and nurse specialists represented a much smaller pool of staff therefore an invitation letter (see Appendix B) was sent to all along with a staff participant information sheet (see Appendix C) that included a "consent to contact" slip that those interested in knowing more about the study could use to indicate that they were happy to be contacted further. Those returning a "consent to contact" slip were contacted by the researcher who provided further information. For those who wished to participate, an interview was arranged at a time and place of the potential participant's choice.

Before each interview the researcher confirmed that the participant had read and understood the information sheet and answered any questions. A consent form (Appendix D) was then completed by the participant and researcher in accordance with the principles of Good Clinical Practice (McGraw *et al.*, 2010) before data collection commenced. The number of individuals involved in each stage of the process is shown in Figure 3-4.

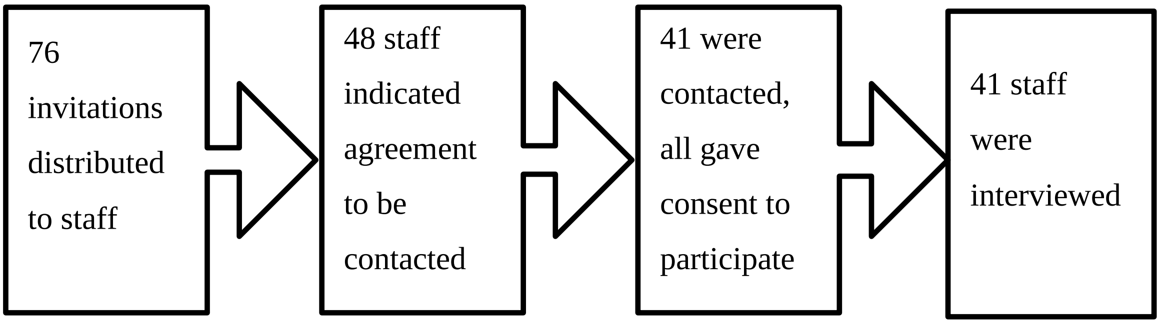


Figure 3-4. Participant Flow Through the Research Process

Phase 1 Data Collection

Data was collected using semi-structured interviews. Individual interviews (as opposed to focus group interviews) were considered the most appropriate method of data collection because of (a) the sensitive nature of the topic area, and (b) the possibility that staff may be inhibited from criticising their services in front of colleagues or organisational superiors. The data collection aimed to collect information about specific issues but also allow interviewees freedom to bring in issues of importance to them, thus a semi-structured interview technique was used (Bryman, 2012). An interview guide was developed and used (see Appendix E).

The same interviewer conducted all interviews. They occurred face-to-face and on an individual basis. Of the health professional group, most chose to be interviewed at work, two chose to be interviewed at home; in all cases the interview took place in a private room. With the consent of participants, all interviews were recorded using a digital audio recorder. Each participant was interviewed once; the shortest interview was 27 minutes and the longest was 107 minutes. At the end of the interviews all participants were thanked and asked if they would like a transcript of their interview and a summary of the primary study findings. No staff interviewee requested the former, but all requested the latter.

Phase 1 Analysis.

The audio recordings were transcribed verbatim by a research secretary including audible, non-verbal utterances and interactions (e.g. long pauses, laughing, crying, interruptions). The transcripts were then checked for accuracy against the audio recording by the researcher, and they were then anonymised by removing names and locations, (changing these to anonymised identifiers such as hospital D, or senior nurse E). Where the participant was male, or a participant was referring to a male colleague, the identifiers were changed from ‘he’ ‘his’ to ‘her’ ‘hers’ in order to protect the identity of the small number of male participants within the nursing and managerial groups. The transcription conventions are shown in Appendix F. The anonymised transcripts then formed the formal data for analysis.

The transcripts from the interview were analysed using a descriptive thematic analysis approach which involved assigning descriptive codes to the data and identifying recurring themes (Saldaña, 2013), then summarising the content of the data (Sandelowski, 2010). A brief overview of the primary project results is provided in the end of study report shown in Appendix G.

3.6.3 Governance

The phase 1 study received ethical approval from the Sunderland Research Ethics Committee on the 28th June 2010 (Ref 10/H0904/27) (see Appendix H). Additionally, the study received site-specific approval from the Research and Development department and Caldicott guardian at each of the participating hospitals. The study was adopted to the UKCRN portfolio database (ref 42001).

As the research midwife taking consent and conducting the interviews, I had completed informed consent and Good Clinical Practice (GCP) training as required by local hospitals, and a letter of access was granted by each of the participating hospital Trusts to allow research activities to take place.

3.6.4 Ethical Issues

Key ethical issues pertaining to the involvement of participants in research were considered for all participant groups (e.g. requirement for consent to be voluntary and informed, respect for interests of participants). In terms of the staff participants, two specific ethical issues were considered; the sensitivity of the topic and the confidentiality of the participants.

Early miscarriage is a sensitive topic that could cause distress to those discussing it. Whilst this was a greater concern for patient participants we were aware that most of the frontline workforce providing care are female, and therefore, statistically, a proportion were likely to have personal, as well as professional, experience of early miscarriage. To prepare for this the researcher had available, at the time of interview, details of support mechanisms for those who have experienced early miscarriage and of organisation specific support mechanisms for staff.

Confidentiality is an important factor to consider for any research study. This study encouraged health care workers to be critical of the care being offered within their organisation and it was important that participants could do so anonymously (i.e. without concerns about being identified by the organisation as providing specific information). The steps taken to address issues of anonymity are shown in Figure 3-5.

Interviews were arranged directly with the participant at a location of their choosing allowing them to participate without colleagues knowing.

The researcher did not discuss the identity of those who participated with other members of participating organisations.

All audio recordings were deleted after they had been transcribed and checked

All identifiable names and locations were changed to anonymised versions in the transcripts (e.g. hospital A, nurse B)

Areas of the transcripts which contained potentially identifying content that could not be reasonably anonymised were flagged as not suitable to include in study outputs such as reports or publications (e.g. where the participant discussed aspects of their role which would identify them). This also meant that, whilst the analysis considered the different job types of participants, the report of this analysis uses more generic descriptors (e.g. frontline, manager, frontline manager) to avoid the identity of participants becoming obvious. Similarly, all respondents are referred to as female (e.g. using descriptors she, her) to avoid compromising the confidentiality of the small number of male interviewees.

Participants were offered a copy of the transcript of their interview with the opportunity for them to flag any passages which they had concerns about (none of the participants requested a copy of their transcript).

Figure 3-5 Actions Taken to Maintain the Anonymity of Staff Participants

3.7 Suitability of the Primary Dataset

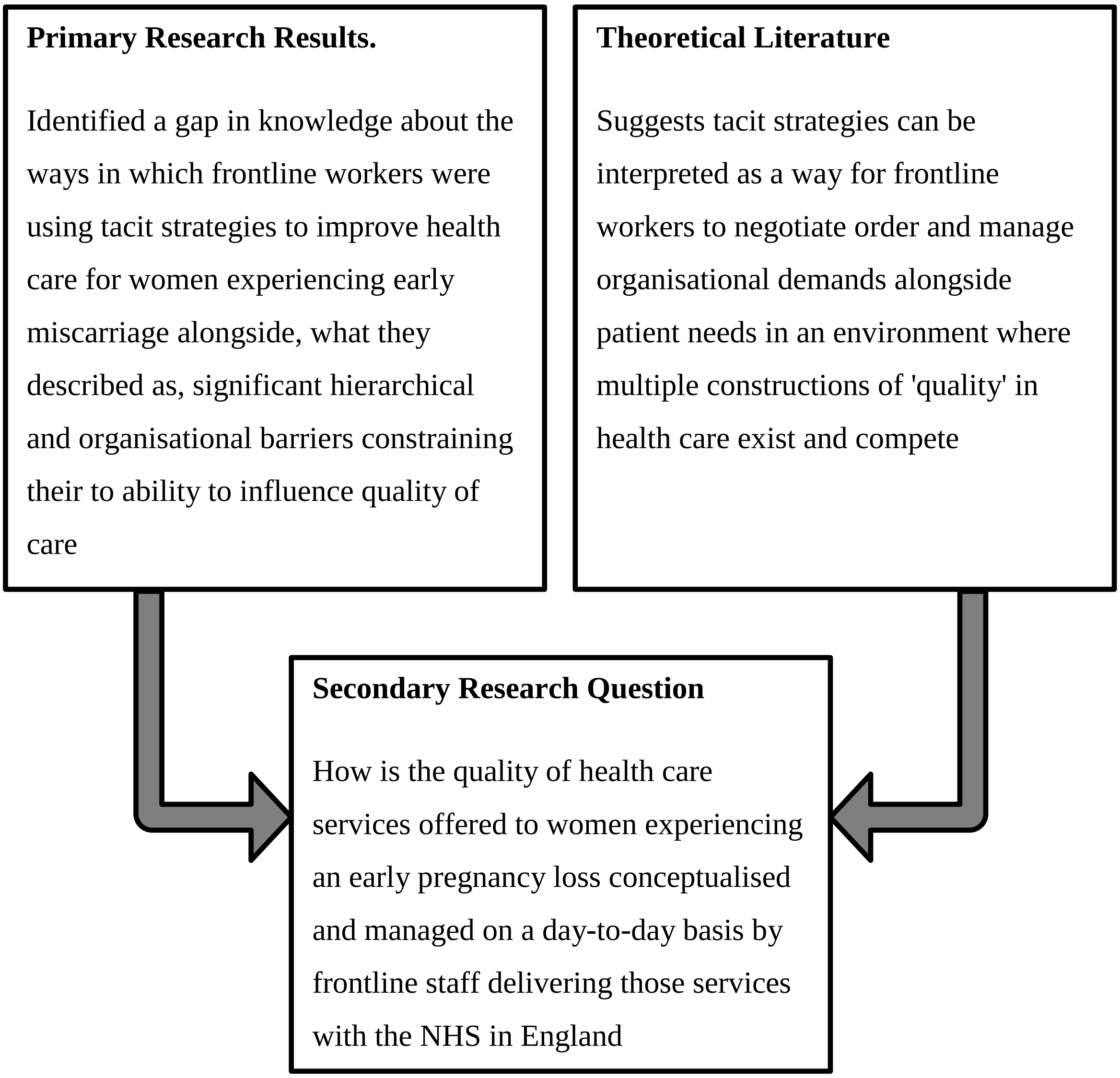
3.7.1 Suitability of Secondary Data Analysis to this Project

Hinds *et al.* (1997) developed a tool to assess the suitability of datasets for secondary analysis based on three factors: accessibility, quality and suitability. These factors were considered before choosing to use secondary data for this study. A key feature of the primary data set which impacts on all of those factors in this case is that I was the researcher who designed and managed the primary project; I was involved in all aspects of it, including taking consent from participants, collecting the data, and leading the original analysis. This conferred a number of advantages to its use in a secondary analysis.

In terms of accessibility there was (a) the opportunity to access the data in its raw form without concerns about compromising the confidentiality of participants, (b) access to, and understanding of, the field notes recorded at the time the interviews were conducted, (c) the opportunity to ensure that consent to the use of data for secondary analyses from participants was a formal part of the consent process, and (d) the opportunity to request permission to reuse the dataset from the bodies funding the primary research. In terms of assessing the quality of the data I had full awareness of the context in which the interview data was collected, and the reactions of interviewees (beyond the audible data included in the transcripts); as context can add additional information to an interview this means that I had access to this additional hidden layer of data (West and Oldfather, 1995). It also meant that I did not need to rely on the competence and integrity of another researcher to feel assured that the study was conducted correctly (e.g. that the study protocol was adhered to, that the data was obtained fairly). The intimate knowledge I had of the content, scope and methods used to create the dataset meant that I was well placed to assess whether the data was suitable to answer the research question posed in this thesis.

These features address many of the concerns relating to the use of secondary data and gave confidence that this was a suitable dataset to use for a secondary analysis. The use of auto-data (i.e. data collected by a researcher which is then reinterpreted by the same researcher) is a well-established and used form of secondary analysis (Heaton, 2004). The application of a theoretical framework and the focus on an aspect of the data identified, but not fully explored, in the original analysis ensured that there was sufficient divergence between the original and secondary study aims, but also enough convergence that the dataset remained relevant. This type of analysis has been termed by Heaton (2004) as "*supra analysis*" explained as an analysis which "*transcends the focus of the primary study from which the data were derived, examining new empirical, theoretical or methodological questions*" (Heaton, 2004 , p38).

The primary study was pragmatic with an ontology that aligned most closely to critical realism, and an analytic approach that was more descriptive than analytic. Heterogeneity between the primary and secondary research questions was achieved by using the results of the primary study to identify a knowledge gap that would be addressed by the secondary analysis. The question was refined as the secondary analysis and engagement with the theoretical literature progressed; this approach to research question generation is not unusual in qualitative research (Silverman 2006). This ensured that the question asked, and the analytic approach taken in the secondary analysis, were sufficiently distinct to generate new knowledge from the dataset (see Figure 3-6).



Primary Research Results.

Identified a gap in knowledge about the ways in which frontline workers were using tacit strategies to improve health care for women experiencing early miscarriage alongside, what they described as, significant hierarchical and organisational barriers constraining their to ability to influence quality of care

Theoretical Literature

Suggests tacit strategies can be interpreted as a way for frontline workers to negotiate order and manage organisational demands alongside patient needs in an environment where multiple constructions of 'quality' in health care exist and compete

Secondary Research Question

How is the quality of health care services offered to women experiencing an early pregnancy loss conceptualised and managed on a day-to-day basis by frontline staff delivering those services with the NHS in England

Figure 3-6. Generation of the Secondary Research Question

This was an interesting dataset, which was, in some respects, challenging to collect (e.g. a multi-site study which involved contentious features such as employees potentially being critical of their employers). Whilst a secondary analysis approach does involve sacrificing control over the ways in which the data were collected, in this case this was outweighed by the benefits of accessing a difficult to collect dataset that was suitable to the research paradigm of the secondary analysis.

3.7.2 Suitability of the Primary Research Methodology

As outlined in section 3.2.4 the secondary research question is situated within a relativist paradigm and is exploratory in nature. This paradigm is typically associated with qualitative research methodologies. The dataset used in the secondary analysis is specifically drawn from the Phase 1 interview study described in the previous section, which also used a qualitative methodology. The primary research methodology, including the method of data collection were therefore, considered to be appropriate and the secondary research question to be sufficiently different to justify a reinterpretation of the dataset.

3.7.3 Suitability of the Primary Research Methods

The primary data was collected using face-to-face semi-structured interviews. This is a well-established mode of data collection which allows the interview be focused around a defined topic, but which also allows the interviewee freedom to talk about the topic from their point of view and bring information of relevance to them into the conversation (Peräkylä and Ruusuvuori, 2011; p470-72). The interviews were therefore broadly about the interviewees' thoughts and opinions about the services they delivered and their experiences of working in those services. This allowed their interpretations of QOC to form the basis of further discussions about any involvement they had had in quality management.

The advantage of using interviews to collect data are that it allows the collection of "*subjective experiences and attitudes*" of the interviewee (Peräkylä and Ruusuvuori, 2011; p529) and the issues discussed need not be time bound (i.e. unlike observational methods where data relates to a specific time frame, interviews can ask about past events or future plans (Bryman, 2012)). It also avoids some of the pragmatic and complex ethical issues involved in collecting "*naturally occurring*" data via observation, especially given the context of this research question (in which it may be considered intrusive for a researcher to be present during a potentially sensitive and emotional event such as early miscarriage).

There are two key limitations to this approach of relevance to the secondary analysis in this project. Firstly, as with all research projects, the participants are self-selecting (i.e. they choose to take part whereas others choose not too). This means that the views presented in the data come specifically from individuals with an interest in the research in some way (e.g. an interest in the topic, a wish to put forward a particular view, beliefs about the utility of the research findings). This was made explicit when one of the interviewees noted that they had chosen to take part in order to make their concerns about the quality of their early miscarriage services more widely heard. This does not invalidate the data collected, but it does mean that those who were unwilling or unable to take part (including those who were not invited) do not have their views represented.

The second limitation is that interviews involve a conversation between two individuals (albeit a very specific type of managed conversation in which the interviewee talks a lot more than the interviewer). In such a conversation the interviewee chooses which information to provide and how to present it; how a health care worker describes providing care may differ hugely from the way that they actually provide care, and they may be guarded against sharing information which would incriminate them or cast them in a bad light (e.g. it seems unlikely that a health care professional would admit to having no interest in quality of care since this would contradict societal expectations about health care workers). This would be more of a limitation in a study employing a realist epistemology (i.e. where a "truth" is being sought), but in a study employing a constructionist paradigm the ways in which interviewees represent themselves is as much interest as how that translates into action.

3.7.4 Selection of the Secondary Data

The full primary dataset is outlined in Table 3-1, page 78. This included 41 interviews with NHS staff that were employed in roles that had variable exposure to the day-to-day care of women receiving care for an early miscarriage. Participants were categorised in relation to the extent to which their role was predominately frontline (Code 1, n=17), managerial (Code 3, n=9), or role that had a substantial component of both managerial and frontline duties (Code 2, n=15). A more detailed breakdown of these roles is shown in Table 3-3.

Involvement Code	Staff Type	Site A	Site B	Site C	Site D	Total
1	Health/Maternity Care Assistant	1	0	1	1	3
1	Staff Nurse/Midwife	1	2	1	1	5
1	Specialist Nurse/Midwife*	3	1	0#	2	6
1	Medical Staff (SpR, ST 3-7) $	2	0	0	0	2
1	Sonographer	0	1	0	0	1
2	Senior Nurse or midwife/Sister/Junior Sister	1	3	2	2	8
2	Consultant	2	1	2	2	7
3	Matron	2	0	0	0	2
3	Clinical/Medical/Nursing Director or Head of Midwifery	2	3	1	1	7
	Totals	14	11	7	9	41

* This describes a nurse or midwife who has taken on a specialist role and has advanced skills in sonography as well as their nurse/midwife qualification. # Some specialist nursing/midwifery staff were categorised under senior nurse/midwife because they had a significant managerial component to their role. [$] Due to time constraints in the primary study Hospital A was the only organisation in which medical staff below consultant level were asked to participate. These are, however, rotational roles and so these participants had experience of early miscarriage care in more than one organisation. The dataset used in the secondary analysis is highlighted in grey.

Table 3-3. Staff Participants by Role and Involvement in Frontline Care Delivery

The primary analysis of the data suggested that two of the organisations were particularly interesting (Hospitals B and D) because they had both recently undertaken a significant reorganisation of their early miscarriage services. The remaining two hospitals were similar in organisational model and stability of services, however including both sites would have been a significant increase in the amount of data to be analysed with no expectation that this would add any additional diversity to the dataset. It was therefore decided to choose one of these sites. Hospital A was chosen because it had a greater number of frontline interviewees, and it was the only site where medical staff below consultant level participated in the study. So all interview data from hospitals A, B, and D were included (the option to include data from hospital C, if data saturation was not reached, remained since the dataset already existed; however this was not necessary). Consideration was given to using only data collected from participants with a frontline care delivery component to their work, however as Evans (2010) suggests that managerial level staff may have an important role in enabling tacit forms of discretionary practice, staff of all levels at sites A, B, and D were included. The dataset used in the secondary analysis is highlighted in grey in Table 3-3.

3.7.5 Analytic Method

The choice of method used for analysis was somewhat dictated by the methodology and the use of a secondary data set. Some analytic methods have protocols, which require analysis to be completed alongside, and have an influence upon, data collection (e.g. grounded theory approaches); this was clearly not possible when the data set already existed in its entirety before the analysis began.

Interpretive phenomenological analysis (IPA) was considered (Smith and Osborn, 2008). This is an analytic technique that focuses on the "*lived experiences*" of participants and, in particular, the "*meanings particular experiences, events, states hold for participants*" (Smith and Osborn, 2008). Whilst the experiences and constructed meanings given by NHS workers to their work were of relevance to the research questions, the importance of actions and processes and shared understandings was also appreciated. Additionally the interview guide was not sufficiently focused around the lived experiences of participants and so IPA was not considered an appropriate analytic method.

Generative thematic analysis describes a more flexible approach to analysis of qualitative data. It is an extensively used analytic technique which has been outlined by Braun and Clarke (2006). It is a six-phase technique during which the researcher continually engages with the dataset in order to identify and interpret recurring patterns and themes. Themes are described to "emerge" from the data in so far as they are grounded in the dataset however this emergence is an active and systematic process that is managed by the researcher. The analytic process is managed over six phases as outlined in Figure 3-7. Whilst this is presented as a linear process, in reality the analysis moved back and forward through the phases as the it became more refined.

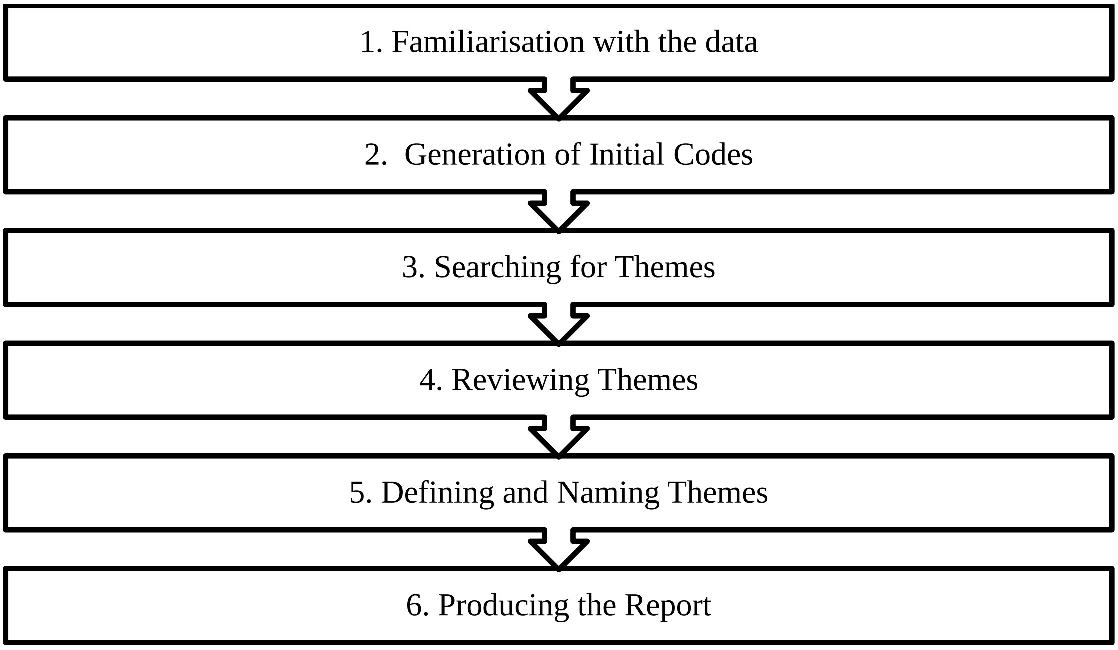


Figure 3-7. The Six Phases of Generative Thematic Analysis (Braun and Clarke, 2006)

This framework was used to analyse the data set as follows:

Phase 1. The data had already been transcribed, checked and anonymised and these transcripts formed the data for analysis. All of the transcripts were read through, with notes taken about any queries or ideas generated.

Phase 2. The transcript documents were entered into a qualitative data manager software programme (Atlas.ti Version 7). The first cycle of coding involved assigning descriptive and process codes to passages of text (Saldaña, 2013). Specific attention was given to passages that related to quality management in terms of; assessing quality of care, responding to instances of suboptimal care, the sequelae following from actions taken to manage quality of care including the reaction and responses of hierarchically superior staff. During the coding process notes were made to record developing ideas and codes were frequently amended (e.g. some codes split into sub codes, some codes grouped into super codes). An example of coding is shown with a data extract in Figure 3-8.

Data Extract (where 034 is interviewee, and AF is interviewer)	Codes / Sub codes
034 I mean always find time to chat really because you've got to for these women, they've got to be given information, and I give information right through the day, I don't just wait until the end of the day and say "right you're, this is gonna happen, that's gonna happen" kind of through the day, when you go in and you do. At the moment you do your obs regularly, and it's absolutely not necessary, especially if we're gonna send them home, we have like a scoring system, but I've been reluctant to let that go because it means that you're going in every, at least every hour, do the obs and chat, so you might just do the blood pressure and say "how you feeling, have you got any pain, are you this, are you that, have you this, do you know what's going to happen when you go home?" and you can just kind of just wheedle in a few minutes all the time through the day to look after them	Finding Time, Chatting Information provision Preparation Unnecessary Care, Physical observations Using one thing (protocol re blood pressure) to gain another (contact time) Pain assessment, Preparing for after treatment "Wheedling" in time
AF Quite crafty	
034 Well it is, cos we were told we had to do it, and then we realised, we thought what we doing, we're gonna send these women home, we can't do their obs every hour they don't need it and they're never, very rarely shocked, and you'd do it if they were poorly wouldn't you? You'd go in and you'd do the vital signs and everything, it's not necessary, but we can do it, to keep the level of care up which is, .. giving them the time yeah, yeah, and somebody, no matter who will always go in and do them obs all day, and then people dip in in the meantime, which is nice, but at least then they get better care than if they were just, if you didn't do their obs some days, it's so mad you'd be thinking 'crikey I haven't been in', wouldn't you you'd think 'aahh, it's dinner time and I haven't been in, I've left her' which would be terrible	Enforced versus voluntary action Professional knowledge of when aspects of care necessary/unnecessary Giving them time Better quality of care Gaining contact time Poor care, leaving patient alone, terrible

Figure 3-8. Example of data coding

Unusual or contradictory accounts were deliberately sought to add depth and incorporate minority views (e.g. there were few instances of frontline nurses explicitly challenging top down policies, so the two cases where this happened in a substantial way were scrutinised to identify differences (e.g. in motivations, actions and personal/organisational consequences).

Phase 3. Once the codes were identified they were incorporated into a mind map using XMind 2013 software, and then moved around into common themes and concepts creating a "concept map" (Davies, 2011); this was a pragmatic choice because I have a personal preference for visual learning and found it easier to conceptualise relationships between codes in this way. This stage involved some codes collapsing into each other, some being split into sub-codes, and some codes being promoted to themes. This was a long and fluid process with many changes made before the preliminary framework was settled upon.

Phase 4. This phase involved reviewing the themes for internal consistency (i.e. checking that the data extracts relating to each theme were consistent and expressed a coherent "story" describing the code (Braun and Clarke, 2014). It also involved ensuring each theme presented a distinct concept. Once this was completed the concept map was checked across the complete dataset to ensure that the themes made sense and identify important data that were not coded or adequately accounted for within the framework.

Phase 5. This phase involved refining the framework to identify relationships between the themes such that they are able to explain an overall narrative which was (a) grounded in the data and (b) incorporated insights gained through engagement with the literature regarding macro and micro level organisational theory. Up until this point the analysis was largely inductive (i.e. the codes and themes and concept map were generated as a consequence of the researcher's interpretation of the dataset). During phase 4 the theoretical concepts relating to the micro-organisational theories outlined in Chapter 3 (section 3.3.2) were introduced into the analytic process. This involved considering the codes and themes, and considering whether the codes, themes, and relationships described shared constructions of quality, and whether patterned and systematic tacit actions that contributed to the management of quality at the street level were evident. It also involved considering the contextual influences of larger structures (organisational rules, professionalism, societal constructs) on thoughts and actions.

Phase 6. The final phase involved the preparation of the findings and discussion sections of this thesis. The following three chapters present the overarching themes and subthemes within each presenting data extracts to support the findings. Chapter seven then presents a discussion of the overall findings in relation to (a) the study question, and (b) the existing knowledge and theory outlined in the literature reviews. It then concludes by outlining the contribution of this study to the knowledge base.

3.7.6 Thesis Timeline

This thesis was completed on a part-time basis over an almost seven year period. The timeline within which this thesis was developed is shown in Table 3-4. This demonstrates that the data collection phase of the study occurred before the development of the research question; this is entirely usual for a study employing a secondary analysis (Heaton, 2004). In some respects the research question developed for the secondary analysis was generated by the analysis conducted for the primary project; this identified that staff appeared to be engaging in informal activities that were influencing QOC. Subsequently this led me to explore organisational theories (and more specifically micro-organisational theories) that offered the opportunity to explore these phenomena, and the impact they have on QOC, in more depth.

Year	Date	PhD Related Activities
1	2010	Project set up and data collection. Completion of literature review on early miscarriage (Chapter 2).
2	2011	Completion of data collection and transcription of all interview data. Completion of literature review on quality management in the NHS (Chapter 1).
3	2012	Review of sociological literature generally and of organisation theory specifically.
4	2013	Development of secondary research question and methodology. Draft completion of Methods Chapter (Chapter 3). Re-acquaintance with data and completion of phase 1 and 2 of data analysis.
5	2014	Completion of phases 3 and 4 of the data analysis.
6	2015	Completion of phases 5 and 6 of the data analysis. Draft completion of all findings chapters (Chapters 4-6).
7	2016	Writing up year. Completion of discussion and conclusion chapters (Chapters 7-8) and review/revision of all other chapters including formatting and referencing. Production of final thesis.

Table 3-4 Evolution of Doctoral Studies

3.8 Limitations and Important Influences

3.8.1 Limitations Related to Study Design

The limitations of the methodology used in this research have been outlined in this chapter. To summarise they are:

- The use of secondary data as the data source has been described alongside its implications for the content of the data set and the limitations it presented in terms of choice of method and methodology. Many of these limitations were offset by using data collected by the researcher conducting the analysis for this thesis.
- The participants were self-selecting in so far as they chose to consent and provide data. Whilst the interviewees spoke about other colleagues, those colleagues have no voice in this research.
- The use of semi-structured interviews to collect data has been described. This technique produced a rich dataset but this is limited in so far it does not capture naturally occurring data, but rather it allows interviewees to choose how they would like to represent themselves and the topic under investigation.
- The use of the health care offered to women experiencing an early pregnancy loss as an exemplar for this study, representing a "case study" design. Disadvantages of this approach are that this context has specific features which are interesting from an analytic viewpoint, but which may limit the extent to which the findings can be assumed to be relevant to other health care contexts without further investigation (Flyvbjerg, 2011).

The use of a constructionist paradigm has been justified. This acknowledges that the knowledge generated during the study is subjective and co-created by the researcher and the research participants; it reflects only one interpretation of the data and the way in which it explains the topic of the research Subjectivity is not considered a limitation in qualitative research of this nature, however it has an impact on the ways in which the findings can be interpreted and used (i.e. they cannot be widely generalised). To aid transparency the next section outlines my background (as the researcher in both the primary and secondary studies) to allow the reader to consider the influence it may have on my analyses and interpretations.

3.8.2 Researcher Influence

> “The complexity of human experience and our shared humanity must figure in to our questions, our investigative processes, and, ultimately, our answers. Our own location must be carefully considered and clearly explained” (Angen, 2000; p392).

My own background firmly places me in the arena of frontline work in the NHS. I began training as a midwife when I was 18, then went onto work as a frontline clinical midwife for 5 years, followed by 16 years of working as a clinical research midwife. This means that I had come into contact with some of the interviewees before the project began. The latter role has involved me working on a number of different research projects, all clinically focused; in some my role was to deliver someone else’s research (e.g. providing women with information about research, taking consent from those who wished to participate and organising and delivering study activities), and others involved me developing and managing research projects based on my own interests (alongside other interested academics and clinicians). Two of the projects I have been involved with brought me directly into contact with women experiencing early pregnancy loss. The first was my involvement with the Human Developmental Biology Resource which involved me speaking with women experiencing early pregnancy loss (termination of pregnancy and miscarriage) regarding the donation of fetal tissue for medical research. The second was my involvement with the primary study described in section 3.6.2; a study that I project managed and for which I collected all study data.

My experience as a research midwife placed me in an interesting position vis-a-vis the frontline delivery of care. Being a research midwife is, in my view, somewhat of an ‘inside observer’ role in so far as I am not constrained by the workload pressures on the ward (since my responsibility is primarily towards research related activities) but yet I am still considered as a clinician by the other staff and I still perform clinical duties when required (e.g. I give advice, answer buzzers, put my arm around patients when they cry). In terms of the clinical team, this leaves me feeling that I am “*one of them*” and “*not one of them*” simultaneously. I notice things the clinical team take for granted or overlook, but I also have some understanding of the organisational factors, which might contribute to the way they act and think. It also had an impact on my ability to converse easily with health care workers during interviews which may have aided a willingness on their part to disclose information they may not have to an “outsider”. It is, however, also possible that it may have impacted on my capacity to probe during interviews as I may have missed opportunities to query taken for granted assumptions because I also take them for granted. It also created a slightly awkward dynamic when I was asking questions which interviewees felt I, as a fellow clinician, would already know the answer to (in one interview I asked a frontline nurse why she felt it was problematic for women if their treatment for miscarriage was delayed and she was speechless that I would need to ask!).

In the initial stages of the data collection for the primary project I did not think beyond a simple cause and effect model (frontline staff do not deliver care as they would wish to because they cannot) but I suspect that was because it offers a simple way of justifying inaction whilst retaining a positive outlook on my profession. Engaging with the sociological literature has been a difficult task; for the most part the language is complex and difficult to decipher with multiple authors using similar terms for different things, or different terms for what seemed like the same things. Perseverance, however, led me to think about my role, and that of my colleagues, in very different ways and taught me to constantly question that which my training as a midwife, and as a research midwife, had taught me to assume. This transformed the direction of the research. The significant introspection this caused as I contemplated my own role in previously supporting care that I personally believed to be less than adequate was uncomfortable to say the least. Nonetheless, my consistent work on the "shop floor" across the time I have been completing this thesis has, I believe, kept me from straying too far from the pragmatic issues that face frontline NHS workers on a day to day basis (the difficult situations occurring at the frontline are experienced as real regardless of whether or not they are socially constructed). I acknowledge that this might be considered a positive or a negative depending on the reader's viewpoint.

Finally, aside from my professional background, I am also a female and a mother. Whilst I have not experienced pregnancy loss, I have personal experience of maternity care, elements of which I found focused on efficiency at the expense of "care", and people-processing styles of care delivery at the expense of holistic practice. I can therefore place myself as both a provider and receiver of care.

By outlining my position I am allowing the reader to consider my position in interpreting and presenting my analysis of the data. Whilst it is true that the study relies on interview data alone, it is also true that I have observed the delivery of early pregnancy care over a number of years and, whilst my observations were not made systematically and they do not formally contribute to the analysis, it is probable that this knowledge and experience has contributed to the ways in which I view the research question, the interpretations I have placed on the outcomes, and the conclusions I reached.

3.9 Thematic Analysis Outline

Thematic analysis identified an overarching narrative in the data; "Who minds the quality gaps?". The word "minds" was chosen deliberately because it has multiple connotations; as a verb it can mean watching over or paying attention to something (e.g. being mindful of a patient's experience of health care), and it can also mean considering something to be important (e.g. I mind whether my patients have a good experience of care) (The Oxford Living Dictionaries). This reflects the data which suggests that all interviewees were aware of, and described being bothered by, suboptimal aspects of their early miscarriage services. It also reflects the way that interviewees described attending to quality shortfalls through their formal and informal activities.

Interviewees conceptualised quality in health care for women experiencing a miscarriage as being that which acknowledges the highly individualised ways in which women respond to miscarriage, and accommodates the need for health care to support emotional, as well as physical, needs. Delivering this type of patient centred care was however described as being challenging in a health care system that manages and measures quality in health care in rational ways, and which is subject to competition for finite and increasingly limited resources; this leaves gaps in care that result in the long standing dissatisfaction with care repeatedly demonstrated in research with women experiencing early miscarriage. It may appear that frontline NHS workers accept that these gaps cannot easily be closed using formal NHS processes and resources because they lack the formal power required to make changes. The data, however, shows that frontline workers do have informal power that allow them to negotiate with each other, and with organisational superiors, in ways that help them to plug the care quality gaps in less obvious ways. Three major themes emerged from the data that outline this situation.

Theme 1. Recognising the Gaps

The first theme centres on the ways in which individual frontline health care conceptualise quality of care in relation to miscarriage. This theme encompasses the ways in which interviewees describe miscarriage as a complex health care event, with a unique set of features, that make care delivery challenging and not conducive to standardised and rigid models of health care delivery. It also outlines organisational features that were seen as integral to a high quality service for women experiencing an early miscarriage. This theme therefore provides insight into aspects of care that frontline NHS workers may aspire to, and the organisational structures they describe themselves operating in. It also explores the notion of experienced frontline workers as a key resource contributing to quality management through their recognition and management of suboptimal care.

Theme 2. Negotiation, compromise and an 'acceptable' quality of care

The second theme focuses on the ways that aspirations for care quality play out on the wards and departments within which care is delivered. This theme outlines the ways in which the parameters of acceptable care quality are constructed through a framework of pragmatism, negotiation, compromise, and the development of local community consensuses.

Theme 3. Managing Quality Gaps at the Frontline

The third theme describes how frontline NHS workers capitalise on their knowledge to develop "*street-level*" practices, and the ways that these practices address different views (e.g. patient, frontline staff, organisational) about quality. I provide insight into how these street level activities may serve to contribute to the replication of practices that systematically fail to meet patient needs and which situate humanistic aspects of healthcare in a subordinate and tenuous place.

A breakdown on the main themes, subthemes, and concepts are illustrated in Figure 3-9. An example of additional detail as applied to an individual branch of the map is shown in Appendix I . The next three chapters (chapters four, five and six) focus on each of the main themes in turn and draw upon the original dataset to explain the context and content of each theme in detail. Chapter seven then situates these themes back within the overarching narrative and views the findings through the lenses of the micro-organisational theories outlined in section 3.3. Overall, this provides an in depth exploration of the ways that the actions and inactions of frontline NHS workers involved in the delivery of services to women experiencing an early miscarriage might contribute to both improvements in QOC, as well as the perpetuation of QOC shortfalls.

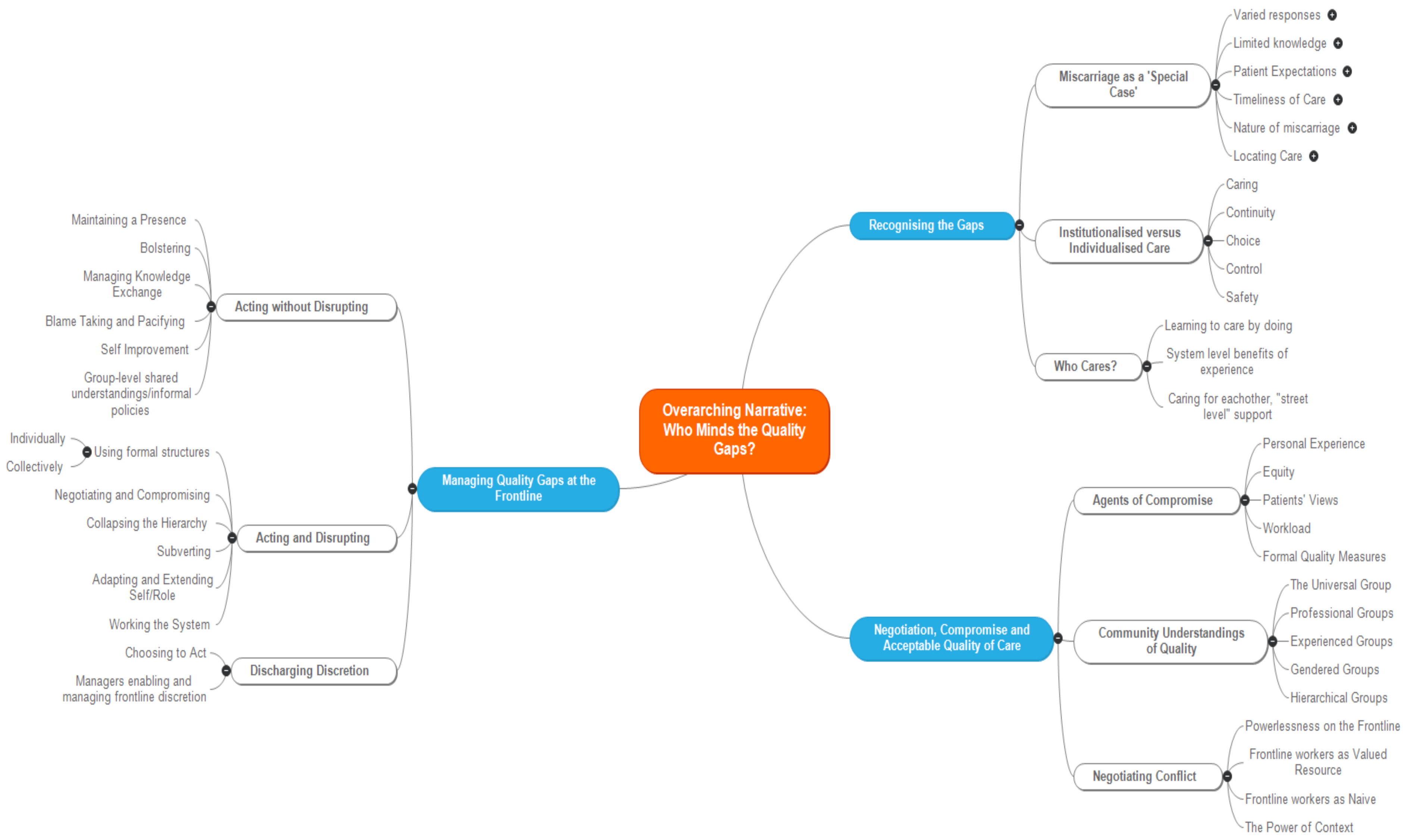


Figure 3-9. Thematic Model

Chapter 4 Findings 1. Recognising the Gaps

This theme emerged from the data as an important backdrop to understanding the actions and inactions of frontline NHS workers in the face of suboptimal QOC. It sets the scene as to the specific challenges presented by the provision of health care to women experiencing early miscarriage, and identifies organisational factors that health care staff consider to be representative of a high quality service for women experiencing this form of pregnancy loss. It also describes the important role that experienced frontline workers are seen as playing in terms of delivering high quality of care in this context. Overall this theme makes the case that early miscarriage is a health care context that poses particular challenges and that the aspects of care considered desirable, but not always achieved in practice, are those that acknowledge the individual needs of patients and attend to those needs holistically (i.e. they attend to physical, emotional, social and psychological needs). Experienced frontline workers are presented as an important resource in terms of being able to recognise such quality gaps and in supporting colleagues to understand and cope with those gaps.

4.1 Miscarriage as a Special Case

Many of the interviewees suggested that miscarriage was an event with features that posed particular challenges to those delivering health care to women experiencing it. The features are not unique in themselves (i.e. there are other health care events which involve the attributes discussed) but it is the combination of these attributes that marks miscarriage out as particularly challenging to manage.

4.1.1 Variable Responses to Miscarriage

As discussed in Chapter Two, a number of adverse emotional and psychological responses have been described to be associated with the experience of miscarriage, and these responses have been described to vary widely between individuals. This was reflected in the interview data, with all frontline interviewees describing their experiences of providing care to miscarriage as a traumatic event that affects individuals in differing and unpredictable ways.

> "I know a reaction from the woman can be anything from 'okay, that's fine' to absolute hysteria" (Frontline manager, nursing, 021)

Delivering health care in these circumstances was described as challenging, and this was compounded by the negative nature of the experience that was described as leading to patients being particularly sensitive or critical.

> “obviously it’s never going to be a positive experience if it’s a pregnancy loss, em, so they’ll always have a few issues” (Frontline, nursing, 012)

Health care workers rarely have a pre-existing relationship with women attending with a threatened or confirmed miscarriage, so they described having to make rapid assessments of each woman to understand her responses and consequently her needs.

4.1.2 Knowledge and Expectations

Patients were described to be generally naïve about miscarriage with, often, little prior experience or knowledge prior to the diagnosis (which was, in many cases, unanticipated). This meant many women had unrealistic expectations about the ability of health care technology to diagnose or prevent miscarriage. Interviewees felt that this led to disappointment or additional distress, and also left women disempowered and vulnerable since they had limited time to assimilate or research information about the reality of their diagnosis and treatment options.

> “they’re totally anticipating happy news, so when you deliver bad news to them it’s a shock” (Frontline manager, nursing, 021)

> “the patients find it frustrating that why can’t I give you an answer there and then when there are times when you just can’t” (Frontline manager, medical, 030)

4.1.3 Timeliness of Care

Women experiencing symptoms of miscarriage were described by most interviewees as being desperate for assessment in order to ascertain whether the pregnancy was viable. This was challenging for those working within Early Pregnancy Assessment Units (EPAU) where, in two of the hospitals, the appointment system meant women sometimes needed to wait up to three days for an appointment.

> “I think it’s just that anybody is.... you know, ‘why can’t you see me now? Why can’t you see me now’, and everybody’s thinking the same thing, ‘I want to be seen now’, so I think if everybody’s thinking that, then, you know when they get in the next available appointment then, obviously people can’t be seen now” (Frontline, nursing, 007)

Furthermore, upon diagnosis, women were described to vary in their demands regarding the speed with which they wished the miscarriage to be completed.

> “You might get a woman who, in here, says ‘right, I want this baby out, and I want it out today, I’m not walking out of here with something dead inside me’ and then you get the opposite woman who wants you know to keep her baby with her as long as she possibly can” (Frontline, nursing, 021)

4.1.4 Taboo Nature of Miscarriage

As described by Murphy and Philpin (2010), miscarriage involves a number of processes that are generally considered to be taboo or uncomfortable (e.g. death, vaginal blood loss, grief, pregnancy loss). This was confirmed by interviewees who noted the need to ensure supportive, sensitive care that maintained women’s dignity (in terms of allowing privacy to allow grieving and discreet management of vaginal bleeding).

> “there’s two rooms on this ward that have got toilets, so if we’ve got more than two and there’s patients in there, the other side room, you have to take the commode down which isn’t, I wouldn’t particularly like using the commode, or they’ve got to walk up the passage to go to the toilet” (Frontline, nursing, 036)

Whilst none of the interviewees described having any discomfort dealing with these issues themselves, some described colleagues who felt fearful or unprepared to deal with this type of care. A few interviewees indicated their belief that working with women experiencing pregnancy loss was not a job that everyone could do.

> “I think it takes a certain kind of person to deal with loss, I mean there’s obviously, nursing staff deal with, er, cancer patients? You know terminally ill people, and you’ve got to have that sort of thing in you, you know. There’s a dignity about death” (Frontline, nursing manager, 049)

> “I think because they either lack interest or they’re just scared of dealing with it, they can’t deal with it, like emotionally” (Frontline, nursing, 010)

4.1.5 Social Nature of Miscarriage

All frontline interviewees noted miscarriage to be an event that can have a significant impact on the partners (and wider family) of women receiving treatment and, as such, many indicated that it was important to ensure partners and family (where relevant) were supported and accommodated alongside patients. Organisationally this represented a challenge since only the women experiencing a miscarriage are formally patients. In two of the hospitals, women receiving in-patient treatment for miscarriage were sometimes nursed in multiple occupancy ward; allowing male partners to stay overnight on female only wards was described to be uncomfortable for everyone involved.

> "some of their partners can be devastated, absolutely devastated when you know their partner loses a baby and their wife or girlfriend loses the baby, in fact that was one thing I think we should consider more, what we do for the male partner, erm, .. I have since, you know, over the years I've found of erm, two women I know who've lost their babies for one reason or another whose partners have then been in ITU with overdoses" (Frontline Manager, Medical, 049)

4.1.6 Locating Care

All interviewees offered opinions about the challenge of appropriately locating care for women experiencing a miscarriage. Some of the challenges related to the issues already discussed in this section (e.g. accommodating partners, maintaining privacy). Aside from these pragmatic issues, interviewees discussed the appropriateness of nursing women experiencing pregnancy loss alongside other patients from an emotional perspective. Miscarriage was viewed by some as "different" to other types of care, for example, general surgery (though this was not a consensus view and some interviewees refuted the distinction).

> "early pregnancy loss patients, and things surrounding early pregnancy loss, is not the same as general surgery, and that needs to be taken out of the mix and put somewhere else" (Frontline, Nursing, 019)

For some interviewees a particular concern was the placement of miscarriage services alongside pregnant women or women undergoing an elective termination of pregnancy. Some interviewees described this as a distressing reminder that other women have on-going pregnancies and that some choose not to continue a healthy pregnancy. Other interviewees acknowledged this but opined that removing women from maternity care as soon as a diagnosis of miscarriage is made could leave some women feeling that their pregnancy had been dismissed or devalued.

> "I think it's very unkind, em, to have people who are going, going through miscarriage and then people who are coming in in labour, I think it's .. it's awful" (Frontline, nursing, 041)

> “even if a lady is miscarrying, she still wants to be recognised that that was a pregnancy, it is a well wanted pregnancy, well most of the time, you know, and I think they like, they do like the fact that they’re actually being acknowledged as a pregnancy and being looked after by midwives rather than other hospitals as gynaecology” (Frontline, nursing, 044)

This demonstrates the complexity involved in siting services for women experiencing miscarriage, however many interviewees suggested that organisations did not consider these issues when structuring their services. An “ideal” environment for such services was universally described by interviewees to be a standalone unit, within which all aspects of the care process (assessment, diagnosis, treatment and follow up) would be managed by a team of knowledgeable and experienced staff.

> “the top and bottom of it, the staff themselves, and what we feel, and even our clinical director, and the medical staff feel, is that we should have a separate early pregnancy unit <…> but we’ve been talking about it for a while, but obviously finances and where would a build, it’s just not financially feasible to do that” (Manager, 052)

In summary, the data suggest that early miscarriage has a number of features that make it an unusual health care context and one that is particularly challenging to ensure that high QOC can be consistently delivered for all patients. These include the variable and unpredictable responses women can have to the experience of miscarriage, the uncomfortable societal aspects of the experience, the need to attend to the needs of the patient’s partner, and the most appropriate place to situate care. Attending to these specific needs requires a flexible approach to health care delivery that may be at odds with dominant models of health care delivery and this is explored further in section 4.2. Another implication of these observations is that recognising quality gaps requires frontline workers to understand the special nature miscarriage as a health care context; the importance of experiential knowledge in relation to this is explored in section 4.3.

4.2 Institutionalised versus Individualised Care

All of the aspects of miscarriage described in the previous section pose particular challenges for frontline staff who described blanket approaches to service delivery for women experiencing a miscarriage as constraining their ability to understand, and respond to, each woman’s needs. Flexibility, and the ability to accommodate differing needs and wishes, was described to be a feature of a good quality service.

> “we try and see them as soon as possible, we try, bend over backwards to fit them in sort of with, you know, if they’ve got childcare problems or, maybe the partner’s away and they’re not back until Thursday or Friday, we’ll try and accommodate that, you know, get them in then, em, and so I think we do quite a good job there in sort of just the way we, .. sort of deal with the women you know, the way we interact with them” (Frontline, nursing, 010)

Interviewees described a number of organisational design attributes that they considered to facilitate the delivery of such individualised care. Organisational designs were generally discussed as structures imposed upon frontline workers, and something that they positioned themselves as having little control over.

Four Cs were identified as being ideal service attributes for women experiencing an early miscarriage; caring, continuity, choice and control. Furthermore it was suggested that “safety”, in terms of preventing harm to patients, was a necessary attribute of any health care service. Whilst these attributes have been broken down into separate analytic sections in this thesis (as they describe different concepts) it is important to acknowledge that the interview data suggests overlap and interaction. Removing or adding one attribute to a service has the potential to compromise or support staff in their abilities to deliver other aspects (see Figure 4-1). For example, where an organisational design restricted patient choice this was described as disempowering and taking control from patients. Similarly lack of continuity was felt by some to limit opportunities for relationship building with patients, leading to them feeling uncared for. Relational aspects of care have been proposed elsewhere to have an impact on patient safety by influencing the extent to which patients are willing to report concerns (Rainey *et al.*, 2015).

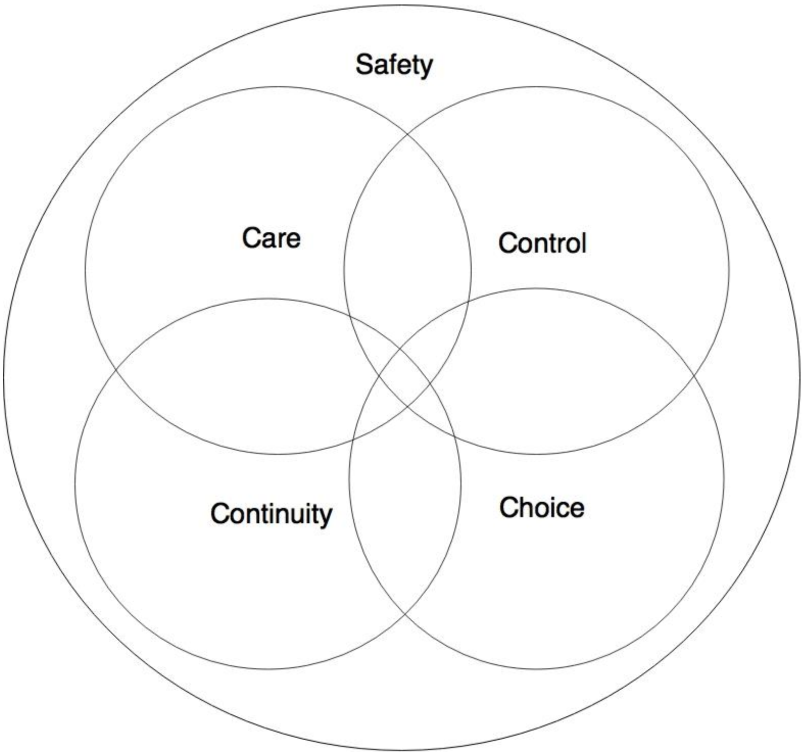


Figure 4-1. Interaction and Overlap in the Attributes of an Ideal Service for Women Experiencing a Miscarriage

4.2.1 Caring

One of the clearest themes emerging from the dataset was the importance of "caring" aspects of health care, and the perceived need for it to be an integral part of the services delivered to women experiencing a miscarriage. Descriptions of what "caring" meant, or what function it played, were vague, but they all related to humanitarian concepts such as empathy, dignity, kindness, compassion, reassurance and understanding.

> "it's a philosophy thing, and, er .. there are .., where somebody's miscarrying, you can't just plonk them into a bed and go away and leave them there, yeah, they need some support, they need, you know, er, .. reassuring, sometimes, consoling and stuff, and so on" (Frontline manager, medical, 035)

A "caring" approach to health care was described as one that acknowledges the patient as an individual (rather than as a "condition") and encourages relationship building between the patient and her frontline carers. This shifts the dynamic from a one way, to a two way, interaction, allowing staff to better understand the experiences and needs of individual patients and respond accordingly. Frontline interviewees repeatedly identified lack of time as a key barrier to them being able to deliver on these caring aspects of health care.

> “I don’t think that the care’s, sort of, jeopardized in any way, I was more thinking of it from a, a relationship building point of view, building that rapport, getting that, you know, getting them to, to sort of build some sort of trust with you so, you know, they feel safe in being there and having, going through this process, feeling they’re able to ask questions, they’re able to say ‘I'm in pain’ or ‘why is this happening to me?’ or having a little cry if they feel like they need a little cry, em, in terms of providing care, they still get that care, they still, you know, we still make sure they’re safe, they’re not bleeding excessively, you know, they’re getting fed, they’re getting a drink, they’re having their analgesia, they’re getting the misoprostol etcetera, so they still get that care but I think in terms of building that relationship, offering that security, you know, I think that’s maybe, on occasion, it can fall down” (Frontline manager, nursing, 022)

Frontline interviewees outlined a number of reasons why they were unable to devote time to these aspects of care; most related to the ways in which services for women experiencing an early miscarriage were organised and the extent to which that restricted the ability of frontline workers to prioritise “caring” over other demands on their time. In this respect, organisational structures were described to have a significant impact on the delivery of relational aspects of care; not because the importance of these aspects of care was unrecognised, but because the resources required to deliver them were not understood or accommodated.

> “the computer, and the all the rest of it, the paperwork, you haven't got time to do it, they're putting more and more emphasis on that and the patient is losing out, because you're thinking right, I cannot sit here with you for half an hour, I've got that to do ... you feel awful, but you do sometimes have to cut it short and you know this woman might want to sit and talk to you about how she's feeling” (Frontline, nursing, 010)

4.2.2 Continuity

Maintaining contact and responsibility for a woman’s care journey was described to have a positive impact on QOC in a number of ways. Interviewees from Hospital B in particular described their (relatively newly) fragmented organisation of care, where a woman’s journey through the care system involved passing through a number of departments and seeing a number of different health care workers. This was described as detrimental to quality of care and often distressing and inconvenient to women. Alternatively, Hospital D delivered almost all of their care within one department and, where possible, all aspects of the patient journey were managed by a small, discrete team.

> "how many places is that? How many different faces and how many different people would they see? So they've gone through Accident and Emergency, possibly ward <X>, come to us, then, er, admitted back to ward <X> or ward <Y>, then they go to department <Z>. Bit of a nightmare really" (Frontline Manager, Nursing, 021 (Site B[19]))

> "they do have continuity of care, they're not going to different department after department, and we are quite small team still so they're not meeting lots of different faces" (Frontline, nursing, 044 (site D))

The benefits of continuity extend beyond the impact on relational aspects of care. Following patients through their care journey was described to enhance feelings of responsibility amongst staff (both for individual patients, and for the service more generally) and increase the potential for staff to have control over the way care is organised. Fragmented care, alternatively, offered the opportunity for busy staff to "pass on" aspects of care they were unable to, or chose not to, engage in, and it often required workers to enter into negotiations with other departments to secure appropriate care.

> "in <our department> we've got a core team so we're on all the time, so we kind of know who's coming, and who should be where, and if they're not here we obviously chase them up. I feel like, we work really well, it's just a shame we have to hand it on somewhere else" (Frontline, nursing, 017)

> "the sonographer will ring 'oh, we've got this lady can we bring her round', or 'we're bringing her round', and you think well, hang on a minute, we've got nowhere to sit her, the ward's heaving, we don't want to bring her round to sit on the corridor when she's upset, she's crying, 'can you send her off for a coffee or something, have you got anywhere around there you can sit her?', 'well no, we're really busy'.. you think well, yes, we are as well, but we've got nowhere to sit her" (Frontline, nursing, 010)

4.2.3 Choice

Being able to (a) give women choices, and (b) acknowledge women's personal wishes, were generally described as essential elements of high quality and individually appropriate care.

---

[19] Site descriptors given for these quotes to allow comparison of site attributes on patient experience.

The role of the frontline worker was viewed as supporting women through their choices and ensuring that those choices remain within professionally defined parameters relating to safety.

> “it shouldn’t really be for medics managing the condition because that’s how they think that should be managed, it’s actually, it should be patient centred so the patient will come in with a particular odd request and actually ask for this or that and, you know, you’re supposed to then accommodate them within the safe confines of, you know, of the protocol really” (Frontline, medical, 006)

Aspects of choice within this context included choices about timing of treatment, type of treatment, and the way in which the miscarried baby is managed[20]. Interviewees described their experiences of situations where organisational constraints meant that some choices were not truly or equally available. This included at Hospital A (where medical management of miscarriage was usually available far more quickly than surgical management), at Hospital B (where timing of treatment was offered but not always open to choice), and at Hospital D (where surgical management of miscarriage was only available to those women who independently requested it).

> “they are given the choice in clinic, do you want medical, surgery, and they’re meant to have the choice of when they want to come in, so I say ‘when do you want to come in’?, and they say ‘such and such’, and really, at the end of the day, I’m giving them the choice but they haven’t particularly got that choice, it’s ‘well, actually, we can’t do it then’” (Frontline, nursing, 036)

Some of the interviewees described their own discomfort in supporting, what they often considered to be unfair, organisational limitations on patients’ choices by withholding information or giving information about choices they knew were unlikely to be available. This was especially the case in situations where they felt that the restricted option would actually meet an individual patient’s needs better than the more freely available option.

---

[20] The need to use of sensitive terminology when discussing miscarriage has been highlighted elsewhere Cameron, M.J. and Penney, G.C. (2005) 'Terminology in early pregnancy loss: What women hear and what clinicians write', *Journal of Family Planning and Reproductive Health Care*, 31(4), pp. 313-314. As there is no single acceptable word to use for the fetal body once passed, I have used the term “baby” here as the data suggest that this is the word most often used by frontline health care staff when speaking to women about their loss, accepting that not all women would use this term when talking about an early miscarriage.

> "most people don't know it's an option, they don't ask for it, em, I think some people struggle with medical management, I think some people do struggle" (Frontline, nursing, 050)

4.2.4 Control

Having a service that allowed patients to retain control over their experience of miscarriage was described to be another important component of a high quality service. This was heavily linked to the provision of information on the basis that sharing knowledge (a) empowered women and enabled them to make informed choices that met their individual needs, (b) alerted them about aspects of miscarriage that they might be otherwise unprepared for (e.g. explaining that miscarriage can be painful), and (c) helped women to recognise when they may need additional medical help (e.g. explaining the parameters of "normal" blood loss). . Communicating adequate and realistic information in a sensitive way was described to be an important skill for staff to have.

> "it's all about information giving really isn't it, giving the correct information, making sure that the patients and their family, er, knows what's gonna happen, and if anything untowards does happen, how to get them in here quickly and safely" (Frontline, nursing, 041)

> "in cases where there is .. there's no definite answer, you know .. but you may erring on one side or the other, you don't want to give too much hope or be too pessimistic" (Frontline, nursing, 012)

Whilst the concept of information provision was linked to ideas of empowerment, in action, frontline workers retained overall control by making decisions about how much information they shared (based on their impressions of the needs of each woman and a wish to avoid overburdening them with too much information).

> "I suppose health care professionals, I wouldn't describe it as stereotyping but you make, you make an assessment of your patient's capability and, em, by the phrases that they use and, em, the questions that they ask, that might allow you to, to make an assessment of what they know or what they understand" (Frontline, Nursing, 012)

Continuity and relationship building were described as facilitating empowerment since they allow greater flexibility in terms of how and when staff give women information and require them to make decisions. More fragmented services involved aspects of information being passed onto other wards and departments, increasing the chance of conflicting advice being given, as well as imposing arbitrary time limits based on organisational factors (such as length of appointment time).

> “I always try and give them the booklet as quickly as I can, em, to say, you know ‘this is what we’re gonna discuss’, and then when I feel it’s relevant with them I’ll say to them, you know, ‘how do you feel about discussing the forms?’ and I’ll go back in to discuss them, and one of them’s to discuss the burial or cremation, did they have, em, any preference?” (Frontline, nursing, 019)

Organisational factors were described as sometimes presenting barriers to effective knowledge sharing with patients. Examples provided included limiting the time available to staff to engage in meaningful conversation, or allocating information provision tasks to staff with limited experience of miscarriage care and limited knowledge of the patient (e.g. at two hospitals the task of taking consent for treatment was allocated to junior medical staff who were not involved in patient care in any other way).

> “the issue that you know you had to then find a doctor, so they’d done all this, and then the doctor has to come in who the woman’s never met, they’ve had all this discussion with the midwife then goes through a pink bit of paper with them and then goes off again, and then it’s the midwife that does the process” (Manager, 027)

Using written information to supplement verbal discussions was viewed as appropriate at all of the hospitals participating in this study, but it was also described to present a particular organisational challenge to staff since it had to be reviewed and agreed by departments outside the wards and departments delivering care. This was described at one of the hospitals to be a lengthy process that prevented frontline staff from easily changing and updating information leaflets. This limited the control frontline staff had over the information they were providing and, in some instances, left them providing women with written information staff considered to be insensitive, incorrect, or out of date.

> “the original information leaflet that was given had baby this and baby that, which is a bit insensitive to those who actually don’t have a baby, as in anembryonic, so that was kind of erm, revamped to take those out and again, that must be about eighteen months ago and that went into somebody else’s system as well so, erm, .. we’re still using the old, the old ones, erm, because I don’t know whether they’re gonna publish these, these new ones” (Frontline manager, nursing, 063)

> “I do understand why the Information Department might want the uniformity in the whole Trust, I understand that, but it does make the process slightly more elongated while if there is a clinical change. I think if the department agrees the, the core body of gynaecologists are agreeing, and it is a safe practise to make, we should just be able to do that” (Frontline manager, medical, 030)

4.2.5 Safety

Within the discussions about the four Cs outlined above, the importance of delivering safe care was described to be paramount. For example, choice and control were only considered appropriate if the information provided to women was based on best evidence and the choices subsequently made by women were considered by interviewees to be safe (in fact a previous adverse outcome was implicated in the reasons for restricting treatment choices at one hospital).

> “we used to offer medical management and surgical management of miscarriage, em .... we had a lady who died, and that changed why we didn’t offer, er, surgical management on weekends anymore, because of cover, so they decided, em, I can’t remember how many years ago now, em, but we were only gonna offer medical management” (Frontline, Nursing, 041)

Issues of safety were predominately linked to physical aspects of health and the prevention of maternal morbidity and mortality. Maintaining patient safety was described to be a key priority for health care organisations, as well as a professional and personal responsibility for workers. Importantly early miscarriage was generally not described as a particularly hazardous event; the focus of care was on strategies designed to monitor patients for signs of impending complications and activities relating to this were not time consuming.

This section has discussed the attributes of health care delivery that interviewees felt should form part of a high quality service for women experiencing early miscarriage. Many of these attributes emphasise models of health care delivery that allow health care workers to (a) operate flexibly in order to respond to the individual and variable needs of each patient and (b) deliver on intangible aspects of care (e.g. caring, kindness). The data however suggest that the organisations that interviewees operated within offered variable opportunities for frontline workers to prioritise individual patient needs over the need to manage care delivery efficiently and in accordance with standardised organisational policies.

4.3 Who cares? Staff Contributions to High Quality Care

A skilled workforce was described as an integral attribute of a high quality health care service for women experiencing problems in early pregnancy. There were a variety of different types of staff delivering miscarriage care within the hospitals included in this study (midwives, nurses, specialist nurses, health care assistants, ultrasonographers, and medical staff). Professional status alone was not described to be a guarantor of high quality service delivery from individual workers, with attributes such as knowledge, attitude and resilience of the staff member being described as important. Where staff were inadequately trained or prepared, this was described to have a negative impact for both the staff member and the patients receiving care.

> "the lady, I think, was the calmest person on duty that day because when she actually delivered, you know, she said 'I'm, I'm', she buzzed the buzzer and she said, you know, 'I'm miscarrying now, everything's happening now'. The auxiliary that was on duty just about passed out, ran out of the ward screaming, er, .. the woman was saying to the staff 'are you alright?' .. and not the other way round" (Frontline manager, Nursing, 021)

4.3.1 Learning by Doing

All interviewees described training to deliver care to women experiencing early miscarriage to be an experiential, rather than an academic, exercise. Most frontline interviewees, and particularly those with a nursing/midwifery background, explained their training to be a long, and sometimes challenging, apprenticeship involving mentorship from more experienced staff members. A key feature of this training was learning to deal with humane aspects of care (e.g. kindness, compassion, sensitivity). Frontline interviewees in nursing/midwifery roles particularly, described the support they gave to new starters to learn both physical and emotional aspects of the job.

> "A lot of staff have said to us that the worst thing that they do when they come into this department is counselling women after they've been told they've had a miscarriage. It's the thing they find hardest to do and longest to learn, .., em, but nobody would be thrown in there and just asked to get on with it, it's a, it's definitely a 'sitting next to Nelly' job, where you mirror the nurses who are most experienced in doing it for however long it takes" (Frontline manager, nurse, 021)

The organisation of services impacted on the way that experiential learning was delivered. Medical interviewees, in particular, highlighted the lack of senior medical input into low risk miscarriage care, which reduced opportunities for junior medical staff to learn from experienced medical staff. Instead, medical staff described learning about both the task based and relational aspects of care from nurses and midwives.

> “they need training, they need the knowledge, they need the understanding, er .. I don’t know, it’s not something we can do, as medical people, em <…> this has got to be a hands on thing, and you’ve got to see it done, that’s why I have to, you know, take you through it, it cannot be done theoretically” (Frontline manager, medical, 035)

4.3.2 System Level Benefits of Experienced Staff

Experienced staff were thus considered to be an asset, not only in terms of their ability to recognise and deliver the sometimes intangible components of a high quality service, but also in their ability mentor less experienced staff. This creates a virtuous circle whereby good quality care (as defined by experienced staff) is managed daily by experienced staff modelling good quality care provision, then replicating it with others by training and informally monitoring the activities of junior staff.

This suggests that a critical mass of experienced staff can act as an informal quality management mechanism. Disruption to the critical mass occurred at Hospital B where a number of experienced staff members resigned or retired within a relatively short time period. This decreased the ratio of experienced/inexperienced staff members available on the ward; interviewees suggested that this compromised their ability to pass on their knowledge to the increasing number of new starters, leading to a gradual decline in quality. In turn this left experienced staff members feeling powerless and frustrated and considering alternative employment themselves.

> “I think people are being put in a situation where they don’t have the skills to do the job, and it’s, it’s, you know, people have left, you know, em, but you know, they just employ more people, you know, and younger people without, er, experience”
> (Frontline manager, medical, 035)

> “we haven’t got enough staff here for me to take somebody off the floor and say ‘right, this girl’s miscarrying, you must come with me as a second pair of hands so that we can go in there and manage her’. You know, quite often you’re there on your own to manage what’s going on, because the rest of the staff are all busy around the ward so, for a hands-on learning, em, opportunity, it’s not really there” (Frontline, nursing, 019)

This critical mass model of quality management was also disrupted at Hospital D where frontline workers were expected to work flexibly across a number of wards according to day-to-day organisational demands. This had clear organisational benefits but several of the frontline interviewees expressed concerns that it diluted feelings of ownership amongst staff, and distributed experienced staff elsewhere, thereby preventing them from providing support to other staff members.

> “we have flexibility of movement, rather than being totally isolated, and I think in a big team that works better, .. and you can manage the budget better, cos they’re there, and it’s just moving them and utilizing them” (Manager, 052)

> “now we work as a floor we seem to get, I don’t know, I feel like our unit draws the short straw if I’m honest since we’ve changed and I feel like if ever anywhere’s short staffed they take staff away from us, and the girls on here, they’re a good team, but we’re constantly busy” (Frontline, nursing, 050)

4.3.3 Peer Support

In addition to supporting educational needs and acting as an informal quality management system, frontline interviewees described supporting each other in ways which promoted resilience and allowed work to continue in the face of difficult or upsetting circumstances. Providing care to women experiencing a miscarriage was described to be emotionally challenging, and requiring the type of “*emotional labour*” described by Hochschild (2012) and noted amongst gynaecological nurses by McCreight (2005). This was evident to varying degrees in all of the interviews with the frontline interviewees, although the ways in which workers described managing it varied; nursing, midwifery and health care support workers were most likely to describe a network of ward/department level peer support which provided support and reassurance, whilst medical staff were less likely to seek peer support. In all cases interviewees described the need to set aside their feelings in order to maintain their ability to function in difficult circumstances.

> "we had, like a sort of network, you know, you could have really stressful days, and I mean we all knew what we were going through and we were all doing it, we were all dealing with it, and we would, sort of, reflect with each other, you know, you don't, sort of, consciously do it, but you tell anyone 'there's a miscarriage and it was really upsetting and she was really upset .. I don't know if maybe I could have done that a bit better', you know, and they would say 'oh well, what did you do? That sounds fine'" (Frontline, nursing, 036)

> "if I was feeling emotional about something, would I go and talk to my consultant about it? Hell, no …. because it might be perceived as a sign of, as a sign of weakness, or you not really coping with what you're doing, you're supposed to just get on with it." (Frontline, medical, 006)

It is notable that it was not only the experience of being involved with miscarriage that caused distress to staff; a number of nursing/midwifery staff described their distress at being unable to deliver care to the standard they personally considered acceptable, or their frustration about feeling that their opinions were not valued; three interviewees openly wept about this issue during their interview.

> "It's wrong, it's frustrating and, erm, .. I think it's just absolutely appalling sometimes, I mean the frustration we feel is immense and then you start to get stressed and *cries*" (Frontline manager, nursing, 063)

This section has outlined the view amongst many interviewees that understanding the needs of women experiencing an early miscarriage requires some level of hands-on experience. This experiential understanding is described to be passed on through informal training and monitoring of less experienced staff and peer-to-peer support. In this way experienced staff are described as an organisational asset in terms of their recognition of, and informal attempts to manage, quality shortfalls.

4.4 Chapter Summary

This theme centres on the issue of quality of health care by outlining some of the challenging aspects of the case study used in this study (early miscarriage) and the features of care that were described by interviewees to contribute to meeting those challenges. A key feature of this theme is the extent to which frontline workers felt that holistic and patient-centric practices for women experiencing early miscarriage are formally supported and resourced within their NHS organisations.

The data suggest, however, that health care workers find these aspects of health care quality the most difficult to deliver on in their everyday work. Health care organisations are seen to be operating in ways that do not specifically resource “caring” aspects of health care, leaving staff to fit it in amongst their other organisational responsibilities. The data suggest that frontline workers perceive organisational task completion and the management of physical health to be prioritised over emotional health in the systems within which they work, and that they act in ways that support that imperative (i.e. meeting acute physical care needs is used as a justification for times that they describe being unable to meet emotional needs or deliver caring aspects of health care). In this respect, women experiencing a low risk early miscarriage are generally at a disadvantage in terms of securing staff time in comparison with other patients.

Finally, the role of staff in a high quality service for women experiencing miscarriage is outlined and, in particular, the ways in which they continue to support, not only individual patients, but whole systems of care through their teaching, modelling, and monitoring activities.

Chapter 5 Findings 2. Negotiation, Compromise and Acceptable Quality of Care

The previous chapter outlined attributes of care for women experiencing early miscarriage that were felt to be integral to the provision of good QOC. It also described that many interviewees felt frustration about their inability to deliver care to an ideal standard, suggesting that interviewees operated in conditions that were less than optimal by their own standards.

This chapter outlines a theme in the data that highlights how interviewees rationalised their acceptance of suboptimal QOC as a reasonable response to challenging circumstances, and explores the factors that influenced their tolerance of lowered QOC standards. It is then proposed that this reconfiguration of expectations is shaped through the development of group understandings about the parameters of acceptable QOC, and through negotiation and conflict between different groups.

5.1 Agents of Compromise

Compromising on QOC was a theme that ran through all of the interviews. Compromise was described by interviewees to be largely unavoidable due to the nature of the NHS (e.g. a service delivered under finite resources and with competing priorities). A societal narrative of fiscal restraint compounded this with several interviewees noting that they were operating in *"times of austerity"* and under organisational demands to produce *"more for less"*. Aiming for ideal care was therefore considered to be unrealistic, and expectations shifted to aiming for the best QOC within the resources available.

> "it's not the best place for women to come in, people who are pregnant and everything, so we're, kind of, going to isolate whatever. We're restricted with the resources, that's what we're trying to work to" (Frontline manager, medical, 057)

There was less agreement about which elements of the miscarriage care package could or should be the compromised, and to what extent. Additionally most interviewees indicated that, whilst they were prepared to compromise to some degree, there was a limit to their tolerance of lower standards.

> "the idea should be to provide a gold star service okay, but, er, we accept we are now living in the real world, sometimes that may not be possible, but, you know, there's a level to which you cannot fall in my opinion so, er, .. and if you're going to drop below that level then, if you, if, if, if, as a clinician, I feel that the patient is going to leave me worse off, then I should not be offering the service" (Frontline manager, Medical, 035)

Whilst all interviewees discussed a need to compromise, the extent to which they were prepared to do so varied between individuals. It also varied within individuals; a number of interviewees described shifts in their tolerance that were either gradual (as a result of constant exposure to challenging working conditions) or acute (as a result of being party to an adverse event).

> "I sometimes think that I do feel that you just, you're like doing, you're doing a job and it's like a rollercoaster ride and, em, when you go on holiday you get off the rollercoaster for a bit and that's it, you can't get off it any other time, it's just constant, yeah, and em, I don't, I don't know, I think it, I think that causes a lot of, em, complacency and, em, ah, what was it, I'm not gonna say frustration, but you sort of feel sometimes a bit despondent" (Frontline manager, nursing, 059)

> "It was because of that incident, I mean you cannot have staff running around screaming because the patients, the patient needs you, she doesn't need that, how traumatic is that for the woman anyway?" (Frontline manager, nursing, 021)

The data suggested a number of personal attributes and experiences that influenced perceptions about the tolerability of lower QOC standards. These are outlined in the following subsections.

5.1.1 Personal Experience

Some interviewees described personalising their assessment of QOC by considering what they themselves would find acceptable, either for themselves or for their own family and friends. In some cases interviewees had experienced miscarriage themselves and they drew upon that experience.

> "if I thought that the lady was treated in a way that I would find acceptable for a member of my family then .. I think that's a good standard" (Frontline, Nursing, 012)

This form of quality assessment mirrors the basis of the friends and family test, which is now administered across NHS services[21].

5.1.2 Equity

The concept of equity featured heavily in many interviews. A number of interviewees described finding it particularly difficult to accept situations where they felt that miscarriage services, and the women accessing them, were unfairly subordinated to other type of health care situations or other types of patients. Resource limitations were no longer an adequate justification to lower standards if resources are available but are distributed unfairly. Inequities which discriminated against women experiencing miscarriage were described on two levels; in the priorities frontline staff have to enact in their everyday work, and in system level decisions about resource allocation.

In respect of the challenge facing individual frontline staff, this almost always related to the competing priorities they faced when caring for multiple patient types; the low physical threat faced by women receiving care for a miscarriage meant that they frequently lost out, in terms of securing staff time, to patients with more acute problems. Staff who worked in areas with less acute competition (i.e. staff working in an antenatal clinic or staff working in an early pregnancy clinic who worked solely with women experiencing miscarriage) did not report this concern, however they did discuss the competition introduced by other task based work, such as completing paperwork or seeing the next patient on a clinic list.

> “on a normal medical ward you’ve got lots of people who need a lot of care and attention, so maybes they are not their priority, the highest priority anyway, and I’m not saying that they think that, but they may have someone who’s seriously ill, so they need to be looking after that person” (Frontline, Nursing, 017)

---

[21] The Friends and Family test is a quality assessment tool used widely across the NHS in England. The test was launched in April 2013 and involves asking patients whether they would recommend the services they have accessed to their friends and/or family (https://www.england.nhs.uk/ourwork/pe/fft/)

> “they [the doctors] come to see patients who are going for ERPCs, then they disappear off to theatre, so you’re lucky if you get then on the ward at half ten, and by then everybody and their granny’s got a list as long as your arm, ‘well I just need to do this and I just need to do that’, ‘yes, but this patient’s been’, ‘well, she’s just going to have to wait a bit longer’” (Frontline manager, nursing, 063)

At a system level, concerns related to comparisons between perceived quality of miscarriage services versus the quality of (a) other services within the same organisation, or (b) miscarriage services in other organisations; concepts of fairness and deservedness were drawn upon to justify frustrations. At all of the participating hospitals interviewees identified a comparator patient group that they felt was systematically favoured to the detriment of women experiencing miscarriage.

> “Labouring women have been prioritized as far as I can see compared to women having early miscarriages, and that may have improved the service for labour wards but has made it a worse service for our early pregnancy people” (Frontline Manager, Medical, 045)

> “it’s great for that minority of people [women having an elective termination], right, we’re pulling out the stops, we’re spending all this money, and then for the miscarriages we do absolutely nothing, you know, we can’t even put them in a separate room because they’ve been told some horrible, the worst news of their lives” (Frontline manager, nursing, 059)

A further comparison was made related to the difference in resource allocation between women experiencing a later versus and early pregnancy loss. Women experiencing the former (e.g. a second trimester miscarriage or a stillbirth) were described to receive care within the maternity department where attention to relational aspects of care were easier to manage (e.g. women are nursed in single rooms and given one to one care from a nurse/midwife). Most frontline interviewees rejected the notion that early pregnancy loss was always a less difficult or less deserving experience than a later loss, so felt frustration at the comparatively poorer QOC received by women experiencing a first trimester miscarriage.

> “I think they all deserve the same treatment no matter where they are in the pregnancy, you know, it’s still a loss to them at the end of the day, they still have a grieving process to go through, and I think they’re not getting that level of support personally, that’s my view” (Frontline, nursing, 019)

Another comparison was drawn upon in the hospitals that had undergone significant organisational changes to their services and interviewees appreciated degradation in the quality of their service.

> "I do feel em, ladies who are having em, medical management are getting a little bit neglected compared to what they used to get, and I think the reason for that is because they're so, so busy and because they have so many other ladies to look after" (Frontline, nursing, 050)

Equity and fairness affected tolerance in both directions. Perceptions that women experiencing an early miscarriage were being unfairly discriminated against made it more difficult for interviewees to tolerate suboptimal QOC, but managerial level interviewees, in particular, also drew upon concepts of equity to justify *lowering* QOC. In hospitals B and D, service changes that compromised the QOC of services for women experiencing early miscarriage were justified by explaining that this was necessary in order to raise QOC in another service, thus attaining equilibrium across the organisation.

> "I said, with a project team set up with key people leading it, getting them onside to see the benefits of the whole of the maternity unit, it wasn't just for making their lives a misery and saying 'right, you've got a marvellous service here, but what about the rest of the service? We've got to make them, you know, equal. So, the <other women on the ward> weren't getting a good service, but your ladies here are getting fantastic service" (Manager, 052)

5.1.3 Patients' Views

Several interviewees described formal quality measurement mechanisms used in their organisation to systematically collect patients' views about their care. This generally took the form of patient satisfaction surveys, analysis of patient complaints, and comment boxes on the wards. For managerial level interviewees this was often their only way of assessing patient views directly, since they had little direct interaction with patients during their care episode.

> "we do surveys all the time, and that involves, er, patient satisfaction and how, what their views are, and how they think we could improve it as well, so everything is taken into consideration" (Frontline, nursing, 041)

Most frontline interviewees also discussed the value of the knowledge they gained through their everyday interactions and observations. Sometimes this related to conversations between themselves and their patients (i.e. when a patient complains directly to a health care worker or thanks them for their care), but interviewees also described using range of non-verbal clues (e.g. observing patients' distress about various aspects of care, receiving thank you cards and gifts from patients).

> "we do get lovely, lovely cards, and boxes of chocolates galore and letters, and so that reflects on the service that we're giving so we know we're getting it right to a degree cos we get loads of cards and loads of gifts, we're very, very lucky" (Frontline manager, nursing, 034)

Some frontline interviewees described discrepancies between their perception of how acceptable QOC was, and how patients rated it using formal quality measurement mechanisms. Generally, the discrepancy involved the frontline staff feeling that the service was worse than formal measures recorded it to be.

> "we do, have done in the past, satisfaction surveys, erm, and ironically nothing major has shown up there, or things might have come back, yeah, satisfaction's difficult" (Frontline manager, Medical, 045)

Some interviewees described this discrepancy as evidence that frontline staffs' perceptions of patient satisfaction were faulty or overly sensitive. Positive formal patient feedback, then, provided reassurance, and promoted tolerance of existing quality standards, regardless of any other concerns being voiced.

> "I don't spend as much time with the patients and, you know, it's quality care but, you know, quality is not about quantity <...> they're in a side unit, they won't see you manically going round the ward, so they might not, well, yeah, we've had no complaints about that" (Frontline Manager, nursing, 022)

Alternatively, some interviewees attempted to rationalise the discrepancies and hypothesised that patients do not report, or recognize, poor quality care because miscarriage is a disempowering and unpleasant experience that left patients vulnerable and unwilling to engage in conflict. Furthermore, it was suggested that patients are limited by a lack of knowledge about miscarriage and about appropriate health care. In this respect interviewees positioned themselves as having greater expertise on matters of QOC than the patients, and were not reassured by positive results from formal quality measurement mechanisms.

> “because patients are so upset and distressed that they’ve lost their baby, you know, they’re just thankful that they’ve got it over with and they’re going home, and they do seem genuinely, you know, pleased that they’ve had decent care, but looking from the outside in, I think ‘hmm, that care’s been rubbish and you don’t really know what good care could be’” (Frontline, Nursing, 019)

In contrast, some interviewees described the opposite position; whereby some patient complaints were felt to be unjustified, either because the patient’s expectations were unrealistically high, or because the grieving process associated with miscarriage could make some women angry or overly sensitive. Furthermore, some interviewees suggested there were disparities in the way that complaints were dealt with (e.g. patients who were vocal and persistent in their complaint were more likely to have their concerns addressed than patients who were more passive).

> “if they don’t fit the criteria [to access the Early Pregnancy Assessment Service], you know, we do say ‘you know, look’.... There has been occasions where they’ve just kept pushing and pushing, and then I suppose that comes back to the ‘who shouts the loudest’[22] really.. em, so you have to take them but, yeah, if they’ve only, say, like had one miscarriage, or they’ve just you know had cramp, like, ages ago, and you know they just want to come in for a dating scan we do say ‘oh no, that doesn’t fit our criteria’.. em .. so yeah, I think you do have to say no to them, and we do say no to them” (Frontline, Health Care Support, 007)

Direct systematic involvement of patients in negotiating the parameters of acceptable care was rarely mentioned in the interviews, and it was suggested that the sensitive nature of miscarriage made it difficult to use typical organisation mechanisms for this (such as patient forums). One interviewee (013) described how patient advocacy groups could fulfil this role; the example given by this interviewee did not, however, relate to miscarriage.

> “I haven’t got a forum to go to with the patients and that’s difficult really, em, I think that so much of gynaecology is so sensitive that it’s not easy to have a patient forum” (Manager, 008)

---

[22] Interviewee is referencing a common saying “*he who shouts loudest, gets*”. In this context meaning that patients who refuse to accept aspects of care they do not agree with, and who continue to demand an alternative, are more likely to have their wishes accommodated than patients who do not complain, or patients who accept staff explanations and comply with organisational policy.

> “We have had groups <…> and they’ve all got a legitimate, em, concern, and you know, we have to respond to them so, I mean we do respond to them” (Manager, 013)

Regardless of how congruent staff perceptions of QOC were with patient reported opinions about quality, it was suggested that formal measures had superior organisational legitimacy. Formal patient complaints in particular were described to instigate organisational procedures, and were more likely to result in action to address deficiencies; conversely a lack of patient complaints was viewed to reflect positively on the service.

> “the <miscarriage> service is not something that <the Trust> get, em, anxious about really because it doesn’t feature on the complaints radars, .. so all of that would give us the, the view that they’re providing a good service, with positive feedback from the service users.” (Manager, 008)

Formal measures of quality were thus represented as a type of organisational currency for both frontline and managerial level staff; where they are positive they could be used to reassure frontline staff or to dismiss their concerns about QOC, and where they were negative they could be used by frontline staff to support pre-existing concerns and as a lever to prompt organisation change.

> “when things go okay, the patients, er, don’t, they don’t know any better <…>, we know it’s not good enough, that’s the bottom line, we don’t need our patients to tell us, er, if they do that would be helpful” (Frontline manager, medical, 039)

5.1.4 Workload

Early miscarriage is the most commonly occurring type of pregnancy loss dealt with by the health service and this was described to increase tolerance to lower QOC in two ways. Firstly, some of staff that experienced regular and frequent frontline exposure to miscarriage described becoming desensitized to patient distress. This was described to be either a passive influence (i.e. processing large volumes of patients deadened sensitivity to each individual one) or an active strategy (i.e. frequent exposure to distressing situations led to protective emotional distancing strategies for some staff).

> “in early pregnancy, miscarriage, because you see so many, and they’re so common, you probably just get used to them eventually” (Frontline manager, medical, 006)

> “it’s become .. it’s not.. what are the words, it’s.. just keeping myself at that distance, that’s, that’s, and not get involved.. too much because I’d,.. I’d be depressed by now, if you took everything on board, but some things you do need to take on board, so, people have recurrent miscarriages, erm, I don’t know how I cope” (Frontline, nursing, 024)

Secondly, many interviewees explained that the volume of women seeking care for symptoms of early miscarriage made any suggested changes to care potentially resource intensive.

> “ideally you would have like a couple of rooms ensuite so that you could put them in there, but the sheer volume of them, we’ve got coming through now as well, we seem to get loads” (Frontline, nurse, 010)

> “it is partly resource and should be, because clearly we couldn’t, I mean, put everybody that’s eight weeks on to our delivery suite” (Manager, 043)

In these cases the disjoint between resource demand and resource availability led to most interviewees accepting that some amount of compromise was unfortunate but inevitable. Managing the workload also led to several frontline interviewees expressing concerns about their need to compromise quality in order to maintain efficiency.

> “you’ve got to get them moving [through clinic] and, you know, sometimes I do feel awful when, you know, that they’ll be crying still, and I’ve got to move them into the next room” (Frontline, nursing, 007)

5.1.5 Formal Quality Measures

As well as the formal patient derived measures of quality described in section 5.1.3, a number of process and outcome driven formal measures were described. The outcomes of these measures provided a vehicle for services to be benchmarked, either against other organisations or against a predetermined quality standard (such as those produced by NICE (National Institute for Health and Care Excellence, 2012a)). Senior managers, in particular, relied heavily on these proxy measures of QOC because of their limited involvement with direct patient care.

> "I wouldn't know that there was an improvement necessary unless I got the Director from the Department of Health saying 'you've got to introduce this new screening programme', I wouldn't know. And if the staff didn't come to me and say 'we think we'd make this 100 percent better by doing this, this, and this', I wouldn't know. But what I do have is the reassurance of knowing that we've got CNST Level 3[23], ISO9002[24], so I'm reassured that we've got a safe service." (Manager, 013)

All interviewees, however, exhibited some degree of scepticism about the extent to which these formal quality measures reflect quality as experience by patients. Some described them as creating unnecessary additional workload that either did not contribute towards quality improvement, or only contributed in a narrow way. Additionally, some questioned the genuine commitment of high-level managers and the Department of Health to delivering high QOC.

> "the Government, in my view, pays lip service to quality, I mean, and, er, er, they, they, they drive down the, the people, and they just have to make savings, er, and I mean, em, if you can get away with, er, a silver service, and get all your boxes ticked, why go for a platinum service that would cost you one and a half times the amount?" (Frontline manager, medical, 039)

> "I think you can get staid and, erm, you can have pre-conceived ideas which are driven by targets, and they're driven by standards, and they're driven by what I need to do as a manager, erm. Is that necessarily always tied up with the expectations and experiences of women? I don't know" (Manager, 049)

The power of formal quality measures was therefore less about their legitimacy, in terms of their relation to actual patient experience, and more about their ability to demonstrate quality externally (which had several benefits including securing resource, avoiding penalty, and providing organisations a competitive advantage).

---

[23] CNST is the Clinical Negligence Scheme for Trusts. This is a body which handles claims and costs against participating NHS Trusts in the event of a clinical negligence claim. Level 3 is the highest assessment and indicates the Trust has been assessed as having a robust system of risk management.

[24] ISO9002 is a certification awarded by the International Standards Organisation and demonstrates that an organisation has been assessed to have a quality management system in place.

> "With, er, all the competition and everybody vying for this and that bit of service, I think they are now looking very closely and knowing that they have to convince the GP, er, commissioners are biased that, er, you do it better than <the next town> or <the next town> or, or any group that pitches their camp opposite [this hospital] and will provide that kind of service" (Frontline Manager, 039)

Another source of external comparison, used by both frontline and managerial interviewees, was information provided by research evidence, particularly when that evidence was collated and the results endorsed by a National body (such as the National Institute of Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG), and the Association of Early Pregnancy Units (AEPU)). Several interviewees described local audits that used these standards to benchmark and to refine QOC within their own services.

> "they're based on, on evidence <…> they're reviewed every three years, they go through risk management for, for ratification, so that's how they are developed, and tweaked, and changed as things go, so for example, if we then found from the audit that the regime changed, causing a higher failure rate we'd go back, we'd look at other regime rates again, we'd change, and we'd tweak again" (Manager, 027)

Just as with patient derived formal quality measures some, but not all, interviewees were reassured if their service performed well against quality standards. Again, they were described in terms of currency in so far as they could be used as a lever to secure additional resource or prompt organisational change, or as a tool to persuade staff that QOC was sufficient or that resource was better allocated elsewhere.

> "you can't sort of go and completely ignore national policies erm .. there are certain things that are out there that I think we could still improve on to keep in line with the national policies, one of them is, all women I think it says, states, in the [Royal College of Obstetricians and Gynaecologists] guidelines that all women should be offered counselling for a miscarriage" (Frontline manager, medical, 045)

This section has outlined that interviewees in this study have described compromise over QOC to be an inherent feature of their jobs, however it has also proposed that there is little consensus about the aspects of care that can or should be compromised. A number of agents of compromise have been identified in the data; that is, ideas and concepts that frontline workers drew upon to decide on the fairness and acceptability of the compromises they encountered or felt they were being asked to make.

5.2 Community Understandings of Quality

The previous section has described compromise as an inevitable feature of working in the NHS and it outlined some of the factors that were described as being important in influencing the extent to which frontline workers are prepared to compromise. These factors impacted on individuals in different ways, however the data also suggested the existence of communities of individuals who shared and agreed similar views about appropriate (and inappropriate) standards of care. These communities sometimes existed as a result of formal organisational allocations; such groupings included wards/departments (e.g. all the workers operating in a single ward or department), job titles or job functions (e.g. managers, frontline workers). Other groupings occurred as a consequence of attributes external to the organisation; such groups included professional groups (e.g. medical staff, nursing staff). Other groups were more conceptual in nature and coalesced as a result of less formal, or less well defined, attributes; such attributes include experience (e.g. groups of individuals with greater versus lesser experience of working with women experiencing early miscarriage).

In terms of QOC, these community groupings operated to promote dominant thinking about QOC (a) internally, and (b) to other communities who might place different parameters around their perception of acceptable quality. These activities could be formal (e.g. by a group of ward staff having ward meetings and developing written protocols) and informal (e.g. by a group sharing and agreeing a view about the nature of quality during informal interactions and moderating that by means of peer pressure). Informal activities in particular were not necessarily performed consciously, or with awareness of their function in influencing and moderating the actions of others. Groupings often had an internal and an external "identity" that comprised of expectations about the way that members of the group should think and act (e.g. nursing interviewees, generally described themselves to have a "caring" identity, and medical interviewees generally agreed that shortfalls in "caring" aspects of health care delivery was more of a nursing, as opposed to a medical, issue).

The groups were constrained by a range of structures external to them (e.g. organisational policies, professional responsibilities) but the groups also appeared to coalesce to develop, sometimes tacit, philosophies about care and understandings of what quality of care means and how much compromise can be tolerated. These community understandings also influenced ideas about whose views are legitimate and who can legitimately instigate organisational change. The data suggest that individuals could belong to more than one group (e.g. one manager drew upon their previous experience in nursing to demonstrate that they retained a caring identity, and several frontline managers drew upon their membership of both frontline and managerial groups to explain their difficulty in reconciling the differing outlooks).

A number of benefits of these communities were described in terms of managing QOC. A good community of understanding operating within, and between, wards was described to be highly advantageous to care delivery (i.e. where a common understanding had evolved amongst all of the staff involved in the delivery of care to women experiencing an early miscarriage about the most appropriate way to deliver care, the formal and informal mechanisms that should be employed to achieve that, and the roles that different staff members should take in the process). This was described to contribute to a cohesive approach to care delivery where the most appropriate way to think and act was accepted and understood between groups. The disadvantage of this was that those outside of the group were not party to the understandings and the ways in which they influenced care practice. As a result, group outsiders were liable to underestimate or misunderstand how far shared understandings were supporting practices beneficial to maintaining QOC.

> “I really don’t think they realized the full extent of what they were losing.. as a service, they probably thought it was a costly thing, a costly service ‘well you can provide that there, and you can provide that there’, but the whole thing just worked so well, they were directly above us, there was good interaction between their team and our team, you know, if they had someone in need we would support them, if we had someone in need they would support us. It just worked really well” (Frontline manager, Nursing, 021)

Development of group understandings was described to involve interactions during which differing views, understandings, experiences and priorities were reflected upon and debated. Organisational structures that allowed opportunities for such interactions were described to be advantageous and structures that inhibited interactions were described as problematic.

> “one of the things they did when they, er, changed it all that everyone came through and they said “we’re going to work it as a floor” so they told them they couldn’t have their own meetings anymore, and that was a disaster” (Manager, 049)

This section outlines some of the groupings that were evident in the data, to explore the link to understandings of QOC in more detail.

5.2.1 The Universal Group

Several interviewees drew upon the idea of "common sense", suggesting that there was a universal human understanding about how things should be; for example, at one of the hospitals, services for women undergoing in-patient treatment for a miscarriage had been delivered on a mix gender ward for a short time. Frontline interviewees were clear that this was inappropriate and made no attempt to explain why that was the case. Transgressions of common sense rules appeared to be particularly difficult for interviewees to tolerate since they challenged deeply held ideas and made it difficult for staff to rationalise acceptable reasons for them to happen.

> "miscarriages are there on a ward where there's men? It was just ridiculous to start with <…> it's common sense isn't it? " (Frontline manager, Nursing, 022)

> "you know, it seems as if it's as plain as the nose on your face that there's, there's a right way and a wrong way of providing care for these women" (Frontline Manager, Nursing, 021)

5.2.2 Professional Groups

Some interviewees proposed ideas about health care that drew upon ideas of professionalism and the expectations they had of their own professional group, or those of their colleagues. This manifested most obviously amongst the frontline nurse/midwife interviewees who found it difficult to tolerate not being able to deliver on the caring aspects of their service (as outlined in the previous chapter) since they linked it to notions of professional identity and responsibility.

> "I'm not doing what I'm supposed to be doing [as a nurse]" (Frontline, nursing, 010)

This was supported by medical interviewees who frequently described deferring to their nursing or midwifery colleagues on matters relating to relational aspects of health care, in order to develop their understandings of the most sensitive ways to approach women experiencing miscarriage.

> "I think we can do more about, to become like nurses, to become like experienced persons who will counsel patients, because without a doubt we can do better and I think that's being incorporated, or being addressed by curricula for us as medical professionals" (Frontline, medical, 006)

Two of the frontline interviewees occupied non-professional roles. They aligned themselves to both their professional colleagues (by supporting them in their work) and to patients (by emphasising their role in attending to relational aspects of health care). In both cases they described themselves as an integral part of the care delivery team, but they also subordinated their views to those of their professional colleagues.

> "I don't know, maybe it's just that I don't think it's my place to, .. sometimes I think, no, you know, I'm not the health professional, I'm not the one with the degree and this, that and the other so, .. em, .. I think well, you know, it's not my job to say.. but you think it" (Frontline, nursing, 007)

5.2.3 Experienced Groups

Interviewees who been involved in the delivery of care to women experiencing an early pregnancy loss for some time suggested their assessments of QOC were superior to those with little understanding or experience of the condition. This was particularly evident in Hospital B where an organisational change meant that an experienced group of staff, with a well-developed sense of how care should be, were moved to another location where they needed to work amongst another group of staff (the other group generally had little experience of early miscarriage, however they were already a cohesive group with an understanding of the way that their ward worked). Interviewees from this hospital described experiencing intense difficulty in merging and, in fact, the experienced group wished to maintain their distinction as the more expert group. The more experienced staff also described being troubled by their perception that QOC had dropped to an unacceptably low level whilst working amongst a group who, they felt, were less concerned or had lower standards.

> "I mean, even the new staff, the newly qualified staff, when you're trying to educate them, you know, they can't see anything wrong in somebody who's miscarrying sitting in a day room for three hours waiting for a bed, because that's the way the ward is" (Frontline, Nursing, 019)

5.2.4 Gendered Groups

Issues of staff gender were discussed solely by male interviewees, two of who specifically suggested that women might be naturally more knowledgeable and empathic about issues relating to pregnancy and reproductive loss. This was not described to preclude male involvement in this type of care, although all male interviewees in this study occupied roles that involved only sporadic involvement in the care journey of women experiencing miscarriage.

> “I mean, thankfully, most of them [frontline nurses], all of them being women, as at now, know that it’s infinitely better to, to be cared for by someone who’s used to such sensitivity as, er, as early pregnancy loss” (Frontline manager, medical, 039)

5.2.5 Hierarchical Groups

The importance of hierarchy was largely linked to the ways in which QOC was understood by frontline versus managerial level staff, and the amount of power each group had to translate their views into action. Lack of involvement from senior managerial staff on the frontline of care delivery was described by a number of frontline interviewees to contribute to the development of divergent understandings and agendas between frontline and managerial groups. This was a clear source of frustration for several frontline interviewees who described organisational decisions being made by individuals that did not understand their potential impacts.

> “I think, if people who are making decisions could just get involved, and just come and do a day in the unit all day, and just see exactly what is going on, cos I think sometimes people don’t know what is going on so, you know, when they are making decisions, sometimes they’re not maybes thought out” (Frontline, nursing, 017)

Managerial level interviewees did not dispute the legitimacy and usefulness of experiential knowledge, although all acknowledged that collecting that information systematically was difficult. Managers also noted that an integral part of their role was to understand and reconcile a number of different perspectives of QOC, and to manage them within organisational constraints. It was suggested by some that frontline workers may not be willing or able to appreciate or understand this.

> “Although they [frontline staff] understand the reason that they’ve been given, they may not have the detail, and sometimes that’s always difficult to be able to provide to staff. Again, as I say, not that there’s any particular secret, you know, but often details are complicated and, you know, and the details, because they contain a lot of details, and it’s very hard to be able to get that back across to staff” (Manager, 049)

Beyond these potentially different understandings about appropriate QOC, the data suggested that there were common understandings amongst frontline groups about the low status of their own beliefs about QOC within an organisational context. Examples were given of concerns about QOC raised by frontline staff that were not acted upon until additional support for this concern arose elsewhere (e.g. interviewees at one hospital described having notified senior managers of their concerns about delivering in-patient care to women experiencing miscarriage on a mixed gender ward. They suggested that these concerns were dismissed until the Operating Framework for the NHS in England 2010/11[25] was published). Similarly, a number of frontline interviewees suggested NHS organisations operate on a reactive basis, meaning that potential problems are only dealt with once they convert to an actual problem.

> "I go to my, sort of like, you know, does someone have to die or write in before anything's done? Yes, yes *laughs* yeah, die, or yeah, something catastrophic has to happen before, yeah, it's not us, we don't make those decisions" (Frontline manager, nursing, 059)

Hierarchies were thus presented as, not only an organisation feature, but also a virtual barrier that created divisions in the amount of information shared between upper and lower rungs of the hierarchy. This meant that there was a motivation for frontline views to remain within the frontline, where they were less liable to challenge or rejection.

> "If you're in your own little group and they say 'oh, you know, I think this, this and this should happen' and I think 'well, how about this?'… and I think they would consider it because I think, you know, with, they see what working relationship we have, but I think if it was, em, more higher up then *laughs* I don't think they would, because basically they see this uniform and they think 'ah, I'm not talking to her'" (Frontline, nursing, 007)

This section has suggested that as well as making personal assessments about the QOC of health care services, interviewees also relied upon shared understandings that had developed within the different groups of individuals they interacted with. These groups were sometimes created artificially (e.g. organisational hierarchical groups) and sometimes developed organically (e.g. groups of staff with longstanding relationships, staff with a lot of experience). The importance of these groups is not only in moderating the beliefs about QOC

---

[25] This document contained specific advice to commissioners on expectations that health care providers should be working towards the elimination of mixed sex wards.

and the acceptability of compromise, but also in understandings about the role of frontline workers in managing quality.

5.3 Negotiating Conflicts in Understanding

> "I think people are having to make decisions they don't want to have to make and that's not just in the NHS it's everywhere isn't it?" (Frontline manager, medical, 045)

Having established that notions of quality develop, and are agreed, within groups based on their exposure to a number of different factors, this section considers the way that these notions interact with each other, especially in cases where they are conflictual.

In cases of conflict, outcomes involved either (a) one party overruling another and imposing their view, or (b) each party negotiating to come to a position where at least some of their views appeared to be accommodated. The extent to which either of these outcomes occurred depending on the amount of power the groups involved in the conflict had over each other, and amount of power being exerted upon the situation by other forces. It is argued that frontline workers often situate themselves as subordinate to their organisational superiors in terms of legitimate power, and that organisational superiors present themselves as respecting frontline understandings of QOC, but being unable to prioritise them above competing views of QOC. Both situations allow a narrative of powerlessness to develop to explain the role of frontline and managerial staff in knowingly supporting suboptimal care practices.

5.3.1 Frontline Workers and Powerlessness

Several examples were given where organisational changes had been imposed, despite the frontline workers explicitly sharing their concerns that they would impact negatively upon QOC. Frontline interviewees described themselves as having little organisational power to bring into the negotiation process since it was felt there was no obligation on the part of the organisation to accommodate those views, and no one to hold accountable if frontline views were overlooked. In these cases the conflict was communicated explicitly between frontline workers and managers.

> "they held meetings and so we made representations but, you know, er, I think we just went through the motions basically *laughs*, I think so, <…> I think so just to say they'd consulted, yes, I think, you know, .. I think they decided really just to end, you know, slash the service and, em, .. they wouldn't listen" (Frontline manager, medical, 035)

Additionally, some frontline workers suggested that there was a need for them to be seen to acquiesce to organisational requirements in order to maintain employment, and retain access to the resources that support service delivery.

> “there was no, em, consultation in it to say that. ‘You’re gonna go, it’s gonna happen, that’s it, and you should be grateful for your job, em, there’s a lot of changes, and if you’re not grateful for your job you’ll be out of a job, because this is what’s paying your wages’, yeah, I mean it was as, as cut-throat as that" (Frontline manager, nursing, 059)

> “I think with the current climate at the minute I think everybody’s thinking, everybody’s feeling a bit like, em, you just keep your head down and get on with your job” (Frontline, nursing, 050)

Frontline workers therefore positioned themselves as being reliant on the approval of organisationally superior managers in order to have their views of quality accommodated; where this was not forthcoming, interviewees suggested that they had no choice but to capitulate and operate with the revised standard of QOC imposed upon them. This created situations whereby frontline workers were able to collectively agree that standards of care were suboptimal, whilst simultaneously rejecting responsibility for delivering care to that standard.

> “at the end of the day that's the way it was, and we didn't have a lot of power to change that so what can you do? You know what it's like, you can be frustrated to death and you just only make yourself angry don't you?” (Frontline manager, nursing, 034)

5.3.2 Frontline Workers and Legitimacy of Knowledge

Most frontline interviewees maintained the position that their version of good QOC had legitimacy because it was based on the real, observed experiences of their patients (as discussed in section 5.2.3). Conflict was thus presented as resulting from those in positions of power either failing to acknowledge this legitimacy or failing to prioritise it. A belief in either of those positions inhibited the willingness of frontline interviewees to share their ideas or concerns beyond the frontline since that incurred risks (of being seen to be disruptive, of being rejected) for little chance of gain. In this respect, frontline workers decided to share or withhold information with managers based on their beliefs about the capacity and willingness of those managers to understand and act upon the views of frontline workers.

> "sometimes a person on the shop floor is the best person to make that decision about things yeah, it's also a risk management issue, you know, who's the best person to wave the aircraft off, the person who's done the checks not the person on the bridge who can't see what's going on" (Frontline manager, medical, 045)

> "I suppose it depends on the hospital in which you work in, whether or not you feel you're free enough to actually then discuss ideas that you might have which are better ideas, and whether or not people who you work with would be receptive to the idea, and whether it's worth it, you know, at the end of the day, you don't really want to come up with ideas, which you think are good ideas, that are going to be rubbished" (Frontline, medical, 006)

In fact all managerial level interviewees agreed that frontline knowledge was valuable and legitimate, although access to this knowledge was described by some as challenging due to hierarchical working arrangements that limit formal and informal interactions between managers and frontline workers (this was more pronounced the higher up the organisational ladder the interviewee's role was). Note that the emphasis within managerial accounts was on "capturing" views implying this to be a one-way transaction that did not include any obligation to act upon those views.

> "if you were to ask me do I think the people who actually deliver the service have a major say in what happens to it? Well, no, I don't think they do, which I think is a real shame because I think there'll be loads of great ideas out there, erm, if only we could think of some way of trying to capture them. But setting out to do that systematically, in a way that actually works, I think that takes a lot of time and a lot of setting up, and we've just been overwhelmed with work basically for the last two or three years." (Manager, 043)

Frontline knowledge was particularly legitimate in terms of understanding the ward or department in which staff were based. This was evidenced by managers who described delegating the day to day running of wards and departments to frontline staff.

> "to be honest, short of being confident that there's a process in place for, erm, putting guidelines together, erm, and the people were, and the people that were offering the service were competent, then I wouldn't want to be involved in their, in the day to day, erm, I mean I think I'd be happy to leave that under their control, and for them to bring problems to me" (Manager, 043)

The power of frontline knowledge was, however, challenged once it left that specific environment and came up against competing views about what a quality means, and against other wards and departments competing for the same resource use.

> "Well, *sighs and laughs* I don't think the bed co-ordinator gives us much priority. I think, you know, when you've got an anxious woman who, who needs to have her pregnancy resolved.. by emptying her uterus in some way, shape, or form, the bed co-ordinator will say 'oh well, you know, put her in for, like, five days' time' and I think no, that's not good enough, you need to work within 48 hours" (Nursing Manager, 021)

In this respect frontline workers were suggested to be naïve (consciously or unconsciously) to the "bigger picture", with an overly narrow focus on their own patient groups that could be challenged as being unreasonable or incorrect when viewed in the context of a whole organisation.

> "a lot of my observed behaviours is that people do understand that there is a major issue in the NHS, always has been, and it's always been, sort of, rationed, and we've got to be careful how we spend the money, and that everyone's got to make a contribution, and managing the services in the most cost-effective way they can .. but that really doesn't apply to them, .. it applies to everyone else" (Manager, 013)

5.3.3 Controlling Context

Managerial level interviewees described their own role in terms of knowing of, and overseeing, these conflicts of understanding. They did not, however, describe themselves as powerful arbiters of the most appropriate version of QOC to use to drive services; instead they positioned themselves as mediators, tasked with reconciling multiple views of quality within the context of organisational requirements. Where organisational decisions privileged the views of others over those of frontline workers, this was generally described with regret and sympathy for both the patients and the frontline staff involved. It was also accompanied by suggestions that managers were not choosing to dismiss frontline views of QOC, but rather circumstances meant that they had no other choice. In this sense managers claimed powerlessness and deflected responsibility for suboptimal QOC in same way as their frontline counterparts have been described to do.

> "I'm there to support, erm, the team in, in, er, you know, in this respect, in, in, arriving at the best service model for, you know, to meet clients' needs but also within, you know, the overall, erm, sort of, .. well taking account of a number of other factors. I hate to get into finances and that, you know what I mean, but finance is important, you know, because there is a financial envelope, you know, and that financial envelope is not necessarily set by us" (Manager, 049)

Where frontline concerns about QOC were explicitly overruled, this generally occurred in situations where organisational changes had been implemented which challenged the frontline working definition of acceptable QOC. In these cases the interactions between frontline and managerial groups involved persuading frontline worker groups to accept that the new terms being imposed upon them were reasonable within the circumstances, and therefore encourage frontline workers to compromise their own view of QOC and continue to provide services. It also sometimes involved deflecting responsibility for maintaining QOC back to frontline workers, or flexing the definition of concepts such as continuity, in order to convince frontline workers to accept that some definition of the concept was still being delivered.

> "we have, erm, like discussions around it, and again, it's really prioritising the work, which I say to them, unfortunately the staffing levels are the staffing levels, and they need to prioritise and obviously work it how they can work it best for themselves, erm, .. and it is difficult and they do find it very, very difficult, but they've got to make decisions on a day to day basis of what patients need, their need to be seen." (Manager, 052)

> "continuity, I think, sometimes it's the continuity of the care that's being given by a group of people, and what your ethos is, of how you're going to care, not just having one person doing it" (Manager, 052)

Finally, managerial level staff had additional powers at their disposal to control the circumstances within which frontline understandings are generated, and one interviewee described how a combination of a carefully chosen senior ward manager, and the desertion of a number of obstructive staff, had led to a more favourable position in negotiating the co-operation of frontline staff.

> “the new Ward Sisters involved .. have got a better, a more open mind towards dealing with the broader range of specialities than perhaps some of the others had in the past, and I think, equally, the .. nurses with the specialist, em, knowledge, the ones who wanted to co-operate and, you know, try and make the service work are there and doing it. The ones who were dissenters in effect have gone now so, so I think, and that, and I think the.. medical staff have come to accept it as well that, em, .. that the, that patients aren’t being disadvantaged by not being cared for in a dedicated <> unit and that, you know, we have done things to make, to improve the situation, and they are working with us as well, so.. it’s a team” (Manager, 013)

This section has discussed the ways in which interviewees described responding to conflicts in opinion about the nature of acceptable QOC. It has been proposed that despite a widespread agreement that the experiential knowledge of frontline workers is legitimate and useful, frontline workers themselves frequently described themselves as constrained and restricted when their views about QOC, and about the acceptability of compromise, conflicted with organisational demands or other views about QOC. Managers generally positioned themselves as managing, rather than defining, the nature of quality, and often described the compromises they were involved in managing as being regrettable but necessary. They described expectations that their frontline workforce would operate as an important defence against QOC compromises by dealing with QOC shortfalls without intervention from organisational superiors. Importantly this section demonstrates that whilst interviewees of all organisational levels were able to identify QOC shortfalls in their service, no one group accepted accountability for these shortfalls.

5.4 Chapter Summary

This chapter has described the theme “Negotiation, Compromise, and an Acceptable Quality of Care”. Overall the content of this theme suggests that frontline workers are constantly required to temper their aspirations regarding QOC. In the absence of formal guidance to help them to decide what can be compromised and to what extent, this study suggests that frontline workers draw upon a number of concepts (e.g. equity, professionalism) to help them to understand and justify (or reject) the compromises that are suggested and made. The development of community understandings about the acceptability or inevitability of compromise appears to provide another important form of support to those operating at the frontline (and those higher up the hierarchy).

When frontline workers find themselves in situations where their position on QOC is in conflict with that proposed by others, interviewees in this study described their views to be subordinate to those of their organisational superiors. This allowed them to propose a narrative whereby their involvement in services of suboptimal QOC could be explained by their powerlessness to insist on improvements. Managerial level workers, however, described themselves to be similarly constrained (in terms of their ability to support the views of frontline workers against other organisational demands) but their role in controlling context, and creating the circumstances within which frontline workers could work flexibly and creatively and develop shared understandings, was highlighted by the differing models of care delivery operating in the organisations involved in this study.

Chapter 6 Findings 3. Managing Quality Gaps at the Frontline

Chapter 4 and Chapter 5 have outlined the attributes that frontline interviewees described as being integral to a high quality service for women experiencing an early miscarriage and have highlighted the importance of intangible or difficult to measure aspects of health care such as 'caring'. It has been argued that whilst the experience and knowledge of frontline workers is broadly considered to be legitimate and aligned to the reality of care as experienced by patients, NHS workers operate in an environment in which they, as a group, have limited power to impose their own views of quality over those of other groups. Organisational hierarchy has been suggested as playing a key role in facilitating frontline acceptance of suboptimal care by suggesting it to be an inevitable feature of a publicly funded health care system with finite resource and infinite demand. Whilst it appears that group understandings about "ideal" care continue to circulate, persuading frontline workers that compromise is rational and reasonable, in order to secure their willingness to work, allows organisations to meet the demands of other powerful agents.

This description, of the ways in which the parameters of acceptable quality come to be, might lead to assumptions that frontline workers are passive in terms of operationalising the important knowledge they have in relation to QOC. They are unable to share or mobilise their knowledge because of constraints imposed by the internal and external forces operating within their organisations. This leaves frontline staff powerless to do anything other than support QOC standards that are defined by others and that are based on proxy measures of quality. This aligns to the model of rationalisation and bureaucracy described by Weber (see Chapter 1) and positions frontline workers within, what Weber termed, an "iron cage" of rationality. This conceptual model underpins the basis of many of the frontline engagement programmes implemented within the NHS that aim to breakdown hierarchal barriers that are seen to be the main factor preventing information sharing.

Micro level organisational theories (as discussed in Chapter 3), challenge this view of the frontline of organisations, since they suggest that frontline workers do have power, and that that power operates within the black box of their shared understandings and everyday frontline activities (activities that organisational superiors may play no part in, and have limited knowledge of). The nature, extent and purpose of those activities have been described as a product of negotiation, and the unofficial policies that result from those negotiations may represent another form of control upon frontline work.

This chapter explores a more analytic theme that focuses on the formal and informal discretionary activities frontline workers describe themselves as engaging in, and explores the extent to which they might contribute to improved QOC (as defined by frontline workers themselves). Ultimately, it is argued that frontline workers engage in a number of informal and discretionary activities that can improve QOC for individual patients whilst also maintaining the functionality of the wards and departments within which they operate. It is also, however posited that these activities form part of a culture where some aspects of care (specifically those pertaining to humane or patient centred aspects of care) are systematically under-resourced. This leads to the perpetuation of QOC shortfalls and the on-going need for frontline workers to engage in discretionary activities; since not all frontline workers are capable or willing to do so, this contributes to the on-going gap between the expressed needs of women experiencing early miscarriage and the care they actually receive.

6.1 Acting Without Disrupting

The first category of activities described here are best conceptualised as non-disruptive actions. This relates to activities that lead to improvements in QOC without disrupting the system within which that care is delivered. These may be activities about which organisational superiors are unaware of, and are thus unaware of the ways in which they are contributing to the quality of services they manage. As the previous chapter noted, some managers expressed an expectation that frontline workers would use their initiative to manage difficult aspects of quality without managerial oversight or support, therefore non disruptive actions to improve quality may represent an informal expectation that managers have of their frontline workforce (although not an explicit formal component of their contract of employment). It is important to acknowledge that these activities have been linked to quality improvement through analysis of the data, rather than by a specific declaration of the interviewees who, in some instances, presented these activities as just part of their job or an effort to maintain functionality in challenging circumstances.

6.1.1 Maintaining a Presence

The first action was the simple act of “being there” and supplying expertise and support. As noted in Chapter four, experienced frontline workers were described as a resource in terms of supporting each other and newer members of staff, and providing an informal quality monitoring function. A number of instances at one hospital were described where experienced frontline nurses had removed themselves from the service (by retiring or obtaining alternative employment) and this was described by interviewees to be a direct result of inability to tolerate poor standards of QOC.

> "They've all gone, and basically all gone cos they were unhappy, you know, and there's a couple of nurses, you know, sort of left who've gone, you know, to, em, .. out of the National Health, you know, which is sad, good nurses, you know, and who loved their jobs who gave 110%" (Frontline, nursing, 036)

This was viewed differently depending on whether the interviewee shared the views of leavers about QOC. Those who consider care quality to be adequate described this as a fortuitous loss of staff members who lacked resilience, whereas those who had concerns about QOC presented refusal to deliver suboptimal care as an admirable and principled response. Either way, it was clear, that leaving did not have a positive impact on quality; only staying offered the opportunity to contribute to the development of formal and informal understandings of QOC, and to engage in the apprenticeship of newer staff.

> "I what do you think of the difference between, like obviously you've stayed but a lot of your colleagues have left, what's the difference between you and them? I mean obviously just your opinion
>
> 019 Em, it's well, first of all because I've tried to make a difference with the patients here that we still look after, and secondly I can't find anywhere else I would rather move to." (Frontline, nursing, 019)

6.1.2 Bolstering the System

Bolstering can be thought of as supporting the system by masking perceived inadequacies in QOC. It was an activity mentioned by many interviewees and it was achieved in a number of ways. A key problem addressed by this activity was the issue of the time available for frontline staff to attend to the aspects of care outlined in chapter four; such as providing information, supporting decision making and attending to relational aspects of care. In such situations interviewees described masking their frustration or of "making time" by setting aside other tasks, or accepting delays which led to frontline staff routinely working outside of their contracted hours.

> "I mean you find every time you pop your head in you go, 'how's it going, are you okay?', 'well can I just ask you this?' and you're thinking, this is it, you know, 'Well you can, but hurry up', and I don't want that to show on my face to these people because they deserve a better standard of care" (Frontline, nursing, 019)

> "I mean you make time anyway, you, I suppose you get a fifteen minute slot for their scan, if you need to, essentially you do two scans, communicate the news, get them all wrapped up and off you know, that's never done in fifteen minutes, but.. you know you can't say well time's up sort of thing, you just have to, have to do it so" (Frontline, nursing, 012)

Another bolstering activity was seen amongst interviewees who described compensating for the inadequacies or errors of other staff members in order to protect patients.

> "I have forced the issue with a few of <my colleagues>, em, one just the other day, I said, 'you know, you have to go and deal with this girl', but then you find you take over because she hasn't got a clue what she's doing" (Frontline, nursing, 019)

Bolstering occurred on a patient-by-patient basis and at the discretion of individual staff members. Bolstering did not address problems at a systematic level thus those engaging in such activities described doing so repeatedly; this was frustrating if colleagues or managers came to expect them to continue to oblige.

> "I sort of go 'oh, I've worked through my lunch' and people, and never stop, you have to put a limit on it, you have to say 'I'm not gonna work after hours, I'm not gonna work through my lunch' because, you know, that the more you give the more they want so, you know, when would it stop?" (Frontline manager, nursing, 059)

6.1.3 Information Management

Information management describes activities aimed at steering patients towards a particular course of action by managing the information shared with them (i.e. withholding or skewing information about options that were not easily available). This was particularly evident in one hospital where surgical management of early miscarriage was not readily available. Frontline workers described managing their conversations with patients to either withhold information about surgical management completely or to make medical management appear to be the best choice.

> “there are ways of putting things over, if you say to a woman, ‘’well the majority of those are done medically here, we feel it’s the more natural way to do, you’re looked after in a room by the midwives who’ve seen you already erm, and most people go home the same day, and you know this is what happens blah, blah, blah, yeah we do have some people that offer surgical management, but there are risks of your anaesthetic, they’ll put you to sleep and you’ll feel really sick and really drowsy afterwards and it would probably be several days before we can get you on the theatre list’. Well, there are ways of putting it *laughs*” (Frontline manager, medical, 045)

In this case skewing information met an organisational need, but it also improved patient experience by preventing them from becoming aware that their choices were being restricted (with the potential for resultant anger, distress, or complaint). It also reduced the chance of them demanding options that would be difficult for frontline staff to organise and result in delays to their treatment.

> “you’re trying to get someone on to an operating list and it can be really, really difficult, erm, it’s one reason to have medical management, to avoid women having to wait for a long period of time” (Frontline manager, medical, 045)

Another example of information control was given by interviewee (035); they described routinely withholding information about outpatient management options because of their concerns about patient safety in the event that an emergency readmission is required. In these cases the patient remained unaware of the organisational problem, or of the existence of this, otherwise appropriate, management option.

> “if the patient has to come in there is no bed, you see, and er, if there’s someone you think might be ectopic you cannot take that risk, because you don’t want them coming and they say ‘there’s no bed’, and when the bed warden finds them a bed on the psychiatry ward, you know, er, where she goes and they don’t know anything about her, it’s a recipe for disaster, so I would not do that, I would keep the patient in” (Frontline manager, medical, 035)

6.1.4 Blame Taking and Pacification

Most interviews noted that patients’ immediate anger or distress about poorer aspects of care were most likely to be directed towards frontline staff. Sometimes this was accompanied by abusive or aggressive behaviour on the part of the patient. Pacifying the patient, or downplaying the seriousness of the complaint, were two ways of dealing with this.

> “it’s just .. really frustrating because then we get the backlash of ‘when am I going to be.. I’ve been sitting here for two hours’, where we’ve been trying to push for the doctor to come, they don’t see that you know and it’s just.. so we get all the flack for the doctors not coming round and <…> it’s not getting at us, it’s because they’re angry, they’re upset, you know, they just want to get away, they just want to get home and it’s, it’s understandable” (Frontline, nursing, 010)

Pacification was designed to manage the immediate situation by acknowledging that the patient’s concerns were valid; they were also used to pre-empt complaints where the staff member themselves felt QOC standards were unacceptable. Frequently interviewees described these apologies to include a caveat that made it clear that the apologiser was not accepting personal responsibility for the poor care; they were apologising for the system, rather than for their role within it.

> “you just apologise and say that ‘we’re doing the best we can, and we’ll be with you as soon as possible, we understand that, you know, you’re upset but, you know, we are doing our best’” (Frontline, nursing, 036)

Interviewees also described pacifying complaining patients by appealing for them to be reasonable and consider hospital workload and the demands of other, perhaps more needy, patients. These arguments are similar to those occurring between managers and frontline staff, as outlined in chapter 5, in so far as they encourage compromise and acceptance that suboptimal care is to be expected.

> “Once I actually sat down and talked to her she, em, she did calm down and I just explained that it was, it wasn’t the sonographers weren’t doing any scans that there had been a problem with some earlier pregnancies that had delayed the list and she accepted that, and went away reasonably happy, yeah.” (Frontline, nursing, 011)

6.1.5 Self-Improvement

Some of the interviewees attempted to improve the QOC they personally could offer by seeking training opportunities, or extending their role above and beyond that mandated by their organisation or job description. Many of the interviewees described their motivation to self-improve as stemming from a sense of personal responsibility to optimise the QOC they were able to deliver. But, whilst this may have improved QOC for the patients those staff cared for, it did not improve quality across the service since not all colleagues were similarly motivated.

> “we’ve all had different experiences of the training as well where I’ve, you see I’ve took it head on .. to go with certain people when they doing the forms and when they’re going through, and.. like.... learn,.. where some staff haven’t done it,.. so I think it should have been a,.. at the end of the day it wasn’t something I particularly wanted to do when I was training, it wasn’t something, but I’ve had, that’s a service we give, but other people have managed to get away with it” (Frontline, nursing, 009)

In summary, this section has described a number of key examples of non-disruptive activities described by participants as forming part of their day-to-day working practices. The common theme underpinning these activities was that they were delivered without disrupting the structures within which they operated, meaning that there was no systematic change. As a result, activities generally needed to be repeated for each instance of suboptimal care. The next section explores types of formal and informal activities that were aimed towards creating a more systemic improvement in QOC.

6.2 Disruptive Actions

This section describes a different set of activities that might be best thought of as disruptive actions. In contrast to the non-disruptive actions described in the previous section, disruptive actions are those that aim to instigate change on a more systematic basis.

6.2.1 Using Formal Organisational Structures Individually

The interviews provided few examples of frontline staff who had independently engaged with formal organisational mechanisms for reporting problems or suggesting change within their organisations. Securing agreement from hierarchical superiors was described to be advantageous in strengthening the position of frontline workers.

> “I said ‘it’s not acceptable’ and, em, I said ‘under no circumstances will I change my mind’ .. em, so one of the gynae consultants, well a couple of the gynae consultants, were in complete agreement. But one of them, who’s a complete pain in the arse, em, he is, he’s just ridiculous, em, he’s like ‘I don’t .. well, you know, we could take them, you know, we’ll see her on the day’ and I went ‘no I won’t see her on the day. I’ve got the rule, and the Medical Director, em <name removed> has totally agreed with what I said” (Frontline manager, nursing, 022)

Engaging formal organisational channels appeared to be most successful when frontline staff approached the task in a rational manner, using formal evidence and measurable outcomes to support their stance (e.g. research evidence, national guidelines, audit, evidence of a specific adverse incident). Cost projection (especially demonstrating that an idea was cost neutral or cost saving) and highlighting risks, appeared to be particularly productive.

> “you have to be able to prove that if you spend x you are going to save twice x, or x plus10%, or whatever” (Frontline manager, nursing, 027)

This created a challenge for frontline staff whose concerns often related to intangible or difficult to measure aspects of care that are not directed towards physical health (as outlined in Chapter 4). Some expressed scepticism that such issues would be taken seriously, and this alone sometimes prevented them from even trying to engage with formal organisational mechanisms.

> “it’s not, em, not so, headlines stuff is it? It’s not,.. you know ‘this woman, if we don’t do this in this situation this woman may die’, it’s not that, it’s not that level of. So, whether it’s, er, a serious point that would be taken seriously? I don’t know, maybe it’s just me *laughs*. It doesn’t happen every day,.. does it significantly add to the distress of the patient? I don’t know. That’s my opinion so, I don’t think I would, you know, say anything about it” (Frontline, nursing, 012)

One feature of formal organisational mechanisms is that they often take a hierarchical approach whereby the concerns and ideas of frontline staff were fed up through a number of managerial level staff, or committees of staff, before they reached those in a position to make a decision about it. This was described as time consuming and left frontline workers in a position where any one of those individuals could prevent their views from proceeding further.

> "because I've got to get permission, I've got to go through my first line manager, who then is going to, who is talking to another matron about it, who will then, will take it to another meeting, and then they'll have another meeting about that meeting, who knows when it's ever gonna get done, and I brought this up years and years ago, and it's all because of that, and I think it's just so frustrating as a senior member of staff that you can't, can't either, you know, just sanction something and say 'right, I want this done, can I have it please, thank you, I'll sort it out', I don't seem to be able to, I can't actually sort anything out, I don't seem to be allowed to do it" (Frontline manager, nursing, 059)

6.2.2 Using Formal Organisational Structures Collectively

Whilst there was variability in the extent to which interviewees described feeling comfortable to escalate their views about suboptimal QOC, all interviewees presented themselves as being confident to present their concerns and suggestions to their peers. Most of the interviewees were also happy to do this with their immediate line manager or organisationally superior members of the clinical team. This was especially the case where the interviewee felt that they worked within a cohesive clinical team featuring respect between team members and a shared vision regarding the features of good QOC. An open and non-hierarchical attitude from immediate superiors (i.e. they welcomed advice and input from team members regardless of occupation or organisational status) also appeared to be supportive of frontline staff airing their concerns and asking for help.

> "the consultants are very, very sensible and very, very amenable, if you've got something sensible to propose, and you've got a reason to propose it" (Frontline, medical, 006)

This allowed activities designed to improve QOC to be pursued en masse. This had a number of benefits including; giving concerns and ideas added legitimacy by demonstrating they were shared by several individuals, diffusing responsibility for the initial report and any consequences arising from it, allowing less organisationally powerful or less confident frontline staff to gain power by their association to more powerful frontline members, allowing members to consolidate skills and knowledge in order to build a more convincing case for the concern or proposed change being reported, providing a readymade team with a shared vision willing to carried forward change, and providing a support mechanism in the event that change was not supported by the organisation.

> “we’ve now been allocated a specific consultant to lead us em, he’s only been in the post a couple of months so it hasn’t had a, a massive impact yet, but hopefully we’ve got a little advocate to stick up for us a bit more now” (Frontline, nursing, 044)

This also allowed frontline staff to identify opportunities for the changes to be made within the team (i.e. through non-disruptive actions and without recourse to the hierarchy of the organisation). Coalescing to work as a group in this way was reported to require space and time for frontline workers to meet to share ideas, propose change and negotiate the ideas or concerns important enough to pursue further. Organisational barriers to achieving this were described including lack of time away from the acute demands of care delivery and dispersal of staff across a number of departments.

> “It was quite useful, yeah, because you got, even if you didn’t feel, sort of able to voice your opinion, .. they would be talking about things and you’d think, you’d get like a different perspective on it and think, ah right, so I’ve obviously picked that up wrong, or, you know, that was, I can see why they did that now and, you know, so yeah” (Frontline, nursing, 010)

Regardless of any additional power operating collectively was felt to be associated with, most frontline interviewees still noted that power ultimately lay with those outside the group. One of the shared understandings of frontline based groups was therefore of their relative powerlessness.

> “it would be quite difficult as a member of the frontline staff to actually instigate that, I think you could probably do it as a group, you know, if everybody felt strongly enough about it, I'm sure, I don't know, I'm not, I'm not that convinced that we would be terribly effective at making any change” (Frontline, nursing, 018)

6.2.3 Negotiating and Compromising

The parameters of acceptable QOC can be imposed upon frontline workers (as outlined in the previous chapter), however there was also evidence of instances where frontline workers had refused to submit and, instead, entered into a situation of negotiation in order to protect QOC. This was a tactic aimed at securing at least some improvement in quality, even if it was not as extensive as frontline workers had originally hoped for, or not in the way they had intended; this could happen when the frontline staff member was persuaded that either their request was not realistic or that it was the best offer they could secure.

> “I think they [frontline staff] have some say....but erm, it is talked about and it’s discussed and it comes to compromise in the end” (Frontline manager, medical, 045)

Compromise sometimes involved focusing on different ways of achieving the same outcome. An example of this was seen in hospital C where a new pattern of care was being implemented; medical management of early miscarriage on an outpatient basis (i.e. treatment in the patient’s own home). Interviewees described this as an innovation driven largely by frontline staff, in part to address concerns about the inappropriate environment in which in-patient early miscarriage care was being delivered, and also in acknowledgement that the nurses no longer felt they could offer adequate emotional support and this might best be replaced by support at home. It met organisational needs since it reduced in-patient capacity and required less resource allocation. Some frontline staff expressed concerns about safety for women receiving outpatient management however accepted the introduction of this innovation on the basis that it (a) operated within strict criteria and (b) met needs that they were no longer able to.

> “that’ll be a huge saving because, em, it’s better for the women, we think, in theory, and it’s better for the unit, it’s better for the women cos they’re not here with pregnant women, and they’re not hearing that thing [referring to sound of fetal heart monitors] bounding away in the background, and they’re not anxious .. to get home and em, and obviously it’s better from the hospital point of view cos you haven’t got a day admission, and we get paid a huge amount of money for a day case admission, it’s a really costly thing, cos you’ve got all that midwifery time haven’t you …. so and of course they’re using all our facilities while they’re here, so there’s all the pads and all that kind of thing, crazy as it might seem, it’s a huge cost saving” (Frontline manager, nursing, 034)

In this sense frontline workers “marketed” their ideas by reframing them in terms of issues that they assumed to be of concern to organisational decision makers and providing information in forms perceived to be valued by organisations (e.g. rational evidence such as surveys or audit). This tactic required the frontline staff member(s) to have a certain level of knowledge of the needs and motivations of the organisation in which they worked. This was reported almost exclusively by frontline managers who, by virtue of their membership of both frontline and managerial communities, had extended knowledge of formal and informal organisational priorities.

> “basically I have to show some kind of income before I would get approval, em, which I know. So, patient experience, probably I may have to do the survey and show them that” (Frontline manager, medical, 057)

6.2.4 Closing the Hierarchical gap

Interviewees described the NHS as a hierarchical structure with a separation between frontline staff and those who held organisational decision-making roles. Bypassing the hierarchical chain of command altogether, and going straight to the top, was considered to generally be a radical move with unpredictable outcomes. Whilst senior managerial level interviewees suggested that they would welcome a closer relationship with frontline staff, they also suggested that this was impractical and not always ideal.

> “if a midwife was to write to me, for example, and say ‘I’ve had this great idea for doing X,Y, and Z but, you know, I cannot get anybody to support me’, I would, I would be prepared to talk to that individual. But I’d have to test the water and say ‘well, have you spoken to your boss first?’ and, you know, ‘what do they say about it?’ and ‘why are they not supporting you in doing this?’, and talk it through but, em,.. it’s happened once or twice,.. em.. but it’s not something you would want to encourage, coming to me” (Manager 013)

At one hospital however, frontline interviewees described an innovative way by which they were able to highlight their concerns about recent service changes to high-level managers in their organisation in a non-confrontational way.

> “I set up the day <…> and then we invited all the em, like the Directors of the Trust <…> it was just to sort of put out there that we’d made such massive changes in a little environment, in a small environment, with little resources and a very small amount of funding to make, to give one to one care in labour, which was the target without comprising care for the women really. Although I actually think that’s slightly compromised, and I did say that on the day, that it had slightly comprised the care of the first trimester women, but that was something we would look at .. which we are” (Frontline manager, nursing, 034)

6.2.5 Subversion

Subversion was another visible tactic described in the interviews to secure QOC. This involved frontline staff deliberately undermining organisational requirements by ignoring them or refusing to enable them. Often this action took place on a collective basis (as indicated by use the use of ‘we’ rather than ‘I’ in the data).

> “We’re not meant to take them [patient referrals] direct. Unless they’ve been booked with a midwife or they’re in our system already. We do, if you know you’ve got a slot at 11 o’clock and someone’s ringing up crying at 9 o’clock saying you know, I’ve started bleeding.” (Frontline, nursing, 017)

A number of interviewees described situations in which they had asserted their power by refusing to work beyond the formal requirements of their role; this represented a refusal to engage in non-disruptive actions (i.e. by refusing to pick up work unfinished by other members of staff or working outside the hours mandated in their contract). These actions were unhelpful to the organisation and sometimes to any patients involved (e.g. staff refusing to work outside their contracted hours might leave work unfinished). The motivations to act in subversive ways generally fell into three categories; (1) the staff member felt disinclined to help the organisation to achieve outcomes which they felt were not important or did not contribute to QOC, (2) the staff member preferred to expose organisational failings rather than support their continuation by engaging in non-disruptive activities, or (3) the activity allowed them to protect their own autonomy and control over their work (e.g. by refusing to take on additional task the worker protects their time and ability to choose what they do with it) .

> “we don’t, kind of, let on that we can do the bloods, that I can do the bloods, otherwise they [medical staff] kind of think ‘ah, you can do bloods, can you do my bloods for me?’ just because they don’t want to do it, people just don’t like it .. I don’t know why cos I absolutely love taking blood from people *laughs* <…> I can take bloods, but we kind of like keep it a little secret” (Frontline, nursing, 007)

> “I don’t make it easy for the Trust because they tried to save money <…> so I said ‘no’, so I’m a bit obstructive in another way, so it’s caused me to be like that, yeah, and maybe I wouldn’t have been if things had been a bit different, I might have been a little bit more helpful but I’m not .. *whispers* I hope nobody listens to these tapes *laughs*” (Frontline manager, nursing, 059)

6.2.6 Adaptation and Extension of Roles

The role of self-improvement in supporting QOC passively has been discussed in section 6.1.5. A more active form of this behaviour existed amongst staff who had independently sought to gain knowledge that would extend their capacity to deliver on specific aspects of care; this increased opportunities for them to exert control over the quality of that aspect of care. Skills extension often involved shifts in roles and responsibilities between different professional and non-professional groups; e.g. nursing staff taking over tasks from medical staff (e.g. ultrasound scanning, obtaining consent to treatment, training medical staff), and health care assistants taking on tasks previously completed by nurses (e.g. venepuncture, recording clinical observations, 'spending time' with patients). This meant that nursing and midwifery staff increased their capacity to provide continuity (in one of the hospitals all aspects of the care journey for a woman experiencing miscarriage were managed entirely by frontline nurses). Direct medical involvement in the care of this patient group had, consequently, decreased substantially (although they retained a role in developing and/or agreeing clinical guidelines to which nurses/midwives could be held accountable, thereby retaining an arm's length control). The drive to pick up extra skills was not always driven by the frontline staff themselves, but frontline staff described being more likely to accept new roles and responsibilities if they appreciated that it could improve QOC (as opposed to it simply meeting an organisational need), and if it was personally interesting to them.

> "I learnt to scan because we thought it'd be a more holistic approach to care for the women, because we did a patient satisfaction survey, and the patients complained that they had to go to another department to be scanned, and that's how come I got to scan, and from there on in obviously more people have scanned, been scanning" (Frontline manager, nursing, 034)

Skills extension in one group of staff often involved another group losing control and expertise in that skill. This trade off was not completely welcomed by all if it involved loss of control due to deskilling or fragmentation of care (thereby losing organisational claims regarding superior knowledge, and increasing the need for the delivery of care to involve negotiations between different wards/departments/staff groups).

> "gradually we're whittling away what we do, you know, it is going elsewhere, so it's sort of more fragmented" (Frontline, nursing, 036)

> "generally <our unit> is a fantastic place for teaching, not just our juniors, but also our, erm, medical students as well, they're very keen on teaching in <our unit> but I guess what I'm saying, it sounds like I'm contradicting myself, is the one bit they don't get is the surgical management of miscarriage" (Manager, 045)

6.2.7 Working the System

This section has outlined some of the ways in which frontline NHS staff described negotiating organisational mechanisms to address their concerns about, and/or improve, QOC for women experiencing early miscarriage. These involved visible actions that sometimes involve risk to the individual, or the groups, pursuing them (e.g. their views could be rejected or they could be subject to organisational reprimand). In addition to these, there were also examples of less obvious activities which were enacted "behind the scenes" and that involved manipulating explicit or implicit organisational structures. These activities relied on the discretion frontline interviewees were afforded as a consequence of a mixture of; their professional status, management styles that delegated responsibilities, their knowledge of gaps or ambiguities in the organisational systems and policies, and their knowledge of the people in the system (i.e. who was most powerful, who was most likely to collude in manipulative activities).

> "as long as, em, there's the support there, they don't tend to sort of dictate anything, it tends to be quite, em, you know, it's just a case of we're there to support you if you need anything, that's the, that's the way it seems to run and it's fine" (Frontline manager, nursing, 059)

> "it depends who's on. <Nurse X> is quite good, em, because obviously she's had a bit to do with the ward, she realises how busy it is" (Frontline, nursing, 010)

Examples of manipulative activities included accelerating patient's access to appointments by falsifying their symptoms and securing privacy for patients by reporting a single room as already occupied before a patient had been admitted. In both instances these actions secure a better QOC for the individual patients involved.

> "the GPs are like it as well, I think they are, I, I don't think they are totally blameless because I think they, as well, can manipulate the system because if they can't get an appointment sooner they'll say 'ah well, I'll ring the Reg and see if they can get her into er, gynae Emergency'" (Frontline, nursing, 007)

In other examples, manipulation was used to achieve improvements in QOC on a more systematic basis. An example of this was evident in one hospital where the development of clinical guidelines was devolved to frontline health care professionals. One frontline manager (034) described how they had deliberately included hourly observation of physical health in the guidelines for the management of early miscarriage, despite knowing this to be clinically unnecessary. This was explained to offer the interviewee an opportunity to secure some regular, dedicated time for frontline workers to spend with patients.

> “they don’t need it and they’re never, very rarely shocked, and you’d do it if they were poorly wouldn’t you? You’d go in and you’d do the vital signs and everything, it’s not necessary. But we can do it, to keep the level of care up which is.. giving them the time yeah, yeah, and somebody, no matter who, will always go in and do them obs all day, and then people dip in in the meantime, which is nice, but at least then they get better care than if they were just, if you didn’t do their obs, some days, it’s so mad, you’d be thinking ‘crikey I haven’t been in’, wouldn’t you? You’d think ‘aahh, it’s dinner time and I haven’t been in, I’ve left her’ which would be terrible. So it’s a bit of a crafty way” (Frontline manager, nursing, 034)

In another example, at the same hospital, a guideline for outpatient management of early miscarriage had been developed. The provision of a courtesy phone call to patients, from frontline staff, had been included ostensibly to maintain safety, but also to allow frontline workers to attend to relational aspects of health care.

> “I don’t know really I just thought it would be nice for them to know that we were only a phone call away and that we are, you know, although they’re doing the treatment themselves, that we are ultimately still looking after them em, just to give them a ring and just see they’re okay, make sure they’ve managed to understand the information that they’ve you know, maybes they all want us to ring them, I don’t know” (Frontline, nursing, 044)

Another form of manipulation came from frontline staff that strategically voiced their concerns to individuals or groups external to their own groups, whom they believed would (a) share their concerns and (b) have power that could be exerted upon the organisation. The group most obviously targeted by this activity were patients. In one hospital frontline workers involved a patient advocacy group.

> “it was also something that we raised our concerns at our er .. maternity liaison meeting where we have our lay representatives too and we made it clear that we had concerns with that” (Frontline manager, medical, 045)

The most pervasive example of this, however, was evident in all of the participating hospitals; it involved frontline staff encouraging patients to make formal complaints to their organisation. As discussed earlier in this chapter, frontline workers were often presented with informal patient complaints, which they sometimes dealt with at ward level (as described in section 6.1.4); encouraging patients, instead, to convert their informal complaints into formal complaints was suggested to be more productive in terms of securing systematic changes to improve QOC.

> “they do come to us, em, and we diffuse a lot of it and maybe, you know, that’s perhaps how we’ve saved a lot of, em, complaints but, em, maybe, maybe I should encourage them to complain, you know put in a written complaint and say ‘this is the only way it would get done’, I mean it’s not to sort of threaten us, it’s just to sort of try and get something done, you know, it’s like most things, we’ve had these, these kind of issues before where you know you try and change something, but it’s not until a patient complains it actually gets listened to, and it only takes one” (Frontline manager, nursing, 059)

> “I don’t like to tell people to complain for the sake of complaining, but if complaints improve a service then I’m all for it, and sometimes you do need to have a complaint that you could look at the service and look at how we’re mis-managing the service, to try and improve it” (Frontline, nursing, 019)

Encouraging patient complaints was a way for frontline staff to gain support for their own concerns about suboptimal QOC, whilst simultaneously indicating to patients that frontline workers were not responsible for deficiencies thereby potentially diffusing any anger being directed towards frontline workers.

This section has described a number of discretionary activities described in the data set that could be conceptualised as mechanisms of quality management. These activities were delivered at the frontline in ways that aimed to create a systemic improvement in services. These activities sometimes involved the use of the formal organisational mechanisms designed to help frontline workers report concerns or suggest changes, however they also sometimes involved more subtle or hidden forms of action. These activities required frontline workers to understand features of the systems in which they operated and recognising opportunities for informal and formal frontline activities. Taken alongside the non-disruptive activities described in the previous section, these activities appear to contradict the notion of frontline powerlessness described in the previous chapter and, instead, suggest some level of power instigated at a local level.

6.3 Shared Understandings and In-House Policies

Section 5.2 outlined the development of communities of understanding wherein cohesive views about the nature of high QOC developed, alongside the extent to which it can be compromised. Further analysis suggests that where these groups involved individuals who worked together, shared views were often translated into ward or department level informal policies; they were informal in so far as they were not written into formal policy, but they were nonetheless powerful in so far as they were widely understood and policed by the group members. There was evidence in the data that the non-disruptive and disruptive activities described in the previous sections were often guided by shared understandings about how things should be done; in this respect they did not necessarily represent a form of agency on the part of frontline workers, but rather another layer of "policy" (albeit informal policy) guiding their choices about when and how to act.

A number of informal policies were evident in the data and they generally mapped to the attributes of high quality care outlined in Chapter 4. This suggests that, whilst frontline staff may appear to compromise on their aspirations regarding QOC, they may actually be using informal communities of understanding to try to achieve them instead. Here, examples of informal policies aimed at improving continuity, caring and timely information provision are shown.

> "what we try to do is if you've done the assessment, and you're on duty, then you look after them and that is the best way, erm, so then hopefully you're gonna be there for most of the day and you're gonna get them, you know, through it" (Frontline, nursing, 063)

> "I mean it's not a, a written sort of thing but it's generally assumed that I will communicate the results of the scan em, straight away, you know, as far as I can, .. can go with that" (Frontline, nursing, 012)

Shared informal policies also functioned to guide relationships between staff; either in terms of supporting each other, or in terms of setting boundaries around when assistance should/should not be offered to colleagues. Either way, the informal policies operated to attempt to secure staff the support and resource they needed to be able to deliver improved QOC.

> "I'm still not really meant to do the bloods, not now, I mean I can do them, but it's sort of the sister on the ward saying 'it's the doctor's job now', the doctors will come up and do the bloods and then I'd track them, so that's, sort of, been taken off us, which is a shame but then again, when it is really busy I haven't got, you know, as much time as I would like to do it, I just don't have the time, I just think what's our job?" (Frontline, nursing, 036)

Difficulties associated with informal policies were evident when their absolute legitimacy was questioned or even dismissed. This was apparent in the case of a ward merger at hospital D where two distinct sets of, in some respects conflicting, informal policies were suddenly operating within one ward simultaneously, with each group of staff involved claiming that their policies were the most appropriate. As informal policies operate within the confines of the frontline, with little to no involvement of senior management, they were also vulnerable; their existence, and their contribution to improved QOC, was unrecognised. This meant that organisational change could unknowingly compromise or obliterate them. When frontline staff made the hidden aspects of their work explicit to hierarchical superiors, agreement about the contribution this made to improved QOC was not always reached, not least because frontline workers had limited evidence of impact beyond their own beliefs or sphere of practice based anecdotal experience.

> "I think Ward <X> maybe got to the point where it was .. doing things that it probably shouldn't have done, but all of the things that they did do, because they didn't go the right way about doing it, I don't mean to say that they were doing anything illegal, but they were doing things for the good of the patient which then had a, you know, a detrimental effect, they didn't, they didn't promote actually what they were actually doing on the ward in a, in a good way that that made them [the managers] say, 'right well now that we realise what you're doing, we'll take your surgical beds over there, but we will provide you with a small little department which can be ran by <experienced> staff, for <miscarriage> patients, but as an out-patient, er, facility'. They just didn't cotton on to that and provide that somewhere else" (Frontline manager, nursing, 021)

6.4 Discharging Discretion

6.4.1 Choosing to Act

The previous sections have outlined a variety of informal and formal actions that frontline interviewees described using in their work, in ways that impact on the quality of the services they deliver. The presence of these activities challenges the idea that frontline workers are passive in the presence of care that they consider to be suboptimal.

For example, when presented with an informal patient complaint the response chosen could be to do nothing, however this would not assist with the immediate problem of an angry or distressed patient who may disrupt the workload of staff members. Instead staff can choose from any combination of placating and apologising to the patient, convincing the patient that their claim is unreasonable, encouraging the patient to make a formal complaint, modify personal practice to prevent recurrence of the issue which led to the complaint, or attempt to alter practice at a ward level by sharing concerns to peers or to organisational superiors.

Which of these options is chosen might depend on a number of factors including how legitimate the staff member considers the complaint to be, how easy or effective it would be to placate the patient, how easy or effective it would be to make a systematic change or to gain organisational approval for it, whether the staff member feels any accountability for the issue which led to the complaint (either personal feelings of responsibility or the perception that they would be blamed), how the staff member feels about the scope of their role, what peers generally do in this situation, and what other demands are being made on staff time when the complaint is made. Some frontline interviewees also described using a portfolio of activities, such that failure to secure formal support from organisational superiors could lead to frontline staff pursuing informal activities to obtain a similar outcome. Conversely, frustration about the failure of informal actions to secure systematic change led some frontline interviewees to seek more formal support.

Not all actions are available to all frontline staff members; some require (a) knowledge of the organisation and the way it operates (e.g. using formal patient complaints as a way to support pre-existing staff concerns requires an understanding of the organisational sequelae that follows such a complaint), (b) the ability to negotiate an informal agreement with colleagues (e.g. a nurse may find it harder to negotiate changes that require medical staff to agree), or (c) a role that offers a degree of organisational responsibility (e.g. not all frontline workers are involved in the development of clinical guidelines).

> "it's [protocol development] to some extent consultant led or any, any trainee who is interested in making a change, who notices that he has these other situations that keep occurring as a problem. So they will bring it up to us in a risk meeting, or just as an individual, but these are senior trainees who will bring up these issues and then we start the thing off for changing the protocol, or making a new protocol if it's required" (Frontline Manager, 030)

It is important to recognise that frontline workers are not contractually obliged to engage in any of these activities, so in this respect they are discretionary and not subject to formal organisational control; although where they evolve as a consequence of group understandings about appropriate practice they may be subject to informal control by peers. Additionally, where actions are not systematic they are enacted on a patient-by-patient basis. This means they might not be operationalized by all staff, and those who do engage in them might not have the capacity or inclination to do so every time they come across an issue; for example, those who discussed encouraging formal patient complaints did not do so with every woman they encountered who expressed dissatisfaction.

This has the potential to lead to the systematic biases described by Lipsky (2010) but it also presents the potential for frontline staff to push their own agenda, or that of the organisation (e.g. where organisational notions of acceptable care are used to make judgements about the reasonableness of patient complaints, and therefore which should be escalated to a formal complaint and which should be dealt with at 'street level').

6.4.2 Enabling and Managing Frontline Discretion

As described in Chapter 3, discretionary actions amongst frontline workers might be viewed by their organisational superiors in two contrasting ways; it can be seen as a mechanism that allows frontline workers to interrupt or distort the implementation of organisational policies, or it can be seen as a mechanism for frontline staff to deliver on policies to the best of their abilities within challenging, or even impossible, circumstances.

Theories regarding the informal activities of frontline workers frequently situate frontline and managerial level workers as two discrete entities, with differing motivations and priorities. In this view managers seek to control frontline discretion in order to minimise the extent to which top-level policies are reinterpreted, which can result in outcomes different from those intended. This view has been criticised by some who suggest that it simplifies what may be a very complex relationship within which managers may be aware of, and perceive value in, the discretionary actions of frontline staff. They may therefore encourage and facilitate it, either formally (through the development policies that are vague and offer freedom of interpretation) or informally (by tacitly agreeing to overlook discrete activities) (Evans, 2011).

Chapter 5 gave some consideration to how power is distributed within organisations in terms of defining the parameters of acceptable QOC. In some respects discretionary activity can be then considered to be, in part, controlled by managers via the formal organisational policies and rules they enforce, and by the negotiations (and non-negotiations) they enter into that result in frontline workers accepting some amount of reduced QOC as inevitable and therefore not requiring action.

There were some examples of frontline discretionary activities that were described to be frustrating and/or incomprehensible to managers. Most notably, a range of activities was employed in one hospital in response to service changes that were unwelcomed by many frontline staff. These activities were unexpected and challenged the smooth implementation of a policy change initiated at the top of the organisational hierarchy; they were viewed as manipulative and subversive.

> “013 there was a degree of sedition as well, because there was lots of people deliberately trying to undermine the process to try and make sure it didn’t happen, but that’s the nature of organisations, em.
>
> I Yeah, how did they do that, what were they doing?
>
> 013 Oh by, em.. soliciting complaints, em, winding up the senior medical staff and such like.. and not fully co-operating with the proposal or the scheme we’d put together to try and make sure there was always a senior presence of the right skilled staff, and preparing the other teams for it as well, so
>
> I So why do you think that happened? Because, on the face of it, you prepared it quite well, you put senior staff in to, kind of, train the <new> staff?
>
> 013 Em,.. I don’t know, it was just human behaviour, which I hadn’t expected” (Manager, 013)

In this particular example, alongside these disruptive activities, the frontline staff involved also described a number of non-disruptive activities that they had engaged in in order to protect patients from lowered QOC; these activities were acknowledged, and welcomed, by managers as facilitating the implementation process. There were other examples in all of the participating hospitals where frontline discretionary activities were acknowledged as contributing towards improved QOC, especially where they related to meeting needs that were not explicitly resourced or controlled by the organisation (e.g. relating to relational aspects of practice). Some interviewees suggested that such informal activities had come to be expected of frontline workers; in some instances, especially where formal and disruptive activities were used, this was presented as a challenge whereby accountability for maintaining good QOC was avoided by managers and directed towards frontline staff.

> “the staff said at the outset that they thought it would be a lesser service somehow and my challenge to them was .. you know, ‘it’s your responsibility, make sure it isn’t a lesser service’” (Manager, 013)

The positive benefits of frontline staff pushing their own agendas regarding quality over organisationally driven agendas was also described by one senior manager (043); they suggested that competitive aspects of the NHS encouraged silo mentalities that created barriers to the type of inter-organisation knowledge sharing between professionals working in different organisations that can facilitate informal quality improvement activities. It was suggested that this could be countered by frontline workers and managers independently developing networks that allow the development of shared understandings about quality management across and between organisations and hierarchies.

> “the people that run organisations such as this are very well motivated, and don’t want to <destabilise other organisations>, they want to offer the best possible care, and the other thing is, erm, that I think could counter it is groups of clinicians getting together to say ‘well, look, how can we co-operate to improve care’ erm, but I suspect that they’re gonna have to take that on themselves rather than being pushed into doing so” (Manager, 043)

Most managers suggested that they valued the ideas and knowledge of frontline workers, and there were several instances where managerial level staff described ways in which they had acted to support frontline staff in their discretionary activities (as in this instance where a nursing manager assists frontline nurses to enforce ideals regarding sensitive practice upon new medical staff). This was particularly in evidence when frontline workers were engaging in non-disruptive activities.

> “when we changed doctors .. yeah, we know quickly, probably without even talking about it, work out who’s really empathetic and who’s not and, yeah, you might, sometimes, if you’ve got somebody who perhaps isn’t as empathetic as you think. It is appropriate, I don’t have a problem of taking them to one side and just saying ‘you know, do you want any help, do you want any support’ or, perhaps ‘I didn’t appreciate the way you spoke to that patient’, ‘I’ve been told this or that’. I wouldn’t just leave it” (Manager, 008)

In addition, examples were provided where managers had supported their staff by using their superior knowledge of formal organisational policy, and of the informal understandings and motivations of external and internal groups and individuals, in order to identity useful organisational levers. This allowed the views of frontline workers to be addressed by linking them to other organisational needs.

> “it [The Essence of Care[26]] was a good tool to be able to go to the Estate Department and say ‘right, privacy and dignity is a really big standard here, these are the things I want you to support me with’ <…> the fact that you could actually back it up with real, sort of, elements of care that were going to support patients, that’s what helped us to get that” (Manager 008)

Drawing parallels to the frontline activities outlined in the previous sections, this can be viewed as a form of non-disruptive discretionary activity on the part of managerial staff since it is not obligatory, and it allows systematic improvement without disrupting organisational systems. It also allows managers to gain approval from both organisational superiors and subordinates. Other forms of non-disruptive managerial activities were in evidence, for example, in the treatment of informal patient complaints.

> “if it’s an informal one [complaint] we just try and sort it out immediately and do it face to face, and you know, there have been occasions where, you know, I’ve got a phone call from the reception desk in the main hospital to say there’s someone here who wants to make a complaint and, it doesn’t always come to me but, em, if that happened I would go up and just try and sort it out there and then. If we get a formal complaint there is a procedure we have to follow” (Manager, 013)

---

[26] The Essence of Care is a Department of Health publication designed for use by NHS organisations. It sets out twelve benchmarks for best practice and care.

> “if there was an edict from above it would have to happen, we’d have to wait and see how we would make it work, but they’ve been asking for about the last five years for us to take ectopics and we haven’t done it and we’re not, we don’t talk about it, we don’t mention it” (Manager, 052)

The motivation to engage in discretionary activities also had some parallels to those relating to frontline interviewees. They can be considered to represent a negotiation because they involve some degree of trading; discretionary activities are offered, by both frontline and managerial staff, in return for a perceived, or a measurable, benefit. The benefit might be organisational (e.g. improved experience for patients and/or staff, improved efficiencies) or personal (e.g. it may make the individual look better or provide increased job satisfaction), or it could be both.

> “I ask the ward managers, I feel they really have the power and they’re the ones that work clinically with the staff, and they’re the ones obviously, through <staff development reviews>, <…>, we do it that way really, and listen to them, and obviously support them in their ideas if we can. Well, if they’re off the wall, absolutely no, if it’s just for their own benefit <…> you can see it being ‘well, what are you going to do for me’ type of thing ‘what are we going to get out of it if I’m going to support you in some training?’ they need to be able to say ‘it will affect this, it will do this, it will bring something back’” (Manager, 052)

As described at the beginning of this section, not all discretionary activities by frontline staff were welcomed by managers, particularly where they involved disruption to the smooth running of services. In some instances managers conceded that they had limited ability to stop or control these behaviours and so modified services to allow the issue instigating the discretionary activity to be addressed in a way that was more manageable and controlled.

> “GPs are very much aware of the criteria for referring in, so they will exaggerate a clinical condition to get you to see somebody urgently, and sometimes it really can be a dating scan, and they know that if they say the patient’s got pain and bleeding, you know, that they exaggerate that potential bleeding, we will see them quickly. But some people will then come and the pregnancy is absolutely fine and they’ll say ‘well, I was just a bit worried, I wanted an early scan to confirm’, I mean we are looking at, em, having this one clinical session at least for dating scans, em, I mean , you know .. what we do at that, likely, would be something like antenatal clinic do now where we’ll offer that, so they can refer for that” (Manager, 008)

In this dataset, interviewees did make clear distinctions between frontline and managerial staff in terms of the shared understandings of each group; as outlined in previous chapters these positioned frontline workers as more concerned with the individual, and ‘relational’, needs of patients. However, boundaries between these two groups were also blurred in some instances, since some workers (frontline managers) occupied roles that involved membership of both groups, and even those in purely managerial roles drew upon the background and experience of frontline health care they had all previously had. In addition, there were understandings that were shared across the two groups; i.e. that QOC was important, that patients appreciate feeling cared for as an individual, that resources are limited, that both frontline and managerial groups are subject to forces beyond their control, and that the physical safety of patients represents a bottom line standard for quality that cannot be transgressed. In this sense frontline and managerial groups could be viewed as a ‘super-group’, who might operate together to negotiate the external forces that impinge on both groups.

> “you can but listen, you can then but go back and say ‘well this is what we would do’, and I have, I have a sneaky feeling what they [the patients] would say is exactly what we would love to give them, which is more nursing time in a, in a, in their own place, em, and we can but ask up the ladder towards the Trust board” (Manager, 027)

6.5 Chapter Summary

This chapter has described an emerging theme that relates to the activities frontline workers engage in in order to manage issues of quality shortfalls in their services. These activities have been categorised as disruptive and non-disruptive, depending on whether they are predominately aimed at managing QOC shortfalls relating to individual patients, or patient groups as a whole. An important feature of these activities is their discretionary nature and this has a number of implications; it means that they are administered inconsistently and opportunities for sharing good practice are also discretionary. Nonetheless the data suggest that some of these activities develop into informal policies; i.e. understandings that come to be shared between frontline worker groups about how things “are” or “should be”. There was also a suggestion that managerial level staff were aware of the existence of these local informal policies (although not always the content of those policies) and, in fact, welcomed their functionality in terms of maintaining QOC (or at least contributing towards improved QOC). In this respect managers engaged in discretionary activities of their own, by supporting or choosing to overlook the activities of frontline workers. In some instances this could be thought to represent a way for managers to work collaboratively with frontline workers to promote QOC improvements that they might personally approve of, but have limited organisational power or resource to support formally.

Chapter 7 Discussion

The previous three chapters outlined the main themes observed in the data relating to the issues facing frontline and managerial staff in their management of QOC for women experiencing an early miscarriage. The overarching narrative is one of struggle to adequately deliver on aspects of care that respond to the needs of women experiencing this reproductive event, in ways that (a) are humane and acknowledge the importance of intangible, emotion-led aspects of health care, and (b) centre care around the very variable responses women are described to have. Interviewees described a shared understanding that compromise is a pervasive and inevitable feature of NHS work. Finally, a number of activities enacted by frontline workers have been described and the ways in which they might influence QOC explored.

The data analysis in this study is informed by a social constructionist approach, aiming to explore the agency frontline workers might have to influence QOC according to their own perceptions of a quality service for women experiencing early miscarriage. This involves considering how the agency of frontline NHS workers might be defined and controlled by structures external to them (the position adopted in much of the policy and literature on the issue of frontline engagement in health care quality improvement), but also how the actions and inactions of frontline workers contribute to the construction and perpetuation of those structures. It considers the hospital as an ever-shifting construct of the interactions and negotiations that occur between individuals, and groups of individuals, internal and external to the organisation. Micro organisational theories of street level bureaucracy and negotiated order (described in Chapter 3) are used as a basis to explore how frontline (or “street level”) workers exert influence over QOC, consciously and unconsciously, via their shared understandings and collective strategies.

This chapter draws on the findings to explore in more detail the idea that the shared understandings, and resultant actions, of frontline NHS staff, represent a professional and organisational solution to the problem of delivering aspects of health care that are widely accepted as being legitimate and important (those that address emotional needs and accommodate personal needs and preferences) but that are not easily accommodated within a health care system that relies heavily on rationalised ways of understanding quality and effectiveness. I argue that the unseen activities frontline workers engage in to supplement structural deficiencies offer a way for workers to address QOC shortfalls, leading to immediate positive impacts on the experiences of the individual women they deliver care to. It will, however, also be argued that, paradoxically, these activities might also contribute to the very structural conditions within which suboptimal QOC for this patient group is perpetuated.

7.1 Quality Services for Women Experiencing Early Miscarriage

The idea that health care services should be of high quality appears undisputed in the literature (Dixon-Woods *et al.*, 2014). Reference to high quality care in the NHS pervades policies, strategies and national guidelines, and it is integral to its constitution (Department of Health, 2015). What exactly high QOC means generally, and in particular service contexts, is ill defined, although a variety of different perspectives have been advanced (e.g. the evidence based care movement or metrics based evaluations). Interviewees in this study were similarly unanimous in their view that high QOC was important, however not homogenous in their views about the specific nature of high QOC for women experiencing an early miscarriage; Chapter 4 demonstrates, however, that their views coalesced around three aspects of care being particularly important:

- Delivering on humane aspects of health care (e.g. those that involve emotional caring, compassion, sensitivity, benevolence)
- Flexible health care that is responsive to the individual and variable responses early miscarriage provokes in women
- Health care that is safe and protects the physical health of patients.

An amalgam of these views as representing a high quality service could be considered to be the "*single ambiguous goal*" that provides the "*symbolic cement*" that binds the negotiations that occur within organisations and that ultimately results in care as delivered (Strauss *et al.*, 1973).

7.1.1 Patient Centred and Humane Care

The areas identified as important in terms of QOC by interviewees in this study are not controversial; in fact they mirror contemporary concerns about NHS services more generally. Interest in the delivery of humane care, incorporating values such as compassion and kindness, has become heightened since the exposure of practices considered to be inhumane in a number of organisations (e.g. at Mid Staffordshire (Francis, 2013) and Winterbourne (Flynn, 2012)). These practices were widely condemned and the complicity of health care professionals in these practices has been described as being particularly troubling and difficult to comprehend (Newdick and Danbury, 2013). Public dismay about these QOC failures implies that the importance of humane components of care is widely accepted, and this is further confirmed in the literature (e.g. (Wensing *et al.*, 1998; Rogers *et al.*, 2000; Sword *et al.*, 2012)).

Similarly, the idea of acknowledging patients as individuals with differing needs and expectations has been widely promoted via the patient or person centred care (PCC) movement (Kitson *et al.*, 2013). PCC is a widely acknowledged model of health care delivery that is frequently referenced in policy documents both nationally and internationally (McCormack *et al.*, 2015; The Health Policy Partnership, 2015). That PCC and humane aspects of health care are important features of a high quality health care service generally is supported by professional strategies for health care professionals (Royal College of Obstetricians and Gynaecologists, 2011; Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012) and national guidelines (National Institute for Health and Care Excellence, 2012b). There have also been high level attempts to restate the importance of humane values in health care, such as the publications of "*Compassion in Practice*", the English National Nursing Vision and Strategy that outlines the importance of six C's (care, compassion, competence, communication, courage and commitment) (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012).

The importance of PCC aspects of care for pregnant women specifically was outlined over two decades ago when the "*Changing Childbirth*" report was published calling for "*choice, continuity and control*" in maternity care (Department of Health, 1993). This has been repeated in subsequent guidance on maternity care that has also highlighted the need for safe and personalised care for pregnant women (Department of Health/Partnerships for Children and Families and Maternity, 2007; The National Maternity Review, 2016). A body of evidence is accumulating that suggests that patients appreciate and benefit from humane and supportive PCC approaches to care delivery in a number of contexts (Wensing *et al.*, 1998; Rogers *et al.*, 2000; O'Donovan, 2007; McCormack *et al.*, 2015; Ross *et al.*, 2015). The evidence base regarding PCC has been described to be relatively new and undeveloped, with the measurement of PCC processes and outcomes only just beginning to be examined (McCormack *et al.*, 2015), and the best ways to support the delivery of PCC poorly understood (O'Donovan, 2007; Deery *et al.*, 2010; Rozenblum *et al.*, 2013). In terms of pregnancy loss, the importance patients place on PCC and humane care is supported by published research (Simmons *et al.*, 2006; Graham *et al.*, 2012; Lisy *et al.*, 2016) however these are also the aspects of care most frequently described to fall short of patient expectations (Moulder, 1998; Simmons *et al.*, 2006; Van Den Berg *et al.*, 2015). As with the wider PCC literature, much of this work is qualitative in nature and provides little measurable evidence as to the specific impact of the presence or absence of caring or PCC practices, or the economic and organisational outgoings required to deliver these aspects of care. Claims that such aspects of care are integral to a high quality service for women experiencing early miscarriage thus have more philosophical, as compared to tangible, support.

A key challenge common to the provision of humane and PCC elements of health care is the complex and intangible nature of values like compassion, and the difficulty in knowing when care has genuinely acknowledged a patient's individual needs (Gillespie *et al.*, 2004). This makes defining, supporting, measuring, and controlling the delivery of humane and PCC very difficult (Tower *et al.*, 2011; Rozenblum *et al.*, 2013; Crawford *et al.*, 2014) although some work towards developing frameworks that identify core elements of PCC has been undertaken (Gerteis, 2002; McCormack and McCance, 2010; Kitson *et al.*, 2013). This lack of evidence base weakens the position of frontline workers in trying to secure resource to deliver on these aspects of care since they are unable to define the nature of "ideal" humane or PCC practices (or, at least, their definitions can be readily challenged) or the amount of resource required to deliver on them, or to provide a rational argument as to the impacts those resources would have on measurable patient outcomes (McCormack *et al.*, 2015; Deery and Fisher, 2016).

7.1.2 Structure or Agency? Explaining Gaps in Care Quality

That PCC and humane care are widely appreciated by patients, frontline workers, managers, and policymakers appears to be undisputed, however this makes persistent deficiencies in these aspects of care for women experiencing early miscarriage all the more difficult to comprehend. From an organisational perspective, and considering ways in which PCC and humane aspects of care are dealt with in the NHS at a macro level, two potential explanations might be inferred.

The first is that suboptimal QOC could be rooted in deficiencies in the values and knowledge of frontline workers; either in terms of their ignorance of their patients' needs and expectations, a failure to appreciate the value of PCC/humane aspects of care, or an emotional detachment resulting from long term exposure to difficult or distressing situations (Hochschild, 2012). This explanation implies that frontline NHS staff have agency to deliver PCC/humane aspect of care, and that they will do so as long as they understand their patients' needs and are personally committed to values such as compassion and the respect of patients as individuals. This is the position evident in efforts to promote PCC and humanistic aspects of health care within the NHS by targeting individuals coming into employment (e.g. Values Based Recruitment strategies (VBR) (Crawford *et al.*, 2014; Miller, 2015)). It is also the basis of strategies designed to monitor frontline practices and remind individual frontline workers of their obligations towards humane practices via education, monitoring and reflective practices; examples include the implementation of Schwartz rounds (Pepper *et al.*, 2012), changes to the ways in which nurses and midwives validate their practice (The Nursing and Midwifery Council, 2015), and explicit statements in professional mission statements and codes (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012; The General Medical Council, 2013; Nursing & Midwifery Council, 2015).

An alternative explanation is that frontline agency is significantly limited by societal and organisational structures; in which case failure to deliver on PCC and humane aspects of care is more of a reflection on these structures than on the workers. This view is supported by the observation that dysfunctional organisational cultures were heavily implicated in the development of inhumane practices at Mid Staffordshire hospitals (Francis, 2010; Francis, 2013). The challenges organisational designs can pose to the delivery of holistic and humane care practices have also been described in clinical and policy literature (McCormack *et al.*, 2010; Crawford *et al.*, 2014; Dixon-Woods *et al.*, 2014; Allan *et al.*, 2015; Ross *et al.*, 2015).

In this study poor frontline worker knowledge was not a plausible explanation since interviewees' descriptions of ideal practices for early miscarriage services mirror those identified in published research. Neither was there any evidence of interviewees rejecting the importance of PCC or humane care practices. Frontline workers drew heavily upon the concept of structure over agency when discussing QOC deficiencies, with frequent reference to bureaucratic and hierarchical constraints that prevented them from driving forward their own visions of QOC (the exception to this was at hospital B where one group of frontline workers indicated that some of their peers *chose* not to become knowledgeable about early miscarriage).

A key complaint from frontline workers related to inflexibilities at a system level that prevented care from being truly centred around patients, alongside a lack of acknowledgement that the relationship building activities required to deliver on some aspects of humane care require time and structural support (e.g. organisational models that promote continuity of carer and allow staff to manage their time in ways that allow for "caring" to sometimes be prioritised (Walsh, 2006)). As outlined in chapter one this view is supported by theories of bureaucracy that favour rationality, formal guidelines and algorithms, and do not easily accommodate the type of flexible working that might be required to deliver PCC and engage in humane care practices. Quality management and improvement activities, in particular, have been described to often rely upon rationalised mechanisms that simplify the concept of quality in ways that may not accommodate complex and ill-defined concepts such as compassion (Dixon-Woods *et al.*, 2014).

In short, the concepts of PCC and humane care do not seem to sit easily in formal organisational structures because of their variable and ill-defined nature, and the difficulties associated with demonstrating their impact. This leads to a situation whereby what is asked of frontline workers, in terms of delivering on the notion of QOC as incorporating safety *and* caring, is not adequately supported (in their own view) by the resources they are offered (Hupe and Buffat, 2014). A superficial analysis might therefore conclude that QOC gaps result from rationalised models that suppress the agency of frontline workers to choose to prioritise their time in favour of these activities, as opposed to the many other organisational demands upon their time.

This is an argument that draws upon concepts of bureaucracy and its ability to suppress individual agency (Morrison, 2006) however, it has been argued elsewhere that bureaucratic models can be used as a way for individuals to reject responsibility for their involvement in circumstances that they find personally objectionable (Cohen, 2001). Micro-organisational models also suggest that health care professionals are unlikely to be completely powerless due to their professional status (Strauss *et al.*, 1973; Freidson, 1988) and the discretion that arises from the intimate nature of the relationship they have with patients (Lipsky, 2010). Understanding the interplay between frontline workers, and the structures within which they operate, therefore offers a useful way to delve deeper into understanding the issues that contribute to the on-going QOC gap for women experiencing early miscarriage.

7.1.3 Implications for Early Miscarriage Health Care

The case been made that, in this study, frontline workers' main concerns in terms of QOC gaps revolved mainly around softer and less tangible aspects of care. It has been argued that incorporating these into rational organisational models may pose particular challenges. Strauss et al (1973) proposed a theory of negotiated order that suggested "*care as delivered*" is a product of constant negotiations between health care workers. Before considering the interactions that occur between frontline staff, it is important to consider the context within which those interactions take place and the potential structural constraints they might engender. Viewing QOC for women experiencing early miscarriage from the perspective of organisational negotiation poses questions about how much leverage frontline workers have when negotiating formal organisational support and resource for PCC and humane care practices; could persistent QOC gaps in early miscarriage services be a product of failure to negotiate successfully? In this study, a number of issues were identified that suggested that frontline workers might be particularly compromised when negotiating about early miscarriage services.

The first issue relates to the nature of early miscarriage as a health care context. It was described by interviewees as (a) high need in relation to intangible aspects of care like PCC and humane activities, and (b) low need in relation to tangible aspects of care due to the low physical threat posed by early miscarriage and the inability to prevent the pregnancy from being lost. Furthermore, and as was the case in the hospitals participating in this study, early miscarriage services are often situated in acute care environments (i.e. intrapartum care, general surgery, and general gynaecology). Such situations offer health care workers limited scope to privilege time and resource towards patients with non-acute needs (Wolf *et al.*, 2012; Ross *et al.*, 2015). It also limits opportunities to prioritise to relational, as opposed to task-based, activities (Wolf *et al.*, 2012; Cockerham, 2015).

Secondly, services for women experiencing early miscarriage are now largely managed and delivered by nurses and midwives. As with this study, medical staff generally operate as support workers on a woman's care journey, rather than taking centre stage. Similarly, expertise in the domain of the "caring" activities associated with humane and PCC care practices has traditionally been seen to reside within the nursing and midwifery professions (Abbott and Meerabeau, 1998; Reiger and Lane, 2013; McAllister *et al.*, 2014; Goodman, 2016). This study supported the continued existence of that assumption; both medical and managerial interviewees asserted that PCC and humane care were an important component of the care offered to women experiencing any form of early pregnancy loss but ascribed expertise, and responsibility, for the delivery of these aspects of care to their nursing and midwifery colleagues. Nurses and midwives have historically not been as organisationally powerful as medical staff, putting nurse/midwife led services at a potential disadvantage in negotiations. Power is further depleted if accountability for managing PCC and humane aspects of care is rejected by the managers and/or colleagues that frontline staff need to negotiate with (Gillespie *et al.*, 2004).

Thirdly, there was limited evidence of opportunities for frontline workers to draw upon extra-organisational sources to bolster their position in negotiations. As discussed already, NHS policy and professional standards are supportive of PCC and humane health care, but vague about their specific nature, leaving so much scope for interpretation as to make their role in supporting frontline workers limited. Public involvement (e.g. via patient advocacy groups or reports in local/national media) was described by managerial level interviewees to provide powerful leverage in discussions about resource allocation but, aside from one hospital where frontline staff had engaged with their Maternity Services Liaison Committee to gain support, there was little evidence of patient views entering into negotiations aside from those that were flagged to managers via formal complaints mechanisms (so only negative aspects of care being highlighted). Miscarriage has been reported to be a health event surrounded by social, emotional and political awkwardness (Moulder, 1998; Layne, 2003), making opportunities for public and patient engagement particularly difficult in this health care context.

Finally, health care commissioners were described as having significant power to dictate the terms of services delivered by health care providers, however the interviews suggested that frontline workers do not routinely interact with commissioners or even have much awareness of their potential influence (only managers and some of the medical frontline managers discussed commissioning during interviews). Additionally, issues of intangibility and the difficulties associated with meaningfully measuring performance on PCC/humane aspects of care would continue to pose significant barriers to frontline staff gaining leverage from this externally powerful agent.

In summary, all of the interviewees in this study acknowledged the need for early miscarriage care to offer individualised care that attends to emotional, as well as physical, needs. However they also suggested that the ways in which service delivery is structured in individual hospitals posed significant challenges to meeting these needs. In particular, early miscarriage care is continually disadvantaged in situations where it has to compete for resource use with other types of health care. The intangible nature of both PCC and humane aspects of care weaken the position of anyone seeking to promote, and compete for resource for, these aspects of care in a healthcare system reliant on rational measurement of processes and outcomes. Early miscarriage has a number of features that make it particularly challenging for frontline workers to maximise their influence in organisational negotiations.

7.2 Negotiating Aspirational, Acceptable, or Abominable Care

7.2.1 Compromise as Inevitable

A theme running throughout the interviews in this study related to the inevitability of compromise in relation to QOC. None of the interviewees suggested that it would be appropriate for services delivered to women experiencing early pregnancy loss to be inhumane or depersonalised, however neither was there evidence that interviewees considered it practical for care to be completely flexible to individual patient needs or that unlimited time could be devoted to meeting patients' emotional needs. Health care workers of all levels were therefore involved in the translation of the relatively abstract notions of PCC and humane care, into practicable solutions in the face of limited, and often reducing, resources.

Most of the interviewees explained that the need to compromise was a product of systemic factors over which they had limited, if any, control. Many interviewees, for example, discussed issues of cost containment and the need to curb public spending. Compromise is thus positioned as a passive action; a tacit acquiescence of circumstances, rather than an explicit decision that PCC and humane care practices are less worthy of resource allocation than other aspects of care, or that there are limits as to how much care can be personalised. Several interviewees explained, for example, that it was preferable to nurse women experiencing early miscarriage in a single bedded room, however this belief could only be enacted when the organisation provided sufficient numbers of such facilities and where other patients do not present a more credible demand for the use of the room (more credible demands described included women experiencing a later gestation miscarriage or women with a communicable infection). Importantly, these priority rules were a mixture of formal (in the case of communicable infection) and informal (in the case of later gestation losses) understandings. Whilst no interviewee stated that the emotional needs of women experiencing an early pregnancy loss are less important or less deserving of privacy, it could be argued that from a patient's point of view the deviation from a *"first come, first served"* policy for room allocation is exactly how it might be experienced, and from a societal point of view, how it might be interpreted.

Viewing this issue of compromise as part of the "*negotiated order*" (Strauss *et al.*, 1973), two different levels of negotiation can be identified. Firstly, in the issue of acceptable levels of compromise regarding QOC, that is the level of care they are prepared to explicitly tolerate in so far as they continue to support it through their on-going work within the organisation.

Secondly, in the ways in which frontline workers agree collectively to act upon, ignore, manipulate or subvert the agreements made in the first level. This will be discussed later in this chapter. Whilst these two levels are presented as distinct concepts in the analysis, they were described in practice as occurring simultaneously, interacting and shifting constantly, and revolving around a single undisputed goal, namely that patients should receive the best QOC that is possible in the circumstances, including care that is safe, patient centred, and humane.

The first level of negotiation represents what Goldman and Foldy (2015) refer to as the *"space before action"* and it occurred both explicitly (as in staff who described interactions between themselves and organisational superiors or impersonal organisational mechanisms) and implicitly (as in staff who collectively and tacitly agree that a certain level of care is tolerable or that collective street level action is desirable). These negotiations are important because they (a) set the scenes within which care is delivered, (b) close or create the QOC gaps frontline staff subsequently have to manage, and (c) define the spaces within which frontline workers can and cannot act (either implicitly or explicitly).

7.2.2 Professional Obligations and Reasonableness

Whilst safety, humane care and PCC models of health care were discussed as being important by interviewees across the disciplines, failing to deliver adequately on the latter two aspects of care was discussed as more of a challenge for those in nursing, midwifery or support worker roles. Several indicated that acting in a caring way was what they were *"*meant to do*",* implying that it formed part of their professional, occupational, or personal identity. This was not observed in the medical interviewees who were more likely to indicate sympathy for their nursing/midwifery counterparts. The expectation that nurses and midwives should be orientated towards "carin*g*" practices has been described both within these professional groups and more generally in society (Abbott and Meerabeau, 1998; Stewart *et al.*, 2012; Kitson *et al.*, 2013; Reiger and Lane, 2013; McAllister *et al.*, 2014).

The data suggested that frontline health care workers were mindful of these professional expectations, but it also suggested the presence of another, sometimes competing, identity; that of the rational and reasonable professional. Several interviewees described their concerns about QOC being countered by suggestions that their aspirations were unrealistic, and failure to recognise the impact of resource limitations and competing priorities was presented as the domain of naïve, narrowly focused individuals who unreasonably disregard the QOC needs of other patients being treated within the organisation.   Being resilient, and being able to maintain service delivery in difficult circumstances, was therefore positioned to be an admirable organisational quality, reflecting the importance placed on resilience in the NHS generally (Hunter and Warren, 2014).

The need to consider organisational needs, and to prioritise rationality over emotionality in health care, have generally been attributes aligned to managerial type roles and identities (Llewellyn, 1998; Gillespie *et al.*, 2004; Stewart *et al.*, 2012; Deery and Fisher, 2016). Stewart *et al.* (2012) proposes that those who move from frontline to managerial roles may have to "*abandon their traditional caring values and adopt those of the economic rationalist system within which they function*" (Stewart *et al.*, 2012; p227), and Llewellyn (1998) suggests the existence of a conceptual boundary between caring aspects of health care and rational aspects of health care management. The idea that rationality might pose a challenge to caring aspects of health care (or vice versa) has been discussed widely in the nursing, midwifery and medical literature (Abbott and Meerabeau, 1998; Kirkham, 1998; Callaghan and Wistow, 2006; Deery, 2008; Deery *et al.*, 2010; Tower *et al.*, 2011; Deery and Fisher, 2016).   Nonetheless, it is suggested that contemporary models of health and social care are pushing these boundaries by creating roles that combine managerial and administrative responsibilities with frontline care delivery duties (as per the "*frontline manager*" in this study) (Llewellyn, 1998; Deery and Fisher, 2016).

This study suggests that frontline professionals are also encouraged to accept organisational identities and incorporate them into their assessments of QOC, an observation also made by authors elsewhere (Llewellyn, 2001; Martin *et al.*, 2004; Bail *et al.*, 2009; Rudge *et al.*, 2011; Spyridonidis and Calnan, 2011; Cheraghi-Sohi and Calnan, 2013; Zhang *et al.*, 2015). The attribute of "being reasonable" was evident as an appropriate organisational identity amongst frontline interviewees of all disciplines, and it functioned to provide external justification of their tolerance of compromise, particularly in relation to intangible aspects of care. Reconciliation of the professional "caring" identity and the organisational "reasonable" identity was managed by maintaining that compromises were regrettable but inevitable due to factors over which frontline workers had no control.

Importantly, this view was shared between groups of frontline workers, thus any individual(s) rejecting these notions would be both criticising and infringing the implicit "street level" understandings of their peers and entering into potential conflict with organisational superiors. This was most evident in hospital B where discrepant views within the frontline nursing community caused discord, and those who rejected compromises relating to PCC and humane aspects of care found themselves arguing with their frontline colleagues as well as their managers. These arguments were not about whether these aspects of care were important, but about the extent to which they could be accommodated.

7.2.3 Negotiating the Parameters of Acceptable Quality

Accepting that compromise on QOC is an inevitable and reasonable (if regrettable) aspect of a publicly funded healthcare system, the parameters of "*reasonable compromise*" (e.g. what is compromised and by how much) need to be defined. Interviewees described negotiating, individually or as a group, to define these parameters and described what might be conceptualised as a "*window of acceptable QOC*"; defined as the space between the lowest level of QOC that staff were willing to tolerate and the highest level of QOC that might reasonably be expected to be provided on a systematic basis within the resources available. In this study the lower level of the window was often defined in terms of safety (i.e. the point where patients become vulnerable to physical threat), whereas the highest level was often defined in terms of the point at which aspirations around PCC and relational models of health care become untenable in light of resource availability (see Figure 7-1).

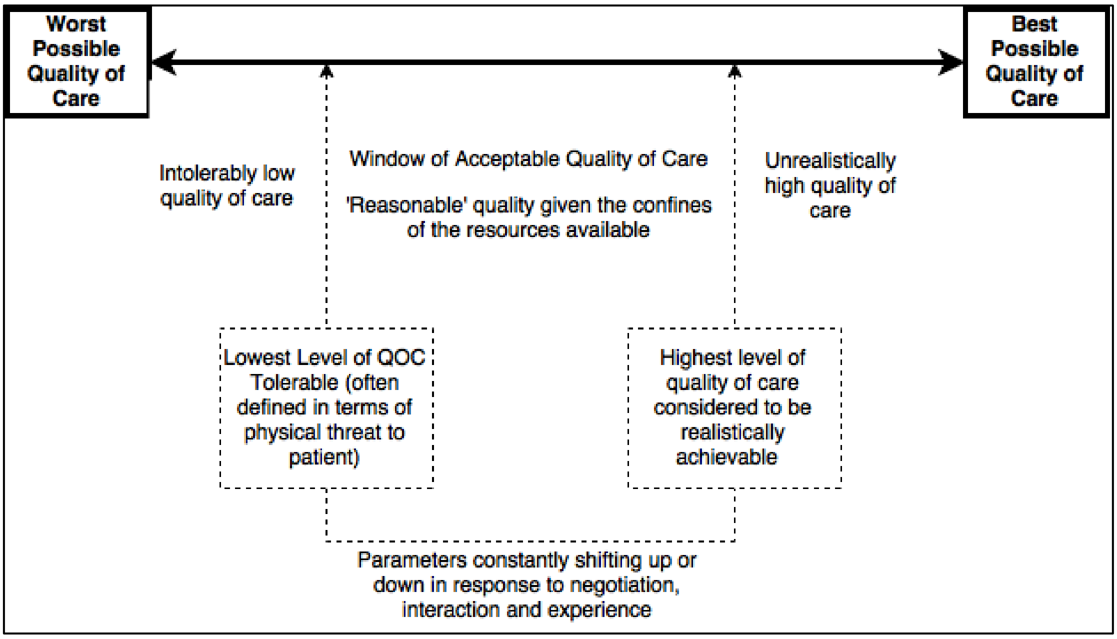


Figure 7-1 Illustration of the Window of Acceptable QOC

Just as in the model of "*negotiated order*" (Strauss *et al.*, 1973), negotiations about the parameters of this window were subjective and constantly open to challenge and change. The parameters varied between different organisations (depending on matters such as organisational ethos, organisational set up of services for women experiencing early miscarriage, level of staff training and support offered, resource availability), and within the same organisation (so on any given day the parameters may shift depending the views of the staff on duty and the extent to which they are willing to negotiate to push their views forward, the workload, and competition from other patients with more time demanding physical care needs.

Interactions, that could be considered to be negotiations, were described between frontline workers with those they viewed to occupy positions of organisational power (i.e. those assumed to be able to allocate resource and impose change; in this study this was generally limited to managers). The power frontline workers exerted in these negotiations was described to be variable; some interviewees described QI initiatives they had proposed and that had been supported by their organisation, and some posited that this largely happened where the proposed change met (or could be depicted to meet) pre-existing organisational priorities and particularly if the initiative was cost saving or cost neutral.

In all instances frontline workers described having no power to insist that managers support their viewpoint (compared to managers who were able impose decisions on frontline workers). Negotiations were therefore often presented as, what Allen (1997) termed "*non-*

negotiated” practice (i.e. a uni-directional power dynamic whereby one party is relatively powerless and reliant on the agreement of the other). Allen (1997) described non-negotiated practice in relation to medical dominance over nursing practitioners, but in this study non-negotiations were generally situated in the frontline worker–manager relationship (medical and nursing/midwifery interviewees described a generally supportive relationship with congruent views and evidence of collaborative working and negotiating). Strauss *et al.*(1973) observed that some staff do not enter into negotiations, and noted that this had the potential to shape the outcome (i.e. care, as delivered and experienced by patients) just as readily as those who were actively engaged. Feelings of powerless and descriptions of inaction therefore do not equate to lack of influence, and the decision to tacitly support suboptimal care (by delivering it on the frontline) forms part of the negotiation.

This suggests that, whether they recognise it or not, NHS workers of all levels are engaged in negotiations about realistic and achievable parameters around the QOC of every day care delivery and, in the case of early miscarriage, specifically around PCC and humane aspects of care. It is, however, important to note that the academic, professional and policy literature does not widely engage in the same debate. Debates about the rationing of health care exist but tend to be focused at a macro or meso scale (e.g. the ethics of equitable resource allocation at national to organisational levels); health care workers are viewed as passive vehicles by which those rationing decisions are implemented (sometimes causing staff distress where they disagree with the decisions or see the human consequence of rationed care (Mitton *et al.*, 2011; Oh and Gastmans, 2015)). Just as observed in this study, ideas of equity, reasonableness and harm prevention pervade the literature on rationing (Ham and Glenn, 2007).

Ham and Robert (2003) claim that health care policymakers have always had to contend with the, often difficult, need to ration care, and suggests that transparency and public accountability have been increasingly involved in contemporary debates about what should and should not be funded (see Table 7-1).

Attribute	Description
Publicity	Decisions must be publicly accessible
Relevance	Rationales for decisions must rest on evidence that fair-minded parties agree are relevant
Appeals	There is a mechanism for challenge and dispute resolution
Enforcement	There is regulation of the process to ensure the first three conditions are met

Table 7-1. Four conditions of accountability for reasonableness (Ham and Robert, 2003; p2)

Even at the macro level of decision making about rationing, personal values, and societal beliefs about deservedness, have been observed to be implicated in decisions about the allocation of “non-essential” treatments and procedures at a national or organisational level (Russell *et al.*, 2014). Legal challenges have also been made in situations where resource limitations have been viewed to reduce QOC below a minimum acceptable threshold with subsequent harm being caused to patients (Beswick, 2007). So, even open and transparent decision making about rationing can be subject to interpretation and challenge.

Compromise over the minutiae of the aspects of care individual patients, or groups of patients, can or should expect to receive are not subject to scrutiny or public debate in this way. Questions such as “how much compassion is enough compassion in the context of finite resource?” are not discussed (Kitson *et al.*, 2013), potentially because policy and public investigations of quality failure present concepts like “compassion” or “sensitivity” as features of health care that do or do not exist. The idea that there may be a limit to the amount of compassion that can be reasonably expected within the NHS is not something that is openly proposed, and yet this study suggests that it is something that NHS workers have to grapple with every day. Lack of open debate leaves such workers with no frame of reference or external support when negotiations involve compromise over these aspects of care. In the absence of clear guidance or debate, interviewees in this study appeared to rely on the shared understandings developed within and between groups, drawing upon concepts such as equity and fairness, to guide them on the limits of reasonable compromise.

A number of different occupationally derived concepts were also described, such as notions of professionalism (e.g. in terms of a need to protect the patient from harm[27] (Sokol, 2013)) and in terms of delivering caring and compassionate services (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012). Health care support workers also drew upon the idea of professionalism and suggested that, in terms of humane aspects of care, all staff felt a duty to uphold professional values regardless of formal professional status. Drawing upon models of evidence based care, research evidence and formal guidelines were also described by some as mechanisms by which they could understand what the parameters of acceptable care might be although, as previously discussed, research and guidelines give only vague guidance in respect of humane and individualised aspects of care (National Institute for Health and Care Excellence, 2012a).

Another way in which frontline workers described benchmarking acceptable parameters of QOC was by making comparisons with the QOC of other services and/or patient groups, and several interviewees alluded to the concept of equity (in so far as women experiencing an early miscarriage should be entitled to QOC as good as that experienced by other patients). Whilst equitable care practices have the potential to provide leverage in negotiations, the interview data demonstrated that issues of equitable care had been used effectively to negotiate reallocation of resource *away* from women experiencing early miscarriage. This indicates that the strategies that frontline workers may draw upon in negotiations may just as easily be used to weaken their position.

7.2.4 Fragmented Intra-Organisational Negotiations

Thus far this discussion has proposed that the frontline NHS workers interviewed engaged (or chose not to engage) in negotiation type interactions that shaped the nature of care as delivered to women experiencing early miscarriage. Whilst negotiated order is a concept that first developed with a focus on frontline-to-frontline interactions, the role of frontline-to-manager interactions has also been proposed to be relevant (Llewellyn, 1998; Baïada-hirèche *et al.*, 2011). This study highlighted a number of actual and virtual negotiations, within and

---

[27] First do no harm or “Primum non nocere” is popularly agreed to form the basis of the Hippocratic Oath. This principle suggests that health care services should aim to never leave a patient in a worse position than if they had not received that care. Sokol, D.K. (2013) '"First do no harm" revisited', *British Medical Journal*, 347, p. f6426 [Online]. Available at: http://www.ncbi.nlm.nih.gov/pubmed/24163087 DOI: 10.1136/bmj.f6426 (Accessed: 30/08/16), ibid.

beyond the frontline that had relevance to QOC management and its impact on care as delivered.

Negotiations regarding the need to compromise were sometimes formal endeavours (e.g. explicitly using organisational mechanisms to propose change or register concerns) but often they were described as occurring during informal interactions between individual (or groups of) frontline workers and their direct line managers. The hierarchical structures of the organisations participating in this study meant that line managers were the individuals most likely to be responsible for communicating organisational policy and proposed changes to frontline workers (as compared to top level managers). This meant that there was limited scope for senior managers to enter into the everyday negotiations that shape care, or to have an awareness of the compromises that were being shaped and accepted at the frontline (beyond that communicated to them by lower level managers). In some respects senior manager interviewees indicated that this was an inevitable consequence of the way that their job is arranged, however several also suggested that their lack of involvement was appropriate and that the management of humane and PCC aspects of care was largely a frontline issue and responsibility.

In addition to these formal and informal negotiations, there was another strata that might be considered to be “assumptive” or “predicted” negotiations. Interviewees made assumptions about the motivations and capacity of other people within their organisation, and their willingness to accept alternate viewpoints and engage in negotiations. These assumptions appeared often to be developed into informal understandings within frontline worker groupings. Conceptual boundaries have already been described in the previous section and the idea that those in frontline roles may see themselves as different to those in managerial roles has been proposed elsewhere (Reiger and Lane, 2013; Dixon-Woods *et al.*, 2014). In such cases managers might be seen to be different to frontline workers in terms of their ethos, motivations, and beliefs. The idea that senior management or policymakers may just not care (as espoused by more than one frontline interviewee) may result from an inability to construct any other reasonable explanation for actions perceived to disregard patients’ feelings or needs (Sims, 2005).

This may help to explain the observation that some interviewees explained their decision not to engage in negotiations as a consequence of their belief that senior managers, or those in positions of power (often presented in the abstract rather than as specific individuals or groups), would dismiss their concerns or suggestions, or would not be in a position to act upon them. Similarly, some managerial level interviewees indicated that they avoided some amount of information exchange with frontline workers on the basis that it would not be understood or appreciated; an observation echoed in other published research (Mitton *et al.*, 2011). This suggests that some negotiations occur solely within the minds of NHS workers, and that these assumptive or predicted negotiations have the potential to stifle or encourage open debate and communication just as readily as explicit communications or informal interactions. Furthermore, where these understandings operate as a collective understanding (e.g. a collective belief amongst a frontline worker group that negotiation with managers is pointless) they may represent an additional layer of organisational "rule" with the power to influence and control the beliefs and willingness to act of individual workers.

The model of negotiated order, then, provides a useful lens with which to view the intra-organisational interactions that might lead to acceptance of care that is suboptimal in nature. It offers the argument that workers at all levels use formal and informal mechanisms to gain leverage and assert their views. It also suggests that non-negotiation may be a product of group and/or individual beliefs about the predicted trajectory of negotiations; assumptions of powerlessness, and predictions of futile negotiations, could impact on the likelihood of workers engaging in informal or formal negotiations.

7.2.5 Fragmented Extra-Organisational Negotiations

The concept of negotiated order has been criticised for focusing too heavily on frontline negotiations, and failing to acknowledge the influences of those external to these relationships. Within this study the influence of parties external to the organisation (i.e. not in direct employment) was evident although this was markedly more apparent in interviews with managerial level interviewees, several of whom discussed the influence of commissioners, policymakers, quality improvement mechanisms and external monitoring bodies (e.g. the Care Quality Commission).

These influences were important because, for the most part, they had a significant impact on resource allocation. In this respect they became important players in negotiations either directly (because they could make demands in relation to the QOC of specific services and define acceptable parameters of QOC), or indirectly (by skewing organisational priorities towards explicit achievement of standards relating to specific types of care that, consequently, results in resource loss to other types of care). It is worth noting that external bodies were not represented as active participants in negotiations, as they had no direct interaction with frontline workers. Their demands were interpreted by organisations and fed down the hierarchy to frontline workers, and the data from this study suggests that this was often interpreted in ways that implied that frontline and managerial level workers had no choice but to comply. Again, this represents a type of assumptive negotiation whereby external negotiators were involved virtually rather than actually; their motivations, intentions and flexibility were assumed, and thus constructed, by those involved in negotiations related to care delivery. Interviewees described no opportunity for frontline workers to turn this into a two-way interaction where they could confirm the veracity of their assumptions or propose alternate views (e.g. those that might emphasise the importance of PCC or humane aspects of care).

At this stage it is worth considering the role of patients in negotiations about the parameters of acceptable QOC; given the importance placed upon the idea of PCC, their involvement in defining what that might mean and providing guidance on acceptable parameters would seem imperative. As described in chapter three, section 3.3.2, Strauss *et al.* (1973) observing interactions within a psychiatric health care facility, described patients who engaged effectively in the day to day negotiations occurring on the frontline of care delivery. In this study patients were generally not described as being especially active in negotiating the terms of their care although some frontline workers described situations during which patients had expressed dissatisfaction or made requests (for example, to access diagnostic tests earlier than local protocol allows for). The extent to which such requests were accommodated is discussed in the next section, however many interviewees suggested that the disempowering nature of the experience of miscarriage meant that many of their patients were ill-equipped to enter into negotiations that involved requesting a significant departure from local clinical and organisational norms.

This section has been concerned with the ways in which compromise, and the acceptable parameters of QOC, are negotiated. On this aspect of negotiation patient input was described in this study to be limited or absent. The literature suggests several reasons why this may be the case; early miscarriage has been described as a societally problematic issue that is not widely discussed, and this stymies opportunities for women to work together to discuss and agree the needs of women experiencing this form of reproductive loss and to petition health care organisations to meet those needs more effectively. More widely, Layne (2006) has suggested that there is a lack of engagement from feminist scholars on the subject of early miscarriage that Layne argues may be due to concerns about the impact they may have on political arguments about elective termination of pregnancy[28]. Inclusion of miscarriage in National policy is also limited; for example, despite the consultation with the Miscarriage Association and the high prevalence of early miscarriage, The National Maternity Review (2016) contains only three references to miscarriage (two referring to risk factors for miscarriage) and three to pregnancy loss generally. It is worth noting that there are some instances where the views of selected groups of women have been publicly debated and this has led to significant national policy change; clearly patients do have the potential to assert a strong position in negotiations, particularly if their views are supported by societal beliefs about acceptable and unacceptable care practices[29].

The involvement of patients in defining parameters of QOC in the organisations participating in this study was limited and exclusive to those patients who were motivated and able to engage in formal complaints mechanisms or attend maternity service liaison committees. In the absence of explicit patient involvement in negotiations, as with policymakers and commissioners, patient views are involved by proxy and based on assumptions as regards their priorities and willingness to compromise on various aspects of care.

---

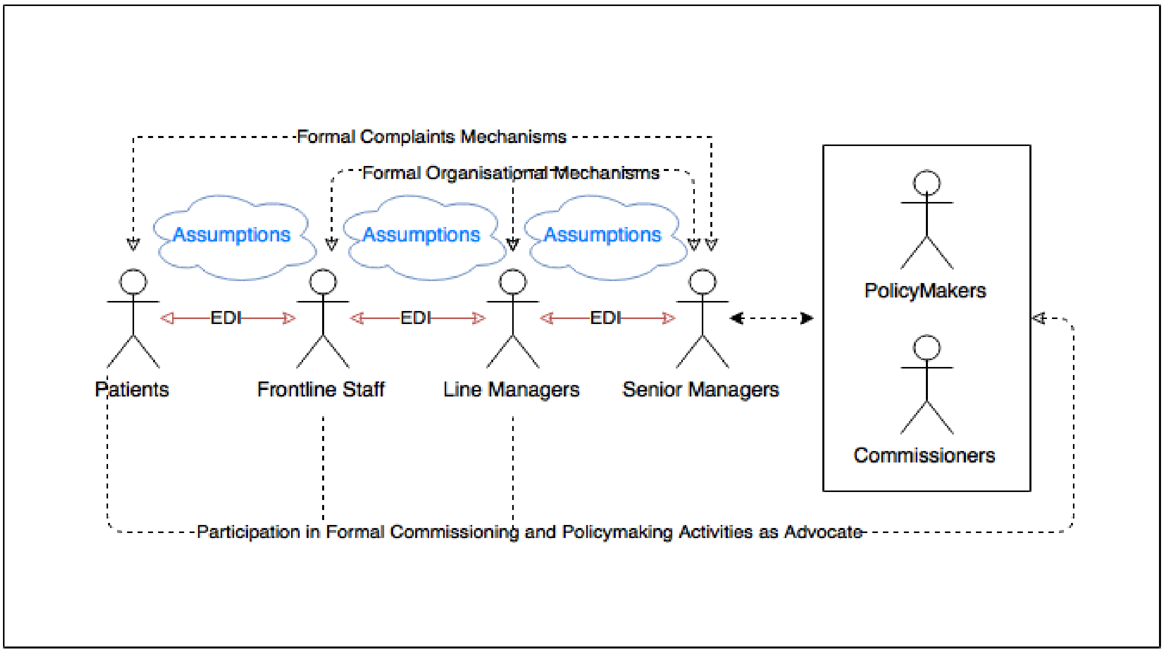
[28] For example, acknowledging the personhood of a fetus lost to early miscarriage could be used to pose questions about the personhood fetuses in early pregnancy generally which, in turn, has implications for a woman's right to terminate an early pregnancy Layne, L.L. (2006) 'Pregnancy and infant loss support: a new, feminist, American, patient movement?', *Social Science and Medicine*, 62(3), pp. 602-613..

[29] The potential for patients to have an impact on care was demonstrated when Channel 4 screened a TV programme that 'exposed' the ways in which hospitals dealt with fetal remains after voluntary and involuntary pregnancy loss, positioning practices around the use of incineration following miscarriage as inappropriate *Amanda Holden: Exposing Hospital Heartache* (2014) Directed by Corke, R. and Carter, P. This was met with publicity in national newspapers and magazines, followed by involvement by the Chief Medical Officer for England and the Human Tissue Authority https://www.hta.gov.uk/news/inappropriate-handling-fetal-remains-hta-letter-chief-medical-officer, who went on to revise their guidance on the disposal of fetal tissues (https://www.hta.gov.uk/sites/default/files/Guidance_on_the_disposal_of_pregnancy_remains.pdf). This is interesting since it (a) is an activity designed to respond to emotional needs of women experiencing miscarriage, (b) it requires greater resource use than using incineration as the primary method of disposal, and (c) it appears to have been enacted as a consequence of societal rejection of incineration as a method of disposal rather than solely as a reaction to the concerns of women experiencing miscarriage.

On the matter of assumptions, policy rhetoric around frontline engagement positions frontline health care workers as natural advocates for their patients. Whilst the findings of this study suggests that frontline health care professionals were knowledgeable about issues of concern to women experiencing miscarriage, it is simplistic to assume that all frontline workers will fully understand their patients, will always be correct in their assessment of best practice, and will always act in their patients' best interests. It is, for example, well documented that nurses and midwives used to minimize contact between a woman and her baby when a stillbirth occurred in the belief that this would lessen maternal distress and harm. More recently research has described this approach as being potentially harmful to many women who felt that their identity as a mother was being dismissed (Thompson, 2012; Ryninks *et al.*, 2014).

In summary, this section has explored the idea that QOC, as experienced on the frontline of care delivery, is an ever shifting construct that is shaped by negotiations between stakeholders within and outside of the environments within which care is delivered. In the absence of explicit guidance and support, and within a context whereby compromise is viewed as an inevitable and reasonable activity, frontline workers are left to draw upon collective understandings, and concepts such as equity, to guide them as to the extent to which compromise over QOC is acceptable. This suggests that frontline workers and their managers are involved in negotiations about abstract and hard to define aspects of health care, which have ill-defined parameters of acceptableness, and which are influenced by agents to whom frontline workers have no direct access.

Furthermore, it is suggested that interactions take place on explicit, implicit and assumed bases, and that hierarchical arrangements that limit meaningful every day interactions between frontline staff and other influential agents lead to assumptions that stifle information sharing. Lack of physical presence during negotiations does not imply no power or relevance; in fact it presents frontline workers with limited scope to negotiate at all and, in this study, led to expressions of powerlessness amongst interviewees of all levels. Where actions (and inactions) are based on assumptions about the thoughts and motivations of "others" this can lead to compromises over QOC that are not scrutinised or debated (see Figure 7-2).



EDI = Every Day Interaction

Figure 7-2 Formal, Informal and Assumptive Interactions

7.3 Caring and Compromising

Section 7.2 argued that NHS workers regularly compromise on quality and cite powerlessness to act, or to reject demands from organisational superiors, as justification for these compromises. This privileging of organisational requirements over personal aspiration echoes the concerns raised by Weber about the implications of bureaucratic organisational models and the "iron cage" that limits the agency of individual workers (Morrison, 2006). There is a well-established literature concerning the ways in which bureaucratic models can encourage individuals to act in ways that compromise their own ethics. Studies that have explored the concept of denial have outlined a number of ways in which individuals might defend their complicity in morally questionable acts (Adams, 2011), with some of these defences relying on the type of collective understandings observed in this study (e.g. claims that groups of individuals are powerless to assert their own views or act outside of organisational or peer norms, and collective beliefs that situations have been, or could be, worse (Cohen, 2001).

These understandings are powerful in so far as they (a) allow frontline workers to justify their continued involvement in, and therefore support for, suboptimal aspects of care, and (b) encourage compliance with organisational requirements through peer pressure. After all, an individual who decides to explicitly reject these collective understandings might be seen to be effectively criticising those who support them (Cohen, 2001; Bauman, 2013). Similarly, if the individual has worked within a suboptimal environment for any period of time, speaking out also involves accepting that they can no longer claim powerlessness as a justification for their previous support of suboptimal care practices (Cohen, 2001). This may explain the observation that organisational "whistle-blowers" experience criticism and rejection from peers as well as from organisational superiors (Delk, 2013). Nonetheless, bureaucracy offers frontline workers the possibility of constructing a persona that meets organisational needs (by implicitly supporting them by delivering compromised QOC) whilst simultaneously maintaining a caring identity (by explicitly rejecting them but denying accountability due to restricted agency).

7.3.1 Discretionary Action: a Problem or a Solution?

The previous sections have described the role of negotiation in influencing and normalising compromises over QOC in NHS services, particularly in relation to care offered to women experiencing early miscarriage. Lipsky (2010) proposed several features of public service work that mean that frontline worker will always find themselves working in compromised situations where their aspirations regarding quality of service are not matched by resource allocation. As discussed previously, this study suggests that some aspects of care do not readily fit within a rationalised structure of quality management, and so may be especially vulnerable to this aspiration-resource gap. According to Lipsky, discretionary practices offer a way for frontline workers to deal with this gap by making their work more manageable (Lipsky, 2010).

7.3.2 The Function(s) of Discretionary Activities

Lipsky's work asserts that frontline workers in the public services act in ways that control their clientele in order to manage the, generally, excessive and relentless workload experienced at the frontline (Lipsky, 2010). Some of the discretionary activities observed in the data could be considered to represent mechanisms that encouraged patients to comply with the organisational compromises and informal rationing that had already been negotiated and agreed (Allen *et al.*, 2004). For example, some frontline interviewees described manipulating the information they provided to guide patients away from treatment choices that their organisation had decided not to provide routinely. Ultimately, any activity aimed at improving QOC could be conceptualised as a form of patient management, since suboptimal care can result in anger amongst patients that frontline workers then have to deal with.

Lipsky's work has, however, been criticised by some as being simplistic in its assumptions about the motivations of frontline workers when they engage in these types of activities (Evans, 2011; Evans, 2015). Other authors have described similar types of knowledge sharing and informal rule development amongst frontline health care workers, used individually or collectively, and motivated by different concerns such as relationship building, ethical action, individualising care, and knowledge management (e.g. nursing workarounds (Debono *et al.*, 2013), mindlines (Wieringa and Greenhalgh, 2015), nursing resistance (Peter *et al.*, 2004), articulation work (Allen, 2014), working the system (Skinner and Maude, 2016), or mindlessness (McCloskey, 2011)). Evans (2015) proposes that frontline workers may be influenced by a range of motivations and suggests that Street Level Bureaucracy is "*an ethical evaluation that lumps together the diverse ways in which front-line discretion is used under the rubric of client-processing*" (Evans, 2015; p287) and further suggests that it presents a view of discretionary practice that is skewed towards organisational evaluations *"based on the point of view that discretion and its use should be evaluated in terms of obedience to managers*" (Evans, 2010; Evans, 2015; p287).

Chapter six has outlined a number of discretionary activities observed in the interview data that could, in some way, be linked to the concept of frontline management of QOC. The nature of these activities support criticism of Lipsky's position in so far as motivations for these activities could be, and were, explained in a number of ways. By way of explanation, consider the examples shown in Table 7-2 that describe a number of discretionary activities observed in the data that could simultaneously be presented as either a quality improvement tactic or a way for frontline workers to manage workload. The way in which any such activity is described might depend on who is asking and in what context they are asking; e.g. when speaking with an organisational superior, a frontline member of staff may justify an unsanctioned discretionary activity primarily performed to improve QOC by linking it to an organisational benefit and emphasise how that activity supports organisational stability. Motivations for this same activity might be described very differently to a colleague or a patient.

Discretionary Activity	Impact on QOC for Patients	Impact on Frontline Workload
Frontline workers apologising to patients for suboptimal aspects of care	Legitimises patient concerns and demonstrates that frontline staff agree and care	Pacifies patients and allows staff to continue to prioritise organisation demands over patient needs
Frontline workers encouraging patients to make formal complaints about unsatisfactory aspects of care	Legitimises patient concerns and demonstrates that frontline staff agree and care	Defers the anger or distress a patient feels and directs it towards someone other than their frontline carer
Frontline workers withholding information about treatment options not routinely offered within their organisation	Manages patient expectations and prevents them from becoming distressed about choice limitations at a time when they are already distressed	Controls patients and avoids the staff member having to deal with patient distress/anger over choice limitations, avoids staff having to make additional effort to secure non-routine, and potentially disruptive or more expensive care
General Practitioners (GP) exaggerating a patient's symptoms in order to access diagnostic services sooner for an anxious patient	Legitimises the patient's anxiety, demonstrates that GP cares	Immediately shifts responsibility for anxious patient and her care away from GP

Table 7-2. Discretionary Activities, Impact on QOC and Workload

Additionally, some of the discretionary activities described in the interviews appeared to create additional workload; for example, the nurse who described incorporating unnecessary clinical observations in local guidelines for care of women experiencing early miscarriage in order to create additional opportunities for contact time with patients.

Altogether this suggests that staff motivations to engage in discretionary activities maybe more complex than Lipsky's model would suggest. Multiple interpretations are possible and it could be argued that interrogating the motivations of frontline workers when they engage in discretionary activities may be less useful than considering their potential impacts on QOC and, more specifically, whether they contribute to addressing or maintaining deficiencies in PCC/humane aspects of care.

7.3.3 How Frontline Workers Plug Quality of Care Gaps

Chapter six has outlined the types of discretionary activities observed in the data that could be considered to contribute to improved QOC for women experiencing early miscarriage. They have been categorised in this thesis as disruptive and non-disruptive depending on whether they were delivered within existing organisation structures or whether they sought to disrupt those structures.

As "informal policies", non-disruptive activities can be considered to be organisationally functional since they attend to immediate QOC deficits for individual patients without requiring the organisation to provide additional support, resource, or renegotiation of conditions. Where they form part of a negotiated collective understanding they can be thought to be effectively institutionalised and operate as another layer of policy (Strauss *et al.*, 1973); informal in their development but influential as a consequence of their internal management (via peer disapproval or support). This study suggests that discretion "rules" are part of the negotiated order of each ward and department, with groups of staff developing informal understandings as regards the way different situations should be dealt with. Discretionary practices are not, then, necessarily evidence of individual agency, since these street-level norms form another structure that may be just as constraining as explicit organisational rules.

A key feature of non-disruptive activities is that those who engage in them are not obviously recompensed for their efforts, even where these might involve significant emotion work and/or unpaid activities. Policies and contracts of employment can direct frontline workers to be sensitive or compassionate but, as has already been discussed, these terms are open to interpretation and difficult to measure, making them very difficult to police or control. A lack of explicit obligation to deliver on PCC/humane aspects of care as part of the paid work of frontline staff, means that any attempt to do so could be understood as "gifting" of care (Bolton, 2000).

This “*gifting*” phenomenon has been observed in other health care contexts (Bolton, 2000; MacBride-Stewart, 2014; Goodman, 2016). Torres *et al.* (2015) theorised that it leads to a “gift economy” that operates alongside the traditional market economy, an economy within which, Goodman (2016) suggests, the value offered by caring is not matched by the price paid for it. Where offering caring as a gift does not offer financial advantage, it has been described as offering positive benefits to professional identity (MacBride-Stewart, 2014), emotional satisfaction (MacBride-Stewart, 2014) and it also allows workers to minimise their exposure to the impact of suboptimal care on the patients they interact with on a day to day basis (Torres *et al.*, 2015). Some care contexts have been described to be particularly likely to involve workers engaging in gifting practices because of their “*emotionful*” nature, and Bolton (2000) observed gynaecological nursing to fall within this category, particularly in relation to its involvement in situations of pregnancy loss.

Disruptive activities are also described in chapter six. These were most likely to be delivered alongside non-disruptive activities rather than instead of them. Most of the disruptive activities described were explicit in nature; those that were implicit required the frontline worker to have knowledge of the organisational levers that might prompt systematic change. Explicit discretionary activities in this study often involved a challenge to the notion that caring and PCC aspects of the services being offered to women experiencing early miscarriage can be delivered regardless of resource allocation or support. These interactions required frontline workers to move beyond street level negotiations and engage in formal mechanisms of communication with organisational superiors.

Moving concerns into the managerial arena posed problems and risks not associated with non-disruptive activities. These include having to negotiate with senior managers (about whom frontline workers had little interpersonal knowledge), having their viewpoint scrutinised and challenged, being held accountable for the consequences of any proposed changes, and being viewed as disruptive or naïve (Dixon-Woods *et al.*, 2014). They also represented an interaction rooted in power imbalances; frontline workers described having no power to insist on their views being accommodated whereas several examples were given of changes imposed upon wards and departments despite the overt concerns of frontline staff. There are, then, clear incentives for frontline workers to manage their concerns about care within the confines of the frontline, since this is where they have most power and leverage to negotiate.

7.3.4 Organisational Support for Frontline Discretion

In the Street level bureaucracy model proposed by Lipsky, the role of managers in facilitating or constraining street level discretion has not been fully explored (Evans, 2011; Evans, 2015). The SLB model proposes that managers are motivated generally by the need to meet policy objectives in as efficient and effective way as possible and to maintain control and order over frontline discretionary activities in order to do this (Lipsky, 2010; p18). This description implies that managers are constrained in their ability to reject organisational and societal norms, a position supported by Stewart *et al.* (2012).

> "Nursing leaders 'vision' is inevitably a product of the system in which they work, and simply aims to achieve its operating imperatives and strategic objectives. In such a context, 'inspiring followers' can constitute no more than a manipulative sport, in which economic rationalist principles are reinforced to the detriment of all except perhaps those employed in government departments charged with setting 'fiscally responsible' but practically impossible targets" (Stewart *et al.*, 2012; p227).

The idea that managers and frontline workers have discordant motivations has, however, been criticised as being simplistic and unhelpful and it has been proposed that managers may both facilitate frontline discretion and act in discretionary ways themselves (Evans, 2010). In this study there was no evidence that managerial level interviewees were ignorant of the concerns frontline interviewees expressed regarding QOC, or that they considered them to be illegitimate. QOC gaps were not, thus, a failure of engagement or evidence of divergent thoughts about PCC/humane aspects of care.

Evan's hypothesis was supported by the data from this study in that managers described an awareness of frontline discretionary activities operating within their services and, furthermore, recognised QOC benefits accruing from them; for example, several noted that frontline workers' willingness to exceed organisational requirements in terms of their delivery of humane aspects of care or to offer additional time, without expectation of recompense, to be an organisational asset. Interviews with managers suggested that they had no desire to define or control the caring activities of their frontline workforce and, in hospitals undergoing organisational change, managers indicated an expectation that frontline workers would manage any resulting care deficits without managerial input. The idea that organisations depend upon paid (and unpaid) care workers plugging QOC gaps by working beyond their contractual requirements has been observed elsewhere:

> "In the face of consumers' unmet needs, state IHSS regulations depend implicitly on the assumption that unmet needs for care will be met outside the care giving marketplace, that family and nonfamily caregivers will go beyond their compensated hours and activities" (Torres *et al.,* 2015; p752)

This suggests that health care managers in this study, rather than being determined to eradicate frontline discretion, instead recognised the functional nature of non-disruptive frontline activities for their organisation. Furthermore there was no suggestion that managers were ambivalent about the importance of humane and PCC aspects of care, and several aligned themselves to their frontline workers by discussing their own previous frontline experiences and caring identities. Protecting these aspects of care was, however, universally described to be a challenge so overlooking, or choosing not to know about, non-disruptive frontline activities offered a way for managers to feel reassured that these aspects of care were being attended to, without having to be concerned about resourcing them or getting into difficult conversations about priorities.

The negotiation in this instance is then an agreement to allow discretion in return for frontline workers using that discretion in ways that do not deliberately or accidentally disrupt the achievement of organisational objectives. Frontline workers then secure the ability to act in discretionary ways but not, necessarily, for the purpose of controlling patients or making work more manageable as Lipsky would suggest, but for a whole variety of reasons. This discretion had to be meaningful however, and if structural factors were felt to impinge upon discretion to the extent that it became impossible to discharge (i.e. by failing to allow the activities described in chapter four, such as offering continuity or relationship building) then frontline workers might reject their part of the negotiation and turn to disruptive activities instead.

Disruptive activities, particularly those that were explicit, presented a challenge to implicit agreements about acceptable compromise and the role of frontline workers in dealing with it. Where they relate to humane/PCC aspects of care, they make a case that successful delivery of such care components requires the allocation of tangible organisational resource, and question how far these internal demands can be accommodated within the context of pre-existing organisation objectives. Disruptive frontline activities have the potential to alter the dynamics of frontline-manager negotiations (e.g. by removing expectations about frontline "gifting" or requiring managers to enforce unpopular change).

7.3.5 Structural Consequences of Discretionary Activity

One of Lipsky's observations was that street-level activities impact upon the structures they operate within, in ways that street-level workers may or may not appreciate (Lipsky, 2010); these impacts may involve supporting structures that street-level workers claim to object to.

In relation to frontline worker engagement in managing QOC within the NHS, this study demonstrated a collective narrative of powerlessness in the face of more powerful agents (within and outside of the organisation) amongst both frontline and managerial level interviewees. Viewing this through a structure versus agency lens, agency to engage was portrayed by interviewees as severely constrained, to the point that their thoughts and recommendations were supported only in instances where they corresponded with the pre-existing needs of external agents (in which case agency might be thought of as largely illusionary).

The non-disruptive activities that frontline workers engage in operate within the confines of the frontline, and so do not have an immediately obvious impact upon structure. As described previously, many of the activities frontline workers engage in to manage QOC are non-disruptive in nature. These activities offer frontline workers a number of benefits including short term increases in QOC for individual patients and maintenance of their own caring identity, as well as management of patient disappointment and potentially difficult to manage responses (MacBride-Stewart, 2014). Even though these activities may not reflect, or may even contradict, formal organisational policies, they have been described in section 7.3.4 as organisationally useful since they maintain organisational stability and manage patient expectations.

In this respect they can be argued to impact on structures since the compliance of frontline health care workers (in not disrupting the systems within which they operate) actively supports those structures; without it the structures may be altered or even cease to exist. For example, this study proposes that suboptimal aspects of QOC for women experiencing early miscarriage relate, in a large part, to aspects of care that are intangible and difficult to manage within a system that is driven by rationalised principles. By managing these QOC gaps using implicit activities that can only ever be offered on a discretionary basis, this re-iterates the idea that these aspects of care do not need to be explicitly resourced, measured or controlled; from an organisational point of view there is little motivation to negotiate on resource allocation for these aspects of care when there is an tacit expectation that they will be delivered regardless (i.e. frontline workers will “gift” it (Bolton, 2000)). It means that managers, who have limited power to radically reorganise resource allocation, have reason to overlook discretionary activities, or to choose not to know about them. They may also be motivated to downplay or avoid knowing the details of care deficiencies (“*strategic ignorance*” (Adams, 2011; p283)). In this respect managers can claim to meet vague policy demands about PCC/humane aspects of care without (a) explicitly acknowledging any compromises that have been made within their organisation, or (b) being drawn into complex arguments about whether existing structures adequately allow for these aspects of care to be recognised and resourced.

Thus, in the face of multiple organisational demands for resource use[30], many of which are external and linked to future financial income, appeals to resource time to devote to “caring” activities[31] have little leverage. This is interpreted by frontline workers as a system level constraint, however their willingness to plug the QOC gaps without disrupting the system means that frontline workers support a cycle of discretionary gifting of care that they, themselves, consider to be oppressive and imposed upon them (Goodman, 2016). This cycle is maintained by collective understandings about what frontline workers “do” and (potentially correct) assumptions about the motivations of managers and the consequences of working outside of these implicit rules.

---

[30] ‘Resource’ meant in terms of not only direct financial support, but also in terms of allowing staff to privilege time towards the delivery of ‘caring’ activities.

[31] ‘Releasing Time to Care’ was a quality improvement programme widely implemented in NHS organisations Wilson, G. (2009) 'Implementation of Releasing Time to Care - the productive ward', *Journal of Nursing Management,* 17(5), pp. 647-654.. It was based on the idea that by streamlining ward based processes, frontline workers could free up time that they could redirect towards direct patient “care”. This proposes the idea that time is a commodity that frontline workers can obtain (by doing their work more efficiently) and then use as they would wish. This programme makes any time savings gained obvious to organisational superiors, and there was no clarity as to how frontline staff might be able to protect any time gained (which, after all, as a paid employee, belongs to their employer), from the many other additional claims that could be placed upon it.

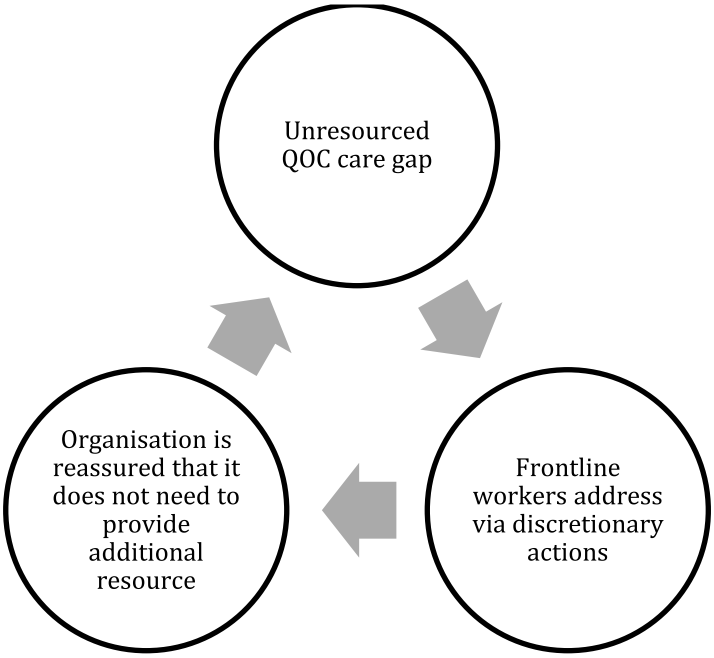


Figure 7-3 Cycle of Care Gifting

The cycle can only be broken if frontline workers withdraw their discretionary efforts (thus leaving individual patients with unresolved QOC gaps that frontline workers have to bear witness to and deal with) or supplement their gifting with disruptive activities that cause organisational superiors to reconsider the acceptability of their position (Figure 7-3). Both involve risk to the frontline workers in terms of their organisational identity (i.e. they may be considered by organisational superiors and/or fellow workers to be subversive or a troublemaker) and their professional identity (i.e. they may be considered by patients to be uncaring).

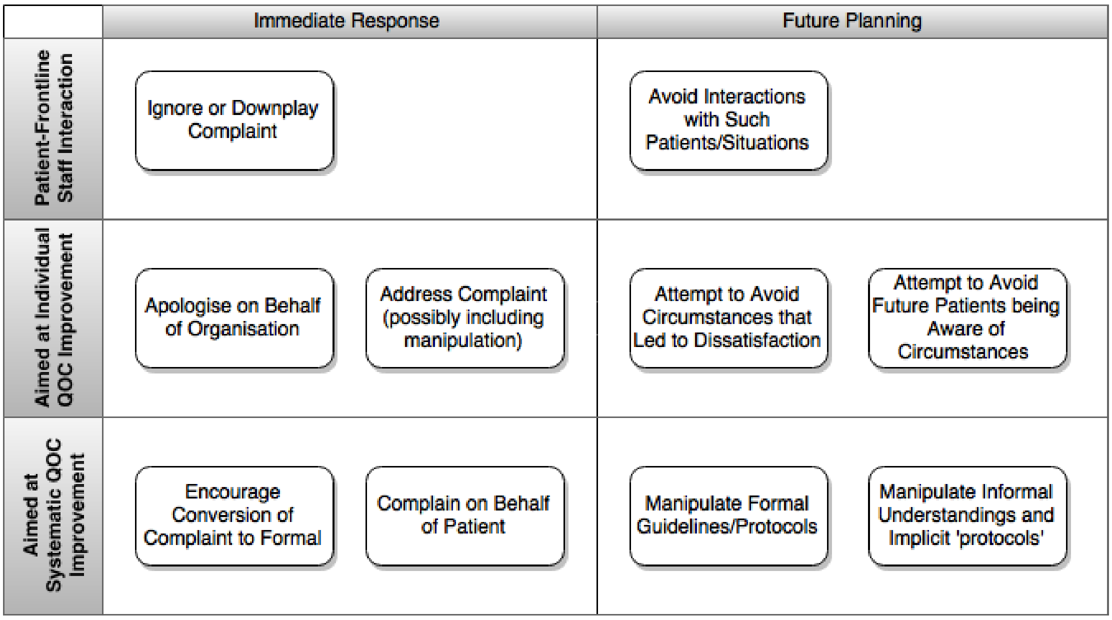
Overt sharing of information about discretionary actions also risks those activities, and any positive results resulting from them, coming under formal organisational control, thus reducing frontline workers control over their own work. As an example, consider the nurse who included unnecessary physical observations in the local protocol for care of women during an early miscarriage in order to gain contact time for “caring” activities; if this information was shared with organisational superiors explicitly, managers are no longer able to claim ignorance and may feel they have no choice but adhere to evidence based care principles and remove that part of the protocol. Staff time can then be reallocated to other tasks.

Alternatively, external factors may unsettle the cycle (e.g. a policy based demand to resource care) although, in this study, it was policy demands to resource *other* services that increased the resource gap in early miscarriage services. The inability to link humane and PCC aspects of care to solid positive outcomes (in terms of health, but also in terms of fiscal or legal issues) puts attempts to improve QOC by addressing these aspects of care in particular at a distinct disadvantage compared to policies that aim to save lives[32] or save money. This demonstrates that whilst frontline discretionary activities may offer strength and power to frontline workers, since they do not require external permission to act and are not subject to scrutiny or evaluation using measures defined by others, they are most effective when they operate within stable structures. Structural change (e.g. changes to the organisation of care, or to the ways the local/national policy conceptualises and measures QOC) have the potential to curtail discretion and/or alter the circumstances within which frontline activities operate, potentially creating new QOC gaps and forcing new negotiations about the way to address them (Skinner and Maude, 2016). A heavy reliance on the internal power frontline workers have within their own wards/departments/professional groups thereby contributes to the feelings of relative powerlessness frontline workers described.

Another way that Lipsky suggested frontline worker activities might contribute to broader social structures is in their unsystematic nature. This means that the response frontline workers have to any given instance of suboptimal care they are confronted with will be managed differently depending on a number of personal and contextual circumstances. Examples seen in the data include how busy the ward is and the nature of the other priorities competing for frontline worker time, how invested the staff member is in the early miscarriage service/organisation, how many informal “tactics” the staff member is aware of and what are the normal and accepted ways for staff to deal with such situations, how legitimate the staff member considers the patient’s dissatisfaction to be, how sympathetic the staff member feels to each woman’s circumstances, and how far the patient is willing to demand change. As an example, Figure 7-4, demonstrates a number of different responses seen in the data to an informal patient complaint and the ways in which those responses might simultaneously improve patient experience and maintain organisational functionality.

---

[32] As in the case of hospital B where introducing one to one care for women during childbirth, as recommended by NICE, reduced the amount of patient contact time frontline workers had with women experiencing early miscarriage. The value of one to one care was linked to quality of experience and maternal and child safety; this study suggests that one to one care for women experiencing early miscarriage would likely improve quality of experience for patients but have limited to no impact on safety.



	Immediate Response	Future Planning
Patient-Frontline Staff Interaction	Ignore or Downplay Complaint	Avoid Interactions with Such Patients/Situations
Aimed at Individual QOC Improvement	Apologise on Behalf of Organisation Address Complaint (possibly including manipulation)	Attempt to Avoid Circumstances that Led to Dissatisfaction Attempt to Avoid Future Patients being Aware of Circumstances
Aimed at Systematic QOC Improvement	Encourage Conversion of Complaint to Formal Complain on Behalf of Patient	Manipulate Formal Guidelines/Protocols Manipulate Informal Understandings and Implicit 'protocols'

Figure 7-4. Potential Response to Expressed Dissatisfaction from Patients

That these issues are circumstantial suggests that women are unlikely to always be treated equally in relation to QOC they receive and the ways in which any dissatisfaction is dealt with. Additionally, patients themselves may react differently to such tactics; for example, not all women will feel confident or competent enough to engage in formal complaints mechanisms, and not all women will accept a staff apology as reason to abandon their complaints. This opens up the possibility that frontline workers may consciously, or unconsciously, incorporate social biases and stereotypes into their choices, thereby replicating and supporting those biases. Despite disputing the idea that women experiencing first trimester miscarriage have lower health care needs than those experiencing a later pregnancy loss, non-disruptive street level activities encourage a woman experiencing early miscarriage to accept the organisational compromises that have been made and also that frontline workers are "doing their best". The societal bias against early versus late miscarriage is replicated in the same way that care gifting by frontline workers helps to replicate inherent biases against intangible versus tangible components of health care.

In summary, non-disruptive street level practices are paradoxical; they solve immediate problems by attending to gaps in PCC and humane aspects of health care and enable staff to retain an identity that is simultaneously caring and organisationally responsible. When they operate within stable structures with a cohesive frontline workforce they are durable and have a significant impact on the ways that frontline staff operate. However they are simultaneously vulnerable in times of organisational change when compromises about QOC may alter, the structures that create spaces for discretion constrict or expand, and cohesive staff groups may be dispersed. At an organisational level, discretionary activities are valuable since they control patient dissatisfaction with QOC gaps in ways that avoid uncomfortable and difficult discussions about the worth of humane and PCC components of health care. They do, however, mean that the issues at the heart of the QOC gap remain unresolved in the longer term. The “gifting” of care often involved in these activities also creates a negotiated order whereby managers and frontline staff come to accept, and expect, that PCC and humane aspects of care are something that frontline staff can and should deal with without support or resource.

Chapter 8 Conclusion

8.1 Thesis Summary

This empirical study has explored the ways in which frontline health care workers involved in the delivery of health care to women experiencing an early miscarriage conceptualise and manage QOC. This is a health care context that, research suggests, suffers from an on-going gap between the care patients say they would like and that which they describe receiving. For this reason the health care services for women experiencing early miscarriage represent a case study of intrinsic analytic value with which to examine the role of frontline health care workers in managing QOC in general (Stake, 1995). The study utilises a secondary data analysis using a social constructionist approach to explore the ways that notions of quality are understood and aspirations regarding high quality come to be agreed (and what happens when they are disputed).

The analysis supports the notion that frontline healthcare perceived structural constraints in relation to their ability to manage care in accordance with their aspirations about QOC and, in many respects, described themselves as powerless to address the QOC deficiencies they encountered in their everyday work. This particularly applies to delivery of "non-rational" aspects of care (i.e. those that attend to emotional needs and acknowledge the patient as an individual) that are described to be particularly important in this health care context. The organisation of services was described as having a significant impact on how far frontline workers are able to engage in the sorts of relationship building and discretionary activities needed to exhibit meaningful concepts such as compassion and to personalise care.

Rather than accepting that frontline powerlessness provides a singular explanation for QOC deficiencies, this study uses the social constructionist ontology and micro organisational theories to delve deeper into the accounts of frontline and managerial level workers to examine why QOC gaps might perpetuate. This approach illuminates QOC management as a complex, fluid and interactive phenomena that involves interactions, negotiations, assumptions and actions from workers at all organisational levels, including those at the frontline. Many of these interactions occur "under the radar" of formal organisational activities and their nature and impact may not be perceptible even to those engaging in them.

A key observation, in relation to negotiation, is the extent to which frontline workers, managers, and even patients are encouraged to compromise on their aspirations regarding high QOC. These compromises are not formally debated, and PCC/humane aspects of care are particularly disadvantaged in negotiations because of their failure to compete for resources with more tangible and measureable aspects of care.

Negotiations about the parameters of acceptable care thereby seem to have taken place in fragmented and unchecked ways with those who allocate resource accessing frontline workers indirectly through organisational hierarchies. The collective views that developed between the groups of workers provided a backdrop against which the reasonableness of compromises was assessed, and the impact of agreeing or rejecting compromise on workers' organisational and professional identities could be understood. Collective understandings can also lead to assumptive negotiations whereby negotiations with other parties can occur without those other parties ever being involved; speculation about the motivation and likely response of organisational superiors led some to conduct anticipatory negotiations that occurred within the confines of conversations in frontline staff rooms or even within the minds of individual workers.

Whilst frontline workers considered themselves to have limited organisational power, their power to influence the experiences of individual women under their care was clear with a number of discretionary, quality-influencing activities being apparent in the data. Many of these activities occurred without disrupting the formal structures within which they operated and they often required frontline workers to go above and beyond their contractual obligations. Whilst these non-disruptive activities offered a functional mechanism to manage the quality of humane/PCC aspects of care, they have a number of potentially negative implications for frontline workers, patients, and the organisation within which they are delivered. By failing to challenge the societal and organisational structures that form the backdrop to the development of suboptimal care practices, they also serve to support those structures and contribute to the perpetuation of suboptimal care. In the case of early miscarriage these unhelpful structures include organisational privileging of tangible over intangible aspects of care, and societal understandings of the impact of early versus later pregnancy losses.

8.2 Study Limitations

Chapter three has already outlined some of the limitations that the methodology used in this study may have on the interpretation of the findings. This includes the self-selected nature of the participants, the use of pre-existing data and secondary data analysis, and the use of qualitative methodologies and the limitations this has in terms of the generalisability of the findings. Clearly the findings are most relevant to those involved in the delivery and management of services to women experiencing early miscarriage however the findings may have relevance to any health care context wherein PCC and humane aspects of care are of importance (although it could be argued that these aspects of care are important to some extent in most health care contexts).

This study uses interview data and therefore the data represents the constructions interviewees chose to present to the interviewer (and to whoever else they believed might be party to the findings). The relationship between how frontline workers describe acting (or not acting) and how they may actually act out (or not) in the field may be very different, especially as the analysis suggested that being seen to be professional and reasonable appear to be important. The biases that frontline workers may consciously or unconsciously introduce into practice via their discretionary practices are difficult to comprehend via verbal descriptions of practice. This does not, however, invalidate the findings of this study; how staff chose to present themselves remains valuable in the context of the research question presented in this study.

8.3 Study Strengths

The work described in this thesis makes a unique contribution to the evidence base related to early miscarriage by exploring the micro-organisational processes that might contribute to the persistent gap between the health care women describe wanting and that which they receive.

8.3.1 Contribution to Knowledge about Early miscarriage

Thus far, research has largely focused on understanding the expectations and experiences of women accessing health care during an early miscarriage; as described in Chapter 2, this literature persistently identifies quality shortfalls but offers little to help us to understand the reasons why these shortfalls might continue to arise. This limits the utility of the research in terms of helping clinicians and policymakers to understand where opportunities to make improvements to their services exist. By explicitly considering the contribution frontline NHS workers make to the quality of the services they deliver, with a particular focus on activities that occur within the confines of the frontline (and that are, therefore, not immediately obvious even within their organisations) this study provides a novel perspective on a longstanding problem.

8.3.2 Contribution to Knowledge about Micro Organisational Theory

This work also contributes to the evidence base regarding micro-organisational theories and, more particularly, those relating to Street Level Bureaucracy (Lipsky, 2010) and Negotiated Order (Strauss *et al.*, 1973). This work applies these theories to a new health care context which has features of particular interest (e.g. the longstanding evidence of a mismatch between patients' expectations and experiences of care, the need for frontline attention to intangible aspects of care in an organisational context where assessments of QOC are targeted at rational aspects of care). It has highlighted useful features of these models in terms of recognising and understanding the negotiations that lead to frontline NHS workers compromising on their aspirations regarding QOC and accepting suboptimal care as standard, and it its illumination of the shared understandings that develop between frontline groupings and guide them in their responses to instances of suboptimal QOC. It also supports some of the criticisms authors such as Evans (Evans, 2015) have made of the SLB model; it suggests that (a) beyond the need to control workload, frontline NHS workers can have complex and multiple motivations to engage in discretionary practices (e.g. QOC improvement, management of their "caring" identity), and (b) the activities of managers are not always motivated by the need to achieve organisational goals and that they may sometimes enable frontline discretion in order to facilitate the delivery of PCC/humane care practices.

8.3.3 Contribution to Knowledge about Secondary Analysis of Qualitative Data

Finally, on a methodological note, this study involved the use of a pre-existing qualitative research dataset for a secondary analysis. This is a technique which, whilst not unusual, is not used widely. The research question posed in this thesis emerged from the original analysis conducted in the primary study; it may have been challenging to obtain additional funding for a study that was exploratory in nature (and which therefore had no certain outcomes) and repeating data collection with a new set of participants on this sensitive topic would have been ethically questionable when a suitable dataset already existed. This work demonstrates that a secondary analysis can be conducted successfully and in a way that complements and expands upon the primary analysis.

8.4 Implications of this Research

8.4.1 Implications for Clinical Care Relating to Early Miscarriage

The findings of this study have significance for those involved in the design and management of services for women experiencing early miscarriage. They contribute to a body of evidence that suggests that a key aspect of the quality gap (between patient expectations regarding care and the care they experience) relates to the more intangible and interpersonal aspects of health care. Whilst most of the existing evidence base presents this view from the perspective of women who have experienced early miscarriage, this presents a more unusual perspective; that of the frontline health care worker involved in the day-to-day care of women experiencing this form of reproductive loss. The congruence between the views of patients and their health care workers offers support to published research that suggests frontline workers are aware of QOC deficiencies, and thus suggests that improving QOC is unlikely to be achieved via tactics aimed at staff education alone (in fact this is likely to be experienced as frustrating or patronising by already knowledgeable staff members).

This study takes the analysis further and highlights some of the issues that may contribute to improvements to, or the perpetuation of, suboptimal care practices. It supports the observation that women experiencing early miscarriage may be a particularly disempowered patient group due to a variety of societal and circumstantial issues (including a lack of societal dialogue about the experience of miscarriage and the often unexpected and sudden nature of miscarriage precluding information gathering by patients). This means that health care assumes an especially important role in providing support and advocating for patients.

With this in mind, this study suggests that services catering to women experiencing early miscarriage could benefit from incorporating the values often highlighted as being important within maternity care policy (i.e. organising services in ways that offer women choice and control over their care, and that provide health care workers with opportunities to spend time with their patients in order to understand their individual needs and then to flex care packages accordingly). In the organisations participating in this study the management of early miscarriage diagnosis was managed via Early Pregnancy Assessment Services (albeit of varying natures) however the organisation of on-going in-patient management of miscarriage was highly variable. Caring aspects of health care were described to be compromised within services that required frontline workers to manage the care of women experiencing early miscarriage alongside patients with more acute physical care needs. Overall this suggests that structural aspects of health care organisation should be an important consideration when early miscarriage services are developed and managed.

Of note is the observation that almost all frontline interviews described a service model that they considered would be optimal for this health care context. This model involves the services offered to women experiencing a miscarriage (including diagnosis, and in-patient and out-patient treatment) being delivered in a dedicated standalone facility. Such a facility would address the issues arising when such women are nursed in wards/units that are dealing with multiple patient types; e.g. the distress that can be caused when women experiencing a miscarriage are exposed to women with an ongoing pregnancy, the difficulties associated with staff being unable to prioritise the emotional care of women experiencing miscarriage over the care of patients with more acute physical care needs, the fragmentation of care that can occur when multiple wards/departments are involved in a woman’s care journey. This model also has the potential to support a dedicated staff group to develop community understandings about QOC based on experience, and to allow peer support practices to develop.

8.4.2 Frontline Staff Engagement and Quality Management

The findings also have implications for aspirations regarding frontline engagement in the NHS. Chapter one outlined some of the mechanisms that have been used to try to facilitate the involvement of frontline NHS workers in quality management. This study confirms the assertion that there is merit in involving frontline workers (because of the knowledge they have of their patients and the services they deliver) however it also suggests that the relationship individual workers have with the structures in which they operate is complex and not entirely within the control of organisational superiors.

The analysis suggests that frontline engagement programmes that treat organisational hierarchies as tangible organisational attributes that can be dismantled at will in order to capitalise on the knowledge that frontline workers own (e.g. managerial walkarounds), fail to account for the multiple layers of informal bureaucracies that exist as constructs in the minds of individual workers and in the everyday interactions frontline workers have with patients, each other and their managers. These constructs guide individuals on matters such as the power they have, they ways in which they should discharge it, and the parameters of intolerable, acceptable and aspirational care. They also offer frontline workers street level power that they may be reticent to give up in return for the type of non-reciprocal arrangement frontline engagement programmes might offer (i.e. there is no mandate for managers to act upon the information frontline workers share).

Genuine engagement with frontline workers may, thus, involve more radical or creative programme designs that acknowledge the restrictions frontline workers operate within and the reasons why they might currently choose to manage their concerns about QOC within the confines of the frontline. The power imbalance inherent in frontline-manager relations poses a specific challenge. Encouraging frontline workers to explore, acknowledge, share, and debate their informal policies in a safe environment may offer a productive way to think about the variety of influences that affect QOC. It may also provide a way to explore the validity of some of the assumptive negotiations that prevent open information sharing.

Engagement strategies might also benefit from open acknowledgement of (a) uncomfortable issues relating to compromise that frontline workers are already dealing with, and (b) the relatively low status of PCC and humane aspects of care receive in terms of resource allocation. Such discussions and debates might benefit from the involvement of externally powerful groups such as patients, policy makers, and health care commissioners.

8.5 Areas for Future Research

Section 8.2 made the case that there may be merit in directly observing the everyday interactions, negotiations, and discretionary activities that occur on the frontline. Such information may offer additional depth to the understandings gained from this study. Ethnography offers a methodology capable of interrogating and exploring every day social practices and the impacts that they can have. This would offer the opportunity to observe how the discretionary activities identified in this study are enacted in everyday practice and also to explore how other agents (e.g. patients, managers) might be involved in, and be affected by, these activities. In particular, it may be useful to consider whether there may be parallels between the way that frontline staff report being encouraged to compromise on their ideals and maintain the identity of a reasonable individual, and the ways that patients may also feel pressured to compromise on their expectations regarding their care and to maintain the identity of a ‘reasonable’ patient.

Overall, this study has suggested that the actions and inactions of frontline workers may contribute to the replication of inequitable practices that discriminate against women experiencing early miscarriage (as compared to other health care contexts). It is not suggested that frontline workers are especially aware of the implications of their actions in so far as supporting the very structures that they consider to constrain them. Critical approaches to research design that involve the active participation of participants in interpreting and acting upon the findings, with the aim of making practical improvements (e.g. action research (Nugus *et al.*, 2012), critical ethnography (Hughes *et al.*, 2002)) have been described to be useful in terms of their "*emancipatory potential and practice relevance*" (Nugus *et al.*, 2012; p1946). Using these techniques in the context of health care for women experiencing early miscarriage, participants could be drawn from a number of stakeholder groups (e.g. patients, frontline workers, managers, commissioners). This study proposes that frontline workers can unwittingly supporting health care structures that they themselves disagree with, and that the negotiations that shape "care as delivered" are sometimes fragmented. Action research or critical ethnography may offer mechanisms that empower frontline workers by improving their understanding of the structures within which they work and their role in constructing them (Goodman, 2016). Ultimately this may assist health care workers to address the issues that contribute to patient dissatisfaction with care in this context.

On the same issue, the very pervasive nature of compromise and negotiation regarding aspirations about QOC was evident in this study. The idea that health care workers might be restricted in their ability to deliver on values-based aspect of care, such as compassion and sensitivity, was evident. Such an observation has numerous implications and further exploration of the compromises and trade-offs that health care workers might be prepared to make would be valuable. Exploring the congruence between this and the values and compromises patients, managers and health care commissioners might make may also provide a useful tool in terms of providing more detailed guidance about the most appropriate ways to develop and deliver an early miscarriage service.

The dissonance associated with maintaining an organisationally acceptable identity alongside a "caring" identity was an emerging finding in this study. The impact of balancing two, sometimes competing, identities on staff and the implications that this has for the services offered within the NHS could be explored further. Of particular interest may be the ways in which frontline workers might develop strategies to protect their ability to care.

Finally, the importance of patient centred and humane care practices have been outlined in this study however the problems related to understanding, measuring and resources such intangibles in the context of organisational driven by techno-rational model have been described to be significant. Building upon research aimed at conceptualising and providing guidance and support on the appropriate parameters of humane and PCC practices may be offer frontline workers the support they require to be able to successfully negotiate QOC according to their own practice based understandings of quality.

8.6 Recommendations

To conclude, this section proposes a number of recommendations based on the findings of this work and the implications it may have for the ways in which (a) early pregnancy loss is managed, and (b) strategies are used in the National Health Service to involve the frontline workforce in quality of care improvement activities.

***Recommendation 1**. Early Pregnancy Loss services could use the model of ideal attributes outlined in this research as a structure on which to base quality improvements in this health care context.* This research has defined a model of optimal care for women experiencing early pregnancy loss. This model, as described in Chapter 4, and illustrated in Figure 4-1 (page 107), outlines the ideal attributes of such a service as well as the structural features of an organisation that might support successful delivery of those attributes (e.g. chapter 4 describes how continuity of carer can offer a number of important benefits such as enhancing opportunities for the development of therapeutic interpersonal relationships between care giver and patient (Jones, 2014), increasing the sense of responsibility health care professionals feel regarding the quality of the care they deliver, and increasing the flexibility health care professionals in the way that they respond to the needs of individual women).

***Recommendation 2.** Consideration regarding the physical placement of early pregnancy loss services has the potential to have a significant impact on the quality of services delivered to this patient group.* The findings of this research clearly identify the difficulties frontline health care professionals experience when the needs of different patients ‘compete’ for their time, and the specific challenges inherent in trying to give ‘caring’ aspects of health care priority over physical and/or acute aspects of care. The frontline workers in this study differed in their opinions about the most appropriate location to site early pregnancy loss services where they are incorporated into a pre-existing service (e.g. maternity, gynaecology, surgery). However, they were consistent in their belief that the best way to deal with this dilemma would be to extend stand-alone early pregnancy assessment units to allow them to deliver treatment as well as assessment. This would enhance the possibility of delivering care to the model described in Recommendation 1 by increasing possibility of continuity of care. It would also allow staff to develop the specialised experiential knowledge noted to be important in this study.

Recommendation 3. *Frontline workers may benefit from being supported to recognize their role in improving quality of the services they deliver, particularly in relation to the implications of their non-disruptive and disruptive activities on longer-term quality.* This research has outlined the complex relationship between the actions and inactions of frontline NHS workers in response to aspects of care they consider to be suboptimal, and to the long term quality of these services. Feelings of powerlessness represented a barrier to frontline workers becoming more engaged in supporting structural change to improve QOC. Encouraging reflexivity in both pre and post registration education and training (individually or within groups of uni or multi-disciplinary groups of staff) may provide a way for frontline workers to (a) understand the power they can and do exert, (b) work together to challenge collective understandings and recognise behaviours that perpetuate suboptimal QOC (e.g. understanding the cycle of care gifting described in chapter 7 (see page 201) could enable frontline workers to understand their role in the cycle and explore ways to break from it). This might be facilitated by research methodologies (particularly participatory methods such as action research).

Recommendation 4. *Frontline workers could be supported in their ability to use their experiential knowledge more effectively if they engaged with other powerful groups, such as patient groups or health care commissioners.* This research suggested that there was limited dialogue between frontline workers and those in a position to instigate change, and that power imbalances (perceived and/or real) can inhibit honest discussion between frontline workers and senior managers. Knowledge sharing between frontline workers and other potentially powerful groups, such as patient groups or health care commissioners, may facilitate debate about the implicit beliefs of frontline workers and provide additional support to instigate change.

Recommendation 5. *Policymakers might consider how they can support the delivery of humane and PCC aspects of care within a health care system which relies on techno-rational methods of measuring the quality and impact of care.* The importance of humane and patient centred health care is evident in many contemporary NHS policies; recognition that physical health care has historically been prioritised over other aspects of health care is also evident in recent moves to achieve ‘parity of esteem’ for mental health care. This research demonstrates the everyday difficulties faced by frontline health care workers in delivering on this because of the intangible nature of these aspects of care. Exploring ways in which the successful delivery of intangible aspects of care can be effectively recognised and resourced could be an important way for policymakers to support frontline staff to deliver on humane care. It might also help to challenge the notion evident in this study that ‘caring’ aspects of care are a frontline responsibility that can be delivered without resource allocation or structural support.

Recommendation 6. *The social theories underpinning this study suggest that policymakers could consider the ways in which those delivering care may reinterpret policies. Policies that are viewed as aspirational because they are vague or not supported by tangible resource allocation are particularly vulnerable to compromise.* This study has described compromise as an integral feature of care delivery for frontline workers in their day to day work. Negotiations around the limits of compromise (the ‘window of acceptable QOC’ illustrated in Figure 7-1) may not be obvious and can result in variability of QOC on important issues (e.g. in relation to human aspect of care). Engaging with frontline workers to develop policies that genuinely address issues of importance to patients, that are not open to multiple interpretations, and that are viewed as realistic, may mitigate against unhelpful ‘street level’ policy reinterpretations. Where compromise is felt to be inevitable, or where issues of inequality are perceived, this might be best addressed by introducing transparency and allowing open debate regarding reasonable limits to the window of acceptable QOC. This might reduce the need for the kind of street level negotiations that have the potential to introduce inequality and support unhelpful societal biases

Recommendation 7. *Further exploration of the relationship between frontline and managerial level NHS workers could enhance understanding of ‘Street Level Bureaucracy’.* The theories of Street Level Bureaucracy and Negotiated Order provide useful lenses with which to understand the complex issues that can result in QOC deficiencies in the NHS. This study has illuminated an important interplay between frontline workers and managers; whilst SLB has previously focused on the activities of frontline workers, further exploration of the role of managers in facilitating frontline discretion, and the implications that this can have for NHS services, could expand understandings of the SLB concept.

Appendices

Appendix A. Timeline for Primary Study

		Project Month																							
	Task	Mar 2010	April 2010	May 2010	Jun 2010	Jul 2010	Aug 2010	Sept 2010	Oct 2010	Nov 2010	Dec 2010	Jan 2011	Feb 2011	Mar 2011	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012
1	Obtaining necessary permissions at 4 study sites	■	■	■																					
2	Completion of staff and patient interviews at 4 study sites (phase 1, Hospitals A-D)				■	■	■	■	■	■	■	■	■	■	■	■									
3	Integrated analysis of staff and patient interviews					■	■	■	■	■	■	■	■	■	■	■	■	■							
4	Presentation of results of interviews and liaison with staff at Hospital A to develop plan of care provision																	■	■						
5	Questionnaire study of patient satisfaction pre policy implementation (phase 2, Hospital A only)																■	■							
6	Implementation of policy recommendations developed in task 4 (Hospital A only)																		■	■	■	■	■	■	■
7	Questionnaire study of patient satisfaction post policy implementation (phase 2, Hospital A)																				■	■			
8	Questionnaire study of patient satisfaction with standard care (phase 2, Hospitals B-D)												■	■	■	■	■	■	■	■	■	■	■	■	
9	Analysis and presentation of phase 2 study results																						■		
10	Focus group study of staff views of engagement in policy development and service changes (phase 3, Hospital A)																			■	■				
11	Analysis and presentation of results of phase 3 study																				■	■	■		
12	Write up and dissemination of overall project results and identification of other areas of care provision suitable for staff/patient engagement model																							■	■

Appendix B. Participant Invitation Letter

<<Relevant NHS Trust Logo>>

Dear <<insert name>>

A Review of Early Pregnancy Care Policy

We are writing to invite you to take part in a study which is exploring views and experiences of health professionals about the care provided to women following diagnosis of miscarriage.

This study is being carried out by Newcastle University. The project has received ethics approval from <<insert name of LREC>>(<<date of approval>>).

The aim of this research project is to explore the views of both health professionals and women (and their partners) who have had experience of providing or receiving health care following the diagnosis of a missed miscarriage. The findings from the project will provide important insight into how current healthcare services impact on those most closely involved (i.e. patients and health professionals), and how such services might be improved. We are contacting you because we feel it is extremely important to make sure that the views of the health professionals involved in the practice are represented in our findings. We enclose an information sheet that gives further details about the study and what it would involve if you agreed to take part.

We very much hope that you will agree to help us with this important study. If you have any queries about the study then one of our study team will be happy to discuss them with you; contact details for the research midwife for this study can be found on page 2 of the information sheet.

Yours sincerely

Local Principal Investigator Name	**Professor Stephen Robson**
Local Principal Investigator Job Title	**Professor of Fetal Medicine**
Principal Investigator	**Chief Investigator**
Local NHS Trust Name	**Newcastle University**

EPCP Study. Health Professional Invitation Letter (Phases 1&3).
Version 1. 13/04/10

Appendix C. Staff Participant Information Sheet

<<Relevant NHS Trust Logo>>

A Review of Early Pregnancy Care Policy
Participant Information Sheet

We would like to invite you to take part in a research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Talk to others about the study if you wish.

Part 1 of this sheet tells you the purpose of this study and what will happen if you take part.
Part 2 gives you more detailed information about the conduct of the study.

Ask us if there is anything that is not clear.

PART 1

What is the purpose of the study?

Miscarriage affects around 1 in 5 pregnancies and women often need to access health care services during a miscarriage. We know from research that this can be a distressing and difficult time for women and their families. We are interested to understand more about health professionals' experiences of organising or providing care to women/couples experiencing miscarriage. The aim of this study is to look at ways in which health professional and patient views can be used to plan the ways in which health care services are provided.

Why have I been invited?

You have been invited because you work within one of the hospitals taking part in this study and have been involved with the management or provision of care to women/couples experiencing miscarriage.

Do I have to take part?

No. It is up to you. If you agree to take part in the study you would be asked to sign a consent form. You are free to withdraw at any time without giving a reason.

What will happen to me if I take part?

The study involves an interview with a research midwife, Allison Farnworth. The interview involves you discussing your experiences of providing care to women/couples experiencing miscarriage. The interview will be arranged at a time convenient to you; it can be conducted at weekends if this is more convenient. The interview can take place at your place of work, or at another location preferred by you, and will normally last about 60 minutes. At the beginning you would be asked to sign a consent form for the study, and you will be given a copy of the consent form to keep. We would also like to tape record our discussion so we have a record of what is said.

The interview can be ended or postponed at any point if you wish and you would not have to answer any questions you didn't want to. A copy of the interview transcript (a written record of what has been said) will be made available to you if you would like to have one. You can withdraw from the study at any time, even after the interview.

What are the possible disadvantages of taking part?

You may feel distressed by talking about the topic of miscarriage and how this relates to your work.

What are the possible benefits of taking part?

There would be no benefit to you taking part in this study but the information we collect will improve our knowledge about the best ways to provide health care to women / couples experiencing miscarriage and the best ways of supporting health professionals providing such care.

Will my taking part in this study be kept confidential?

All information that is provided by you during the research will be kept strictly confidential. Detailed information is given on this in Part 2.

What if there is a problem?

Any complaint about the way you have been dealt with during the study will be addressed. More detailed information about this is given in part 2.

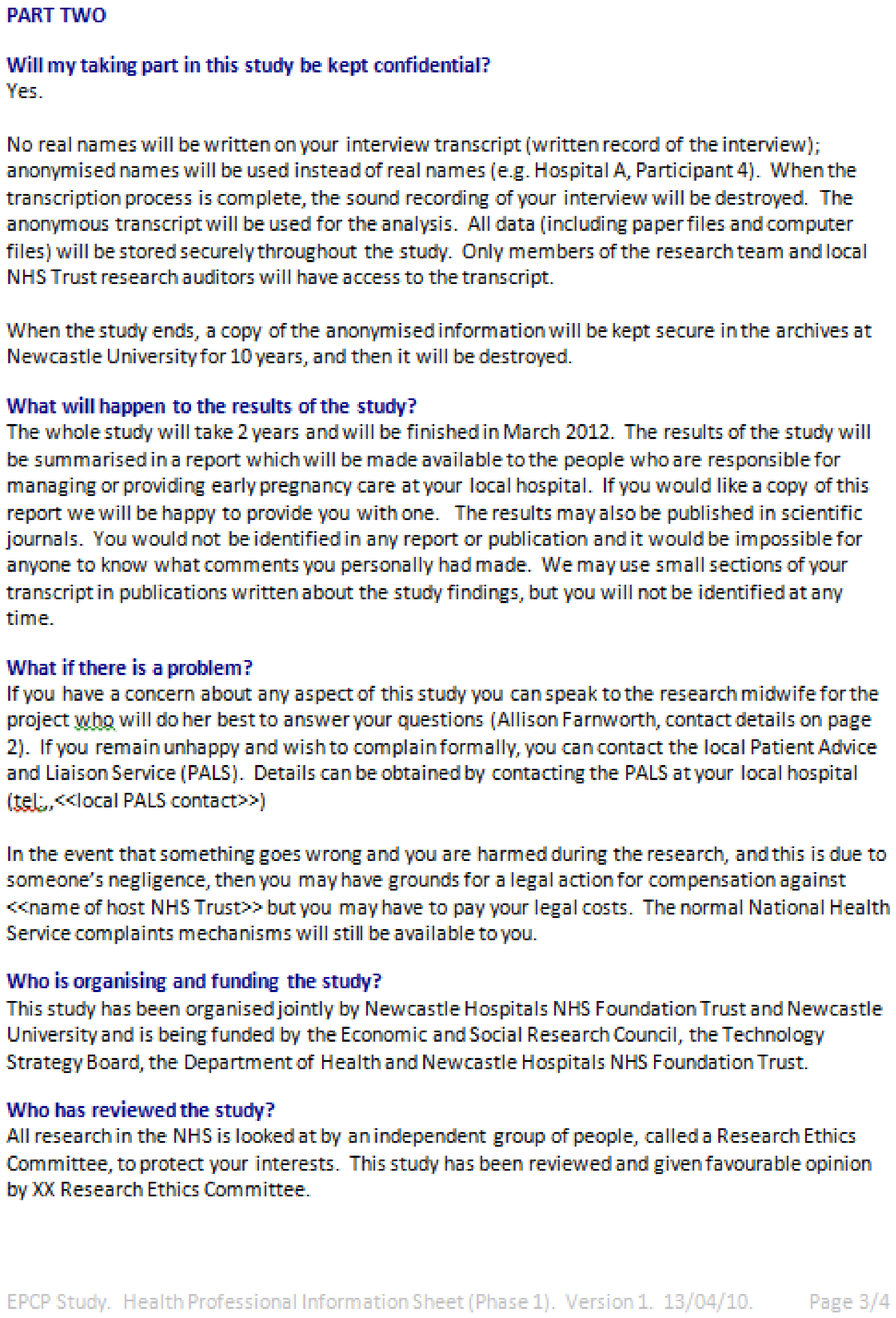
Contact for Further Information

The research midwife co-ordinating this study is Allison Farnworth and Allison's contact details are:

☎ (0191) 222 7510
🖳 a.farnworth@ncl.ac.uk
✉ Research Midwives Office, Level 6, Leazes Wing, Royal Victoria Infirmary, Richardson Road, Newcastle upon Tyne, NE1 4LP.

If you would prefer to speak with someone from your own hospital the lead study contact for your local hospital is <<lead clinician name>>, <<lead clinician hospital>>, <<lead clinician contact number>>

This completes part 1 of the information sheet. If the information in part 1 has interested you and you are considering participation, please read the additional information in part 2 before making any decision.



PART TWO

Will my taking part in this study be kept confidential?

Yes.

No real names will be written on your interview transcript (written record of the interview); anonymised names will be used instead of real names (e.g. Hospital A, Participant 4). When the transcription process is complete, the sound recording of your interview will be destroyed. The anonymous transcript will be used for the analysis. All data (including paper files and computer files) will be stored securely throughout the study. Only members of the research team and local NHS Trust research auditors will have access to the transcript.

When the study ends, a copy of the anonymised information will be kept secure in the archives at Newcastle University for 10 years, and then it will be destroyed.

What will happen to the results of the study?

The whole study will take 2 years and will be finished in March 2012. The results of the study will be summarised in a report which will be made available to the people who are responsible for managing or providing early pregnancy care at your local hospital. If you would like a copy of this report we will be happy to provide you with one. The results may also be published in scientific journals. You would not be identified in any report or publication and it would be impossible for anyone to know what comments you personally had made. We may use small sections of your transcript in publications written about the study findings, but you will not be identified at any time.

What if there is a problem?

If you have a concern about any aspect of this study you can speak to the research midwife for the project who will do her best to answer your questions (Allison Farnworth, contact details on page 2). If you remain unhappy and wish to complain formally, you can contact the local Patient Advice and Liaison Service (PALS). Details can be obtained by contacting the PALS at your local hospital (tel:,<<local PALS contact>>)

In the event that something goes wrong and you are harmed during the research, and this is due to someone's negligence, then you may have grounds for a legal action for compensation against <<name of host NHS Trust>> but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Who is organising and funding the study?

This study has been organised jointly by Newcastle Hospitals NHS Foundation Trust and Newcastle University and is being funded by the Economic and Social Research Council, the Technology Strategy Board, the Department of Health and Newcastle Hospitals NHS Foundation Trust.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by XX Research Ethics Committee.

Where can I get further information?

If you would like further information about research in the NHS you can access the National Research Ethics Service website at http://www.nres.npsa.nhs.uk/. If you would like more information specifically about this research project you can contact a member of the research team using the contact details given on page 2.

What should I do if I want to take part in this study?

If you wish to take part in this study you should complete the contact slip below and provide some information about how you would like the researcher (Allison Farnworth) to contact you. An addressed envelope is enclosed for you to return this to you (the postage is already paid). Once the slip has been received you will be contacted to discuss the study further. Returning this slip does not mean you have to take part in the study; it just means that you would like to consider it further.

Thank you for taking the time to read this information sheet.

This information sheet is yours to keep.

✂---

I agree / do not agree* to be contacted to discuss taking part in the above study

Signature ____________________________ Date__________

Print name____________________________

Telephone number (s)________________________________

(best time to call*: daytime/evening/anytime)

Email ____

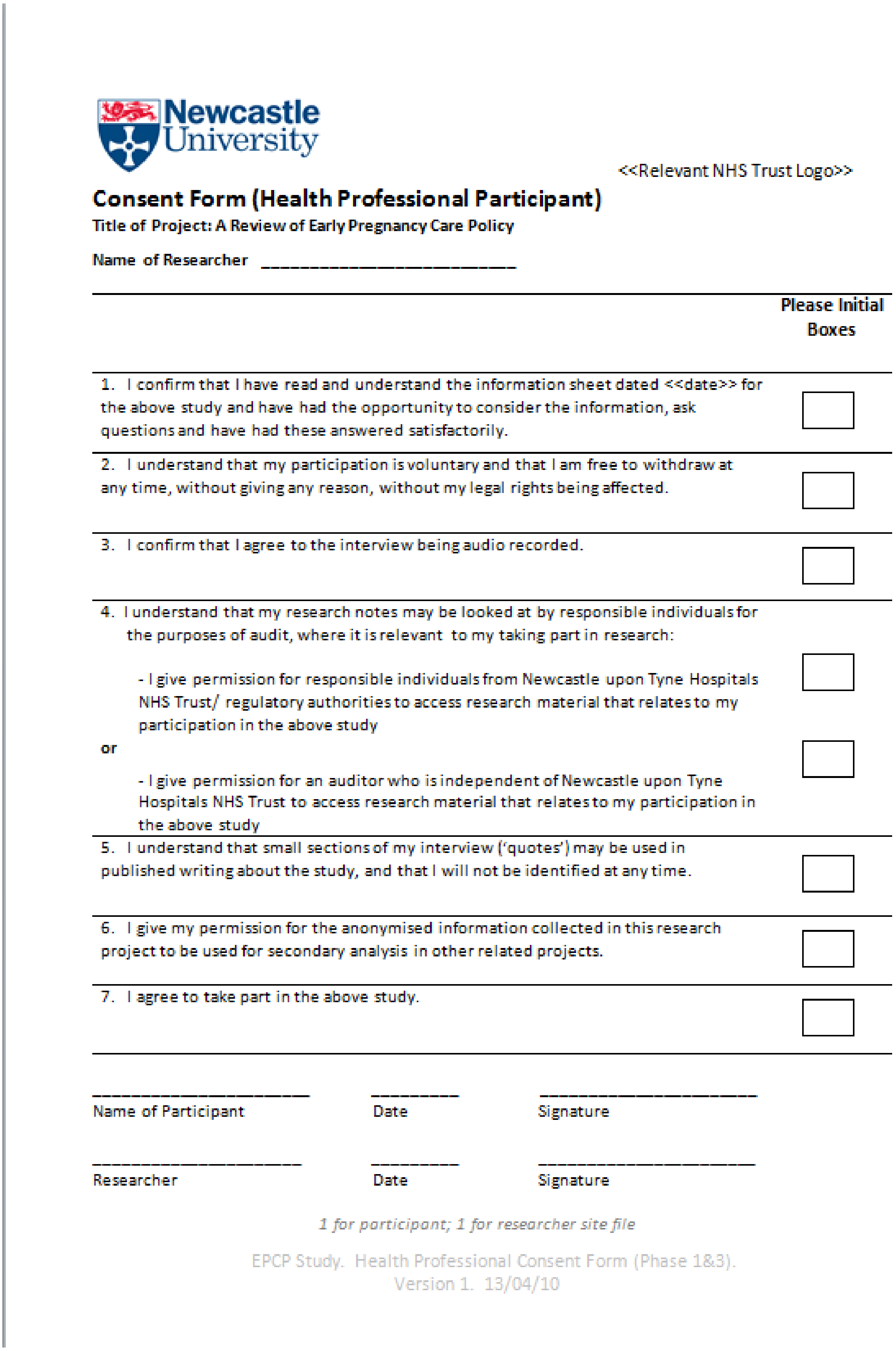
*Please delete as appropriate

Please return this in the enclosed stamped addressed envelope.

Alternatively you can contact the researcher (Allison Farnworth) directly to pass on your contact details on (0191) 222 7510 or at a.farnworth@ncl.ac.uk

EPCP Study. Health Professional Information Sheet (Phase 1). Version 1. 13/04/10. Page 4/4

Appendix D. Participant Consent Form



Newcastle University

<<Relevant NHS Trust Logo>>

Consent Form (Health Professional Participant)

Title of Project: A Review of Early Pregnancy Care Policy

Name of Researcher ___________________________

	Please Initial Boxes
1. I confirm that I have read and understand the information sheet dated <<date>> for the above study and have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	☐
3. I confirm that I agree to the interview being audio recorded.	☐
4. I understand that my research notes may be looked at by responsible individuals for the purposes of audit, where it is relevant to my taking part in research: - I give permission for responsible individuals from Newcastle upon Tyne Hospitals NHS Trust/ regulatory authorities to access research material that relates to my participation in the above study	☐
or - I give permission for an auditor who is independent of Newcastle upon Tyne Hospitals NHS Trust to access research material that relates to my participation in the above study	☐
5. I understand that small sections of my interview ('quotes') may be used in published writing about the study, and that I will not be identified at any time.	☐
6. I give my permission for the anonymised information collected in this research project to be used for secondary analysis in other related projects.	☐
7. I agree to take part in the above study.	☐

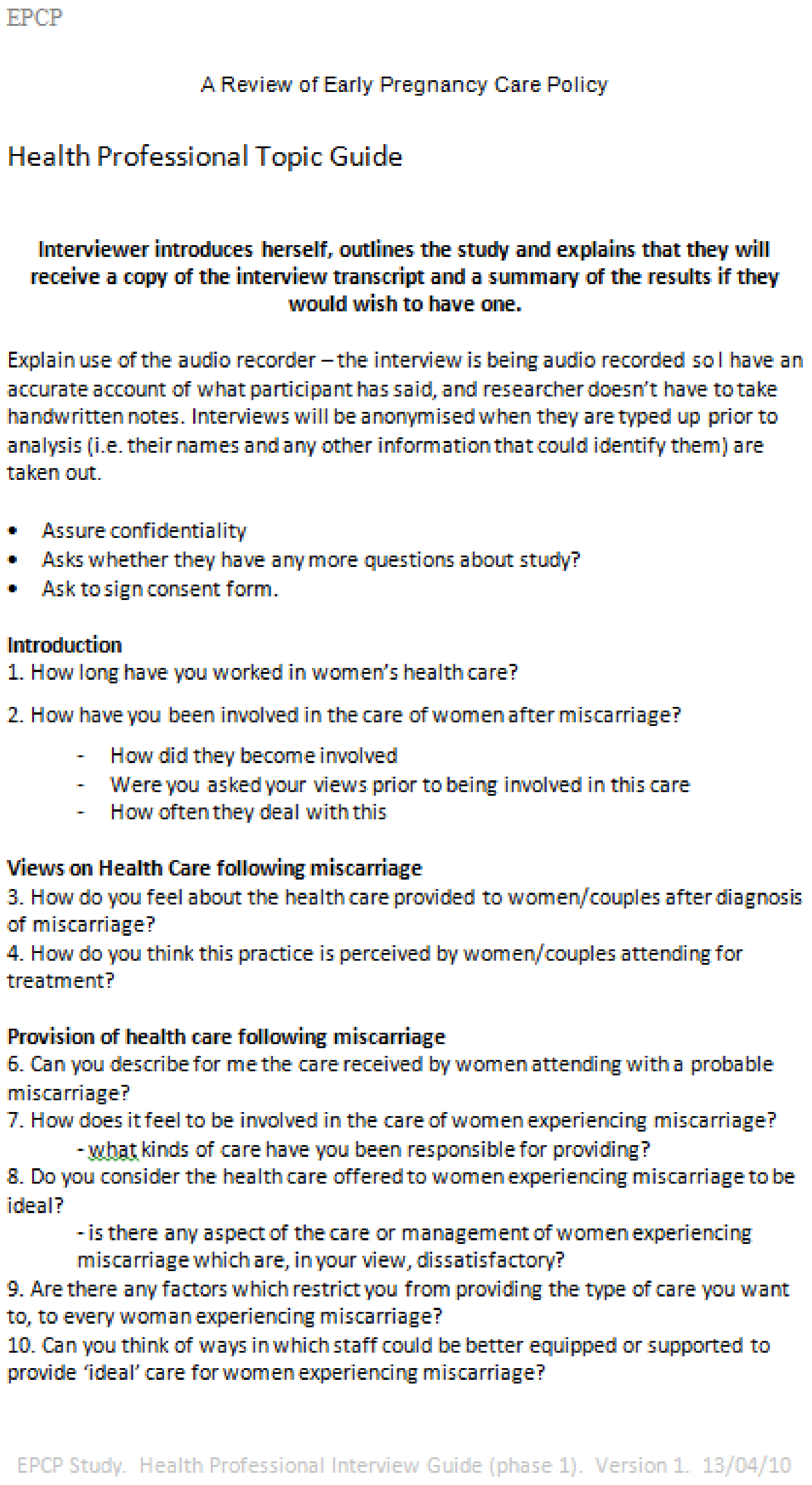
_______________________ __________ _______________________
Name of Participant Date Signature

______________________ __________ _______________________
Researcher Date Signature

1 for participant; 1 for researcher site file

EPCP Study. Health Professional Consent Form (Phase 1&3).
Version 1. 13/04/10

Appendix E. Interview Schedule



EPCP

A Review of Early Pregnancy Care Policy

Health Professional Topic Guide

Interviewer introduces herself, outlines the study and explains that they will receive a copy of the interview transcript and a summary of the results if they would wish to have one.

Explain use of the audio recorder – the interview is being audio recorded so I have an accurate account of what participant has said, and researcher doesn't have to take handwritten notes. Interviews will be anonymised when they are typed up prior to analysis (i.e. their names and any other information that could identify them) are taken out.

- Assure confidentiality
- Asks whether they have any more questions about study?
- Ask to sign consent form.

Introduction

1. How long have you worked in women's health care?

2. How have you been involved in the care of women after miscarriage?

   - How did they become involved
   - Were you asked your views prior to being involved in this care
   - How often they deal with this

Views on Health Care following miscarriage

3. How do you feel about the health care provided to women/couples after diagnosis of miscarriage?

4. How do you think this practice is perceived by women/couples attending for treatment?

Provision of health care following miscarriage

6. Can you describe for me the care received by women attending with a probable miscarriage?

7. How does it feel to be involved in the care of women experiencing miscarriage?

   - what kinds of care have you been responsible for providing?

8. Do you consider the health care offered to women experiencing miscarriage to be ideal?

   - is there any aspect of the care or management of women experiencing miscarriage which are, in your view, dissatisfactory?

9. Are there any factors which restrict you from providing the type of care you want to, to every woman experiencing miscarriage?

10. Can you think of ways in which staff could be better equipped or supported to provide 'ideal' care for women experiencing miscarriage?

EPCP Study. Health Professional Interview Guide (phase 1). Version 1. 13/04/10

11. Who decides the treatment protocols and institutional policies applying to women experiencing miscarriage?
12. What influence do you feel you have on the way health care is provided to women experiencing miscarriage?

Staff support
14. What support, if any, is given to staff involved in caring for women experiencing miscarriage?
15. Can you think of ways in which staff could be better supported?

End of interview

- I have reached the end of my questions. Is there anything else you would like to add?
- How did you feel about the interview?
- Are there any questions you would like to ask me about the study?
- Thank them for giving up their time.

- Ask them if they still agree for the interview to be analysed.
- Ask them if they would like a copy of the transcript.
- Ask them whether they would like a summary of the findings at the end of the study.
- Ask them whether they would like the opportunity to approve direct quotations prior to publication in academic journals

Appendix F. Transcription Conventions

Each participant has a unique number identifying them; numbers were given sequentially and have no meaning in themselves. In quotations where only one person is speaking the participant number is given at the end of the quote. Participants are references as (study number, manager/frontline manager/frontline). The participants' study site is only given where a direct comparison is being made between the type of response given by staff at different sites. In quotations that include more than one person speaking: 'I' refers to the interviewer and the participant is referred to by their study number. The following abbreviations and conventions are used in the quotes shown in the thesis.

Example	***Meaning***
..	Speaker took a short pause (up to 2 seconds)
….	Speaker took a longer pause (over 2 seconds)
<…>	A portion of text has been removed from the quote to aid understanding
<text>	A portion of text has been changed to maintain anonymity
[this hospital]	Text has been added to a quote to provide meaning to the reader, e.g. when the speaker talked about 'they' 'he' 'she' etc.
Text?	The speaker phrased their speech as a question
non-verbal	Non-verbal interaction/response from the speaker, e.g. *laughs* *cries*, OR modification to verbal response, e.g. *whispers*
<u>Emphasis</u>	Speaker placed extra emphasis on these words
'blah blah'	Speaker quoted something they, or someone else, said

Local dialect particulars

Interviews were transcribed verbatim and regional dialects mean that some words might lose their meaning to those who are not familiar with the North East accent. Some words have been modified to make sense to the reader (e.g. it is not unusual for a North Easterner to pronounce 'my' as 'me', and 'me' as 'uz'; these have been modified in the quotes provided). Two further words appear frequently in the quotes that are not standard English; they are 'gonna' (meaning 'going to') and 'cos' (meaning 'because'). Finally, one participant uses the word 'aye' (meaning 'yes').

Appendix G. End of Primary Study Report

Project Start Date: 8th March 2010

Project End Date: 7th March 2012

Chief Investigator: Professor Stephen C Robson

Methods

The project was conducted over three phases; each phase informing the next.

- **Phase 1.**

  A qualitative interview study of patient and staff views of health care for early pregnancy loss. Participants comprised of:

  Patients. Women who had recently experienced an early pregnancy loss at one of the study sites were interviewed regarding their experiences of their health care and their opinions about ways in which care could be improved. All women were invited to include their partner in the interview (where applicable). All women were interviewed in their home up to 4 weeks following their hospital care.

  Staff. Staff members who are involved in the delivery or management of early pregnancy loss services at the four study sites were interviewed regarding their experiences of providing or managing this care, opinions about improvements, and experiences of frontline involvement in service improvement.

- **Phase 2.**

  A patient survey of satisfaction with early pregnancy loss health care.

  A postal questionnaire was sent out to women who had recently experienced health care for an early pregnancy loss at any of the study sites. The survey was sent out four weeks after the woman's discharge from hospital care. Agreement to receive the questionnaire was sought whilst the patient was in hospital and return of the questionnaire indicated their consent to participate. The questionnaire included 19 statements which were answered on a Likert scale; the 19 statements related to important features of care as extracted from the Phase 1 patient data. The final three questions were open ended and requested information about any particularly positive or negative aspects of care.

This phase also included a series of workshops which were delivered to frontline and managerial staff within the early pregnancy loss services at the Royal Victoria Infirmary. The purpose of the workshops was to present the results from the first phase of the project and develop ideas for service improvements to meet patient needs.

- **Phase 3.**

An interview study of health care staff views regarding frontline engagement in service improvement.

A series of interviews (focus group or individual depending on the wishes and availability of the participants) with staff from the early pregnancy loss services at Site 1, including those involved in the phase 2 workshops.

This phase also included the development of a toolkit describing the process of involving frontline staff and patients in the development of service improvement ideas.

Recruitment

Recruitment to each phase, per study site is shown in Table I.

Table I. Recruitment to KTP EPCP study

	Site A			**Site B**			**Site C**			**Site D**			**Total**
	Patients	**Partners**	**Staff**	**Patients**	**Partners**	**Staff**	**Patients**	**Partners**	**Staff**	**Patients**	**Partners**	**Staff**	
Phase 1													
Invited	7		18	15		21	17		19	12		18	**127**
Consented	2	0	14	4	1	11	11	7	7	7	2	9	**72**
Phase 2													
Invited	118			56						36			
Agreed	116			53						30			
Returned survey	76			30			29			19			154
Phase 3													
Invited			12										
Consented			11										

- Recruitment to Phase 1 was less than initially projected. This was phase was a qualitative interview study and recruitment ceased after data saturation was reached.
- Recruitment to Phase 2 was less than projected at two of the study sites. This was due to (a) difficulties in accessing potential participants and (b) lower numbers of women attending with an early pregnancy loss than anticipated. Recruitment exceeded the target at the other two sites so overall phase two recruitment was as planned.
- Recruitment to Phase 3 was as planned.

Results

Phase 1.

A thematic analysis of the interview data was conducted. This provided two main streams of information:

i) Concepts of 'ideal' early pregnancy care and areas for improvement at the study sites involved. The main attributes of 'ideal care' are encompassed in a model of place, people, and processes. The attributes overlap and can interact (so, for example, if the process involves patients waiting for long periods when they are distressed then patients may interpret this as staff not caring) making assessment of complaints complex. Staff highlighted their frustration with inadequate processes which are distressing to both patients and themselves.

Table II. Attributes of Ideal Early Pregnancy Loss Health Care

People	Processes	Place
Knowledgeable Sensitive Able to deal with grief Responsive Available Respectful	Consistency Continuity (of people and processes) Responsive (especially in relation to pain relief) Timely (patients seen quickly, but not rushed into decisions) Good information provision	Offers privacy Offers dignity (i.e. single toilets rather than stalls) Unable to identify ideal location for care; good and bad points about gynaecology/general surgery/maternity wards Clean

ii) Ideas about the powers that shape how services are designed and delivered within a health care organisation, the ways in which frontline staff can be helped or hindered from engaging in service improvement activities, and the negative outcomes associated with failure to provide suitable mechanisms for frontline staff to engage.

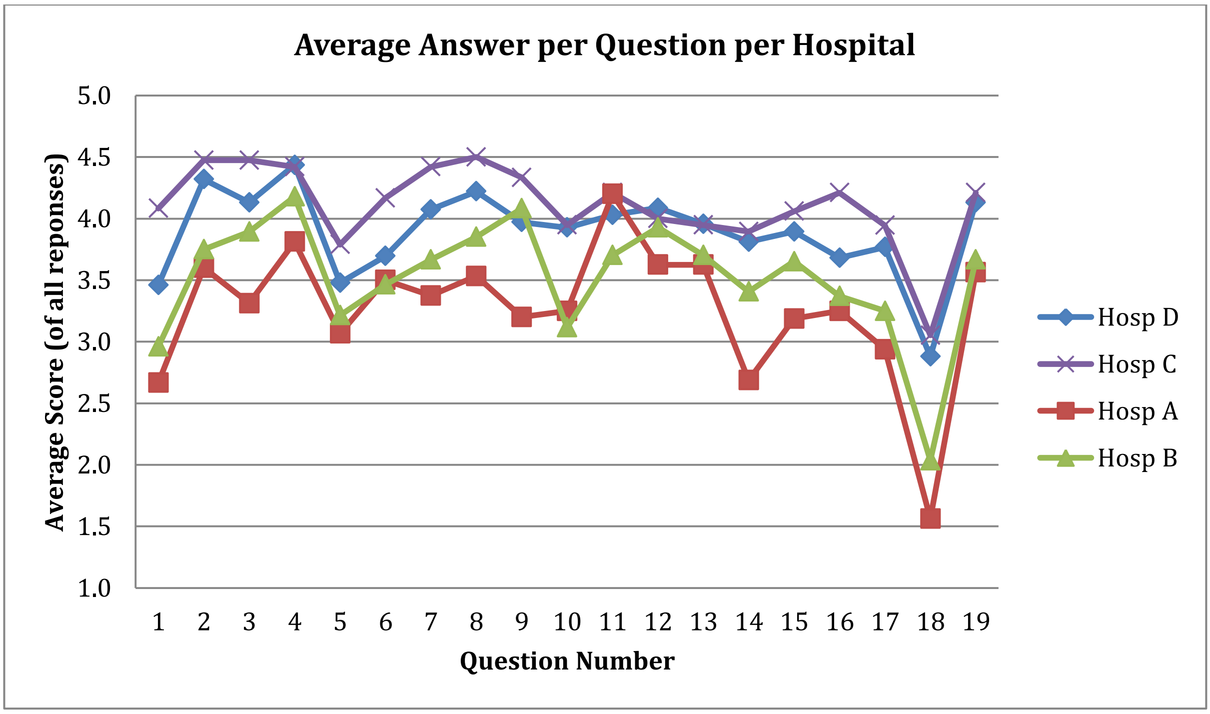
Phase 2.

This phase consisted of two activities:

i) A patient satisfaction survey. This was a 19 item survey sent to women four weeks after they had attended one of the study sites for treatment of a miscarriage (the survey was only sent out to women who agreed to receive it). 154 responses were received in a mixture of postal (82%) and telephone (18%) responses. The results indicated significant differences in the patient satisfaction with care rating between the study sites. They also highlighted universal areas of decreased satisfaction around the areas of information provision (consistency and accuracy), waiting times (for assessment, treatment, and whilst in hospital) and provision of investigation into the reason for the miscarriage. Open ended responses highlighted site specific issues at each of the study sites.

Figure 1 shows the average response per question per hospital (with 5 being the most desirable response and 1 being the least desirable). Details of the questions are shown in the survey (Appendix 1).

Figure III.



ii) A series of multi-disciplinary and multi-departmental workshops were held at Site 1. The workshops were held to feedback the results of phase 1 and to facilitate the active involvement of relevant frontline staff (from the early pregnancy loss services at Site 1) in service improvement activities. A total of three workshops were held; they were highly interactive and consisted of problem identification, idea generation, consensus building and forward planning. The first two workshops were held with frontline staff only; the final workshop included frontline staff, managerial staff, academic staff, and a patient representative. A series of 12 improvement ideas were generated and three were chosen and agreed to take forward.

Phase 3.

Phase 3 consisted of qualitative evaluation with the frontline and managerial staff involved with the project. The purpose was to ascertain the views of staff about the involvement of frontline staff and patients in service improvement activities. 11 staff members agreed to take part; 6 were interviewed in focus groups, and 5 were interviewed individually (because of logistic problems in arranging a time/date suitable to all). A further staff member provided her feedback by email.

The results suggested that patient engagement was universally considered to be positive; especially amongst this patient group who often did not provide feedback. Involvement of a patient representative during the phase 2 workshops was considered challenging to some frontline staff but ultimately worthwhile. Frontline involvement in improving services was universally accepted as a positive idea. The frontline workshops were generally considered to be valuable in giving staff the opportunity to reflect on the care being offered and identify tangible solutions to problems. As they were multi-disciplinary and multi-departmental it also allowed for joint problem solving. The staff felt that the changes proposed could have a positive impact on patient care although some remained sceptical about whether changes would be actioned. All of the staff who had participated in the workshops and interviews said that they would be prepared be involved in similar initiatives in the future. Areas for improvement were also identified; the most frequently mentioned area was around staff time with many staff experiencing difficulty being able to be released from their clinical duties to attend the workshops or read through materials provided to them. Better engagement with medical staff was also identified as an area which could have been improved.

Conclusion

The project identified some of the attributes of ‘ideal’ health care for women/couples experiencing early pregnancy loss as well as some of the barriers and facilitators to staff providing this care. The importance of providing a mechanism for frontline staff to identify opportunities for service improvement was highlighted. A series of engagement workshops were held which resulted in a number of service improvement ideas which were supported by frontline and managerial staff and which mapped directly to the expressed needs of women with direct experience of early pregnancy loss care. The project represents an effective approach to engaging frontline staff and patients in the process of improving local health care policy and practice. The service changes proposed by the project are now being managed by the Women’s Services Directorate.

Dissemination

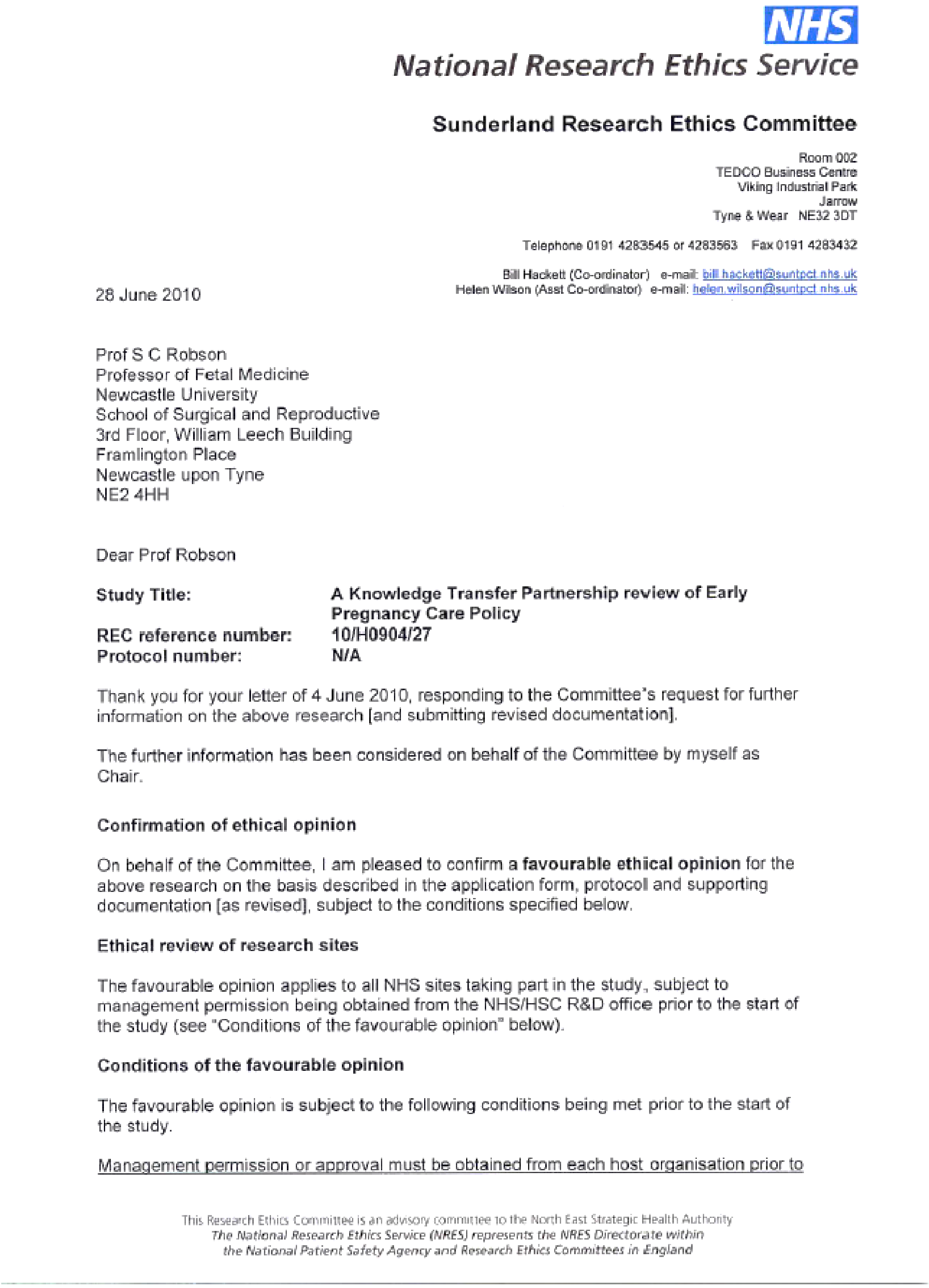
A toolkit outlining the process of replicating this project has been produced; it has been designed to be generic and applicable to a wide variety of the services delivered within the Newcastle Hospitals. This toolkit will be held and managed by the Quality and Effectiveness department within the Trust.

The project has been presented at a number of levels within Newcastle hospitals including at board level (e.g. Clinical Governance and Quality Committee), at the Newcastle Hospitals Trust nursing conferences (2011, and 2012), at departmental meetings and at ward level within Newcastle. We are also planning to present the results at the other study sites involved in the project.

We have maintained a dialogue with the consumer representative members of our steering group and the associate who managed the project is planning to write a joint article for submission to the Miscarriage Association regarding the project.

We will be producing a short overview of the study results to be disseminated to all of the people who participated in the project and who indicated that they would like to receive a copy of the results.

Appendix H. Letter from Ethical Committee Confirming Approval



NHS
National Research Ethics Service

Sunderland Research Ethics Committee

Room 002
TEDCO Business Centre
Viking Industrial Park
Jarrow
Tyne & Wear NE32 3DT

Telephone 0191 4283545 or 4283563 Fax 0191 4283432

Bill Hackett (Co-ordinator) e-mail: bill.hackett@suntpct.nhs.uk
Helen Wilson (Asst Co-ordinator) e-mail: helen.wilson@suntpct.nhs.uk

28 June 2010

Prof S C Robson
Professor of Fetal Medicine
Newcastle University
School of Surgical and Reproductive
3rd Floor, William Leech Building
Framlington Place
Newcastle upon Tyne
NE2 4HH

Dear Prof Robson

Study Title: **A Knowledge Transfer Partnership review of Early Pregnancy Care Policy**
REC reference number: **10/H0904/27**
Protocol number: **N/A**

Thank you for your letter of 4 June 2010, responding to the Committee's request for further information on the above research [and submitting revised documentation].

The further information has been considered on behalf of the Committee by myself as Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a **favourable ethical opinion** for the above research on the basis described in the application form, protocoll and supporting documentation [as revised], subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to

This Research Ethics Committee is an advisory committee to the North East Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. *Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

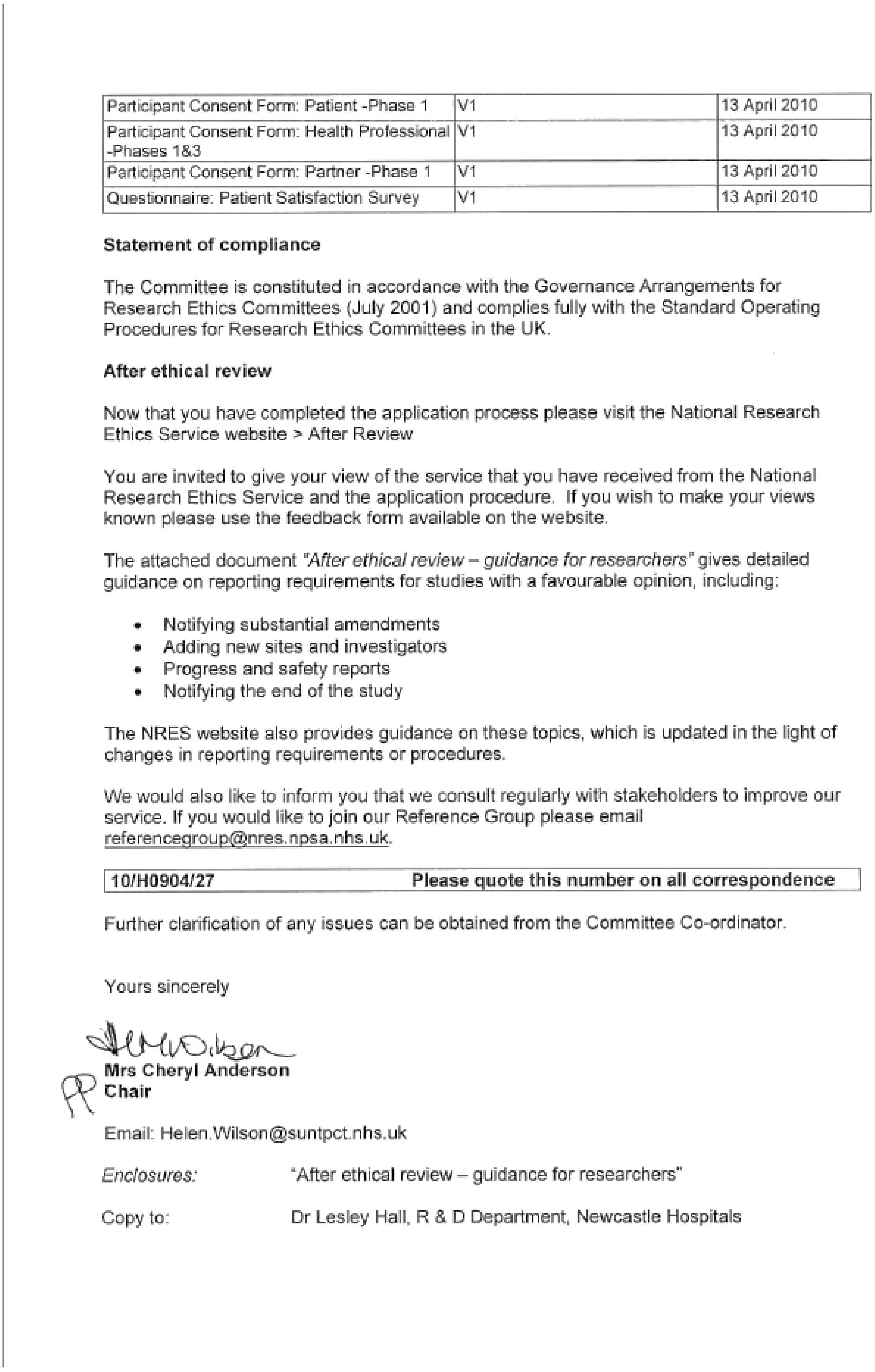
Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Investigator CV	Allison Farnworth	20 April 2010
Investigator CV	Professor SC Robson	16 April 2010
Investigator CV	Dr Ruth Graham	01 June 2010
Protocol	V1 - 60 pages	13 April 2010
Knowledge Transfer Partnership KTP007733		24 February 2010
Study Flowchart -Three phases	V1	13 February 2010
Phase 1 Consent Process Flowchart	V1	13 April 2010
REC application	IRAS V 2.5	16 April 2010
Covering Letter	From Professor SC Robson	20 April 2010
Covering Letter		04 June 2010
Interview Schedules/Topic Guides	V1 Health Professional Topic Guide -Phase 1	13 April 2010
Interview Schedules/Topic Guides	V1 Patient Interview Guide - Phase 1	13 April 2010
Interview Schedules/Topic Guides	V1 Health Professional Focus Group -Phase 3	13 April 2010
Letter of invitation to participant	V1 - Phase 1	13 April 2010
Letter of invitation to participant	V1 Health Professional - Phases 1&3	13 April 2010
Letter of invitation to participant	V1 Patient - Phase 2	13 April 2010
GP/Consultant Information Sheets	V1 GP letter - phase 1	13 April 2010
Participant Information Sheet: Patient Information sheet Phase 1	V1	13 April 2010
Participant Information Sheet: Participant Information sheet -Partner Phase 1	V1	13 April 2010
Participant Information Sheet: Participant Information sheet - Health Professional Phase 1	v1	13 April 2010
Participant Information Sheet: Patient Information sheet - Phase 2	V1	13 April 2010
Participant Information Sheet: Participant Information sheet -Health Professional	V1	13 April 2010
Response to Request for Further Information		



Participant Consent Form: Patient -Phase 1	V1	13 April 2010
Participant Consent Form: Health Professional -Phases 1&3	V1	13 April 2010
Participant Consent Form: Partner -Phase 1	V1	13 April 2010
Questionnaire: Patient Satisfaction Survey	V1	13 April 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H0904/27	**Please quote this number on all correspondence**

Further clarification of any issues can be obtained from the Committee Co-ordinator.

Yours sincerely

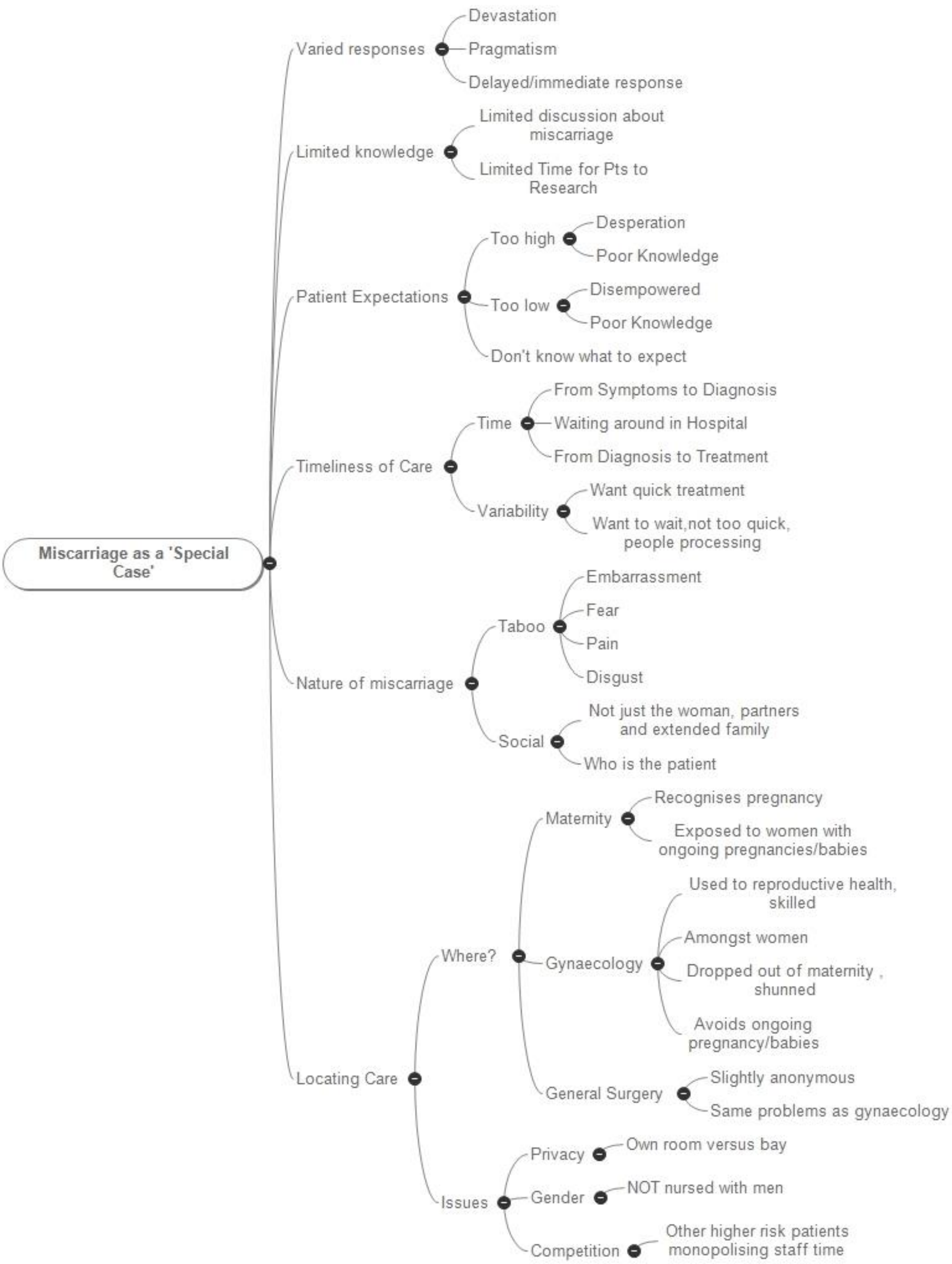
Mrs Cheryl Anderson
Chair

Email: Helen.Wilson@suntpct.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Dr Lesley Hall, R & D Department, Newcastle Hospitals

Appendix I. Example of Detailed Coding in Concept Map



References

Abbott, P. and Meerabeau, E. (1998) 'Professionals, professionalization and the caring professions', in Abbott, P. and Meerabeau, E. (eds.) *The Sociology of the Caring Professions*. 2nd edn. London: UCL Press, pp. 1-19.

Abboud, L. and Liamputtong, P. (2005) 'When pregnancy fails: Coping strategies, support networks and experiences with health care of ethnic women and their partners', *Journal of Reproductive and Infant Pyschology*, 23(1), pp. 3-18.

Abboud, L.N. and Liamputtong, P. (2003) 'Pregnancy loss: what it means to women who miscarry and their partners', *Social Work in Health Care*, 36(3), pp. 37-62.

Adams, G.B. (2011) 'The Problem of Administrative Evil in a Culture of Technical Rationality', *Public Integrity*, 13(3), pp. 275-285.

Admasachew, L. and Dawson, J. (2011) 'The association between presenteeism and engagement of National Health Service staff', *Journal of Health Services Research and Policy*, 16(SUPPL. 1), pp. 29-33.

Adolfsson, A., Bertero, C. and Larsson, P.-G. (2006) 'Effect of a structured follow-up visit to a midwife on women with early miscarriage: a randomized study', *Acta Obstetricia et Gynecologica Scandinavica*, 85(3), pp. 330-335.

Adolfsson, A., Larsson, P.G., Wijma, B. and Bertero, C. (2004) 'Guilt and emptiness: women's experiences of miscarriage', *Health Care for Women International*, 25(6), pp. 543-60.

Aij, K.H., Simons, F.E., Widdershoven, G.A.M. and Visse, M. (2013) 'Experiences of leaders in the implementation of Lean in a teaching hospital - Barriers and facilitators in clinical practices: A qualitative study', *BMJ Open*, 3(10).

Akhter, P., Padmanabhan, A., Babiker, W., Sayed, A., Molelekwa, V. and Geary, M. (2007) 'Introduction of an early pregnancy assessment unit: audit on the first 6 months of service', *Irish Journal of Medical Science*, 176(1), pp. 23-26.

Allan, H.T., Odelius, A., Hunter, B.J., Bryan, K., Knibb, W. and Shawe, J. (2015) 'Gatekeeping access to the midwifery unit: Managing complaints by bending the rules', *Health*, 19(6), pp. 652-669.

Allen, D. (2014) 'Re-conceptualising holism in the contemporary nursing mandate: from individual to organisational relationships', *Social Science and Medicine*, 119, pp. 131-138.

Allen, D., Griffiths, L. and Lyne, P. (2004) 'Accommodating health and social care needs: routine resource allocation in stroke rehabilitation', *Sociology of Health & Illness*, 26(4), pp. 411-432.

Allen, J. (1997) 'Reflexive modernization: Politics, tradition and aesthetics in the modern social order - Beck,U, Giddens,A, Lash,S', *Transactions of the Institute of British Geographers*, 22(2), pp. 263-265.

Anand, G., Chhajed, D. and Delfin, L. (2012) 'Job autonomy, trust in leadership, and continuous improvement: An empirical study in health care', *Operations Management Research*, 5(3-4), pp. 70-80.

Angen, M.J. (2000) 'Evaluating interpretive inquiry: reviewing the validity debate and opening the dialogue', *Qualitative Health Research*, 10(3), pp. 378-395.

Aniteye, P. and Mayhew, S.H. (2013) 'Shaping legal abortion provision in Ghana: using policy theory to understand provider-related obstacles to policy implementation', *Health Research Policy and Systems*, 11 [Online]. Available at: http://health-policy-systems.biomedcentral.com/articles/10.1186/1478-4505-11-23 DOI: Artn 23 10.1186/1478-4505-11-23 (Accessed: Jul 6).

Armenta, A. (2016) 'Between public service and social control: policing dilemmas in the era of immigration enforcement', *Social Problems*, 63(1), pp. 111-126.

Astley, W.G. and Van de Ven, A.H. (1983) 'Central perspectives and debates in organizational theory', *Administrative Science Quarterly*, 28(2), pp. 245-273.

Attree, M. (2005) 'Nursing agency and governance: registered nurses' perceptions', *Journal of Nursing Management*, 13(5), pp. 387-396.

Attree, M. (2007) 'Factors influencing nurses' decisions to raise concerns about care quality', *Journal of Nursing Management*, 15(4), pp. 392-402.

AuYoung, M., Duru, O.K., Ponce, N.A., Mangione, C.M. and Rodriguez, H.P. (2015) 'Frontline experiences of a practice redesign to improve self-management of obesity in safety net clinics', *The Journal of Ambulatory Care Management*, 38(2), pp. 153-163.

Bacidore, V., Warren, N., Chaput, C. and Keough, V.A. (2009) 'A collaborative framework for managing pregnancy loss in the emergency department', *JOGNN: Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 38(6), pp. 730-738.

Baggott, R. (2004) *Health and Health Care in Britain*. 3rd edn. Houndmills: Palgrave Macmillan.

Baïada-hirèche, L., Pasquero, J. and Chanlat, J.F. (2011) 'Managerial responsibility as negotiated order: a social construction perspective', *Journal of Business Ethics*, 101, pp. 17-31.

Bail, K., Cook, R., Gardner, A. and Grealish, L. (2009) 'Writing ourselves into a web of obedience: a nursing policy analysis', *International Journal of Nursing Studies*, 46(11), pp. 1457-1466.

Baker, G.R. and Denis, J.-L. (2011) 'Medical leadership in health care systems: from professional authority to organizational leadership', *Public Money and Management*, 31(5), pp. 355-362.

Bansen, S.S. and Stevens, H.A. (1992) 'Women's experiences of miscarriage in early pregnancy', *Journal of Nurse-Midwifery*, 37(2), pp. 84-90.

Barry, M.J., Hauck, Y.L., O'Donoghue, T. and Clarke, S. (2014) 'Newly-graduated midwives transcending barriers: mechanisms for putting plans into actions', *Midwifery*, 30(8), pp. 962-967.

Basak, S., Van Roon, Y., Ghosh, B. and Sriemevan, A. (2013) 'Diagnosis and management of pregnancy of unknown location (PUL): the completed audit cycle', *BJOG: An International Journal of Obstetrics and Gynaecology*, 120, pp. 560-561.

Bauman, Z. (1991) *Modernity and the Holocaust*. Ithaca, N.Y.: Cornell University Press.

Bauman, Z. (2013) *Modernity and the Holocaust*. Hoboken: Wiley.

Bergen, A. and While, A. (2005) ''Implementation deficit' and 'street-level bureaucracy': policy, practice and change in the development of community nursing issues', *Health and Social Care in the Community*, 13(1), pp. 1-10.

Berger, P.L. and Luckmann, T. (1979) *The Social Construction of Reality : a treatise in the sociology of knowledge*. Harmondsworth: Penguin.

Beswick, J. (2007) 'A first class service? Setting the standard of care for the contemporary NHS', *Medical Law Review*, 15(2), pp. 245-252.

Betts, D., Dahlen, H.G. and Smith, C.A. (2014) 'A search for hope and understanding: An analysis of threatened miscarriage internet forums', *Midwifery*, 30(6), pp. 650-656.

Betts, D., Smith, C. and Dahlen, H. (2012) *17th Congress of the Federation of Asian and Oceania Perinatal Societies, FAOPS and the 16th Annual Congress of the Perinatal Society of Australia and New Zealand*. Sydney, Australia, March. Journal of Paediatrics and Child Health.

Betz, G. and Thorngren, J.M. (2006) 'Ambiguous loss and the family grieving process', *Family Journal*, 14(4), pp. 359-365.

Beutel, M., Deckardt, R., von Rad, M. and Weiner, H. (1995) 'Grief and depression after miscarriage: their separation, antecedents, and course', *Psychosomatic Medicine*, 57(6), pp. 517-526.

Bicking Kinsey, C., Baptiste-Roberts, K., Zhu, J. and Kjerulff, K.H. (2015) 'Effect of multiple previous miscarriages on health behaviors and health care utilization during subsequent pregnancy', *Women's Health Issues*, 25(2), pp. 155-161.

Bignardi, T., Condous, G., Alhamdan, D., Kirk, E., Van Calster, B., Van Huffel, S., Timmerman, D. and Bourne, T. (2008) 'The hCG ratio can predict the ultimate viability of the intrauterine pregnancies of uncertain viability in the pregnancy of unknown location population', *Human Reproduction*, 23(9), pp. 1964-1967.

Bigrigg, M.A. and Read, M.D. (1991) 'Management of women referred to early pregnancy assessment unit: care and cost effectiveness', *British Medical Journal*, 302, pp. 577-579.

Bjerregaard, T. and Klitmoller, A. (2010) 'Frontline problem solvers: the structuring of frontline service work', *International Journal of Public Administration*, 33(8), pp. 421-430.

Blohm, F., Friden, B. and Milsom, I. (2008) 'A prospective longitudinal population-based study of clinical miscarriage in an urban Swedish population', *BJOG: an international journal of obstetrics and gynaecology*, 115(2), pp. 176-182.

Blohm, F., Friden, B., Platz-Christensen, J.J., Milsom, I. and Nielsen, S. (2003) 'Expectant management of first-trimester miscarriage in clinical practice', *Acta Obstetricia et Gynecologica Scandinavica*, 82(7), pp. 654-658.

Bloom, P.N. and White, P.J. (2016) 'The moral work of subversion', *Human Relations*, 69(1), pp. 5-31.

Bolton, S.C. (2000) 'Who cares? Offering emotion work as a ‘gift’ in the nursing labour process', *Journal of Advanced Nursing*, 32(3), pp. 580-586.

Bolton, S.C. (2005) 'Women's work, dirty work: the gynaecology nurse as 'other'', *Gender, Work and Organization*, 12(2), pp. 169-186.

Bonde, J.P., Jorgensen, K.T., Bonzini, M. and Palmer, K.T. (2013) 'Miscarriage and occupational activity: a systematic review and meta-analysis regarding shift work, working hours, lifting, standing, and physical workload', *Scandinavian Journal of Work, Environment and Health*, 39(4), pp. 325-334.

Bonfill, X., Roque, M., Aller, M.B., Osorio, D., Foradada, C., Vives, A. and Rigau, D. (2013) 'Development of quality of care indicators from systematic reviews: the case of hospital delivery', *Implementation science*, 8, p. 42 [Online]. Available at: http://www.implementationscience.com/content/8/1/42 DOI: http://dx.doi.org/10.1186/1748-5908-8-42.

Bottomley, C., Van Belle, V., Mukri, F., Kirk, E., Van Huffel, S., Timmerman, D. and Bourne, T. (2009) 'The optimal timing of an ultrasound scan to assess the location and viability of an early pregnancy', *Human Reproduction*, 24(8), pp. 1811-1817.

Bourdieu, P. and Wacquant, L.J.D. (1992) *An invitation to reflexive sociology*. Oxford: Polity Press.

Bourne, T., Barnhart, K., Benson, C.B., Brosens, J., Calster, B.V., Condous, G., Coomerasamy, A., Doubilet, P.M., Goldstein, S.R., Gould, D., Kirk, E., Mol, B.W., Raine-

Fenning, N., Stalder, C. and Timmerman, D. (2013) 'NICE guidance on ectopic pregnancy and miscarriage restricts access and choice and may be clinically unsafe', *British Medical Journal*, 346(7892), p. f197.

Brady, G., Brown, G., Letherby, G., Bayley, J. and Wallace, L.M. (2008) 'Young women's experience of termination and miscarriage: a qualitative study', *Human Fertility*, 11(3), pp. 186-190.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), pp. 77-101.

Braun, V. and Clarke, V. (2014) 'What can "thematic analysis" offer health and wellbeing researchers?', *International Journal of Qualitative Studies on Health and Well-Being*, 9, pp. 1-2.

Brier, N. (2004) 'Anxiety after miscarriage: a review of the empirical literature and implications for clinical practice', *Birth: Issues in Perinatal Care*, 31(2), pp. 138-142.

Brin, D.J. (2004) 'The use of rituals in grieving for a miscarriage or stillbirth', *Women and Therapy*, 27(3-4), pp. 123-132.

Brodkin, E.Z. (2008) 'Accountability in street-level organizations', *International Journal of Public Administration*, 31, pp. 317-336.

Brodkin, E.Z. (2012) 'Reflections on street-level bureaucracy: past, present, and future', *Public Administration Review*, 72(6), pp. 940-949.

Brodkin, E.Z. (2015) 'The inside story: street-level research in the US and beyond', in Hupe, P., Hill, M. and Buffat, A. (eds.) *Understanding Street-Level Bureaucracy*. Bristol: Policy Press, pp. 25-42.

Bruhn, A. (2015) 'Changing occupational roles in audit society-the case of Swedish student aid officials', *Nordic Journal of Working Life Studies*, 5(1), pp. 31-50.

Bryman, A. (2012) *Social Research Methods*. 4th edn. Oxford: Oxford University Press.

Bullen, J. and Fisher, K.R. (2015) 'Is housing first for mental health community support possible during a housing shortage?', *Social Policy and Administration*, 49(7), pp. 928-945.

Burr, V. (2003) *Social Constructionism*. 2nd edn. London ; New York: Routledge.

Busuioc, E.M. and Lodge, M. (2016) 'The reputational basis of public accountability', *Governance-an International Journal of Policy Administration and Institutions*, 29(2), pp. 247-263.

Callaghan, G.D. and Wistow, G. (2006) 'Publics, patients, citizens, consumers? Power and decision making in primary health care', *Public Administration*, 84(3), pp. 583-601.

Cambra-Fierro, J., Melero-Polo, I. and Vázquez-Carrasco, R. (2014) 'The role of frontline employees in customer engagement', *Revista Española de Investigación en Marketing ESIC*, 18(2), pp. 67-77.

Cameron, M., Penney, G., Maclennan, G., McLeer, S. and Walker, A. (2007) 'Impact on maternity professionals of novel approaches to clinical audit feedback', *Evaluation and the Health Professions*, 30(1), pp. 75-95.

Cameron, M.J. and Penney, G.C. (2005) 'Terminology in early pregnancy loss: What women hear and what clinicians write', *Journal of Family Planning and Reproductive Health Care*, 31(4), pp. 313-314.

Carter, P., Ozieranski, P., McNicol, S., Power, M. and Dixon-Woods, M. (2014) 'How collaborative are quality improvement collaboratives: a qualitative study in stroke care', *Implementation Science*, 9(1), p. 32 [Online]. Available at: http://www.ncbi.nlm.nih.gov/pubmed/24612637 DOI: 10.1186/1748-5908-9-32.

Cecil, R. (1994a) ''I wouldn't have minded a wee one running about': miscarriage and the family', *Social Science and Medicine*, 38(10), pp. 1415-1422.

Cecil, R. (1994b) 'Miscarriage: women's views of care', *Journal of Reproductive and Infant Pyschology*, 12, pp. 21-29.

Chan, C. and Tam, M. (2014) 'The role of boundary ambiguity: a new understanding on perinatal grief and psychological distress among Chinese women who experience miscarriage after IVF', *Human Reproduction*, 29, pp. i257-i258.

Chandler, L., Wyatt, M. and Roberts, I. (2010) 'Lost in translation: reviewing the role of the discharge liaison nurse in Wales', *Health Services Management Research*, 23(1), pp. 1-4.

Checkland, K., Marshall, M. and Harrison, S. (2004) 'Re-thinking accountability: trust versus confidence in medical practice', *Quality and Safety in Health Care*, 13(2), pp. 130-135.

Chen, C.Y., Yen, C.H. and Tsai, F.C. (2014) 'Job crafting and job engagement: the mediating role of person-job fit', *International Journal of Hospitality Management*, 37, pp. 21-28.

Chenven, L. and Copeland, D. (2013) 'Front-line worker engagement: greening health care, improving worker and patient health, and building better jobs', *New Solutions: a Journal of Environmental and Occupational Health Policy*, 23(2), pp. 327-345.

Cheraghi-Sohi, S. and Calnan, M. (2013) 'Discretion or discretions? Delineating professional discretion: The case of English medical practice', *Social Science and Medicine*, 96, pp. 52-59.

Chung, T.K., Lee, D.T., Cheung, L.P., Haines, C.J. and Chang, A.M. (1999) 'Spontaneous abortion: a randomized, controlled trial comparing surgical evacuation with conservative management using misoprostol', *Fertility and Sterility*, 71(6), pp. 1054-1059.

Clarke, J. (1998) 'Doing the right thing? Managerialism and social welfare', in Abbott, P. and Meerabeau, E. (eds.) *The Sociology of the Caring Professions*. 2nd edn. London: UCL Press, pp. 234-254.

Clarke, J. (2005) 'Peforming for the public: doubt, desire, and the evaluation of public services', in Du Gay, P. (ed.) *The Values of Bureaucracy*. Oxford: Oxford University Press,, pp. 211-232.

Cockerham, W.C. (2015) 'Max Weber: bureaucracy, formal rationality and the modern hospital', in Collyer, F. (ed.) *The Palgrave Handbook of Social Theory in Health, Illness and Medicine*. New York: Palgrave Macmillan, pp. 124-138.

Cohen, P.M., Ptaskiewicz, M. and Mipos, D. (2010) 'The case for unit-based teams: a model for front-line engagement and performance improvement', *The Permanente Journal*, 14(2), pp. 70-75.

Cohen, S. (2001) *States of Denial: Knowing about atrocities and suffering*. Cambridge: Blackwell.

Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser (2012) *Compassion in Practice*. Department of Health Health, D.o. [Online]. Available at: https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf (Accessed: 12/06/16).

Condon, L. (2008) 'Child health promotion in the United Kingdom: does health visitors' practice follow policy?', *Journal of Advanced Nursing*, 62(5), pp. 551-561.

Conrad, P. and Barker, K.K. (2010) 'The social construction of illness: key insights and policy implications', *Journal of Health and Social Behavior*, 51, pp. S67-S79.

Conway, K. (1995) 'Miscarriage experience and the role of support systems: a pilot study', *British Journal of Medical Psychology*, 68(Pt 3), pp. 259-267.

Conway, K. and Russell, G. (2000) 'Couples' grief and experience of support in the aftermath of miscarriage', *British Journal of Medical Psychology*, 73 Pt 4, pp. 531-545.

Corbet-Owen, C. and Kruger, L.-M. (2001) 'The health system and emotional care: Validating the many meanings of spontaneous pregnancy loss', *Families, Systems, and Health*, .19(4), p. pp.

Cordle, C. and Prettyman, R.J. (1994) 'A 2-year follow-up of women who have experienced early miscarriage', *Journal of Reproductive and Infant Pyschology*, 12, pp. 37-43.

Amanda Holden: Exposing Hospital Heartache (2014) Directed by Corke, R. and Carter, P.

Courpasson, D. and Clegg, S. (2006) 'Dissolving the iron cages? Tocqueville, Michels, bureaucracy and the perpetuation of elite power', *Organization*, 13(3), pp. 319-343.

Cranley, L.A., Norton, P.G., Cummings, G.G., Barnard, D., Batra-Garga, N. and Estabrooks, C.A. (2012) 'Identifying resident care areas for a quality improvement intervention in long-term care: a collaborative approach', *BMC Geriatrics*, 12 [Online]. Available at: http://bmcgeriatr.biomedcentral.com/articles/10.1186/1471-2318-12-59 (Accessed: 26/08/16).

Crawford, P., Brown, B., Kvangarsnes, M. and Gilbert, P. (2014) 'The design of compassionate care', *Journal of Clinical Nursing*, 23(23-24), pp. 3589-3599.

Crow, R., Hampson, S., Kimber, A., Thomas, H., Gage, H., Hart, J. and Storey, L. (2002) *The measurement of satisfaction with healthcare: implications for practice from a systematic review of the literature*. London: HMSO.

Cumming, G., Klein, S., Bolsover, D., Lee, A., Alexander, D., Maclean, M. and Jurgens, J. (2007) 'The emotional burden of miscarriage for women and their partners: trajectories of anxiety and depression over 13 months', *BJOG: An International Journal of Obstetrics and Gynaecology*, 114, pp. 1138-1145.

Currie, V., Harvey, G., West, E., McKenna, H. and Keeney, S. (2005) 'Relationship between quality of care, staffing levels, skill mix and nurse autonomy: literature review', *Journal of Advanced Nursing*, 51(1), pp. 73-82.

Dallabetta, G., Chandrasekaran, P., Wheeler, T., Das, A., Ramakrishnan, L., Kumta, S. and Moore, J. (2014) 'Rolling out new biomedical HIV prevention tools: what can be learned from Avahan, the India AIDS initiative?', *Sexual Health*, 11(2), pp. 207-216.

Dalton, V.K., Harris, L.H., Clark, S.J., Cohn, L., Guire, K. and Fendrick, A.M. (2009) 'Treatment patterns for early pregnancy failure in Michigan', *Journal of Women's Health*, 18(6), pp. 787-793.

Dalton, V.K., Harris, L.H., Gold, K.J., Kane-Low, L., Schulkin, J., Guire, K. and Fendrick, A.M. (2010) 'Provider knowledge, attitudes, and treatment preferences for early pregnancy failure - art. no. 531.e1', *American Journal of Obstetrics and Gynecology*, 202(6), pp. E1-E1.

Darney, B.G., VanDerhei, D., Weaver, M.R., Stevens, N.G. and Prager, S.W. (2013) '"We have to what?": lessons learned about engaging support staff in an interprofessional intervention to implement MVA for management of spontaneous abortion', *Contraception*, 88(2), pp. 221-225.

Daugherty, J.D., Blake, S.C., Kohler, S.S., Culler, S.D., Hawley, J.N. and Rask, K.J. (2013) 'Quality improvement training: experiences of frontline staff', *International Journal of Health Care Quality Assurance*, 26(7), pp. 627-641.

Davies, H., Powell, A. and Rushmer, R. (2007) *Health Care Professionals' Views on Clinician Engagement in Quality Improvement. A literature review.* London: The Health Foundation.

Davies, M. (2011) 'Concept mapping, mind mapping and argument mapping: what are the differences and do they matter?', *Higher Education*, 62(3), pp. 279-301.

Davison, C.M., Kahwa, E., Edwards, N., Atkinson, U., Roelofs, S., Hepburn-Brown, C., Aiken, J., Dawkins, P., Rae, T. and MacFarlane, D. (2013) 'Ethical challenges and opportunities for nurses in Hiv and Aids community-based participatory research in Jamaica', *Journal of Empirical Research on Human Research Ethics*, 8(1), pp. 55-67.

De Jager, F. (1994) 'Satisfaction with hospital care and interventions after pregnancy loss', *Death Studies*, 18(1), pp. 41-64.

de Kok, B., Hussein, J. and Jeffery, P. (2010) 'Joining-up thinking: loss in childbearing from inter-disciplinary perspectives', *Social Science and Medicine*, 71(10), pp. 1703-1710.

Dearmon, V., Roussel, L., Buckner, E.B., Mulekar, M., Pomrenke, B., Salas, S., Mosley, A., Brown, S. and Brown, A. (2013) 'Transforming Care at the Bedside (TCAB): enhancing direct care and value-added care', *Journal of Nursing Management*, 21(4), pp. 668-678.

Dearmon, V.A., Riley, B.H., Mestas, L.G. and Buckner, E.B. (2015) 'Bridge to shared governance: developing leadership of frontline nurses', *Nursing Administration Quarterly*, 39(1), pp. 69-77.

Debono, D.S., Greenfield, D., Travaglia, J.F., Long, J.C., Black, D., Johnson, J. and Braithwaite, J. (2013) 'Nurses' workarounds in acute healthcare settings: a scoping review', *Bmc Health Services Research*, 13 [Online]. Available at: <Go to ISI>://WOS:000319412100001 DOI: Artn 175

10.1186/1472-6963-13-175 (Accessed: 18/08/2016).

Deery, R. (2008) 'The tyranny of time: tensions between relational and clock time in community-based midwifery', *Social Theory and Health*, 6(4), pp. 342-363.

Deery, R. and Fisher, P. (2016) 'Professionalism and person-centredness: developing a practice-based approach to leadership within NHS maternity services in the UK', *Health Sociology Review*, (0), pp. 1-17 [Online]. Available at: http://dx.doi.org/10.1080/14461242.2016.1159525 DOI: 10.1080/14461242.2016.1159525 (Accessed: 30/08/2016).

Deery, R.D., Hughes, D.M.A. and Kirkham, M. (2010) *Tensions and barriers in improving maternity care : the story of a birth centre*. Oxford: Radcliffe Pub.

Delk, K.L. (2013) 'Whistleblowing: is it really worth the consequences?', *Workplace Health and Safety*, 61(2), pp. 61-64.

Department for Business Innovation & Skills (2015) *Whistleblowing: Guidance for Employers and Code of Practice*. London: The Stationery Office.

Department of Health (1993) *Changing Childbirth*. London: HMSO.

Department of Health (2008) *High quality care for all : NHS next stage review final report*. London: The Stationery Office.

Department of Health (2015) *The NHS Constitution. The NHS belongs to us all*. London: Department of Health.

Department of Health/Partnerships for Children and Families and Maternity (2007) *Maternity Matters: choice, access and continuity of care in a safe service*. London: Department of Health.

Dickinson, H., Ham, C., Snelling, I. and Spurgeon, P. (2012) *Are we there yet? Models of medical Leadership and their effectiveness: an exploratory study*. London: National Institute for Health Research HMSO.

Dickson, E.W., Anguelov, Z., Vetterick, D., Eller, A. and Singh, S. (2009) 'Use of lean in the emergency department: a case series of 4 hospitals', *Annals of Emergency Medicine,* 54(4), pp. 504-510.

DiMarco, M., Renker, P., Medas, J., Bertosa, H. and Goranitis, J.L. (2002) 'Effects of an educational bereavement program on health care professionals' perceptions of perinatal loss', *Journal of Continuing Education in Nursing*, 33(4), pp. 180-186.

Diop-Christensen, A. (2015) 'Is 'making work pay' effective for the 'unemployable'? The impact of benefit sanctions on social assistance recipients in Denmark', *Journal of European Social Policy,* 25(2), pp. 210-224.

Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., McCarthy, I., McKee, L., Minion, J., Ozieranski, P., Willars, J., Wilkie, P. and West, M. (2014) 'Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study', *BMJ Quality and Safety*, 23(2), pp. 106-115.

Dixon-Woods, M., McNicol, S. and Martin, G. (2012) 'Ten challenges in improving quality in healthcare: lessons from the Health Foundation's programme evaluations and relevant literature', *BMJ Quality and Safety*, 21(10), pp. 876-884.

Dokko, G., Nigam, A. and Rosenkopf, L. (2012) 'Keeping steady as she goes: A negotiated order perspective on technological evolution', *Organization Studies,* 33(5-6), pp. 681-703.

Donabedian, A. (2005) 'Evaluating the quality of medical care (Reprinted from The Milbank Memorial Fund Quarterly, vol 44, pg 166-203, 1966)', *Milbank Quarterly*, 83(4), pp. 691-729.

Du Gay, P. (2000) *In Praise of Bureaucracy : Weber, organization, ethics*. London: SAGE.

Durgahee, T. (2003) 'Higher level practice: degree of specialist practice?', *Nurse Education Today*, 23(3), pp. 191-201.

Dyer, C. (2012) 'Surgeon is taking claims of victimisation over whistleblowing to High Court', *British Medical Journal*, 345, p. e8247.

Edey, K., Draycott, T. and Akande, V. (2007) 'Early pregnancy assessment units', *Clinical Obstetrics and Gynecology*, 50(1), pp. 146-153.

Edwards, S., Birks, M., Chapman, Y. and Yates, K. (2016) 'Miscarriage in Australia: the geographical inequity of healthcare services', *Australasian Emergency Nursing Journal*, 19(2), pp. 106-111.

Elston, M.A. (2009) 'Remaking a trustworthy medical profession in twenty-first-century Britain', in Gabe, J. and Calnan, M. (eds.) *The new sociology of the Health Service*. London: Routledge, pp. 17-36.

Engel, J. and Rempel, L. (2016) 'Health professionals' practices and attitudes about miscarriage', *The American Journal of Maternal-Child Nursing*, 41(1), pp. 51-57.

Evans, L., Lloyd, D., Considine, R. and Hancock, L. (2002) 'Contrasting views of staff and patients regarding psychosocial care for Australian women who miscarry: a hospital based study', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 42(2), pp. 155-160.

Evans, T. (2007) 'Confidentiality in mental health services: a negotiated order?', *Qualitative Social Work*, 6(2), pp. 213-229.

Evans, T. (2010) *Professional Discretion in Welfare Services Beyond Street-Level Bureaucracy*. Farnham: Ashgate Publishing Ltd.

Evans, T. (2011) 'Professionals, managers and discretion: critiquing street-level bureaucracy', *British Journal of Social Work*, 41(2), pp. 368-386.

Evans, T. (2015) 'Professionals and discretion in street-level bureaucracy', in Hupe, P., Hill, M. and Buffat, A. (eds.) *Understanding Street-Level Bureaucracy*. Bristol: Policy Press.

Evans, T. and Harris, J. (2004) 'Street-level bureaucracy, social work and the (exaggerated) death of discretion', *British Journal of Social Work*, 34, pp. 871-895.

Exton, R. (2010) 'Enterprising health: creating the conditions for entrepreneurial behaviour as a strategy for effective and sustainable change in health services', *Journal of Health Organization and Management*, 24(5), pp. 459-479.

Farrar, M. (2013) 'Reducing bureaucracy in the NHS', *The Guardian*edn). [Online] Available at: http://www.theguardian.com/healthcare-network/2013/mar/25/how-bureaucracy-nhs-reduced (Accessed: 15/08/16).

Farren, J., Jalmbrant, M., Ameye, L., Joash, K., Mitchell-Jones, N., Tapp, S., Timmerman, D. and Bourne, T. (2016) 'Post-traumatic stress, anxiety and depression following miscarriage or ectopic pregnancy: a prospective cohort study', *BMJ Open*, 6(11), p. e011864.

Farren, J., Jalmbrant, M., Miell, S., Stalder, C. and Bourne, T. (2013) 'The emotional impact of early pregnancy complications: A response to NICE guidelines', *BJOG: An International Journal of Obstetrics and Gynaecology*, 120, p. 556.

Fenwick, J., Jennings, B., Downie, J., Butt, J. and Okanaga, M. (2007) 'Providing perinatal loss care: satisfying and dissatisfying aspects for midwives', *Women and Birth*, 20(4), pp. 153-160.

Ferlie, E., Fitzgerald, L., Wood, M. and Hawkins, C. (2005) 'The nonspread of innovations: the mediating role of professionals', *Academy of Management Journal*, 48(1), pp. 117-134.

Fineman, S. (1998) 'Street-level bureaucrats and the social construction of environmental control', *Organization Studies*, 19(6), pp. 952-974.

Finlay, S. and Sandall, J. (2009) '"Someone's rooting for you": continuity, advocacy and street-level bureaucracy in UK maternal healthcare', *Social Science and Medicine*, 69(8), pp. 1228-1235.

Flynn, M. (2012) *South Gloucester Safeguarding Adults Board. Winterbourne View Hospital. A serious case review*.South Gloucester Council.

Flynn, R. (2002) 'Clinical governance and governmentality', *Health Risk & Society*, 4(2), pp. 155-173.

Flyvbjerg, B. (2011) 'Case Study', in Denzin, N.K. and Lincoln, Y.S. (eds.) *The SAGE Handbook of Qualitative Research*. Fourth Edition edn. London: SAGE, pp. 301-316.

Ford, S. (2012) *Tell me about bonkers bureaucracy*. Available at: http://www.nursingtimes.net/roles/nurse-managers/tell-me-about-bonkers-bureaucracy-says-dh-nurse/5042597.article (Accessed: 31/08/16).

Forster, A. (2000) 'Evaluating the EU-ASEM relationship: a negotiated order approach', *Journal of European Public Policy*, 7(5), pp. 787-805.

Francis, R. (2010) *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust. January 2005-March 2009. Volume 1*. London: HMSO.

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust public inquiry*.Mid Staffordshire NHS Foundation Trust Public Inquiry.

Freeman, T. (2002) 'Using performance indicators to improve health care quality in the public sector: a review of the literature', *Health Services Management Research*, 15(2), pp. 126-137.

Freeman, T. and Walshe, K. (2004) 'Achieving progress through clinical governance? A national study of health care managers' perceptions in the NHS in England', *Quality and safety in health care*, 13(5), pp. 335-343.

Freidson, E. (1988) *Profession of Medicine : a study of the sociology of applied knowledge : with a new afterword*. Chicago: University of Chicago Press.

Frost, J., Bradley, H., Levitas, R., Smith, L. and Garcia, J. (2007) 'The loss of possibility: scientisation of death and the special case of early miscarriage', *Sociology of Health and Illness*, 29(7), pp. 1003-1022.

Fuertes, V. and Lindsay, C. (2015) 'Personalization and street-level practice in activation: the case of the UK's work programme', *Public Administration*, pp. 526-541.

Gabbay, J. and le May, A. (2004) 'Evidence based guidelines or collectively constructed "mindlines?" Ethnographic study of knowledge management in primary care', *British Medical Journal*, 329(7473), p. 1013 [Online]. Available at: http://www.ncbi.nlm.nih.gov/pubmed/15514347 DOI: 10.1136/bmj.329.7473.1013 (Accessed: 13/08/16).

Gaede, B.M. (2016) 'Doctors as street-level bureaucrats in a rural hospital in South Africa', *Rural and Remote Health*, 16(1), pp. 3461-3461.

Geller, P.A., Kerns, D. and Klier, C.M. (2004) 'Anxiety following miscarriage and the subsequent pregnancy: a review of the literature and future directions', *Journal of Psychosomatic Research*, 56(1), pp. 35-45.

Geller, P.A., Psaros, C. and Kornfield, S.L. (2010) 'Satisfaction with pregnancy loss aftercare: are women getting what they want?', *Archives of Women's Mental Health*, 13(2), pp. 111-124.

General Medical Council (2013) *Good Medical Practice*. Manchester: General Medical Council.

Gerber-Epstein, P., Leichtentritt, R.D. and Benyamini, Y. (2009) 'The experience of miscarriage in first pregnancy: the women's voices', *Death Studies*, 33(1), pp. 1-29.

Gergett, B. and Gillen, P. (2014) 'Early pregnancy loss: perceptions of healthcare professionals', *Evidence Based Midwifery*, 12(1), pp. 29-34.

Gerrish, K., Nolan, M., McDonnell, A., Tod, A., Kirshbaum, M. and Guillaume, L. (2012) 'Factors influencing advanced practice nurses' ability to promote evidence-based practice among frontline nurses', *Worldviews on Evidence Based Nursing*, 9(1), pp. 30-39.

Gerteis, M. (2002) *Through the Patient's Eyes : understanding and promoting patient-centered care*. 1st edn. San Francisco: Jossey-Bass.

Gevaert, O., De Smet, F., Kirk, E., Van Calster, B., Bourne, T., Van Huffel, S., Moreau, Y., Timmerman, D., De Moor, B. and Condous, G. (2006) 'Predicting the outcome of pregnancies of unknown location: Bayesian networks with expert prior information compared to logistic regression', *Human Reproduction*, 21(7), pp. 1824-1831.

Giddens, A. (2013) *The Constitution of Society*. Hoboken: Wiley.

Gilbert, A., Hockey, P., Vaithianathan, R., Curzen, N. and Lees, P. (2012) 'Perceptions of junior doctors in the NHS about their training: results of a regional questionnaire', *BMJ*

Quality and Safety, [Online]. Available at: http://qualitysafety.bmj.com/content/early/2012/01/11/bmjqs-2011-000611.abstract DOI: 10.1136/bmjqs-2011-000611 (Accessed: 25/01/16).

Gillespie, R., Florin, D. and Gillam, S. (2004) 'How is patient-centred care understood by the clinical, managerial and lay stakeholders responsible for promoting this agenda?', *Health Expectations*, 7(2), pp. 142-148.

Gilson, L., Elloker, S., Olckers, P. and Lehmann, U. (2014) 'Advancing the application of systems thinking in health: South African examples of a leadership of sensemaking for primary health care', *Health Research Policy and Systems*, 12 [Online]. Available at: <Go to ISI>://WOS:000338359600001 DOI: 10.1186/1478-4505-12-30 (Accessed: 19/07/16).

Gimbel, S., Voss, J., Mercer, M.A., Zierler, B., Gloyd, S., Coutinho Mde, J., Floriano, F., Cuembelo Mde, F., Einberg, J. and Sherr, K. (2014) 'The prevention of mother-to-child transmission of HIV cascade analysis tool: supporting health managers to improve facility-level service delivery', *BMC Research Notes*, 7, p. 743.

Gjersoe, H.M. (2016) 'Getting sick and disabled people off temporary benefit receipt: strategies and dilemmas in the welfare state's frontline', *Nordic Journal of Working Life Studies*, 6, pp. 129-145.

Glaser, B.G. and Strauss, A.L. (1968) *The Discovery of Grounded Theory. Strategies for qualitative research*. London: Weidenfeld & Nicolson.

Goddard, M., Mannion, R. and Smith, P. (2000) 'Enhancing performance in health care: a theoretical perspective on agency and the role of information', *Health Economics*, 9(2), pp. 95-107.

Goddijn, M. and Leschot, N.J. (2000) 'Genetic aspects of miscarriage', *Best Practice and Research in Clinical Obstetrics and Gynaecology*, 14(5), pp. 855-865.

Godfrey, M., Smith, J., Green, J., Cheater, F., Inouye, S.K. and Young, J.B. (2013) 'Developing and implementing an integrated delirium prevention system of care: a theory driven, participatory research study', *BMC Health Services Research*, 13, p. 341 [Online]. Available at: http://www.ncbi.nlm.nih.gov/pubmed/24004917 DOI: 10.1186/1472-6963-13-341 (Accessed: 30/08/16).

Gold, K.J. (2007) 'Navigating care after a baby dies: a systematic review of parent experiences with health providers', *Journal of Perinatology*, 27(4), pp. 230-237.

Goldman, L.S. and Foldy, E.G. (2015) 'The space before action: The role of peer discussion groups in frontline service provision', *Social Service Review*, 89(1), pp. 166-202.

Goodman, B. (2016) 'The missing two Cs - commodity and critique: obscuring the political economy of the 'gift' of nursing', *Journal of Research in Nursing*, 21(4), pp. 325-335.

Gracia, C.R., Sammel, M.D., Chittams, J., Hummel, A.C., Shaunik, A. and Barnhart, K.T. (2005) 'Risk factors for spontaneous abortion in early symptomatic first-trimester pregnancies', *Obstetrics and Gynecology*, 106(5 Pt 1), pp. 993-999.

Graham, R., Embleton, N., Farnworth, A., Mason, K., Rankin, J. and Robson, S. (2012) 'Experiences of reproductive loss: the importance of professional discretion in caring for a patient group with diverse views', in Earl, S., Komaromy, C. and Layne, L. (eds.) *Understanding Reproductive Loss*. Surrey: Ashgate Publishing Ltd, pp. 205-219.

Graham, R.H. (2006) 'Lacking compassion - sociological analyses of the medical profession', *Social Theory and Health*, 4(1), pp. 43-63.

Graham, S., Brookey, J. and Steadman, C. (2005) 'Patient safety executive walkarounds', in Henriksen, K., Battles, J.B., Marks, E.S. and Lewin, D.I. (eds.) *Advances in Patient Safety: From Research to Implementation (Volume 4: Programs, Tools, and Products)*. Rockville (MD).

Grant, A. (2013) 'The effect of the use of discretion on occupational therapists' professional identity', *British Journal of Occupational Therapy*, 76(9), pp. 409-417.

Grant, G. (2015) *Red tape lunacy that damns the NHS bureaucrats: Staff forced to fill in seven-page form (including suicide risk and human rights assessment) just to move an office printer*. Available at: http://www.dailymail.co.uk/news/article-2955063/Red-tape-lunacy-damns-NHS-bureaucrats-Staff-forced-seven-page-form-including-suicide-risk-human-rights-assessment-just-office-printer.html (Accessed: 05/08/2016).

Green, D. and Sawyer, A.M. (2010) 'Managing risk in community care of older people: perspectives from the frontline', *Australian Social Work*, 63(4), pp. 375-390.

Greenhalgh, T. (2009) 'Chronic illness: beyond the expert patient', *British Medical Journal*, 338, pp. 629-631.

Greenhalgh, T., Howick, J. and Maskrey, N. (2014) 'Evidence based medicine: a movement in crisis?', *British Medical Journal*, 348, p. g3725 [Online] (Accessed: 16/08/16).

Greenhalgh, T. and Russell, J. (2009) 'Evidence-based policymaking: a critique', *Perspectives in Biology and Medicine*, 52(2), pp. 304-318.

Grey, C., Wells, S., Exeter, D.J., Hanham, G., Zhao, J. and Kerr, A.J. (2014) 'Stakeholder engagement for the New Zealand Atlas of Healthcare Variation: cardiovascular disease secondary prevention: VIEW-3', *The New Zealand Medical Journal*, 127(1400), pp. 81-91.

Grissom, J.A., Kern, E.C. and Rodriguez, L.A. (2015) 'The "representative bureaucracy" in education: educator workforce diversity, policy outputs, and outcomes for disadvantaged students', *Educational Researcher*, 44(3), pp. 185-192.

Groene, O., Klazinga, N., Wagner, C., Arah, O.A., Thompson, A., Bruneau, C. and Sunol, R. (2010) 'Investigating organizational quality improvement systems, patient empowerment, organizational culture, professional involvement and the quality of care in European hospitals: the 'Deepening our Understanding of Quality Improvement in Europe (DUQuE)' project', *BMC health services research*, 10, p. 281 [Online]. Available at: http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-10-281.

Gross, K., Schellenberg, J.A., Kessy, F., Pfeiffer, C. and Obrist, B. (2011) 'Antenatal care in practice: an exploratory study in antenatal care clinics in the Kilombero Valley, south-eastern Tanzania', *BMC Pregnancy and Childbirth*, 11 [Online]. Available at: <Go to ISI>://WOS:000296468200001 DOI: 10.1186/1471-2393-11-36 (Accessed: 01/08/16).

Guba, E.G. (1990) 'The alternative paradigm dialog', in Guba, E.G. (ed.) *The Paradigm dialog*. Newbury Park, Calif. ; London: Sage Publications, pp. 17-30.

Guba, E.G. and Lincoln, Y.S. (1994) 'Competing paradigms in qualitative research', in Denzin, N.K. and Lincoln, Y.S. (eds.) *Handbook of Qualitative Research*. Thousand Oaks: Sage Publications, pp. 105-117.

Hajjaj, F.M., Salek, M.S., Basra, M.K.A. and Finlay, A.Y. (2010) 'Non-clinical influences on clinical decision-making: a major challenge to evidence-based practice', *Journal of the Royal Society of Medicine*, 103(5), pp. 178-187.

Ham, C. (2009) *Health Policy in Britain*. 6th edn. Basingstoke: Palgrave Macmillan.

Ham, C. and Glenn, R. (2007) *Reasonable Rationing*. Maidenhead: McGraw-Hill Education.

Ham, C. and Robert, G.B. (2003) *Reasonable rationing : international experience of priority setting in health care*. Maidenhead: Open University Press.

Hamama-Raz, Y., Hemmendinger, S. and Buchbinder, E. (2010) 'The unifying difference: dyadic coping with spontaneous abortion among religious Jewish couples', *Qualitative Health Research*, 20(2), pp. 251-261.

Hamilton, J., Verrall, T., Maben, J., Griffiths, P., Avis, K., Baker, G.R. and Teare, G. (2014) 'One size does not fit all: a qualitative content analysis of the importance of existing quality improvement capacity in the implementation of Releasing Time to Care: the Productive Ward in Saskatchewan, Canada', *BMC Health Services Research*, 14, p. 642 [Online].

Hannan, T.J. and Celia, C. (2013) 'Are doctors the structural weakness in the e-health building?', *Internal Medicine Journal*, 43(10), pp. 1155-1164.

Harrison, M.B., Nicklin, W., Owen, M., Godfrey, C., McVeety, J. and Angus, V. (2012) 'Activating knowledge for patient safety practices: a Canadian academic-policy partnership', *Worldviews on Evidence Based Nursing*, 9(1), pp. 49-58.

Harrison, S. (2015) 'Street-level bureaucracy and professionalism in health services', in Hupe, P., Hill, M. and Buffat, A. (eds.) *Understanding Street-Level Bureaucracy*. Bristol: Policy Press, pp. 61-78.

Harwood, B. and Nansel, T. (2008) 'Quality of life and acceptability of medical versus surgical management of early pregnancy failure', *BJOG: An International Journal of Obstetrics & Gynaecology*, 115(4), pp. 501-508.

Haws, R.A., Mashasi, I., Mrisho, M., Schellenberg, J.A., Darmstadt, G.L. and Winch, P.J. (2010) '"These are not good things for other people to know": How rural Tanzanian women's experiences of pregnancy loss and early neonatal death may impact survey data quality', *Social Science & Medicine*, 71(10), pp. 1764-1772.

Health and Social Care Information Centre (2015) 'NHS Maternity Statistics - England, 2014-15: Provider level analysis' 25/11/2015. 15/04/2016. Health and Social Care Information Centre. Available at: http://www.hscic.gov.uk/catalogue/PUB19127/nhs-mate-eng-2014-15-pla-tab.xlsx.

Health and Social Care Information Centre (2016) 'NHS Workforce Statistics - March 2015, Provisional Statistics; National Table' 22nd June 2016. 1st July 2016. p. 2. Available at: http://www.hscic.gov.uk/catalogue/PUB20913/nhs-work-stat-mar-2016-nat-hee-tab.xlsx.

Heaton, J. (2004) *Reworking Qualitative Data*. London: SAGE.

Hechenbleikner, E.M., Hobson, D.B., Bennett, J.L. and Wick, E.C. (2015) 'Implementation of surgical quality improvement: auditing tool for surgical site infection prevention practices', *Diseases of the Colon and Rectum*, 58(1), pp. 83-90.

Hemminki, E., Veerus, P., Virtanen, J. and Lehto, J. (2013) 'A qualitative study on clinical research in Finland: fragmented governance and volume in the 2000s', *BMJ Open*, 3(2).

Henman, P. and Gable, A. (2015) '"Schooling" performance measurement: the politics of governing teacher conduct in Australia', *Policy and Society*, 34(1), pp. 63-74.

Hewa, S. and Hetherington, R.W. (1990) 'Specialists without spirit - crisis in the nursing Profession.', *Journal of Medical Ethics*, 16(4), pp. 179-184.

Hewison, A., Gale, N., Yeats, R. and Shapiro, J. (2013) 'An evaluation of staff engagement programmes in four National Health Service Acute Trusts', *Journal of Health, Organisation and Management*, 27(1), pp. 85-105.

Hildingsson, I., Waldenstrom, U. and Radestad, I. (2002) 'Women's expectations on antenatal care as assessed in early pregnancy: number of visits, continuity of caregiver and general content', *Acta Obstetricia et Gynecologica Scandinavica*, 81(2), pp. 118-125.

Hill, K. (2009) 'Improving services provided in an early pregnancy assessment clinic', *The Nursing Times*, 105(6), pp. 18-19.

Hinds, P.S., Vogel, R.J. and ClarkeSteffen, L. (1997) 'The possibilities and pitfalls of doing a secondary analysis of a qualitative data set', *Qualitative Health Research*, 7(3), pp. 408-424.

Hjorne, E., Juhila, K. and van Nijnatten, C. (2010) 'Negotiating dilemmas in the practices of street-level welfare work', *International Journal of Social Welfare*, 19(3), pp. 303-309.

Hobbs, J.A. (2012) 'Newly qualified midwives' transition to qualified status and role: assimilating the 'habitus' or reshaping it?', *Midwifery*, 28(3), pp. 391-399.

Hochschild, A.R. (1983) *The aged heart : fthe commercialization of human feeling*. Berkeley: University of California Press.

Hochschild, A.R. (2012) *The Managed Heart : commercialization of human feeling*. Updated edn. Berkeley, Calif. ; London: University of California Press.

Hoggett, P. (1996) 'New modes of control in the public service', *Public Administration*, 74(1), pp. 9-32.

Hood, C. and Dixon, R. (2015) 'What we have to show for 30 years of new public management? Higher Costs, More Complaints', *Governance*, 28(3), pp. 265-267.

Hoybye-Mortensen, M. (2015) 'Decision-making tools and their Influence on caseworkers' room for discretion', *British Journal of Social Work*, 45(2), pp. 600-615.

Hoyle, L. and Grant, A. (2015) 'Treatment targets in emergency departments: nurses' views of how they affect clinical practice', *Journal of Clinical Nursing*, 24(15-16), pp. 2211-2218.

Hughes, D., Deery, R. and Lovatt, A. (2002) 'A critical ethnographic approach to facilitating cultural shift in midwifery', *Midwifery*, 18(1), pp. 43-52.

Hughes, L.C. (2012) 'Bridging the gap between problem recognition and treatment: the use of proactive work behaviors by experienced critical care nurses', *Policy Polit Nurs Pract*, 13(1), pp. 54-63.

Hunter, B. (2004) 'Conflicting ideologies as a source of emotion work in midwifery', *Midwifery*, 20(3), pp. 261-272.

Hunter, B. and Warren, L. (2014) 'Midwives experiences of workplace resilience', *Midwifery*, 30(8), pp. 926-934.

Hunter, C., Bretherton, J., Halliday, S. and Johnsen, S. (2016) 'Legal compliance in street-level bureaucracy: a study of UK housing officers', *Law and Policy*, 38(1), pp. 81-95.

Hupe, P. and Buffat, A. (2014) 'A public service gap: capturing contexts in a comparative approach of street-level bureaucracy', *Public Management Review*, 16(4), pp. 548-569.

Hupe, P., Hill, M. and Nangia, M. (2014) 'Studying implementation beyond deficit analysis: the top-down view reconsidered', *Public Policy and Administration*, 29(2), pp. 145-163.

Iedema, R., Allen, S., Sorensen, R. and Gallagher, T.H. (2011) 'What prevents incident disclosure, and what can be done to promote it?', *Joint Commission Journal on Quality & Patient Safety*, 37(9), pp. 409-417.

Ijkema, R., Langelaan, M., Van de steeg, L. and Wagner, C. (2014) 'What impedes and what facilitates a quality improvement project for older hospitalized patients?', *International Journal for Quality in Health Care*, 26(1), pp. 41-48.

Ipsos MORI (2008) *What Matters to Staff in the NHS*. London: Department of Health.

Jackson, D., Firtko, A. and Edenborough, M. (2007) 'Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review', *Journal of Advanced Nursing*, 60(1), pp. 1-9.

Jackson, D., Peters, K., Andrew, S., Edenborough, M., Halcomb, E., Luck, L., Salamonson, Y. and Wilkes, L. (2010) 'Understanding whistleblowing: qualitative insights from nurse whistleblowers', *Journal of Advanced Nursing*, 66(10), pp. 2194-2201.

Jameton, A. (1984) 'Introduction: ethics, nursing and the crisis in health care', in Jameton, A. (ed.) *Nursing practice. The ethical issues*. London: Prentice Hall, pp. 1-17.

Jeffs, L.P., Lo, J., Beswick, S. and Campbell, H. (2013) 'Implementing an organization-wide quality improvement initiative: insights from project leads, managers, and frontline nurses', *Nursing Administration Quarterly*, 37(3), pp. 222-230.

Jhamb, B.J. (2013) ''I am pregnant but I am not pregnant'. Management of pregnancy of unknown location', *BJOG: An International Journal of Obstetrics and Gynaecology*, 120, pp. 518-564.

Johnson, D.P. (2008) *Contemporary Sociological Theory : an integrated multi-level approach*. London: Springer.

Johnson, O.P. and Langford, R.W. (2015) 'A randomized trial of a bereavement intervention for pregnancy loss', *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 44(4), pp. 492-499.

Jones, J.S. (2014) 'Interpersonal Relations in Nursing Theory', in Fitzpatrick, J.J. and McCarthy, G. (eds.) *Theories Guiding Nursing Research and Practice: making nursing knowledge development explicit*. New York: Springer Publishing Company, pp. 173-182.

Juma, P.A., Edwards, N. and Spitzer, D. (2014) 'Kenyan nurses involvement in national policy development processes', *Nursing Research and Practice*, 2014 [Online]. Available at: http://www.ncbi.nlm.nih.gov/pubmed/25349731 DOI: 10.1155/2014/236573 (Accessed: 15/08/16).

Karadaghi, G. and Willott, C. (2015) 'Doctors as the governing body of the Kurdish health system: exploring upward and downward accountability among physicians and its influence on the adoption of coping behaviours', *Human Resources for Health*, 13 [Online]. Available at: <Go to ISI>://WOS:000355969500001 DOI: 10.1186/s12960-015-0039-x (Accessed: 14/08/16).

Karatepe, O.M. (2013) 'The effects of work overload and work-family conflict on job embeddedness and job performance the mediation of emotional exhaustion', *International Journal of Contemporary Hospitality Management*, 25(4), pp. 614-634.

Keane, H. (2009) 'Foetal personhood and representations of the absent child in pregnancy loss memorialization', *Feminist Theory*, 10(2), pp. 153-171.

Kellie, J., Milsom, B. and Henderson, E. (2012) 'Leadership through action learning: a bottom-up approach to 'best practice' in 'infection prevention and control' in a UK NHS trust', *Public Money and Management*, 32(4), pp. 289-296.

Kemmis, S.E. and McTaggart, R.E. (1988) *The action research planner*. 3rd edn. Victoria, Australia: Deakin University.

Keogh, B. (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. London: Department of Health.

Kerpershoek, E., Groenleer, M. and de Bruijn, H. (2016) 'Unintended responses to performance management in Dutch hospital care bringing together the managerial and professional perspectives', *Public Management Review*, 18(3), pp. 417-436.

Kersting, A., Dolemeyer, R., Steinig, J., Walter, F., Kroker, K., Baust, K. and Wagner, B. (2013) 'Brief internet-based intervention reduces posttraumatic stress and prolonged grief in parents after the loss of a child during pregnancy: a randomized controlled trial', *Psychotherapy and Psychosomatics*, 82(6), pp. 372-381.

Kersting, A., Kroker, K., Schlicht, S., Baust, K. and Wagner, B. (2011) 'Efficacy of cognitive behavioral internet-based therapy in parents after the loss of a child during pregnancy: Pilot data from a randomized controlled trial', *Archives of Women's Mental Health*, 14(6), pp. 465-477.

Khalil, A., Syngelaki, A., Maiz, N., Zinevich, Y. and Nicolaides, K.H. (2013) 'Maternal age and adverse pregnancy outcomes: a cohort study', *Obstetrical and Gynecological Survey*, 68(12), pp. 779-781.

Khatri, N., Brown, G.D. and Hicks, L.L. (2009) 'From a blame culture to a just culture in health care', *Health Care Management Review*, 34(4), pp. 312-322.

Kim, C.S., Spahlinger, D.A., Kin, J.M., Coffey, R.J. and Billi, J.E. (2009) 'Implementation of lean thinking: one health system's journey', *The Joint Commission Journal on Quality and Patient Safety*, 35(8), pp. 406-413.

Kirkham, M. (1998) 'Professionalization: dilemmas for midwifery', in Abbott, P. and Meerabeau, E. (eds.) *The Sociology of the Caring Professions*. 2nd edn. London: UCL Press, pp. 123-156.

Kirkup, B. (2015) *The Report of the Morcambe Bay Investigation*. London: The Stationery Office Office, T.S.

Kitson, A., Marshall, A., Bassett, K. and Zeitz, K. (2013) 'What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing', *Journal of Advanced Nursing*, 69(1), pp. 4-15.

Klier, C.M., Geller, P.A. and Neugebauer, R. (2000) 'Minor depressive disorder in the context of miscarriage', *Journal of Affective Disorders*, 59(1), pp. 13-21.

Kong, G.W., Chung, T.K., Lai, B.P. and Lok, I.H. (2010a) 'Gender comparison of psychological reaction after miscarriage-a 1-year longitudinal study', *BJOG: An International Journal of Obstetrics and Gynaecology*, 117(10), pp. 1211-1219.

Kong, G.W., Chung, T.K. and Lok, I.H. (2014) 'The impact of supportive counselling on women's psychological wellbeing after miscarriage - a randomised controlled trial', *BJOG: An international journal of obstetrics and gynaecology*, 121(10), pp. 1253-1262.

Kong, G.W., Lok, I.H., Lam, P.M., Yip, A.S. and Chung, T.K. (2010b) 'Conflicting perceptions between health care professionals and patients on the psychological morbidity following miscarriage', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 50(6), pp. 562-567.

Korczynski, M., Hodson, R., Edwards, P.K. and Ebooks Corporation. (2006) *Social Theory at Work*. Oxford: Oxford University Press UK.

Kristensen, S.R., McDonald, R. and Sutton, M. (2013) 'Should pay-for-performance schemes be locally designed? Evidence from the Commissioning for Quality and Innovation (CQUIN) Framework', *Journal of Health Services and Research Policy*, 18(2 Suppl), pp. 38-49.

Lasker, J.N. and Toedter, L.J. (1994) 'Satisfaction with hospital-care and interventions after pregnancy loss', *Death Studies*, 18(1), pp. 41-64.

Lawal, A.K., Rotter, T., Kinsman, L., Sari, N., Harrison, L., Jeffery, C., Kutz, M., Khan, M.F. and Flynn, R. (2014) 'Lean management in health care: definition, concepts, methodology and effects reported (systematic review protocol)', *Systematic Reviews*, 3, p. 103.

Layder, D. (1985) 'Power, Structure and Agency', *Journal for the Theory of Social Behaviour*, 15(2), pp. 131-149.

Layne, L.L. (1990) 'Motherhood lost: cultural dimensions of miscarriage and stillbirth in America', *Women and Health*, 16(3/4), pp. 69-98.

Layne, L.L. (2003) *Motherhood lost: a feminist account of pregnancy loss in America*. New York ; London: Routledge.

Layne, L.L. (2006) 'Pregnancy and infant loss support: a new, feminist, American, patient movement?', *Social Science and Medicine*, 62(3), pp. 602-613.

Lee, C. (2012) ''She was a person, she was here': The experience of late pregnancy loss in Australia', *Journal of Reproductive and Infant Psychology*, 30(1), pp. 62-76.

Lee, C. and Slade, P. (1996) 'Miscarriage as a traumatic event: a review of the literature and new implications for intervention', *Journal of Psychosomatic Research*, 40(3), pp. 235-44.

Lee, C., Slade, P. and Lygo, V. (1996) 'The influence of psychological debriefing on emotional adaptation in women following early miscarriage: a preliminary study', *British Journal of Medical Psychology*, 69(Pt 1), pp. 47-58.

Levine, C.H. and Cumming, G. (2015) 'Memorial services offered following an early pregnancy loss in Scotland', *The Practising Midwife*, 18(3), pp. 23-26.

Liberati, E.G., Gorli, M., Moja, L., Galuppo, L., Ripamonti, S. and Scaratti, G. (2015) 'Exploring the practice of patient centered care: the role of ethnography and reflexivity', *Social Science and Medicine*, 133, pp. 45-52.

Lincoln, Y.S., Lynham, S.A. and Guba, E.G. (2011) 'Paradigmatic controversies, contradictions, and emerging confluences, revisited', in Denzin, N.K. and Lincoln, Y.S. (eds.) *The Sage Handbook of qualitative research*. 4th edn. Thousand Oaks: Sage, pp. 97-128.

Lipsky, M. (1980) *Street-Level Bureaucracy. Dilemmas of the individual in public services*. New York: Russell Sage Foundation.

Lipsky, M. (2010) *Street-Level Bureaucracy. Dilemmas of the individual in public services*. New York: Russell Sage.

Lisy, K., Peters, M.D.J., Riitano, D., Jordan, Z. and Aromataris, E. (2016) 'Provision of meaningful care at diagnosis, birth, and after stillbirth: A qualitative synthesis of parents' experiences', *Birth: Issues in Perinatal Care*, 43(1), pp. 6-19.

Littlewood, J. (1999) 'From the invisibility of miscarriage to an attribution of life', *Anthropology and Medicine*, 6(2), pp. 217-230.

Liu, B., Almaawiy, U., Moore, J.E., Chan, W.H., Straus, S.E. and Team, M.o. (2013) 'Evaluation of a multisite educational intervention to improve mobilization of older patients in hospital: protocol for mobilization of vulnerable elders in Ontario (MOVE ON)', *Implementation Science*, 8 [Online]. Available at: <Go to ISI>://WOS:000321448000001 (Accessed: 04/08/14).

Llewellyn, S. (1998) 'Boundary work: costing and caring in the social services', *Accounting, Organizations and Society*, 23(1), pp. 23-47.

Llewellyn, S. (2001) ''Two-way windows': clinicians as medical managers', *Organization Studies*, 22(4), pp. 593-623.

Lloyd-Smith, E., Curtin, J., Gilbart, W. and Romney, M.G. (2014) 'Qualitative evaluation and economic estimates of an infection control champions program', *American Journal of Infection Control*, 42(12), pp. 1303-1307.

Lok, I.H., Yip, A.S., Lee, D.T., Sahota, D. and Chung, T.K. (2010) 'A 1-year longitudinal study of psychological morbidity after miscarriage', *Fertility and Sterility*, 93(6), pp. 1966-1975.

Lombarts, M.J., Rupp, I., Vallejo, P., Sunol, R. and Klazinga, N.S. (2009) 'Application of quality improvement strategies in 389 European hospitals: results of the MARQuIS project', *Quality and Safety in Health Care*, 18 Suppl 1, pp. i28-37.

Loyens, K. and Maesschalck, J. (2010) 'Toward a theoretical framework for ethical decision making of street-level bureaucracy: existing models reconsidered', *Administration and Society*, 42(1), pp. 66-100.

Luise, C., Jermy, K., Collons, W.P. and Bourne, T.H. (2002a) 'Expectant management of incomplete, spontaneous first-trimester miscarriage: outcome according to initial ultrasound criteria and value of follow-up visits', *Ultrasound in Obstetrics and Gynecology*, 19(6), pp. 580-582.

Luise, C., Jermy, K., May, C., Costello, G., Collins, W.P. and Bourne, T.H. (2002b) 'Outcome of expectant management of spontaneous first trimester miscarriage: observational study', *British Medical Journal*, 324(7342), pp. 873-875.

Lynch, M. (1998) 'Towards a constructivist genealogy of social constructivism', in Velody, I. and Williams, R. (eds.) *The Politics of Constructionism*. London: SAGE, pp. 13-32.

Maben, J., Latter, S. and Clark, J.M. (2006) 'The theory–practice gap: impact of professional–bureaucratic work conflict on newly-qualified nurses', *Journal of Advanced Nursing*, 55(4), pp. 465-477.

MacBride-Stewart, S. (2014) 'Motivations for the 'gift-of-care' in the context of the modernisation of medicine', *Social Theory and Health*, 12(1), pp. 84-104.

MacConnell, G., Aston, M., Randel, P. and Zwaagstra, N. (2013) 'Nurses' experiences providing bereavement follow-up: An exploratory study using feminist poststructuralism', *Journal of Clinical Nursing*, 22(7-8), pp. 1094-1102.

Macfarlane, A. and O'Reilly-de Brun, M. (2012) 'Using a theory-driven conceptual framework in qualitative health research', *Qualitative Health Research*, 22(5), pp. 607-618.

Mackintosh, N. and Sandall, J. (2010) 'Overcoming gendered and professional hierarchies in order to facilitate escalation of care in emergency situations: the role of standardised communication protocols', *Social Science and Medicine*, 71(9), pp. 1683-1686.

Mann, S. (2005) 'A health-care model of emotional labour: an evaluation of the literature and development of a model', *Journal of Health Organization and Management*, 19(4-5), pp. 304-317.

Marinetto, M. (2011) 'A Lipskian analysis of child protection failures from Victoria Climbie to "Baby P": a street-level re-evaluation of joined-up governance', *Public Administration*, 89(3), pp. 1164-1181.

Marko, E.K., Buery-Joyner, S.D., Sheridan, M.J., Nieves, K., Khoury, A.N. and Dalrymple, J.L. (2015) 'Structured teaching of early pregnancy loss counseling', *Obstetrics and Gynecology*, 126(4), pp. 1S-6S.

Martin, G., Ozieranski, P., Willars, J., Charles, K., Minion, J., McKee, L. and Dixon-Woods, M. (2014) 'Walkrounds in practice: corrupting or enhancing a quality improvement intervention? a qualitative study', *The Joint Commission Journal on Quality and Patient Safety*, 40(7), pp. 303-310.

Martin, G.P., McKee, L. and Dixon-Woods, M. (2015) 'Beyond metrics? Utilizing 'soft intelligence' for healthcare quality and safety', *Social Science and Medicine*, 142, pp. 19-26.

Martin, G.P., Phelps, K. and Katbamna, S. (2004) 'Human motivation and professional practice: of knights, knaves and social workers', *Social Policy and Administration*, 38(5), pp. 470-487.

Matovu, J.K., Wanyenze, R.K., Mawemuko, S., Okui, O., Bazeyo, W. and Serwadda, D. (2013) 'Strengthening health workforce capacity through work-based training', *BMC International Health and Human Rights*, 13(8) [Online]. Available at: http://dx.doi.org/10.1186/1472-698X-13-8 DOI: http://dx.doi.org/10.1186/1472-698X-13-8 (Accessed: 16/08/16).

Maxwell, J.A. (2012) *A Realist Approach for Qualitative Research*. Thousand Oaks, Calif. ; London: SAGE.

Maynard-Moody, S. and Musheno, M.C. (2003) *Cops, Teachers, Counselors : stories from the front lines of public service*. Ann Arbor ; [Great Britain]: University of Michigan Press.

McAlearney, A.S., Garman, A.N., Song, P.H., McHugh, M., Robbins, J. and Harrison, M.I. (2011) 'High-performance work systems in health care management, part 2: qualitative evidence from five case studies', *Health Care Management Review*, 36(3), pp. 214-226.

McAllister, M., Madsen, W. and Holmes, C. (2014) 'Newton's cradle: a metaphor to consider the flexibility, resistance and direction of nursing's future', *Nursing Inquiry*, 21(2), pp. 130-9.

McAra, L. and McVie, S. (2012) 'Negotiated order: the groundwork for a theory of offending pathways', *Criminology and Criminal Justice*, 12(4), pp. 347-375.

McCann, L., Granter, E., Hassard, J. and Hyde, P. (2015) '"You can't do both - something will give": Limitations of the Targets Culture in Managing UK Health Care Workforces', *Human Resource Management*, 54(5), pp. 773-791.

McCloskey, R. (2011) 'The 'mindless' relationship between nursing homes and emergency departments: what do Bourdieu and Freire have to offer?', *Nursing Inquiry*, 18(2), pp. 154-164.

McCormack, B., Borg, M., Cardiff, S., Dewing, J., Jacobs, G., Janes, N., Karlsson, B., McCance, T., Mekki, T.E., Porock, D., Lieshout, F.v. and Wilson, V. (2015) 'Person-centredness - the 'state' of the art', *International Practice Development Journal*, 5, pp. 1-15.

McCormack, B., Dewing, J., Breslin, L., Coyne-Nevin, A., Kennedy, K., Manning, M., Peelo-Kilroe, L., Tobin, C. and Slater, P. (2010) 'Developing person-centred practice: nursing outcomes arising from changes to the care environment in residential settings for older people', *International Journal of Older People Nursing*, 5(2), pp. 93-107.

McCormack, B. and McCance, T. (2010) *Person-Centred Nursing; theory and practice*. Oxford: Wiley-Blackwell.

McCreight, B.S. (2005) 'Perinatal grief and emotional labour: a study of nurses' experiences in gynae wards', *Internation Journal of Nursing Studies*, 42(4), pp. 439-448.

McGraw, M.J., George, A.N., Shearn, S.P., Hall, R.L. and Haws, T.F. (2010) *Principles of Good Clinical Practice*. Pharmaceutical Press,.

Medved, C.E. and Heisler, J. (2002) 'A negotiated order exploration of critical student-faculty interactions: Student-parents manage multiple roles', *Communication Education*, 51(2), pp. 105-120.

Miller, K.L. and Kontos, P.C. (2013) 'The intraprofessional and interprofessional relations of neurorehabilitation nurses: a negotiated order perspective', *Journal of Advanced Nursing*, 69(8), pp. 1797-1807.

Miller, S.L. (2015) 'Values-based recruitment in health care', *Nursing Standard*, 29(21), pp. 37-41.

Mintzberg, H. (1979) *The Structuring of Organizations*. London: Prentice-Hall.

Mitton, C., Peacock, S., Storch, J., Smith, N. and Cornelissen, E. (2011) 'Moral distress among health system managers: exploratory research in two British Columbia health authorities', *Health Care Analysis*, 19(2), pp. 107-121.

Molnar, A.M., Oliver, L.M. and Geyman, J.P. (2000) 'Patient preferences for management of first-trimester incomplete spontaneous abortion', *The Journal of the American Board of Family Practice*, 13(5), pp. 333-337.

Moohan, J., Ashe, R.G. and Cecil, R. (1994) 'The management of miscarriage: Results from a survey at one hospital. Jan-Mar 1994', *Journal of Reproductive and Infant Psychology*, 12(1), pp. 17-19.

Moriates, C., Mourad, M., Novelero, M. and Wachter, R.M. (2014) 'Development of a hospital-based program focused on improving healthcare value', *Journal of Hospital Medicine*, 9(10), pp. 671-677.

Morrison, K. (2006) *Marx, Durkheim, Weber : formations of modern social thought*. 2nd edn. London: SAGE Publications.

Morrow, E., Robert, G., Maben, J. and Griffiths, P. (2012) 'Implementing large-scale quality improvement: lessons from The Productive Ward: Releasing Time to Care', *International Journal of Health Care Quality Assurance*, 25(4), pp. 237-253.

Moulder, C. (1994) 'Towards a preliminary framework for understanding pregnancy loss ', *Journal of Reproductive and Infant Psychology*, .2(1), pp. 65-67.

Moulder, C. (1998) *Understanding Pregnancy Loss: Perspectives and Issues in Care*. London: Macmillan Press.

Moulder, C. (1999) 'Miscarriage: preparing SHOs for their role in hospital care', *Journal of Obstetrics and Gynaecology*, 19(1), pp. 54-55.

Muller, A., Rohrs, S., Hoffman-Wanderer, Y. and Moult, K. (2016) '"You have to make a judgment call". - Morals, judgments and the provision of quality sexual and reproductive health services for adolescents in South Africa', *Social Science and Medicine*, 148, pp. 71-78.

Murphy, F. and Merrell, J. (2009) 'Negotiating the transition: caring for women through the experience of early miscarriage', *Journal of Clinical Nursing*, 18(11), pp. 1583-1591.

Murphy, F. and Philpin, S. (2010) 'Early miscarriage as 'matter out of place': an ethnographic study of nursing practice in a hospital gynaecological unit', *International Journal of Nursing Studies*, 47(5), pp. 534-41.

Murphy, F.A. (1998) 'The experience of early miscarriage from a male perspective', *Journal of Clinical Nursing*, 7(4), pp. 325-332.

Murphy, F.A., Lipp, A. and Powles, D.L. (2012) 'Follow-up for improving psychological well being for women after a miscarriage', *Cochrane Database Syst Rev*, (3), p. CD008679.

Murphy, S. (2012) 'Bereaved Parents: A Contradiction in Terms', in Komaromy, C., Earle, S., Komaromy, C. and Layne, L.L. (eds.) *Understanding reproductive loss : perspectives on life, death and fertility*. Surrey, England: Ashgate Publishing Ltd.

Musters, A.M., Koot, Y.E.M., Van Den Boogaard, N.M., Kaaijk, E., MacKlon, N.S., Van Der Veen, F., Nieuwkerk, P.T. and Goddijn, M. (2013) 'Supportive care for women with recurrent miscarriage: A survey to quantify women's preferences', *Human Reproduction*, 28(2), pp. 398-405.

Nanda, K., Peloggia, A., Grimes, D., Lopez, L. and Nanda, G. (2006) 'Expectant care versus surgical treatment for miscarriage', *The Cochrane Database of Systematic Reviews*, (2), p. CD003518.

National Institute for Health and Care Excellence (2012a) *CG1154: Ectopic pregnancy and miscarriage: diagnosis and initial managment*. NICE.

National Institute for Health and Care Excellence (2012b) *QS15: Patient experience in adult NHS services*. National Institute for Health and Care Excellence.

Neilson, J.P., Gyte, G.M., Hickey, M., Vazquez, J.C. and Dou, L. (2010) 'Medical treatments for incomplete miscarriage (less than 24 weeks)', *The Cochrane Database of Systematic Reviews*, (1), p. CD007223.

Neugebauer, R., Kline, J., Bleiberg, K., Baxi, L., Markowitz, J.C., Rosing, M., Levin, B. and Keith, J. (2007) 'Preliminary open trial of interpersonal counseling for subsyndromal depression following miscarriage', *Depression and Anxiety*, 24(3), pp. 219-222.

Neugebauer, R., Kline, J., Markowitz, J.C., Bleiberg, K.L., Baxi, L., Rosing, M.A., Levin, B. and Keith, J. (2006) 'Pilot randomized controlled trial of interpersonal counseling for subsyndromal depression following miscarriage', *Journal of Clinical Psychiatry*, 67(8), pp. 1299-1304.

Neugebauer, R., Kline, J., Shrout, P., Skodol, A., O'Connor, P., Geller, P.A., Stein, Z. and Susser, M. (1997) 'Major depressive disorder in the 6 months after miscarriage', *JAMA*, 277(5), pp. 383-388.

Newdick, C. and Danbury, C. (2013) 'Culture, compassion and clinical neglect: probity in the NHS after Mid Staffordshire', *Journal of Medical Ethics*.

Nicolay, C.R., Purkayastha, S., Greenhalgh, A., Benn, J., Chaturvedi, S., Phillips, N. and Darzi, A. (2012) 'Systematic review of the application of quality improvement methodologies from the manufacturing industry to surgical healthcare', *British Journal of Surgery*, 99(3), pp. 324-335.

Nielsen, V.L. (2015) 'Personal attributes and institutions: gender and the behavior of public employees. Why gender matters to not only "gendered policy areas"', *Journal of Public Administration Research and Theory*, 25(4), pp. 1005-1029.

Niinimaki, M., Jouppila, P., Martikainen, H. and Talvensaari-Mattila, A. (2006) 'A randomized study comparing efficacy and patient satisfaction in medical or surgical treatment of miscarriage', *Fertility and Sterility*, 86(2), pp. 367-372.

Nikcevic, A.V. (2003) 'Development and evaluation of a miscarriage follow-up clinic', *Journal of Reproductive and Infant Psychology*, 21(3), pp. 207-217.

Nikcevic, A.V., Kuczmierczyk, A.R. and Nicolaides, K.H. (2007) 'The influence of medical and psychological interventions on women's distress after miscarriage', *Journal of Psychosomatic Research*, 63(3), pp. 283-290.

Nikcevic, A.V., Tunkel, S.A., Kuczmierczyk, A.R. and Nicolaides, K.H. (1999) 'Investigation of the cause of miscarriage and its influence on women's psychological distress', *British Journal of Obstetrics & Gynaecology*, 106(8), pp. 808-813.

Nojomi, M., Akbarian, A. and Ashory-Moghadam, S. (2006) 'Burden of abortion: induced and spontaneous', *Archives of Iranian Medicine*, 9(1), pp. 39-45.

Nugus, P., Greenfield, D., Travaglia, J. and Braithwaite, J. (2012) 'The politics of action research: “If you don't like the way things are going, get off the bus”', *Social Science and Medicine*, 75(11), pp. 1946-1953.

Nugus, P., Greenfield, D., Travaglia, J., Westbrook, J. and Braithwaite, J. (2010) 'How and where clinicians exercise power: Interprofessional relations in health care', *Social Science and Medicine*, 71(5), pp. 898-909.

Nursing & Midwifery Council (2015) *The Code. Professional standards of practice and behaviour for nurses and midwives* London: The Nursing and Midwifery Council.

Nursing and Midwifery Council (2010) *Raising and escalating concerns. Guidance for nurses and midwives.* London: Nursing and Midwifery Council.

O'Byrne, D. (2011) *Introducing Sociological Theory*. Dorset.

O'Donovan, A. (2007) 'Patient-centred care in acute psychiatric admission units: reality or rhetoric?', *Journal of Psychiatric and Mental Health Nursing*, 14(6), pp. 542-548.

O'Dowd, A. (2011) 'Changes to NHS reforms will increase bureaucracy and treble the number of statutory organisations', *British Medical Journal*, 342, p. d4168 [Online] (Accessed: 30/08/16).

O'Rourke, D. and Wood, S. (2009) 'The early pregnancy assessment project: The effect of cooperative care in the emergency department for management of early pregnancy complications', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 49(1), pp. 110-114.

Oates, J., Casikar, I., Campain, A., Muller, S., Yang, J., Reid, S. and Condous, G. (2013) 'A prediction model for viability at the end of the first trimester after a single early pregnancy evaluation', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 53(1), pp. 51-57.

Oberg, S.A. and Bringselius, L. (2015) 'Professionalism and organizational performance in the wake of new managerialism', *European Political Science Review*, 7(4), pp. 499-523.

Ogden, J. and Maker, C. (2004) 'Expectant or surgical management of miscarriage: a qualitative study', *BJOG: An International Journal of Obstetrics and Gynaecology*, 111(5), pp. 463-467.

Oh, Y. and Gastmans, C. (2015) 'Moral distress experienced by nurses: a quantitative literature review', *Nursing Ethics*, 22(1), pp. 15-31.

Olesen, M.L., Graungaard, A.H. and Husted, G.R. (2015) 'Deciding treatment for miscarriage - experiences of women and healthcare professionals', *Scandinavian Journal of Caring Sciences*, 29(2), pp. 386-394.

Olsen, J.P. (2006) 'Maybe it is time to rediscover bureaucracy', *Journal of Public Administration Research and Theory*, 16(1), pp. 1-24.

Othman, N. and Nasurdin, A.M. (2013) 'Social support and work engagement: a study of Malaysian nurses', *Journal of Nursing Management*, 21(8), pp. 1083-1090.

Parand, A., Burnett, S., Benn, J., Pinto, A., Iskander, S. and Vincent, C. (2011) 'The disparity of frontline clinical staff and managers' perceptions of a quality and patient safety initiative', *Journal of Evaluation in Clinical Practice*, 17(6), pp. 1184-1190.

Parker, L.E., Kirchner, J.E., Bonner, L.M., Fickel, J.J., Ritchie, M.J., Simons, C.E. and Yano, E.M. (2009) 'Creating a quality-improvement dialogue: utilizing knowledge from frontline staff, managers, and experts to foster health care quality improvement', *Qualitative Health Research*, 19(2), pp. 229-242.

Paton, F., Wood, R., Bor, R. and Nitsun, M. (1999) 'Grief in miscarriage patients and satisfaction with care in a London hospital. Aug 1999', *Journal of Reproductive and Infant Psychology*, 17(3), pp. 301-315.

Peel, E. and Cain, R. (2012) ''Silent' miscarriage and deafening heteronormativity: a British experiential and critical feminist sccount', in Earle, S., Komaromy, C. and Layne, L.L. (eds.) *Understanding reproductive loss : perspectives on life, death and fertility*. Farham, Surrey, England ; Burlington, VT: Ashgate, pp. 79-92.

Pepper, J.R., Jaggar, S.I., Mason, M.J., Finney, S.J. and Dusmet, M. (2012) 'Schwartz Rounds: reviving compassion in modern healthcare', *Journal of the Royal Society of Medicine*, 105(3), pp. 94-95.

Peräkylä, A. and Ruusuvuori, J. (2011) 'Analyzing Talk and Text', in Denzin, N.K. and Lincoln, Y.S. (eds.) *The Sage handbook of qualitative research*. 4th ed. edn. Thousand Oaks: Sage, pp. 529-544.

Peter, E., Lunardi, V.L. and Macfarlane, A. (2004) 'Nursing resistance as ethical action: literature review', *Journal of Advanced Nursing*, 46(4), pp. 403-416.

Peters, K., Luck, L., Hutchinson, M., Wilkes, L., Andrew, S. and Jackson, D. (2011) 'The emotional sequelae of whistleblowing: findings from a qualitative study', *Journal of Clinical Nursing*, 20(19-20), pp. 2907-2914.

Petrou, S. and McIntosh, E. (2009) 'Women's preferences for attributes of first-trimester miscarriage management: a stated preference discrete-choice experiment', *Value in Health*, 12(4), pp. 551-559.

Petrou, S., Trinder, J., Brocklehurst, P. and Smith, L. (2006) 'Economic evaluation of alternative management methods of first-trimester miscarriage based on results from the MIST trial', *BJOG: An International Journal of Obstetrics & Gynaecology*, 113(8), pp. 879-889.

Picker Institute Europe (2015) 'NHS Staff Survey'. 01/07/16. Available at: http://www.nhsstaffsurveys.com/Caches/Files/NHS%20Staff%20Survey%202015%20job1_sheet1_mean-2.xls.

Pineles, B.L., Park, E. and Samet, J.M. (2014) 'Systematic review and meta-analysis of miscarriage and maternal exposure to tobacco smoke during pregnancy', *American Journal of Epidemiology*, 179(7), pp. 807-823.

Plagge, J. and Atntick, J.R. (2009) 'Perceptions of perinatal loss: miscarriage versus stillbirth', *Women's Health and Urban Life*, 8(2), pp. 113-127.

Poddar, A., Tyagi, J., Hawkins, E. and Opemuyi, I. (2011) 'Standards of care provided by Early Pregnancy Assessment Units (EPAU): a UK-wide survey', *Journal of Obstetrics and Gynaecology*, 31(7), pp. 640-644.

Porter, M. (2009) 'BMA view on whistleblowing', *British Medical Journal*, 339, p. b4405 [Online]. Available at: http://www.bmj.com/content/339/bmj.b4405 (Accessed: 19/08/16).

Powell, A., Rushmer, R. and Davies, H. (2009) *A Systematic Narritive Review of Quality Improvement Models in Health Care*. The Universities of Dundee and St Andrews Scotland, N.Q.I.

Prettyman, R.J. and Cordle, C. (1992) 'Psychological aspects of miscarriage: attitudes of the primary health care team', *British Journal of General Practice*, 42(356), pp. 97-99.

Price, M., Fitzgerald, L. and Kinsman, L. (2007) 'Quality improvement: the divergent views of managers and clinicians', *Journal of Nursing Management*, 15(1), pp. 43-50.

Puddifoot, J.E. and Johnson, M.P. (1997) 'The legitimacy of grieving: the partner's experience at miscarriage', *Social Science and Medicine*, 45(6), pp. 837-845.

Radford, E.J. and Hughes, M. (2015) 'Women's experiences of early miscarriage: implications for nursing care', *Journal of clinical nursing*, 24(11-12), pp. 1457-1465.

Raffay, J. (2014) 'How staff and patient experience shapes our perception of spiritual care in a psychiatric setting', *Journal of Nursing Management*, 22(7), pp. 940-950.

Rainey, H., Ehrich, K., Mackintosh, N. and Sandall, J. (2015) 'The role of patients and their relatives in 'speaking up' about their own safety - a qualitative study of acute illness', *Health Expections*, 18(3), pp. 392-405.

Rausch, M., Lorch, S., Chung, K., Frederick, M., Zhang, J. and Barnhart, K. (2012) 'A cost-effectiveness analysis of surgical versus medical management of early pregnancy loss', *Fertility and Sterility*, 97(2), pp. 355-360.

Reagan, L.J. (2003) 'From hazard to blessing to tragedy: representations of miscarriage in twentieth-century America', *Feminist Studies*, 29(2), pp. 357-378.

Reed, M. (2003) 'The agency/structure dilemma in organization theory', in Tsoukas, H. and Knudsen, C. (eds.) *The Oxford Handbook of Organization Theory*. 1st edn. Oxford ; New York: Oxford University Press, pp. 289-309.

Reeves, S., Albert, M., Kuper, A. and Hodges, B.D. (2008) 'Why use theories in qualitative research?', *British Medical Journal*, 337, p. a949.

Reeves, S., Rice, K., Conn, L.G., Miller, K.L., Kenaszchuk, C. and Zwarenstein, M. (2009) 'Interprofessional interaction, negotiation and non-negotiation on general internal medicine wards', *Journal of Interprofessional Care*, 23(6), pp. 633-645.

Regan, L., Backos, M. and Rai, R. (2011) *The Investigation and Treatment of Couples with Recurrent First-trimester and Second-trimseter Miscarriage. Green-top Guideline No. 17*. Royal College of Obstetricians and Gynaecologists.

Reiger, K. and Lane, K. (2013) ''How can we go on caring when nobody here cares about us?' Australian public maternity units as contested care sites', *Women and Birth*, 26(2), pp. 133-137.

Renner, C.H., Verdekal, S., Brier, S. and Fallucca, G. (2000) 'The meaning of miscarriage to others : is it an unrecognized loss?', *Journal of Loss and Trauma*, 5(1), pp. 65-76.

Rhone, S.A., Hodgson, Z.G., Moshrefzadeh, A. and Maurer, C. (2012) 'A Canadian urban early pregnancy assessment clinic: a review of the first year of operation', *Journal of Obstetrics and Gynaecology Canada*, 34(3), pp. 243-249.

Rice, P.L. (2000) 'When the baby falls!: the cultural construction of miscariage among Hmong women in Australia', *Women and Health*, 30(1), pp. 85-103.

Rivett, G. (1998) *From Cradle to Grave; fifty years of the NHS*. London: King's Fund.

Rogers, A., Karlsen, S. and Addington-Hall, J. (2000) ''All the services were excellent. It is when the human element comes in that things go wrong': dissatisfaction with hospital care in the last year of life', *Journal of Advanced Nursing*, 31(4), pp. 768-774.

Ross, E.J. (2015) '‘I think it’s self-preservation’: risk perception and secrecy in early pregnancy', *Health, Risk and Society*, 17(5-6), pp. 329-348.

Ross, H., Tod, A.M. and Clarke, A. (2015) 'Understanding and achieving person-centred care: the nurse perspective', *Journal of Clinical Nursing*, 24(9-10), pp. 1223-1233.

Roueche, A. and Hewitt, J. (2012) ''Wading through treacle': quality improvement lessons from the frontline', *BMJ Quality and Safety*, 21(3), pp. 179-183.

Rowlands, I.J. and Lee, C. (2010) ''The silence was deafening': Social and health service support after miscarriage', *Journal of Reproductive and Infant Psychology*, 28(3), pp. 274-286.

Royal College of Obstetricians and Gynaecologists (2011) *High Quality Women's Health Care; proposal for change*. London: RCOG.

Rozenblum, R., Lisby, M., Hockey, P.M., Levtzion-Korach, O., Salzberg, C.A., Efrati, N., Lipsitz, S. and Bates, D.W. (2013) 'The patient satisfaction chasm: the gap between hospital management and frontline clinicians', *BMJ Quality and Safety*, 22(3), pp. 242-250.

Rubington, E. and Weinberg, M.S. (1995) *The Study of Social Problems : seven perspectives*. 5th edn. New York: Oxford University Press.

Rudge, T., Holmes, D. and Perron, A. (2011) 'The rise of practice development with/in reformed bureaucracy: discourse, power and the government of nursing', *Journal of Nursing Management*, 19(7), pp. 837-844.

Russell, J., Swinglehurst, D. and Greenhalgh, T. (2014) ''Cosmetic boob jobs' or evidence-based breast surgery: an interpretive policy analysis of the rationing of 'low value' treatments in the English National Health Service', *BMC Health Services Research*, 14, p. 413.

Ruston, A. (2006) 'Interpreting and managing risk in a machine bureaucracy: Professional decision-making in NHS Direct', *Health Risk and Society*, 8(3), pp. 257-271.

Ryan, M. and Hughes, J. (1997) 'Using conjoint analysis to assess women's preferences for miscarriage management', *Health Economics*, 6(3), pp. 261-273.

Ryninks, K., Roberts-Collins, C., McKenzie-McHarg, K. and Horsch, A. (2014) 'Mothers' experience of their contact with their stillborn infant: An interpretative phenomenological analysis', *BMC Pregnancy and Childbirth*, 14.

Saario, S. (2012) 'Managerial reforms and specialised psychiatric care: a study of resistive practices performed by mental health practitioners', *Sociology of Health and Illness*, 34(6), pp. 896-910.

Sackett, D.L. (1997) 'Evidence-based medicine', *Seminars in Perinatology*, 21(1), pp. 3-5.

Saldaña, J. (2013) *The Coding Manual for Qualitative Researchers*. 2nd ed. edn. Los Angeles ; London: SAGE.

Sandelowski, M. (2010) 'What's in a name? qualitative description revisited', *Research in Nursing and Health*, 33(1), pp. 77-84.

Sands - Stillbirth and neonatal death charity (2016) *Sands - Stillbirth and neonatal death charity*. Available at: https://www.uk-sands.org (Accessed: 1st April 2016).

Scamell, M. (2011) 'The swan effect in midwifery talk and practice: a tension between normality and the language of risk', *Sociology of Health and Illness*, 33(7), pp. 987-1001.

Schatzman, L. and Strauss, A. (1966) 'A sociology of psychiatry: a perspective and some organizing foci', *Social Problems*, 14(1), pp. 3-16.

Schneider, H., English, R., Tabana, H., Padayachee, T. and Orgill, M. (2014) 'Whole-system change: case study of factors facilitating early implementation of a primary health care reform in a South African province', *BMC Health Services Research*, 14(609) [Online]. Available at: http://www.ncbi.nlm.nih.gov/pubmed/25432243 DOI: 10.1186/s12913-014-0609-y (Accessed: 21/04/2015).

Schofield, J. (2001) 'The old ways are the best? The durability and usefulness of bureaucracy in public sector management', *Organization*, 8(1), pp. 77-96.

Scott, W.R. (1987) 'The adolescence of institutional theory', *Administrative Science Quarterly*, 32, pp. 493-511.

Scourfield, P. (2015) 'Even further beyond street-Level bureaucracy: the dispersal of discretion exercised in decisions made in older people's care home reviews', *British Journal of Social Work*, 45(3), pp. 914-931.

Séjourné, N., Callahan, S. and Chabrol, H. (2010a) 'Support following miscarriage: what women want', *Journal of Reproductive and Infant Psychology*, 28(4), pp. 403-411.

Séjourné, N., Callahan, S. and Chabrol, H. (2010b) 'The utility of a psychological intervention for coping with spontaneous abortion', *Journal of Reproductive and Infant Psychology*, 28(3), pp. 287-296.

Séjourné, N., Fagny, J., Got, F., Lacroix, P., Pauchet, C. and Combalbert, L. (2016) 'Internet forums following a miscarriage: a place for women in particular pain?', *Journal of Reproductive and Infant Psychology*, 34(1), pp. 28-34.

Shim, J.K. (2010) 'Cultural health capital: A theoretical approach to understanding health care interactions and the dynamics of unequal treatment', *Journal of Health and Social Behavior*, 51(1), pp. 1-15.

Silverman, D. (2011) *Interpreting Qualitative Data : a guide to the principles of qualitative research*. 4th edn. London: SAGE.

Simmons, R.K., Singh, G., Maconochie, N., Doyle, P. and Green, J. (2006) 'Experience of miscarriage in the UK: qualitative findings from the National Women's Health Study', *Social Science and Medicine*, 63(7), pp. 1934-1946.

Simms, R.A., Yelland, A., Ping, H., Beringer, A.J., Draycott, T.J. and Fox, R. (2014) 'Using data and quality monitoring to enhance maternity outcomes: a qualitative study of risk managers' perspectives', *BMJ Quality and Safety*, 23(6), pp. 457-464.

Simpson, R. and Bor, R. (2001) ''I'm not picking up a heart-beat': experiences of sonographers giving bad news to women during ultrasound scans', *British Journal of Medical Psychology*, 74, pp. 255-272.

Sims, D. (2005) 'You bastard: a narrative exploration of the experience of indignation within organizations', *Organization Studies*, 26(11), pp. 1625-1640.

Singer, S.J., Rivard, P.E., Hayes, J.E., Shokeen, P., Gaba, D. and Rosen, A. (2013) 'Improving patient care through leadership engagement with frontline staff: a Department of Veterans Affairs case study', *The Joint Commission Journal on Quality and Patient Safety*, 39(8), pp. 349-360.

Sinuff, T., Muscedere, J., Rozmovits, L., Dale, C.M. and Scales, D.C. (2015) 'A qualitative study of the variable effects of Audit and feedback in the ICU', *BMJ Quality and Safety*, 24(6), pp. 393-399.

Skinner, J. and Maude, R. (2016) 'The tensions of uncertainty: midwives managing risk in and of their practice', *Midwifery*, 38, pp. 35-41.

Smith, J.A. and Osborn, M. (2008) 'Interpretative phenomenological analysis', in Smith, J.A. (ed.) *Qualitative Psychology : a practical guide to research methods*. 2nd edn. Los Angeles: SAGE Publications, p. 276.

Smith, L.F., Frost, J., Levitas, R., Bradley, H. and Garcia, J. (2006) 'Women's experiences of three early miscarriage management options: a qualitative study', *British Journal of General Practice*, 56(524), pp. 198-205.

Snow, T. (2011) 'NMC urges registrants to raise concerns about colleagues', *Nursing Standard*, 25(42), p. 9.

Sokol, D.K. (2013) '"First do no harm" revisited', *British Medical Journal*, 347, p. f6426 [Online]. Available at: http://www.ncbi.nlm.nih.gov/pubmed/24163087 DOI: 10.1136/bmj.f6426 (Accessed: 30/08/16).

Somekh, B. and Lewin, C. (2011) *Theory and Methods in Social Research*. 2nd edn. Los Angeles ; London: SAGE.

Spyridonidis, D. and Calnan, M. (2011) 'Are new forms of professionalism emerging in medicine? The case of the implementation of NICE guidelines', *Health Sociology Review*, 20(4), pp. 394-409.

Squier, H.C., Ries, A.L., Kaplan, R.M., Prewitt, L.M., Smith, C.M., Kriett, J.M. and Jamieson, S.W. (1995) 'Quality of well-being predicts survival in lung transplantation candidates', *Americal Journal of Respiratory and Critical Care Medicine*, 152(6 Pt 1), pp. 2032-2036.

Stake, R.E. (1995) *The Art of Case Study Research*. Thousand Oaks ; London: Sage Publications.

Stewart, L., Holmes, C. and Usher, K. (2012) 'Reclaiming caring in nursing leadership: a deconstruction of leadership using a Habermasian lens', *Collegian*, 19(4), pp. 223-229.

Great Britain. *Still-Birth (Definition) Act 1992 c.29: Elizabeth II*. (1992) London: The Stationery Office.

Stratton, K. and Lloyd, L. (2008) 'Hospital-based interventions at and following miscarriage: literature to inform a research-practice initiative', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 48(1), pp. 5-11.

Strauss, A.C., Schatzman, L., Ehrlich, D., Bucher, R. and Sabshin, M. (1973) 'The hospital and its negotiated order', in Salaman, G. and Thompson, K.A. (eds.) *People and Organisations*. London: Longman for Open University Press, pp. 147-169.

Suhag, A. and Berghella, V. (2014) 'Cervical cerclage', *Clinical Obstetrics and Gynecology*, 57(3), pp. 557-567.

Svensson, R. (1996) 'The interplay between doctors and nurses - a negotiated order perspective', *Sociology of Health and Illness*, 18(3), pp. 379-398.

Swanson, K.M. (1999) 'Effects of caring, measurement, and time on miscarriage impact and women's well-being', *Nursing Research*, 48(6), pp. 288-298.

Swartz, D. (1997) *Culture & Power : the sociology of Pierre Bourdieu*. Chicago ; London: University of Chicago Press.

Sword, W., Heaman, M.I., Brooks, S., Tough, S., Janssen, P.A., Young, D., Kingston, D., Helewa, M.E., Akhtar-Danesh, N. and Hutton, E. (2012) 'Women's and care providers' perspectives of quality prenatal care: a qualitative descriptive study', *BMC Pregnancy and Childbirth*, 12, p. 29 [Online]. Available at: http://ovidsp.ovid.com/athens/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=22502640 DOI: http://dx.doi.org/10.1186/1471-2393-12-29 (Accessed: 25/07/14).

Takle, M. (2015) 'Immigrant organisations as schools of bureaucracy', *Ethnicities*, 15(1), pp. 92-111.

Thanoon, O., Gharaibeh, A. and Mahmood, T. (2015) 'The implications of obesity on pregnancy outcome', *Obstetrics, Gynaecology and Reproductive Medicine*, 25(4), pp. 96-101.

Thapar, A.K. and Thapar, A. (1992) 'Psychological sequelae of miscarriage: a controlled study using the general health questionnaire and the hospital anxiety and depression scale', *British Journal of General Practice*, 42(356), pp. 94-96.

The Association of Early Pregnancy Units (2007) *Guidelines 2007*. AEPU.

The Bristol Royal Infirmary Inquiry (2001) *The Report of the Public Inquiry into children's heart surgery atthe Bristol Royal Infirmary 1984-1995. Learning from Bristol.* London The Department of Health.

The Department of Health (2010) *Equity and Excellence: Liberating the NHS*. London: HMSO.

The General Medical Council (2012) *Raising and Acting on Concerns About Patient Safety*. London: The General Medical Council.

The General Medical Council (2013) *Good Medical Practice*. London: The General Medical Council.

The Health Policy Partnership (2015) *The State of Play in Person-Centred Care*. London: The Health Policy Partnership Partnership, T.H.P.

The Miscarriage Association (2016) *The Miscarriage Association*. Available at: http://www.miscarriageassociation.org.uk/ (Accessed: 13/07/16).

The National Institute of Health and Care Excellence (2013) *NICE Charter*. Available at: https://www.nice.org.uk/Media/Default/About/Who-we-are/NICE_Charter.pdf (Accessed: 23rd October 2015).

The National Maternity Review (2016) *Better Births. Improving outcomes of maternity services in England*. London.

The NHS Confederation (2016) *Key Statistics on the NHS*. Available at: http://www.nhsconfed.org/resources/key-statistics-on-the-nhs (Accessed: 01/06/16).

The Nuffield Trust (2011) *Snapshot Survey of Health Leaders on the Government's NHS reforms*. London: The Nuffield Trust Trust, T.N.

The Nursing and Midwifery Council (2012) *Midwives Rules and Standards*. London: HMSO.

The Nursing and Midwifery Council (2015) 'Revalidation. How to revalidate with the NMC'. London: The Nursing and Midwifery Council.

The Oxford Living Dictionaries *Definition of mind in English*. Available at: https://en.oxforddictionaries.com/definition/mind (Accessed: 15/08/2016).

The Royal College of Obstetricians and Gynaecologists (2006) *The Management of Early Pregnancy Loss*. London: RCOG.

The World Health Organization (2006) *Reproductive Health Indicators : guidelines for their generation, interpretation and analysis for global monitoring.* The World Health Organization Organization, T.W.H.

Thompson, P. and Alvesson, M. (2005) 'Bureaucracy at work: misunderstandings and mixed blessings', in Du Gay, P. (ed.) *The Values of Bureaucracy*. Oxford: Oxford University Press.

Thompson, S. (2012) ''As If she never existed': changing understandings of perinatal loss in Australia in the Twentieth and Early Twenty-First Century', in Komaromy, C., Earle, S., Komaromy, C. and Layne, L.L. (eds.) *Understanding reproductive loss : perspectives on life, death and fertility*. Surrey, England: Ashgate Publishing Ltd.

Timberlake, M.T. (2016) 'The path to academic access for students with significant cognitive disabilities', *Journal of Special Education*, 49(4), pp. 199-208.

Timmons, S., Baxendale, B., Buttery, A., Miles, G., Roe, B. and Browes, S. (2015) 'Implementing human factors in clinical practice', *Emergency Medical Journal*, 32(5), pp. 368-372.

Torres, J.M., Kietzman, K.G. and Wallace, S.P. (2015) 'Walking the line: navigating market and gift economies of care in a consumer-directed home-based care program for older adults', *Milbank Quarterly*, 93(4), pp. 732-760.

Tower, M., Rowe, J. and Wallis, M. (2011) 'Normalizing policies of inaction - the case of health care in Australia for women affected by domestic iolence', *Health Care for Women International*, 32(9), pp. 855-868.

Traynor, M., Nissen, N., Lincoln, C. and Buus, N. (2015) 'Occupational closure in nursing work reconsidered: UK health care support workers and assistant practitioners: A focus group study', *Social Science and Medicine*, 136, pp. 81-88.

Trinder, J., Brocklehurst, P., Porter, R., Read, M., Vyas, S. and Smith, L. (2006) 'Management of miscarriage: expectant, medical, or surgical? Results of randomised controlled trial (miscarriage treatment (MIST) trial)', *British Medical Journal*, 332(7552), pp. 1235-1240.

Tromp, M., Ravelli, A.C., Reitsma, J.B., Bonsel, G.J. and Mol, B.W. (2011) 'Increasing maternal age at first pregnancy planning: health outcomes and associated costs', *Journal of Epidemiology and Community Health*, 65(12), pp. 1083-1090.

Truss, C., Alfes, K., Delbridge, R., Shantz, A. and Soane, E. (2014) *Employee Engagement in Theory and Practice*. Routledge,.

Tsartsara, E. and Johnson, M.P. (2002) 'Women's experience of care at a specialised miscarriage unit: An interpretative phenomenological study', *Clinical Effectiveness in Nursing*, 6(2), pp. 55-65.

Tunde-Byass, M. and Cheung, V.Y. (2009) 'The value of the early pregnancy assessment clinic in the management of early pregnancy complications', *Journal of Obstetrics and Gynaecology Canada*, 31(9), pp. 841-844.

Turner, B.S. and Samson, C. (1995) *Medical Power and Social Knowledge*. 2nd edn. London: Sage Publications.

Ulmestig, R. and Marston, G. (2015) 'Street-level perceptions of procedural rights for young unemployed people - A comparative study between Sweden and Australia', *Social Policy and Administration*, 49(3), pp. 394-411.

van Berkel, R. and Knies, E. (2016) 'Performance management, caseloads and the frontline provision of Social Services', *Social Policy and Administration*, 50(1), pp. 59-78.

Van Den Akker, O.B. (2011) 'The psychological and social consequences of miscarriage', *Expert Review of Obstetrics and Gynecology*, 6(3), pp. 295-304.

Van Den Berg, M., Dancet, E.A.F., Van Der Veen, F., Goddijn, M. and Mol, F. (2015) 'Patient-centered care for couples faced with early pregnancy complications: a systematic review of the literature', *Human Reproduction*, 30, pp. i194-i195.

Van Den Berg, M., Goddijn, M., Ankum, W.M., Van Woerden, E.E., Van Der Veen, F., Van Wely, M. and Hajenius, P.J. (2014a) 'An early pregnancy assessment unit improves quality of care and reduces health care costs', *30th Annual Meeting of the European Society of Human Reproduction and Embryology*. Munich Germany, July. pp. i71-i72.

Van den Berg, M.M., Vissenberg, R. and Goddijn, M. (2014b) 'Recurrent miscarriage clinics', *Obstetrics and Gynecology Clinics of North America*, 41(1), pp. 145-155.

van den Berk-Clark, C. (2016) 'The dilemmas of frontline staff working with the homeless: housing first, discretion, and the task environment', *Housing Policy Debate*, 26(1), pp. 105-122.

Van Den Boogaard, E., Goddijn, M., Leschot, N.J., Van Der Veen, F., Kremer, J.A.M. and Hermens, R.P.M.G. (2010) 'Development of guideline-based quality indicators for recurrent miscarriage', *Reproductive BioMedicine Online*, 20(2), pp. 267-273.

Van Den Boogaard, E., Hermens, R.P.M.G., Franssen, A.M.H.W., Doornbos, J.P.R., Kremer, J.A.M., Van Der Veen, F. and Goddijn, M. (2013) 'Recurrent miscarriage: do professionals adhere to their guidelines', *Human Reproduction*, 28(11), pp. 2898-2904.

Van Den Boogaard, E., Hermens, R.P.M.G., Leschot, N.J., Baron, R., Vollebergh, J.H.A., Bernardus, R.E., Van Der Veen, F., Kremer, J.A.M. and Goddijn, M. (2011) 'Identification of barriers for good adherence to a guideline on recurrent miscarriage', *Acta Obstetricia et Gynecologica Scandinavica*, 90(2), pp. 186-191.

Van der Aa, P. and van Berkel, R. (2015) 'Fulfilling the promise of professionalism in street-level practice', in Hupe, P., Hill, M. and Buffat, A. (eds.) *Understanding Street-Level Bureaucracy*. Bristol: Policy Press, pp. 263-278.

van der Sijpt, E. (2010) 'Marginal matters: pregnancy loss as a social event', *Social Science and Medicine*, 71(10), pp. 1773-1779.

Vartanian, T.P. (2011) *Secondary data analysis*. New York: Oxford University Press.

Venance, S.L., LaDonna, K.A. and Watling, C.J. (2014) 'Exploring frontline faculty perspectives after a curriculum change', *Medical Education*, 48(10), pp. 998-1007.

Wahba, K., Shah, A., Hill, K. and Hosni, M.M. (2015) 'A novel early pregnancy assessment unit/gynaecology assessment unit dashboard. An experience from a UK district general hospital', *Journal of Obstetrics and Gynaecology*, 35(7), pp. 703-706.

Wallace, J. and Pease, B. (2011) 'Neoliberalism and Australian social work: Accommodation or resistance?', *Journal of Social Work*, 11(2), pp. 132-142.

Wallace, R.R., Goodman, S., Freedman, L.R., Dalton, V.K. and Harris, L.H. (2010) 'Counseling women with early pregnancy failure: Utilizing evidence, preserving preference', *Patient Education and Counseling*, 81(3), pp. 454-461.

Wallbank, S. and Robertson, N. (2008) 'Midwife and nurse responses to miscarriage, stillbirth and neonatal death: A critical review of qualitative research', *Evidence Based Midwifery*, 6(3), pp. 100-106.

Wallbank, S. and Robertson, N. (2013) 'Predictors of staff distress in response to professionally experienced miscarriage, stillbirth and neonatal loss: A questionnaire survey', *International Journal of Nursing Studies*, 50(8), pp. 1090-1097.

Walsh, D. (2006) 'Subverting the assembly-line: childbirth in a free-standing birth centre', *Social Science and Medicine*, 62(6), pp. 1330-1340.

Walsh, D. and Downe, S. (2005) 'Meta-synthesis method for qualitative research: a literature review', *Journal of Advanced Nursing*, 50(2), pp. 204-211.

Walshe, K. and Freeman, T. (2002) 'Effectiveness of quality improvement: learning from evaluations', *Quality and Safety in Health Care*, 11(1), pp. 85-87.

Waring, J.J. and Bishop, S. (2010) 'Lean healthcare: rhetoric, ritual and resistance', *Social Science and Medicine*, 71(7), pp. 1332-1340.

Warner, A., Saxton, A., Indig, D., Fahy, K. and Horvat, L. (2012) 'Women's experience of early pregnancy care in the emergency department: a qualitative study', *Australasian Emergency Nursing Journal*, 15(2), pp. 86-92.

Warr, J. (2002) 'Experiences and perceptions of newly prepared health care assistants (Level 3 NVQ)', *Nurse Education Today*, 22(3), pp. 241-250.

Wastell, D., White, S., Broadhurst, K., Peckover, S. and Pithouse, A. (2010) 'Children's services in the iron cage of performance management: street-level bureaucracy and the spectre of Svejkism', *International Journal of Social Welfare*, 19(3), pp. 310-320.

Weber, M., Parsons, T. and Giddens, A. (2001) *The Protestant Ethic and the Spirit of Capitalism*. London: Routledge.

Wells, J.S.G. (1997) 'Priorities, 'street level bureaucracy' and the community mental health team', *Health and Social Care in the Community*, 5(5), pp. 333-342.

Wendt, K., Crilly, J., May, C., Bates, K. and Saxena, R. (2014) 'An outcomes evaluation of an emergency department early pregnancy assessment service and early pregnancy assessment protocol', *Emergency Medicine Journal*, 31(e1), pp. e50-54.

Wensing, M., Jung, H.P., Mainz, J., Olesen, F. and Grol, R. (1998) 'A systematic review of the literature on patient priorities for general practice care. Part 1: Description of the research domain', *Social Science and Medicine*, 47(10), pp. 1573-1588.

West, J. and Oldfather, P. (1995) 'Pooled case comparison: an innovative for cross case study', *Qualitative Inquiry*, 1(4), pp. 452-462.

White, A.R., Nathan, N.L. and Faller, J.K. (2015) 'What do I need to vote? dureaucratic discretion and discrimination by L

local election officials', *American Political Science Review*, 109(1), pp. 129-142.

Wieringa-de Waard, M., Bindels, P.J., Vos, J., Bonsel, G.J., Stalmeier, P.F. and Ankum, W.M. (2004) 'Patient preferences for expectant management vs. surgical evacuation in first-trimester uncomplicated miscarriage', *Journal of Clinical Epidemiology*, 57(2), pp. 167-173.

Wieringa, S. and Greenhalgh, T. (2015) '10 years of mindlines: a systematic review and commentary', *Implementation Science*, 10, p. 45 [Online]. Available at: http://www.ncbi.nlm.nih.gov/pubmed/25890280 DOI: 10.1186/s13012-015-0229-x (Accessed: 30/08/16).

Wilcox, A.J., Weinberg, C.R., Oconnor, J.F., Baird, D.D., Schlatterer, J.P., Canfield, R.E., Armstrong, E.G. and Nisula, B.C. (1988) 'Incidence of early loss of pregnancy', *New England Journal of Medicine*, 319(4), pp. 189-194.

Wilkinson, J., Powell, A. and Davies, H. (2011) *Are Clinicians Engaged in Quailty Improvement?* London: The Health Foundation.

Williams, M.V., Li, J., Hansen, L.O., Forth, V., Budnitz, T., Greenwald, J.L., Howell, E., Halasyamani, L., Vidyarthi, A. and Coleman, E.A. (2014) 'Project BOOST implementation: lessons learned', *South Medical Journal*, 107(7), pp. 455-465.

Wilson, G. (2009) 'Implementation of Releasing Time to Care - the productive ward', *Journal of Nursing Management*, 17(5), pp. 647-654.

Wittich, C.M., Reed, D.A., Ting, H.H., Berger, R.A., Nowicki, K.M., Blachman, M.J., Mandrekar, J.N. and Beckman, T.J. (2014) 'Measuring reflection on participation in quality improvement activities for maintenance of certification', *Academic Medicine*, 89(10), pp. 1392-1397.

Wojnar, D.M., Swanson, K.M. and Adolfsson, A. (2011) 'Confronting the inevitable: A conceptual model of miscarriage for use in clinical practice and research', *Death Studies*, 35(6), pp. 536-538.

Wolf, A., Ekman, I. and Dellenborg, L. (2012) 'Everyday practices at the medical ward: a 16-month ethnographic field study', *BMC Health Services Research*, 12, p. 184 [Online]. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22748059 DOI: 10.1186/1472-6963-12-184 (Accessed: 30/08/13).

Wong, M.K., Crawford, T.J., Gask, L. and Grinyer, A. (2003) 'A qualitative investigation into women's experiences after a miscarriage: implications for the primary healthcare team', *British Journal of General Practice*, 53(494), pp. 697-702.

Woods-Giscombe, C.L., Lobel, M. and Crandell, J.L. (2010) 'The impact of miscarriage and parity on patterns of maternal distress in pregnancy', *Research in Nursing and Health*, 33(4), pp. 316-328.

Wooff, A. (2015) 'Relationships and responses: policing anti-social behaviour in rural Scotland', *Journal of Rural Studies*, 39, pp. 287-295.

Wren, J. and Craven, B. (1999) 'A cost-effectiveness study of changing medical practice in early pregnancy', *Clinical Performance Quality Health Care*, 7(4), pp. 172-177.

Wright, S. and McSherry, W. (2013) 'A systematic literature review of Releasing Time to Care: The Productive Ward', *Journal of Clinical Nursing*, 22(9-10), pp. 1361-1371.

Wynn, J.D., Draffin, E., Jones, A. and Reida, L. (2014) 'The Vidant Health quality transformation', *The Joint Commission Journal on Quality and Patient Safety*, 40(5), pp. 212-218.

Yap, S.J., Watts, J.C., Faithfull, T.J., Wong, S.Z., Wylde, K.L. and McGurgan, P.M. (2014) 'Is tissue an issue? Current practice and opinion in Western Australia for routine histopathology on products of conception', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 54(5), pp. 493-496.

Yoo, J.J. and Arnold, T.J. (2014) 'Customer orientation, engagement, and developing positive emotional labor', *Service Industries Journal*, 34(16), pp. 1272-1288.

You, J.H. and Chung, T.K. (2005) 'Expectant, medical or surgical treatment for spontaneous abortion in first trimester of pregnancy: a cost analysis', *Human Reproduction*, 20(10), pp. 2873-2878.

Zallman, L., Tendulkar, S., Bhuyia, N., Dube, B., Early, S., Arredondo, M., Puleo, R., Sengupta, N., Alsan, B. and Hacker, K. (2013) 'Provider's' perspectives on building research and quality improvement capacity in primary care: a strategy to improve workforce satisfaction', *Clinical and Translational Science*, 6(5), pp. 404-408.

Zhang, J., Haycock-Stuart, E., Mander, R. and Hamilton, L. (2015) 'Navigating the self in maternity care: how Chinese midwives work on their professional identity in hospital setting', *Midwifery*, 31(3), pp. 388-394.

Ziviani, J., Darlington, Y., Feeney, R., Rodger, S. and Watter, P. (2013) 'Service delivery complexities early intervention for children with physical disabilities', *Infants and Young Children*, 26(2), pp. 147-163.

Zucker, L.G. (1983) 'Organizations as institutions', in Bacharach, S.B. (ed.) *Research in the Sociology of Organizations*. Stamford, Connecticut: Jai Press, pp. 1-47.