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**The Implementation of Total Quality
Management Within Purchasing District
Health Authorities of The NHS**

Joseph Watkinson

A thesis submitted in partial fulfilment of the
requirements of Sheffield Hallam University for
the degree of Doctor of Philosophy

October 1996

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PUBLICATIONS ARISING FROM THIS THESIS

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(1996) "Signalling Quality: TQM and the British National Health Service", First International Research Conference on Quality Management, 5-7 February, Melbourne, Australia.

With Gladstone, B.W. and Morris, D.S. (1995) "Quality and the Superordinate Customer: Helping or Hindering the Implementation of TQM in the British National Health Service", in Curwen, P. (ed) The Changing Global Environment, Sheffield, UK. ISBN 0863395430

(1995) "Is TQM being Squeezed out of the NHS?", in Kanji, G.K. (ed) Total Quality Management: Proceedings of the First World Congress, Chapman and Hall, London, ISBN 0412643804

ABSTRACT

At its most basic, Total Quality Management (TQM) is about improving quality across the whole of an organisation by meeting customer requirements. The benefits claimed to be enjoyed by organisations which have implemented TQM include substantial reductions in costs and increased efficiency and customer satisfaction.

This research considered TQM within the context of the programme of National Health Service (NHS) reforms, introduced by the Government, and intended to reduce operating costs and improve the quality of care. The creation of the NHS internal market in 1991 required Purchasers and Providers of health care to enter into a contractual arrangement between themselves, in which price, volume and quality of service delivery were to be stipulated.

Against this background, the research has analysed attempts to implement TQM within District Health Authorities (DHAs) since assuming the role of Purchasers of health care in the internal market. It has examined the extent of TQM awareness and understanding within DHAs and assessed the prospects for its successful implementation.

The research was based on data secured through interviews with DHA Service Quality Managers and a postal questionnaire distributed to all DHAs in England.

The results revealed that while quality remained an official priority for NHS managers, TQM had not been widely adopted by DHAs and that there was an overall lack of awareness and understanding of TQM principles. Difficulties associated with implementation including a lack of expertise, a lack of resources, a high incidence of organisational change, the lack of senior management commitment, and an overall willingness to allow quality to be afforded a lower priority than other issues.

Although previous research has been carried out concerning the implementation of TQM within the NHS, it has exclusively focused on the activities of Providers. This is the first piece of research to have focused on the implementation of TQM from the perspective of the Purchaser and, therefore, has developed both an understanding of TQM within a function

which is distanced from the customer interface, and has provided a more accurate picture of the state of TQM within the NHS as a whole.

CHAPTER 1 INTRODUCTION TO THE RESEARCH

Concern about the quality of care must be as old as the health care professions themselves. But an honest concern about quality, however genuine, is not the same as methodical assessment based on reliable evidence (Morgan and Everett 1991)

BACKGROUND TO THE RESEARCH

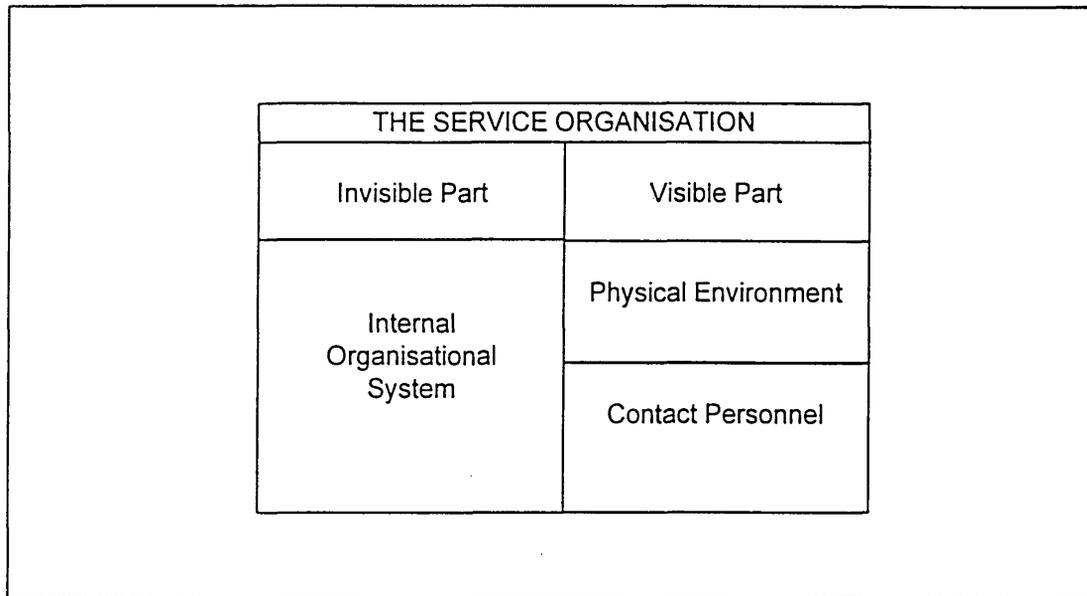
The quality movement has been gathering momentum over the past few years. It has expanded out of the manufacturing sector, where it originated, into service organisations and there has also been evidence of its adoption by those operating in the public sector. (see, for example, Gaster 1995)

The National Health Service (NHS) has not been immune to this influence with the development of strategic approaches to quality and the implementation of effective quality improvement initiatives ranking high on management agendas. In particular, the concept of Total Quality Management (TQM) has received notable attention (Morgan and Murgatroyd 1994). This interest in quality by the NHS has been closely associated with a period of radical reform culminating in the establishment of an internal or quasi-market whereby Purchasers (District Health Authorities and GP Fund-holders) contract with Providers (NHS Trusts) for the delivery of acute health care.

THE AIMS OF THE RESEARCH

The service organisation has been depicted by Eiglier and Langeard (1976) as consisting of visible and invisible parts (see Figure 1.1). Within the NHS, Providers may be considered to be the visible part whilst Purchasers, in the form of District Health Authorities (DHAs) exist as the invisible element of the organisation, but are no less important. The purpose of this research is to examine the issue of quality management within the invisible component of the NHS.

FIGURE 1.1 THE SERVICE ORGANISATION



Source: Adapted from Eiglier and Langeard (1976)

Given the level of interest in quality within the NHS, it is not surprising that it is an area in which a considerable amount of research has been undertaken. For example, Dalley et al (1991) traced the experiences of various quality improvement programmes which had been set up, at that time, throughout the NHS. The analysis provided a comprehensive comparative study of the quality movement taking place in the NHS. The study covered all the District and Regional Health Authorities (DHAs and RHAs) in England and Wales and revealed the extent to which quality management was taking hold. However, the study pre-dated the creation of the internal market in 1991. It did not, therefore, take account of the purchasing role now undertaken by DHAs. Similarly other writers, (see, for example Koch 1992) have addressed the subject of TQM within the NHS, but from the perspective of the health care provider. There has been no research undertaken to examine the implementation of TQM from the point of view of the Purchaser. This represents a serious omission which is only slowly being recognised. (see, for example, Benton 1994; Audit Commission 1995)

This research, therefore, has analysed the extent to which Total Quality Management (TQM) has been implemented within District Health Authorities as Purchasers of health care within the NHS. It explores the rationale behind implementation; determines how far a uniform approach has been adopted; identifies the key issues impacting on the implementation process; assesses the availability of information regarding quality within the NHS, and examines the impact of NHS reforms. Furthermore, the research establishes whether, or not, there have been

differences in the approaches towards implementing TQM by DHAs and the nature, causes, and impact of the observed differences.

In order to meet these objectives, a series of sequential steps have been followed which are covered in each of the chapters. Hence, Chapter Two guides the reader through the methodology which underpinned the research process. Chapter Three analyses the philosophy of TQM; provides a critique of the work of the leading writers and commentators on the subject; and delineates the basic tenets of TQM. Anomalies which exist within the TQM literature are identified and considered, whilst Chapter Four discusses the strategic role of quality.

There was an overall bias within the literature towards the manufacturing environment, with less focus on the adaptation of TQM principles to the service sector and relatively little on the experience of public sector services. Chapters Five and Six redress this balance.

Chapter Five examines the unique nature of service quality and the work of Gronroos (1984), Haywood-Falmer (1988) and the SERVQUAL model of Parasuraman et al (1985; 1988), which explains the concept of service quality in terms of service attributes and the gap between customer expectations and customer perceptions. However, it is by no means certain that this model could be applied to all service situations. In particular, there has been a substantial debate concerning the notion of quality within the public sector which is addressed in Chapter Six.

In order to provide a context for the research, the thesis presents an overview of the history of the NHS in Chapter Seven. This allows the reader to develop an understanding of the policy decisions that have been made, from the creation of the NHS, through to the establishment of the internal market and the associated concern for improved quality in health service delivery and the increased awareness of and interest in the concept of TQM.

The empirical element of this research focused on the comparative analysis of the strategic implementation of TQM within all of the District and Regional Health Authorities in England. Central to this was the comparison made between the prescribed approach to implementing TQM as laid down in the literature, and the approach undertaken at Regional and District level. The analysis of the results involved assessing and analysing the differences and similarities between them and is dealt with in three chapters.

Chapter Eight identified the quality activities undertaken within DHAs and the degree of collaboration which took place with other NHS parties. Chapter Nine identified the extent to which quality initiatives were supported by suitable measurement and monitoring systems, whilst Chapter Ten considered the nature of the TQM activities which were being undertaken within DHAs and RHAs.

Overall, the research has established whether it has been the case that Regional and District Health Authorities have chosen to adopt an homogeneous model of TQM or individualistic approaches, and the effect this has had. The research has also analysed the degree to which TQM initiatives at District level have been influenced by the implementation process adopted elsewhere in the NHS.

The research has contributed to knowledge by providing an understanding of the implementation of TQM in an, hitherto, unresearched area and has provided a comparative basis from which to analyse the implementation of TQM among Providers in the NHS. It has helped to determine whether those parts of the NHS, which do not exist at the customer-organisation interface, have a different perception of quality and understanding of TQM to those which do. In addition, it has helped to further comprehend the practical realities of implementing TQM.

CHAPTER 2 METHODOLOGY

INTRODUCTION

This chapter sets out the methodology employed in this thesis in order to secure data used in the analysis. The choice of methodology is discussed and critically evaluated using appropriate research to support the chosen approach.

THE METHODOLOGICAL PROCESS

In discussing the role of theory and concepts within quantitative and qualitative research Bryman (1988) noted that qualitative researchers often reject the idea of using theory as a precursor to an investigation except, perhaps, as a means of providing an initial orientation to the situation as in "grounded theory", since it may not reflect the subject's view as to what is going on and what is important. It is marked by a concern with the discovery of theory rather than the verification of theory (Filstead 1979).

Nevertheless, Lipset (1964) argued that quantitative data can be just as exploratory and insightful as qualitative data. Other writers, such as Halfpenny (1979), identified the respective link between quantitative and qualitative methodologies, and nomothetic and ideographic modes of reasoning. Nomothetic reasoning attempts to establish findings which are immutable, whilst an ideographic approach places its findings in a particular time period and location. It is the inability of the latter to establish generalisations which is one cause of criticism. A survey approach is taken to represent a nomothetic approach.

On the other hand, Bryman (1988) indicated that even quantitative surveys might be criticised for attempting to establish generalisations because they are often not based on true random samples. Furthermore, quantitative research has received criticism for being too static whilst qualitative methods are better able to identify linkages between events and activities and to explore peoples' interpretations of those factors which produce events.

Perspectives such as phenomenology, symbolic interactionism and naturalism led qualitative researchers to suggest that nothing can be taken for granted (Walsh 1972). Quantitative research tended to view social reality as static and beyond the control of the actor whereas the image from

qualitative research, is one of a socially constructed reality. This was demonstrated by Bryman (1988) using a comparative study into organisation structure. The Aston studies (Pugh and Hickson 1976) considered organisational structure to be influenced by such factors as a firm's size and the technology it employed. In turn, an organisation's structure was seen as influencing the behaviour of its members. This approach depicted organisational structure as an external entity and a constraint upon the actor. It differed significantly from the qualitative approach adopted by Straus et al (1963) whose work, undertaken in a psychiatric hospital, suggested that organisational structure was a "negotiated order" with the behaviour of the hospital members being largely unaffected by formal structures in the form of rules and role prescriptions. Rather, the various sub-groups determined their own structure through a continuous process of negotiation and re-negotiation.

Data emanating from quantitative studies are often depicted as being hard, rigorous and reliable. This has suggested that it exhibits considerable precision, having been gathered using systematic procedures and can be readily replicated by another investigator. Such attributes have often appeared to make quantitative data more persuasive, particularly to policy makers (Bryman 1988). On the other hand, Walker (1985) stated that "certain research questions cannot be answered by quantitative methods, while others cannot be answered by qualitative ones."

The methodological debate appears, therefore, to comprise of two distinct sets of arguments; one, epistemological in nature and the other technical. For those writers who argue that it is legitimate to combine the different methodologies, then the technical argument does not appear to provide many obstacles. However, from an epistemological standpoint, combining the two forms of methodology seems to be more problematic. If one accepts the view that quantitative research and qualitative research represents two divergent paradigms, then, one also accepts that there are incompatible ideas about how social reality should be studied (Gvba 1985).

My own research employed a mixture of both quantitative and qualitative methods and, thus, followed the form of Dalley et al's (1991) investigation into quality management initiatives in the NHS. This work, however, did not restrict itself to particular forms of quality management but was an overview of quality management initiatives in general taking place in the NHS at a time when a focus on quality was only just beginning to be emphasised. Furthermore, it was undertaken before the first wave of NHS Trusts came on stream in April 1991 and also before the establishment of the TQM pilot sites, which received the financial support of the Department of Health.

Dalley et al's (1991) research confined itself to establishing the extent to which quality management was being pursued in the NHS through identifying the numbers of quality activities taking place and the nature of these activities in order to determine whether or not there was any pattern in the type of initiative being implemented. It did not, however, focus upon any specific form of quality management but was concerned with forming an overview of the initial steps the NHS was taking to meet the new stress being placed on quality of care. The empirical work was based on a questionnaire which was distributed to all the 199 District Health Authorities in existence in March 1989. The information obtained from this questionnaire was supplemented by follow up visits to selected Health Authorities, looking in detail at the way in which they were implementing their quality strategies.

More recently, Joss et al (1994) undertook a major research project into the implementation of TQM in the NHS. This research was undertaken in eight TQM pilot sites implementing TQM, four non-TQM sites, and two commercial sites of Thames Water Utilities and Post Office Counters. This research involved carrying out face to face interviews with a cross section of members in each organisation in order to discover people's feelings towards and experience of implementing TQM. However, the pilot sites already had established TQM programmes and non-TQM sites were actively pursuing something similar.

Whilst Joss et al (1994) identified Regional and District Health Authorities as potential driving forces behind the implementation of TQM, they concluded that neither had fulfilled expectations because they had chosen not to implement TQM themselves. For this reason an in depth examination of the roles of Regional and District Health Authorities in implementing TQM in the NHS had not been included in the study. The initial stage of this investigation began in May 1991 and therefore preceded the Priorities and Planning Guidelines 1994/95 laid down in The NHS Management Executive letter EL(93)54, which made a specific requirement that

NHS authorities and Trusts should demonstrate an organisation wide approach to quality through the development of quality improvement strategies which should be made explicit in business plans, specify continuously reviewable standards for services, and require changes arising from audit to be implemented.

This was spelt out more specifically in EL(93)116, which stated that an organisation-wide approach to quality was relevant to both purchasers and providers of health care alike. Furthermore, it could be distinguished by:

Commitment to quality and leadership from the Chief Executive;

Quality forming an integral part of both corporate objectives and individual staff objectives, and both reflecting the organisation's business;

The presence of an organisation-wide quality management programme incorporating training in the use of quality tools and techniques;

All staff having access to training to enable them to develop and make best use of their skills as part of an effective human resource strategy;

High quality care achieved through teamwork and partnership with integrated working involving every member of the organisation

Effective communications both within the organisation and between it and other bodies e.g. providers to inform purchasers of structural changes which affect service provision.

Following this directive, health authorities would be obliged to more earnestly reflect on the systematic implementation of quality management. Although there was no compulsion concerning how this should be achieved, it would be worth establishing the extent to which health authorities had sought to adopt TQM as a means of meeting this requirement.

The approach I adopted employed three research methods and followed that used both by Dalley et al (1991) and Joss et al (1994). Specifically, this consisted of interviews, a postal questionnaire and analysis of organisational documents. Essentially, this was survey research, and more specifically, a descriptive survey (Gill and Johnson 1991). Thus, the research was concerned with studying the specific characteristics of a population at a particular point in time or at varying times; as opposed to analytical survey, which focuses upon causal relationships achieved through the statistical control of variables using such methods as regression analysis. Several writers have pointed out the usefulness of merging qualitative and quantitative methods (see, for example, Gill and Johnson 1991; Hakim 1987).

The combination of methodologies within a piece of research is referred to as triangulation. The term is frequently used interchangeably with that of multi-method/multi-trait or convergent validation (Gill and Johnson 1991). Some researchers have employed a triangulation approach in a relatively limited role, for example, Hammersley and Atkinson (1983) supplemented qualitative research findings with participant observation, interviewing and documentary sources. However, the most obvious reason for adopting a triangulated approach is to combine the relative strengths of the different research approaches and to cancel out their weaknesses. According to Webb et al (1966), researchers would feel more confident in their findings if their study employed more than one method of investigation. Bryman (1988) claimed that by combining quantitative and qualitative methodologies, and by demonstrating mutual confirmation of results, researchers' claims for validity are enhanced. However, he also noted that this was not always achieved and cited the work carried out by Shapiro (1973) into the effectiveness of an education programme that had been implemented in certain schools in America.

In that study, both quantitative and qualitative methods had been employed, but, whilst the qualitative findings suggested a higher quality of learning environment in those schools which were following the programme, the quantitative indicators of classroom performance failed to establish a difference between those schools adopting the programme and those which had not. In this particular instance, the qualitative findings were given more weighting in terms of what constituted an accurate account.

Bryman (1988), however, argued that it was not the purpose of triangulation to opt for one set of findings over another when one was faced with a discrepancy, but rather it should act as a prompt for further probing to determine the causes of the discrepancies and, in turn, may itself further the inquiry in its own right. Thus, triangulation becomes less of a means to placate the factions on each side of the methodological divide, but a valid methodology in itself. Incidentally, Brewer and Hunter (1989) made a distinction between triangulation and multi-methods, considering the former to be a sub-set of the latter. They suggested that the whole process of research would benefit from a multi-method approach. Some writers, such as Hoinwell and Jowell (1977) discussed the use of undertaking initial exploratory qualitative research as a first step in the design of a structured survey. Hakim (1987) also highlighted its use in providing illustrative examples of typical, deviant or minority cases.

THEORY AND PRACTICE

With this in mind, it was decided to undertake exploratory interviews with Service Quality Managers at three DHAs and one RHA. In addition, the views of the "Quality Team" of the NHS Management Executive based in Leeds were sought in order to gain an insight into how the implementation of TQM in the NHS is considered from the Centre's perspective.

The choice of DHAs and RHAs included in the initial exploratory interviews was entirely arbitrary although their general proximity to Sheffield was a key factor for the sake of convenience. Information indicating which health authorities were implementing TQM were kept by the Department of Health (DoH) but only included basic details. In the list of TQM initiatives sent by the DoH, 42 projects were recorded dating from 1989 until 1992. However, there were only vague references made to the TQM activity taking place and, more ominously, several projects were further referenced as "unsuccessful". Furthermore, the listed dates preceded (a) the decisive change in the role of the DHA from overseeing directly managed units to becoming a purchaser of health care, (b) a rationalisation of purchasing authorities which resulted in the merger of many DHAs, from a total of 199 DHAs in 1989 to 103 DHAs in 1995 and (c) the

formation of Health Commissions. Initially, this was done on an informal basis but has now received official endorsement, through the merger of DHAs with Family Health Service Associations (FHSA). The document, therefore, could not be relied upon to determine which purchasing health authorities were implementing TQM.

Although the initial exploratory interviews held with the Service Quality Managers were useful in providing general information, none of the health authorities were found to be implementing TQM, indeed one of the managers was unfamiliar with the term "TQM". This in itself, however, was informative. The sample of health authorities was too small to be considered representative of the whole country although the material obtained from these interviews could be used as a basis to construct a questionnaire which would be sent out all the DHAs in England. In addition, an identical questionnaire would be sent to all RHAs in England.

Questionnaire Design

The difficulties associated with designing questionnaires are well documented. A vital skill according to Gill and Johnson (1991), is the ability to structure, focus, phrase and pose sets of questions in a manner that is intelligible to respondents. Furthermore, they suggested that questions need to minimise bias and provide data which can be statistically analysed. Writers, such as Goode and Hatt (1952) also stressed the need to undertake a pre-test study in order to test the questionnaire for any discrepancies or misunderstandings which may have inadvertently been built into it. Their criteria for recognising poor questionnaire design was as follows:

- (1) A lack of order in the answers - random distributions of social phenomena are unusual. Often the cause is a question or a set of questions which is open to interpretation. Two of the most common causes are using difficult words and/ or asking for too much information in one question.
- (2) All or none responses - in this instance, the probable cause is a question which is likely to lead to a clichéd or stereotypical answer.
- (3) A high proportion of "don't knows" suggests
 - i. The question was too vague
 - ii. The question was too complex
 - iii. The question involved difficult answers requiring expert help
 - iv. The respondent was not in a position to answer the question. This latter point necessitates a rethink about the sample. The sample may have included respondents who either could not relate to the questions, or, that the records or list from which the sample was drawn was out of date.

- (4) A great number of qualifications or irrelevant comments - is often a result of attempting a premature specification of possible answers leading respondents to add their own choices or make qualifying statements to support the choice which they have made.
- (5) A high proportion of refusals - can be caused by a variety of reasons, including the sensitive nature of the research, a perceived lack of anonymity or confidentiality, or simply the time involved to complete the questionnaire
- (6) Substantial variation in the answers when the questions are reordered - indicates built in bias (leading questions) and inadequate wording has been used.

Goode and Hatt (1952) also provided advice on the extent to which a postal questionnaire represented a valid research method. The criteria being:

- (a) The type of information required
- (b) The type of respondent reached
- (c) The accessibility of the respondents
- (d) The precision of the hypothesis

Vast quantities of data can not be effectively secured from a postal questionnaire. It would be unrealistic to expect respondents to take more than 10-25 minutes to complete a questionnaire and the questionnaire would only be effective if the respondent was both able and willing to express him or herself clearly. In the absence of an interviewer, there is less scope to ask detailed questions and no scope to query responses or for respondents to seek clarification of questions.

Goode and Hatt (1952) also pointed out that not all groups respond equally well to questionnaires. It was clear that a certain level of literacy was required to complete a questionnaire. Filling in a questionnaire was also a time consuming process and not all groups would be able or willing to do this. However, these criticisms have chiefly arisen out of surveys, which have been conducted using samples drawn from a large, heterogeneous population, rather than specific research situations where more literate groups are the focus of the study. Indeed, the writers indicated that a questionnaire was extremely valid for select groups of respondents, especially if the respondents involved were well educated, with a strong interest in the subject. It was felt, therefore, that there was particular justification for using a questionnaire.

My chief concern was that NHS managers, inundated with questionnaires from various interested parties seeking to determine their views about the NHS reforms, may have resented an intrusion upon their time. However, following conversations with such managers, all the indications were

that this was not particularly considered an intrusion.. Apparently, altruism on the part of NHS managers, was as powerful a reason for completing a questionnaire as any other.

In order to secure a high response rate, further advice from Goode and Hatt (1952) was followed. This was to use simple, clear instructions; a clear, well presented layout on good quality paper; and to include a pre-paid self addressed envelope to facilitate the return of the questionnaire.

If problems are encountered using postal questionnaires, then a biased result can be being obtained. This can occur if the questionnaire draws a response from a particular subset of the original sample to whom the questionnaire was sent. Problems of selecting an unbiased sample however were not a feature of this particular research. The total number of health authorities is relatively small which allowed the entire population to be used. In addition, because the postal questionnaire sought a response from a select group of respondents, that is, managers responsible for overseeing the implementation of quality management within the health authorities, then it was unlikely that the postal questionnaire would elicit responses from a biased minority. There might, nevertheless, be a problem with non co-operation.

Sudman (1985) identified four possible reasons for non co-operation with postal questionnaires:

- (1) The respondent was busy and time would be better spent on more worthwhile activities
- (2) The purpose of the survey was not clear and its value was viewed as low
- (3) There was concern about the confidentiality of results
- (4) The questions appeared to be biased or did not allow respondents a full range of choices

To overcome these problems, it was suggested that the title, purpose and sponsor of the research was made clear; to stick to a single, professional topic; and to leave room for expanded comments. However, Simon (1978) warned of the difficulty in employing open ended questions in a survey because they required time and patience on the part of the respondent to complete. Furthermore, they also relied on the ability of respondents to express themselves clearly and succinctly. The respondents to my questionnaire could reasonably be assumed to be educated professionals and therefore this issue would not present a problem.

When using open ended questions, Conner (1985) found that women and those with a keen interest in the topic gave more detailed responses than men and those without an interest. Given that interest levels of quality management in the NHS were high (see Dalley et al 1991; Joss et al 1994) and women were well represented at management level in the NHS, this boded well for the

investigation. During the course of the research, one postal questionnaire was completed on a face-to face basis at the request of a woman manager from a Regional Health Authority who was extremely interested in the research topic and wished to discuss the issues in greater depth.

Response Rates

In considering response rates, Sciemiatycki (1979) noted that postal questionnaires secured the lowest response rate compared to telephone or face to face interviews. However, he found that there was no evidence to suggest that face to face interviews secured a higher quality response than the telephone and, indeed, the postal questionnaire elicited more accurate information than the telephone. These conclusions were reached following research into the health of households in Montreal, Canada, and it was probable that respondents might have felt embarrassed about some of the topics that were being studied. As a result, respondents may have felt more comfortable providing answers to a postal questionnaire, which offers anonymity, rather than to an interviewer and, thus, were more likely to provide truthful answers. Furthermore, the postal questionnaire enabled respondents to reflect on the questions and to consult other people. The questionnaire sent out to NHS Health Authorities requested supporting documentation to be supplied and this might not have been ready to hand and it was anticipated that such consultations would take place. From a cost point of view, Sciemiatycki (1979) concluded that there would only be an advantage in carrying out face-to-face interviews if there was a substantial difference in both the quantity and quality of response and there appeared to be no such advantage.

The Balance Between Different Methodological Approaches

Hakim (1987) noted that qualitative data is often undervalued as a research method because it is frequently assigned only a supporting role to supplement other types of study, or as an exploratory device in the initial stages of a research project. However, she cited the work of Vevers (1973) and Terkel (1974) as examples of studies where qualitative data has been used as the predominant methodology. She also noted that there was justification for undertaking qualitative research after the main survey so that in-depth interviews could be carried out on highly selective samples suggested by survey responses. So, for example, it would be a straightforward matter to identify which health authorities were implementing TQM and to contact these health authorities at a later stage for more in-depth analysis.

The health authorities were requested to supply documents which supported their quality management efforts. It was expected that these would consist of training material and business plans which laid out how the health authorities intended to meet the requirements laid out in EL(93)54, to demonstrate organisation-wide quality.

Confidentiality Of The Data

Frey (1986) considered the question of anonymity and confidentiality and posited the view that very few surveys could be considered anonymous because there was usually some way of tracing respondents. A confidential response, on the other hand, is one made by a respondent whose identity is known but is kept secret. Postal and telephone surveys have some advantage in establishing confidentiality but there has been very little research undertaken on the relation of refusals, premature termination or misleading responses which were caused by doubts about confidentiality.

King (1970), Fuller (1974) and Wildman (1977) found no differences in response rates to postal questionnaires with pre-mailed identification numbers and those without, whilst research on the impact of confidentiality statements did not provide consistent evidence that there was a significant impact on refusal rates, responses to sensitive questions, item non-response rates or other data quality factors. (Reamer 1979; Frey 1986) There appeared to be some apprehension on the part of respondents, however, when faced with vociferous assurances of confidentiality which may have affected the quality of responses. (Reamer 1979; Frey 1986). More important factors which had a bearing on response rates appeared to be the subject topic of the survey and the manner in which it was presented. Equally, the respondents themselves would be a factor as there might be sub-groups within the population who were more likely to be adversely affected by assurances of confidentiality and who felt more vulnerable.

Formatting The Postal Questionnaire Used In This Dissertation

Each postal questionnaire used in this dissertation clearly identified the health authority to which it had been sent with the name of the Health Authority printed in the top left hand corner of the first page. Two respondents who completed the questionnaire cut out the identifying name and were discounted from the analysis. It was true that an alternative, more covert method of identifying each Health Authority could have been employed, however, the work of King (1970) and Wildman (1977) did not suggest that this would necessarily have improved the quality or quantity of responses. Moreover, the fact that the identity of the Health Authority could be removed and that only two Health Authorities chose to do this, indicated that anonymity was not a factor influencing the respondents.

The questionnaire and covering letter can be seen in Appendix 1. The questionnaire was addressed to the Chief Executive of each Health Authority although it was not anticipated that this person would necessarily complete the questionnaire. The letter did not press the Chief Executives to complete the questionnaire, not because of a lack of understanding on quality

management on their part, but because there are many demands on their time and consequently a very low response rate would have resulted. It was, therefore, important to determine the position of the person who had completed the questionnaire.. It was also felt it important to discover how long the person had held this position in order to verify a relationship between the position held and the efforts being made to implement TQM.

The series of sub-questions which together formed question one, sought to establish which basic quality management activities were being carried out and to identify whether provider units, neighbouring District Health Authorities, the Regional Health Authority or the NHS Management Executive had been involved. This would indicate the extent of collaboration between the different parties. The second question sought to determine whether or not one of these parties was dominant in determining how the outcome of the activities, detailed in question one, was resolved.

A fundamental aspect of TQM is the requirement to study key processes and measure outcomes. Thus, question three posed the simple inquiry as to whether, or not, the Health Authority measured and monitored the quality of its own activities. In addition, question four prompted those respondents who had replied in the affirmative to the previous question, to state how the measurement and monitoring of quality was carried out in their particular organisation.

Question five set out to discover how many Health Authorities were, in their opinion, carrying out their activities under a TQM philosophy. The question invited those respondents who answered "yes" to expand upon how this was done. Those respondents who answered "no" were then requested to provide the reasons why they had chosen not to implement TQM. In order to facilitate the responses to this question, a list of possible reasons was provided to act as a prompt. It was decided not to use this as the first question for fear that those Health Authorities not implementing TQM would fail to complete the questionnaire believing it was not relevant to them. The opening questions, instead, referred to those activities which all Health Authorities might reasonably be expected to be undertaking and hopefully entice respondents into completing the whole questionnaire.

Question six was concerned with determining the extent of awareness of quality improvement activities taking place across the NHS. Room for comments was included to allow respondents to state how they had found out about such activities. Perhaps more importantly, question seven enquired whether or not this awareness had influenced the approach taken by the Health Authority towards quality improvement. If the Health Authority indicated that, although it was aware of

quality improvement activities taking place elsewhere it had chosen not to adapt its approach, then it was invited to state reasons for this.

Questions eight and nine were concerned with examining the impact of NHS reforms on quality management in the Health Authorities. Question eight focused on which reforms had had the most impact and question nine identified the nature of this impact. Both these questions were phrased in a non opinion forming manner, that is, they were not looking to determine whether or not respondents were in favour of the reforms in order to avoid leading questions. The information secured from these two questions would, therefore, be very factual and hopefully would indicate not simply changes in opinion towards quality within the health service, but, technical or procedural effects. The clear focus on the impact of the NHS reform process within the phrasing of the question, would indicate changes which had come about solely as a result of the reforms rather than those arising from other influences.

The Validity of Telephone and Face-to Face Interviews

Sciemiatycki (1979) highlighted the usefulness of the telephone in prompting non-respondents to return postal questionnaires. Initially, a follow-up letter was sent out to those Health Authorities which had not responded to the questionnaire within four weeks of it being distributed. After a further four weeks had elapsed, non-respondents were contacted by telephone.

Most discussions of survey research refer to work carried out using samples drawn from large populations. However, Dexter (1970) Denition (1972) Zuckerman (1972) and Becker and Meyers (1974) all indicated that elite, special interest groups, such as political figures, lawyers and so forth, are more amenable to face-to-face interviews rather than postal or telephone surveys. Frey (1983) argued that the ability of the telephone to contact prospective respondents who are members of elite populations, warrants further exploration. It would be difficult to argue that NHS managers constituted an elite group, however, the pressures on their time are high and one manager felt it would be difficult to secure an interview with her except over the telephone.

Interviews over the phone, or by face-to-face methods, did not show significant differences in response variation to most items. However, Groves and Kahn (1979) suggested that the telephone was likely to produce more missing data on sensitive topics than face-to face interviews. Sciemiatycki (1979) reported finding no differences in missing data for non- sensitive items, but for sensitive items, postal questionnaires produced lower item non-response rates than the telephone or face-to-face interviews. On the other hand, O'Toole et al (1986) found that a postal survey produced higher non-response rates than telephone or face-to-face interviews. This ran

contrary to most evidence, but could be accounted for by the focus of the research on knowledge versus attitude, rather than perceived threat. Basically, telephone and postal survey methods seemed to produce the highest rates of non response. The presence of the interviewer contributed to lower rates in household and intercept interviews.

Follow-up Interviews

It was intended that follow up interviews would be held with managers in those health authorities which had indicated that they were pursuing a TQM initiative. A literature review was, therefore, undertaken to determine which would be the most appropriate method of conducting these interviews. Given the wide geographic spread of the respondents, the possibility of using telephone interviews was also considered.

In the past, telephone interviews have been criticised because of the apparent difficulty in conducting in-depth interviews over the phone (Simon 1978). However, Colombos (1969) succeeded in engaging a group of specialist doctors in interview over the telephone for an average of 50 minutes. Likewise, Rogers (1976) reported no problems whilst conducting similar length interviews with the general public of a large city and found no difference in response quality on complex items between telephone and face-to-face interviews.. This was significant for my own research because the costs associated with travelling to carry out face-to-face interviews, coupled with the ability to elicit large amounts of reliable information over the telephone, made the technique very attractive.

The follow-up interviews were used in order to add a further dimension to the research. Posing complex and probing questions was more difficult with postal questionnaires than with telephone or face-to-face interviews. Some of the follow up interviews were conducted face-to- face and some were conducted over the telephone.

CHAPTER 3 THE NOTION OF QUALITY

INTRODUCTION

The idea of quality is apparently universally accepted and welcomed, with three quarters of businesses in the United Kingdom having embarked upon implementing some sort of quality initiative (Wilkinson and Willmott 1995). In many ways this is not surprising given that it is difficult to mount a convincing argument against the production and delivery of quality goods and services. Nevertheless, it has not always proved easy to establish what aspects of quality and quality management have been universally accepted and welcomed.

MANAGING QUALITY

Prior to the industrial revolution, quality was built into products by skilled craftsmen whose reputation relied upon their ability to make "quality" products (Flood 1993). Quality was managed through the formation of Guilds which upheld standards and gave consumers confidence about the quality of merchandise within a particular trade.

Several writers have referred to the existence of standard measures as evidence of quality control. For example, Khan and Hashim (1983) noted the presence of a uniform system of weights and measures in ancient Babylon. Military forces, in particular, have long since recognised the importance of dealing with quality products. George (1972) described the policy drawn up by the Arsenal of Venice, the largest industrial plant in the sixteenth century, which laid an emphasis on standardisation and inter-changeability of parts and Morrison (1994) cited the awarding of a contract to Eli Whitney to produce 10,000 muskets for the US Army, where jigs were employed enabling unskilled workers to manufacture interchangeable parts in large numbers and at low cost.

It was imperative that goods destined for the front line were safe and reliable and, therefore, efforts were made to apply some form of quality control within the armaments factories. According to Liebart (1976), however, these efforts centred on attempts to "control", "assure" or "guarantee" quality and were based on methods of inspection which sought to intercept defective products before they left the factory, warranted them after being despatched or recalled them if necessary.

The Industrial Revolution, however, brought about a radical change in the way work was carried out. The organisation of work, in the form of mass production, became closely associated with the influential writers of the Scientific Management School, such as Taylor (1947) and Weber (1964) and relied upon the concept of the division of labour whereby tasks were split down into constituent activities. Whilst it is beyond the scope of this thesis to enter into a full debate regarding the relevance of this form of production, it should be noted that a consequence of task fragmentation was to remove individual responsibility for quality and replace it with an inspection function whose responsibility was to weed out non-standard products (see, for example, Huczynski and Buchanan 1991).

Just as the Guilds had been established to help safeguard quality of workmanship, inspection associations were similarly formed in order to formalise and disseminate ideas, and to uphold standards. These associations included, for example, the Technical Inspection Association, formed in 1919 and which became incorporated into the Institution of Engineering Inspection in 1922 (Flood 1993). Whilst these inspectorates might be criticised for focusing on "problem detection" rather than "problem prevention", they were at least responsible for two notable achievements. Firstly, they acknowledged the importance of quality as a discipline in its own right and secondly, they attempted to manage quality on a structured and scientific basis. Thus aligning themselves well with those elements attributed to the influential Scientific Management School.

One of the early pioneers to pursue such an approach was W.A. Shewhart. He worked as a statistician for AT & T Bell Laboratories during the 1920s and 1930s. He demonstrated how statistics could be beneficially applied to manufacturing processes, particularly by the use of control charts to monitor and evaluate production and thereby improve quality. The ideas of Shewhart (1931) established the statistical basis which underpinned the quality improvement approaches of other writers, notably, Dr W. Edwards Deming. These ideas demonstrated that preventing the occurrence of defective items represented a more effective means of managing quality than an approach which relied upon identifying defects once they had occurred.

According to Collard (1989), however, this was not always an accepted point of view. In the period following the Second World War, there was a general belief that improving quality represented an unnecessary disruption to the production process which would adversely affect economies of scale, add to costs and cause a loss of competitiveness. The Japanese, on the other

hand, were in the process of trying to rebuild their shattered economy at the end of hostilities and were more receptive to the ideas of quality management.

THE JAPANESE INFLUENCE

MacDonald and Piggott (1990) have noted that a little over thirty years ago Japan had a reputation for poor quality merchandise. According to Neave (1989), however, the Union of Japanese Scientists and Engineers (JUSE), which had been specifically established to assist with the process of economic regeneration, developed a keen interest in the quality control techniques used by the American forces during the war. Several members of JUSE met Deming on his first visit to Japan in 1947 when he was invited by General MacArthur's government of occupation to assist in preparing for a forthcoming Japanese census. They recognised his name from documentation about quality control techniques from the Bell Telephone Laboratories and consequently invited Dr. Deming to Japan again this time to address industry leaders.

Deming was keen to ensure that top management were present at these addresses. In his opinion it was the failure to direct his teachings at senior managers in America which had led them to eschew and/or remain ignorant of his ideas. His teachings marked the beginning of what became known as Total Quality Management (TQM) although Deming, ironically enough, sought to distance himself from the term believing it to be prone to misunderstanding and misuse.

The Japanese have long since acknowledged quality as the foundation upon which the success of their organisations has been built. However, Western management has generally remained more sceptical and various alternative theories have been put forward suggesting why the Japanese have been so successful. For example, in a series of articles for the Financial Times in 1981, Christopher Lorenz wrote:

Despite all the current Western alarms about robot factories, the consistent theme behind Japan's rise to industrial pre-eminence has not, until recently, been due to particularly advanced technology, certainly not in product design. Instead the key has been on efficient, reliable improvement and manufacture of relatively standard designs. Central to that approach has been a universal commitment to quality within the country's leading companies from the very top to the bottom of the enterprise

In 1984 a delegation of British industrialists, including managers and trade unionists, was invited to Japan to discover the Japanese approach to quality management. Questioned as to why they were prepared to do this, their Japanese hosts responded:

... it would take you ten years to get where we are now and by that time we shall be further ahead. And besides we know you won't do it. (cited in Collard, 1989)

In an attempt to make up lost ground, Western managers sought to copy a number of Japanese innovations including Just-in-Time scheduling and Quality Circles. Hill (1991a) suggests that the latter was probably the most tangible discovery emanating from Japan during the late 1970s and early 1980s.

Quality Circles have been described by Dale and Boaden (1994) as:

a voluntary group of between six and eight employees from the same work area. they meet, usually in company time for one hour per week or fortnight, under the leadership of their work supervisor, to solve problems relating to improving their work activities and environment.

The uptake of Quality Circles in the UK was apparently high. Incomes Data Services (1985) reported that over 400 British companies were operating Quality Circles and Collard and Dale (1989) reported a failure rate of only 20%. These figures, however, mask a more complex picture. For example, Ambler and Overholt (1982) reported a failure rate of 50% amongst US companies and Bradley and Hill (1983) conceded that the willingness to embrace Quality Circles in Britain was as much an attempt to address industrial relations problems, by increasing employee participation, as it was a mechanism to tackle problems of poor quality. In this respect the authors deemed the quality circle movement to have limited value. Finally, Griffen (1988) undertook a longitudinal research programme between 1983 and 1986 comparing the experiences of Quality Circle members with those of non-members in one particular programme. The study found that members experienced positive benefits compared to non-members, in terms of changing attitudes, greater job satisfaction and involvement. In addition, management reported improvements in quality and cost savings, but both sets of effects began to wear off after about eighteen months and had generally disappeared after three years.

Discussion of Quality Circles within the literature identified two purposes to which they have been put and, in Britain at least, quality improvement may have been of secondary importance to human resource management objectives. Thus, in examining possible reasons why Quality Circles fail it is important to consider the industrial relations context. Ramsay (1977), for example, offered the concept of "cycles of control" in suggesting that the extent to which companies experiment with participation takes place on a cyclical basis. Thus, when senior management face industrial relations problems, they act by offering greater participation as a means of placating the work force. Ramsay argued that participation schemes in general were likely to be limited both in substance, offering workers little scope for meaningful decision

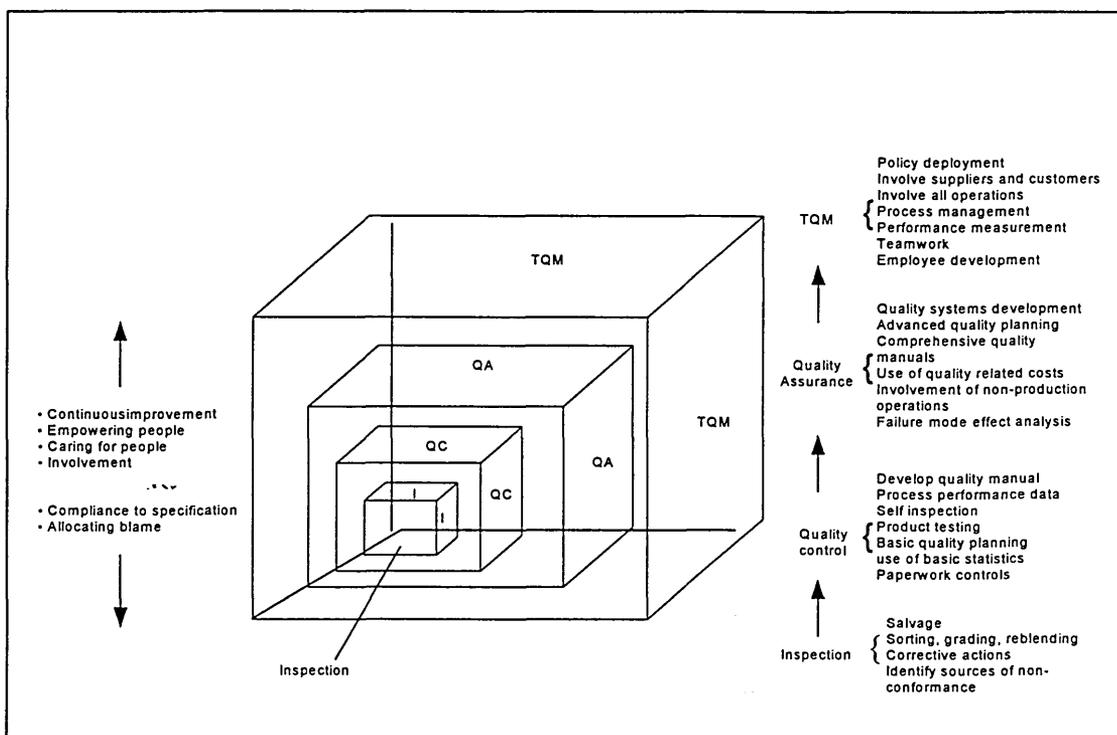
making, and duration. He concluded that they were merely a response to re-establish management's threatened legitimacy.

In summarising evidence from the British experience of using Quality Circles, Hill (1991b) concluded that Quality Circles, outside the context of Total Quality Management, were unlikely to work and Lillrank and Kano (1989) in a detailed study of 21 Japanese companies, stressed that it was unusual for these organisations to use Quality Circles without TQM. Most Quality Circles appear to have failed because they were implemented in isolation without an overall objective or framework as to what they were supposed to achieve or how they should be managed.

TOTAL QUALITY MANAGEMENT

Despite the popularity and widespread interest surrounding it, there is no agreed definition or accepted theory of TQM. It is a phenomenon which appears to have evolved over a period of time. Dale et al (1994) identified TQM as a quality management approach which subsumed all others.

FIGURE 3.1 THE FOUR LEVELS OF QUALITY MANAGEMENT



Source: Dale, Boaden and Lascelles (1994)

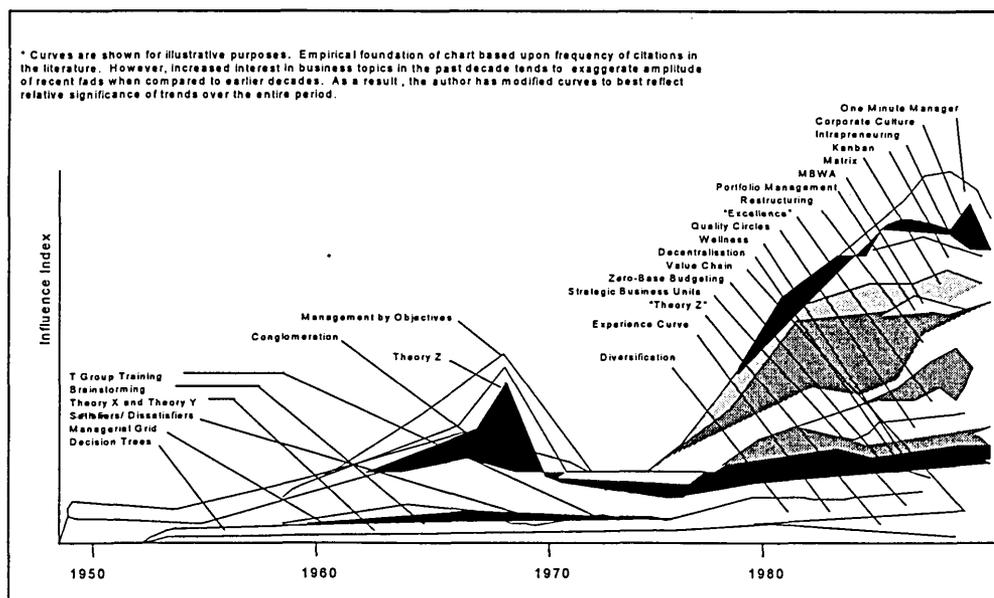
A number of writers can be identified within the literature as having been particularly influential in shaping the development of TQM, namely Deming (1982; 1986), Juran (1964; 1974) and Crosby (1979; 1984). So much so that they have been accorded the status of guru.

THE EMERGENCE OF THE MANAGEMENT GURU

The Oxford English Dictionary defines a guru as "a leader or chief theoretician of a movement". The term is one which has been used increasingly within the field of management and prompted Kennedy (1993) to contemplate a set of reasons why the work of management gurus is so appealing. She suggested that true "gurudom" relies upon timing, originality, forcefulness, a gift for self-promotion and the ability to encapsulate memorably what others immediately recognise as true. In essence it is the ability to generate original, durable thinking on the hard matter of managing people and resources to a receptive audience.

The ability to engender such thinking, however, is apparently fraught with difficulties. Pascale (1990) has traced the development of management ideas over time and has demonstrated their tendency to initially flourish and then subsequently die.

FIGURE 3.2 EBBS, FLOWS, AND RESIDUAL IMPACT OF BUSINESS FADS 1950-1988



Source: Pascale (1990)

Pascale (1990) suggested that the development of universal management concepts, and the willingness of organisations to experiment with and implement new ideas during times of declining fortunes, arose due to the development of "professional" management. Underlying this was the notion that a set of generic concepts existed upon which all management activity was based and that this, in turn, lent itself to mass marketing techniques.

The result of this has been twofold. Firstly, the market for management tools and techniques has become saturated with products offering ease of implementation and demonstrable results. Secondly, the business world has seized upon these tools and techniques and has implemented them based on their exaggerated and unsubstantiated claims, discarding them when they fail to live up to expectations, and casting around for the next fad as a replacement. This point of view has been supported by Gill and Whittle (1992) who compared TQM with the earlier concepts of Management by Objectives (MBO) and Organisational Development (OD), and concluded that each shared a number of similar features which accounted for their transient nature. These included a lack of coherent theory supporting the concepts with practice ahead of research and a trend towards “anti-intellectualism” with ideas reduced to bullet-point plans and check lists.

A number of writers (see, for example, Wilkinson and Witcher 1991; Wilkinson and Willmott 1995) lay the blame for the lack of rigorous assessment of management fads on the unwillingness of academics to critically evaluate TQM, which, in turn, left the quality management field free to consultants who were keen to promote TQM as a panacea for all organisational ills. Although there may be an element of truth in this statement, it failed to acknowledge the work of such as Whittle (1988) who, ironically, found a lack of critical discussion and a high degree of consensus within the TQM literature, and Oliver (1990), who examined the “social” conditions necessary for total quality to operate successfully. These references are included to illustrate the point that the TQM literature has not been devoid of critical evaluation and indeed such analysis dates back to a time when the popularity of TQM was arguably at its highest. More recently, Chatterjee and Yilmaz (1993), Nwabueze, Haigh and Morris (1995) and Tuckman (1995) have all provided their own particular criticisms of TQM.

The belief that it is the responsibility of the academic community to provide the critique rests on two assumptions. The first is that only academics are in a position to undertake this task. The second is that business leaders would be more willing to accept academic opinion and ideas rather than those emanating from elsewhere. The popularity of two books: “In Search of Excellence” whose authors, Peters and Waterman (1982) have a business consultancy background and “The Change Masters” (Kanter 1983) whose author is a Professor at Harvard Business School has placed doubts on these assumptions.

It would appear that factors such as having an easily digested, practical and well timed message are perceived by practising managers as being more important than the methodological flaws that may have existed in the research which underpinned the message (Guest 1992). Criticisms of

unscrupulous selling on the part of over eager consultants, therefore, must be tempered by notions of "caveat emptor" on the part of those wishing to implement the latest miracle cure.

WHO EXACTLY ARE THE QUALITY GURUS ?

Labelling the leading thinkers as "gurus" has been a particular feature in much of the TQM literature although the basis upon which this label has been attached remains unclear. For example, Flood (1993) found no difficulty in elevating Feigenbaum, Taguchi and Shingo to guru status, whilst MacDonald and Piggott (1991) were more comfortable in distinguishing between "major" gurus of Deming, Crosby, and Juran and "minor" gurus, the latter comprising Conway, Feigenbaum, Harrington, Imai, Ishikawa, Mizuno, Schonberger and Taguchi.

More sceptical commentators have suggested that the guru term is only appropriate because it conjures up images of mysticism (Pollit 1993). But does this mysticism exist because the issue is complex or because it lacks substance? It is true that the leading writers have stressed different aspects of managing quality. Authors, such as Oakland (1989), have dismissed such differences as being merely semantic. Others, have seen discrepancies as indicative of fundamental problems within the whole TQM philosophy and, thus, have had difficulty reconciling the differences (Wilkinson et al 1993; Willmott 1995).

Definitions of TQM can appear deceptively simple, thus, BS 4778 Part 3 (1991) defined TQM as:

A management philosophy embracing all activities through which the needs and expectations of the customer and the community, and the objectives of the organisation are satisfied in the most efficient way by maximising the potential of all employees in a continuing drive for improvement.

However, the British Quality Association offered three alternative definitions of quality. The first focused on the so called "soft" aspects of culture, customer orientation, teamwork, and employee participation. The second definition highlighted more technical aspects such as methods, control of work, statistical procedures or the so called "hard aspects". The third was a mixture of both hard and soft elements and attempted to stress both the technical and people aspects of TQM.

It has been possible to trace certain similarities between TQM and the development of Human Resource Management (HRM). Storey (1989; 1992) identified both "hard" and "soft" approaches to HRM, the former rooted in the rational Scientific School of Management and the latter in the Human Relations School. The tensions which exist within HRM were highlighted by Keenoy (1990) who noted that "a remarkable feature of HRM is the brilliant ambiguity of the term" and that it could mean whatever one chose it to mean. He saw this feature as the cover for an

ideological shift in the employment relationship brought about by market pressures and similar criticisms have been made of TQM by Tuckman (1991; 1992).

An alternative approach, favoured by Morgan and Murgatroyd (1994), has been to seek out the similarities within TQM rather than concentrate on the differences. Thus, TQM was identified as involving everything in an organisation, a society, or a community, which in the eyes of others, determined its reputation on a comparative basis with the best of the best alternatives: TQM was a total system of quality improvement with decision making based on facts rather than gut feeling; TQM was not only about the quality of the specific product or service which the end user or the customer purchased but was also about everything an organisation did internally to achieve continuous performance improvement. TQM assumed that quality was the outcome of all activities that took place within an organisation; that all functions and all employees had to participate in the improvement process; that organisations needed both quality systems and a quality culture. TQM was a way of managing an organisation so that every job, every process, was carried out first time every time. The key to achieving sustainable quality improvement, according to Sptitzer (1993), was through the adoption of TQM principles.

In order to make sense of the diverse messages emanating from the quality literature, several writers have suggested that a rigid adherence to the work of one particular guru is inappropriate. (see Jackson 1990; Chatterjee and Yilmaz 1993; Bajaria 1995). Others, such as Dale and Cooper (1992), have observed that many organisations start off by adopting the teachings of one of the gurus although the implementation process soon moves organisations to develop their own tailored models, using ideas borrowed from each of the gurus, to suit individual circumstances.

Synthesising the gurus' ideas has been advocated by Bendell (1991) and Bajaria (1995). On the other hand, Smith (1986) Dale et al (1994) and Oakland (1990) all identify confusion amongst chief executives concerning the approach to take, as a major barrier to the implementation of TQM.

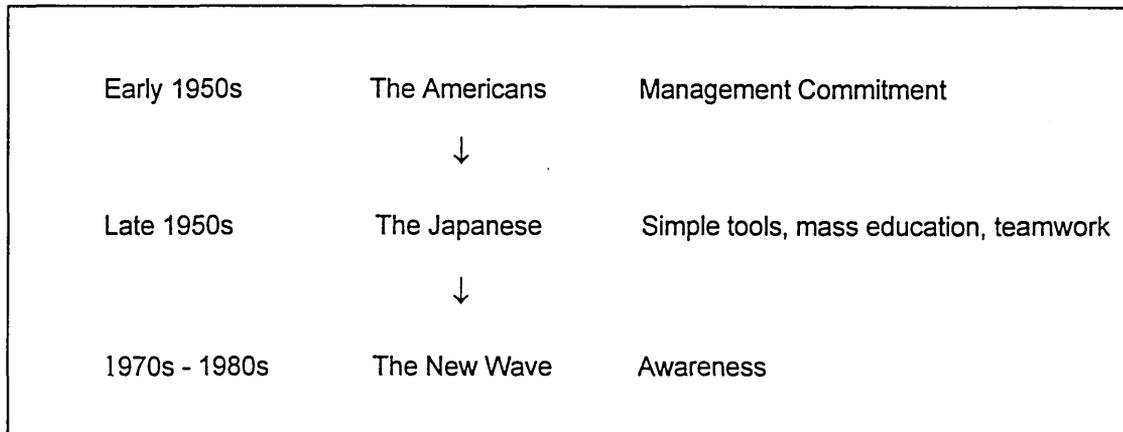
The high incidence of reported TQM failures, around 80-85% in the UK (see The Economist, 1992), indicates that its implementation has not been straight forward. It has been suggested that the problem of implementation might well relate to problems associated with the concept itself. Several writers, for example, have highlighted the limited extent to which the TQM literature draws upon established organisational theory. In particular, doubts have been raised by Wilkinson et al (1991; 1993) about the efficacy of TQM with its implicit view of management as a technical resource and where decision making process is rational and linear in nature. Organisations as political entities (see Morgan 1986) are not touched upon by the gurus. If TQM

did not have its roots within organisation theory, it is necessary to determine exactly from where it stems and how it has taken shape over time.

THE DEVELOPMENT OF TQM

In tracing the history of TQM a number of commentators have identified key stages through which it has gone. Bendell (1991) has suggested that it is possible to trace its development through three periods:

FIGURE 3.3 THE SHAPING OF TQM



Source: Bendell (1991)

Such simplistic categorisation inevitably leads to an understatement of the contributions made by each of the main authorities. Attempts to encapsulate the teachings of the gurus into a set of key words do both an injustice to the gurus by belittling their contributions and add little to furthering the understanding of the subject as the message is diluted (see, for example, Neave 1995).

An alternative approach to understanding the development has been to focus on how it has been applied in the West as a means of understanding its development. Tuckman (1992) considered TQM to have evolved through four phases:

First phase:	late 1970's, early 1980's	some experimentation with Quality Circles. Mostly effects firms in direct competition with industrial sectors in which Japan had concentrated, e.g. electronics and motor industries.
Second phase:	from the mid 1980's	major companies, often affected by world recession, concerned with control of suppliers and subcontractors.
Third phase:	from mid 1980's	a growing concern with customer service particularly in the service sector.

Fourth phase: from late 1980's penetration of concerns with "customer service" in areas which had not previously had not recognised the existence of customers.

The ability of TQM to deliver quality was, therefore, seen to have developed from the application of statistical techniques to operations, to a "commodification" of the production process. In addition, Tuckman (1992) shared a similar point of view about TQM as Ramsay (1977) did about participation schemes in general, that TQM represented an attempt to legitimise the intensification of management control by achieving consensus on the need to improve quality.

TQM AS A CULTURAL CHANGE TOWARDS A NEW PARADIGM

The quality management literature frequently identified culture change as the feature which differentiated TQM from other approaches (Atkinson 1991). The nature and scope of this culture change is one which can apparently move an organisation towards a new paradigm.

Kuhn (1970) defined a paradigm shift as a new conceptual tradition involving a radical change in interpretation where science takes a wholly new and changed perspective towards an area of knowledge and activity. Bounds et al (1994) demonstrated how TQM may be conceived as a paradigm shift by focusing on three integral elements, namely, customer value, organisational systems, and continuous improvement..

TABLE 3.1 DESCRIPTION OF OLD PARADIGM AND NEW EMERGING PARADIGM ON TOPICS FOR THE THEME OF CUSTOMER VALUE STRATEGY

Topics	Old Paradigm	New Paradigm
Quality	Meeting specifications, inspected into product, make trade offs among quality, cost, schedule	One component of customer value, managed into process, seek synergy among quality, cost and schedule
Measurement.	Internal measure of efficiency, productivity, costs, and profitability, not necessarily linked to customers	All measures linked to customer value
Positioning	Competition	Customer segments
Key stakeholder	Stockholder, boss (other stakeholders are pawns)	Customer (other stakeholders are beneficiaries)
Product design	Internal, sell what we can build	External, build what customers need

Source: (Bounds et al 1994)

TABLE 3.2 DESCRIPTION OF OLD PARADIGM AND NEW EMERGING PARADIGM ON TOPICS FOR THE THEME OF ORGANISATIONAL SYSTEMS

Topics	Old Paradigm	New Paradigm
Cross-functional approach	Negotiation across functional interfaces to obtain co-operation	Cross-functional systems defined, owned and optimised
Technology	To deal with complexity, to eliminate people problems	To reduce complexity, source of optimisation for customer value
Employee involvement	Focus on hygiene factors	Focus on strategic factors
Human Resource Management	Regarded as a staff responsibility, administration of personnel, hiring, firing, and handling complaints	Regarded as a critical resource
Role definition	Task and job descriptions set limits	Vision inspires flexibility
Culture	Social and emotional issues are suppressed, politics and power dominate	Connect with individual sense of purpose, emotions and social meaning
Structure	Specialisation, tall hierarchy with functional emphasis	Integration, flat hierarchy with team emphasis

Source: (Bounds et al 1994)

TABLE 3.3 DESCRIPTION OF OLD PARADIGM AND NEW EMERGING PARADIGM ON TOPICS FOR THE THEME OF CONTINUOUS IMPROVEMENT

Topics	Old Paradigm	New Paradigm
Occasion	Focused new product development, episodic, reactive to problems, big breakthroughs only	Focused on broader systems, unending, proactive to opportunities, big breakthroughs and small steps
Approach	Trial and error	Scientific method
Response to error	Punish, fear, cover up, seek people fix, employees are responsible	Learning openness, seek process/system fix, management is responsible
Decision-making perspective	Individual political expediency, short term	Strategic, long-term, purposeful for organisation
Managerial roles	Administer and maintain status quo, control others	Challenge status quo, prompt strategic improvement
Authority	Top driven via rules and policies	Customer driven through vision, enablement and empowerment
Focus	Business results through quotas and targets	Business results through capable systems, means tied to results
Control	Scoring, reporting, evaluating	Statistical study of variation to understand causes
Means	Delegated by managers to staff and subordinates	Owned by managers who lead staff and subordinate

Source: (Bounds et al 1994)

According to Ishikawa (1985), the work of Juran and Feigenbaum was instrumental in developing quality improvement into a management philosophy. Feigenbaum (1956) introduced the concept of Total Quality Control as:

The underlying principle of this total quality view... is that, to provide genuine effectiveness, control must start with the design of the product and end only when the product has been placed in the hands of a customer who remains satisfied ... the first principle to recognise is that quality is everyone's job.

Prior to this, Juran (1951) had provided managers with the quality trilogy of Quality Planning, Quality Control and Continuous Quality Improvement:

Quality Planning is the activity of developing the products and processes required to meet customer's needs. It involves a series of universal steps which can be abbreviated as follows:

Establish quality goals

Identify the customers - those who will be impacted by the efforts to meet the goals

Determine the customers' needs

Develop product features that respond to customers' needs

Develop processes which are able to produce these product features

Establish process controls, and transfer the resulting plans to the operating forces

Quality Control consists of the following steps:

Evaluate actual operating performance

Compare actual performance to quality goals

Act on the difference

Continuous Quality Improvement is the means of raising quality performance to unprecedented levels referred to as "breakthrough":

Establish the infrastructure needed to secure annual quality improvement

Identify the specific needs for improvement - the improvement projects

For each project establish a project team with clear responsibility for bringing the project to a successful conclusion

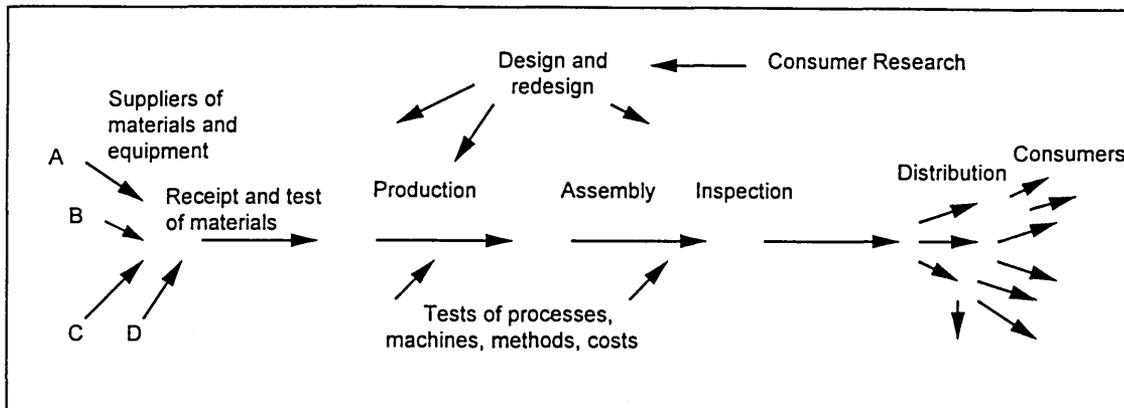
Provide the resources, motivation, and training needed by the teams to diagnose the causes, stimulate establishment of remedies and establish controls to hold the gains (Juran 1992).

For Deming (1986), the appreciation of the need for a system was important. He suggested that "any substantial improvement must come from action on the system, the responsibility of management."

Deming viewed production as a system and stated that:

Improvement of quality envelops the entire production line from incoming materials to the consumer, and redesign of product and service for the future.

FIGURE 3.4 PRODUCTION VIEWED AS A SYSTEM



Source: Deming (1986)

Deming (1986), Juran, (1992) and Feigenbaum (1956) all agreed that management responsibility was a “must” for quality improvement. However, in his application of Total Quality Control, Feigenbaum suggested that a substantial part of the responsibility for quality lay with the quality control department. He also suggested that quality improvement relied on more than the application of SPC.

DEFINING QUALITY

Any study into TQM must naturally include a discussion of the term quality itself. Understanding quality is no easy matter. Crosby (1979) implicitly positioned his view of quality within the new paradigm by urging the rejection of "common sense" notions of quality.

The first struggle, and it is never over, is to overcome the "conventional wisdom" regarding quality. In some mysterious way each new manager becomes imbued with the conventional wisdom. It says that quality means goodness that it is unmeasurable; that error is inevitable; and that people don't give a damn about doing good work.

The definition of quality was the first of his four absolutes for quality improvement; quality was conformance to requirements. Juran (1992) was vehemently critical of this definition arguing that customer requirements might be mistaken, which could lead to the production of faulty or dangerous goods. He preferred the alternative "fitness for purpose" which was essentially a customer based view.

W.E. DEMING

According to Deming (1986), understanding the causes of variance in the manufacturing process was the key to achieving quality in production. If the causes of variance were identified and located, they could then be eradicated. This in turn would produce greater consistency and an enhanced product reputation. Even so Deming (1986) recognised that statistics by themselves were not enough:

Brilliant applications attracted much attention but the flare of statistical methods by themselves in an atmosphere in which management did not know their responsibilities, burned, sputtered, fizzled and died out. What the men did was to solve individual problems. Control charts proliferated, the more the better. Quality control departments sprouted. They plotted charts, looked at them and filed them. They took quality control away from everyone else, which was wrong as quality control is everybody's job. They put out fires not perceiving the necessity to improve processes.

The Deming approach challenged traditional business philosophy, which focused on the efficient use of inputs and implied that quality adds to costs. He developed a Quality Centred Model to enable a process of continuous improvement. For Deming (1986), the implications for moving to the a new quality centred paradigm were clear.

TABLE 3.4 A COMPARISON OF THE TRADITIONAL MODEL AND QUALITY MODEL

The Traditional Model	Deming's Quality Centred Model
<p style="text-align: center;">Reduce Input Costs (people, methods, equipment)</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Lower unit costs</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Increase profits</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Improve return on investment</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Stay in business</p>	<p style="text-align: center;">Improve Quality</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Productivity Up</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Costs Down</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Prices Down</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Markets Increase</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">Stay in business</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">More Jobs and better return on investment</p>

Source: Personnel Management, July (1987)

Deming's aforementioned focus on the causes of variation led him to distinguish between two types of variation:

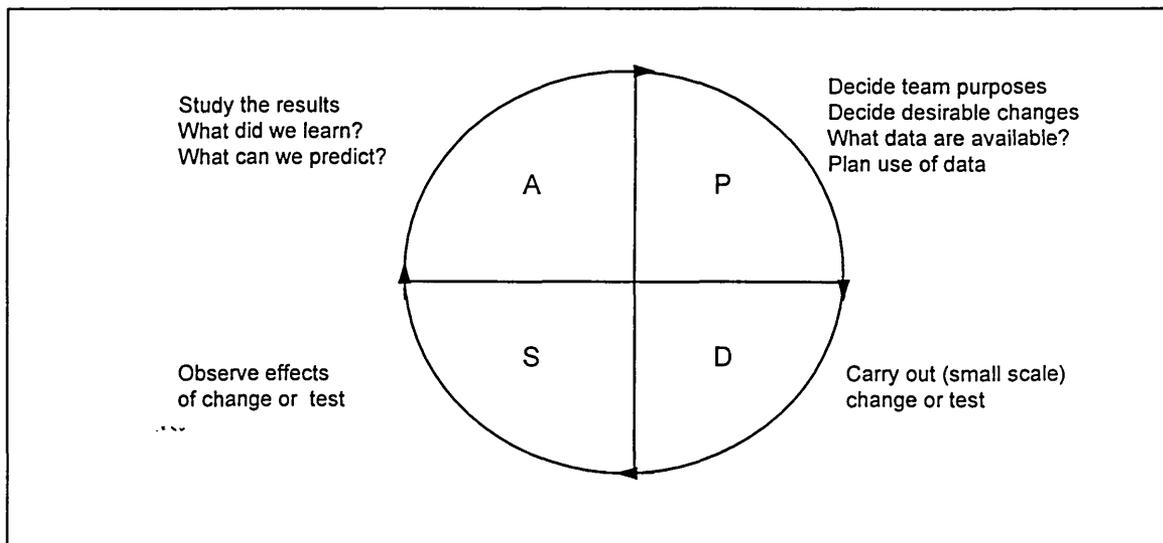
- (a) Common causes
- (b) Special (assignable) causes

He stated that special causes were those which prevented a process from remaining statistically constant and whose causes were easily assignable. Examples of special causes included changes in operator, materials and machinery. Common causes on the other hand were inherent in a process and were caused by the design of the process or operation. Whilst operators may be able to identify them, only management can resolve them (Deming 1986).

For Deming, it was management's responsibility both to distinguish between the two types of variance and to recognise that, without management action or support, opportunities for improvement were limited. Deming believed that confusion over the two types of causes of variance could make matters worse and led him to conclude that senior management were responsible for as much as 94% of quality problems. Furthermore, he suggested that exhortations and incentives to produce better quality would have little impact.

Deming encouraged the systematic approach to problem solving where he employed what he termed the Shewhart cycle although it is often referred to as the PDCA (Plan, Do, Check, Action) and later the PDSA (Plan, Do, Study, Act) cycle.

FIGURE 3.5 THE PDSA CYCLE



Source: Bendell (1991)

Much of Deming's later work, however, concentrated on challenging the style of Western management

Everyone doing his best is not the answer. It is first necessary that people know what to do. Drastic changes are required. The first step in the transformation is to know how to change... Long term commitment to new learning and new philosophy is required of any management that seeks transformation. The timid and faint hearted, and people that expect quick results are doomed to disappointment (Deming 1986).

The essence of Deming's work was embodied in his 14 points for management. He warned of the danger of treating them as a simple recipe for improvement and maintained that they did not represent the total understanding of his philosophy. Rather, as Neave (1990) explained, the 14 points were "vehicles for opening up the mind to new thinking, to the possibility that there are radically different and better ways of organising our businesses and working with people."

TABLE 3.5 DEMING'S 14 POINTS

(1)	Create constancy of purpose to improve product and service
(2)	Adopt the new philosophy for new economic age by management learning responsibilities and taking leadership for change
(3)	Cease dependence on inspection to achieve quality and eliminate the need for mass inspection by building quality into the product
(4)	End awarding business on price ; instead minimise total cost and move towards single suppliers for items
(5)	Improve constantly and forever the system of production and service to improve quality and productivity and to decrease costs
(6)	Institute training on the job
(7)	Institute leadership ; supervision should be to help do a better job
(8)	Drive out fear so that all work effectively for the organisation
(9)	Break down the barriers between departments ; encourage two way communication in order to foresee problems and anticipate opportunities
(10)	Eliminate slogans, exhortations and numerical targets . Most problems lie within the system rest with management to solve.
(11)	Eliminate quotas or work standards , and management by objectives or numerical goals; substitute leadership.
(12)	Remove barriers that rob people of their right to pride of workmanship
(13)	Institute a vigorous education and self improvement programme
(14)	Put everyone in the company to work to accomplish the transformation

In addition to his 14 points, Deming outlined a series of obstacles which could seriously undermine attempts to build on them. He referred to these as the deadly diseases:

TABLE 3.6 DEMING'S FIVE DEADLY DISEASES

(1)	A general lack of constancy and purpose
(2)	Too much emphasis on short term profit
(3)	A lack of unsuitable evaluation of performance, merit rating or annual review
(4)	Management is too mobile
(5)	Management decision making too readily relies on quantitative data without paying due consideration to less tangible or hidden factors

Deming provided an action plan to help organisations to overcome the 5 deadly diseases and to strive to meet the 14 Points. The action plan comprised of broad principles rather than a specific method:

- (1) Management must endeavour to meet the 14 Points, overcome the Deadly Diseases, agree meaning for the organisation and develop a plan of direction
- (2) Management must take pride and develop courage for the new direction
- (3) Management need to explain to everyone why change is necessary
- (4) Every company activity should be divided into stages. The customer(s) of each stage need to be identified. Continual improvement of methods should take place at every stage.
- (5) Start as soon as possible. Deming advocated the use of the Shewhart cycle as being useful for improving any stage.

Deming (1986) placed great importance on the need to view an organisation as a system. This grew from his belief that it is the whole that needs to be optimised rather than the individual parts. The 14 points of management are said to flow from the application of the System of Profound Knowledge and to lead to a situation of optimisation (Deming 1994). The System of Profound Knowledge consisted of four interrelated parts:

(a) Appreciation of a system

Managers needed to understand the relationships which exist between different functions and activities such that in the long term everybody would gain

(b) Knowledge of statistical theory

Distinguishing between the two types of variation, understanding process capability and the use of control charts. Having knowledge of interactions and loss functions and how to accomplish effective leadership and teamwork.

(c) Theory of knowledge

The need to examine why things happened, not simply how things happened. Predicting future success based on past experience was futile unless the underlying theory was understood.

(d) Knowledge of psychology

An awareness of the different theories of human interaction and motivation.

Finally Deming talked of a "New Climate" consisting of joy in work, innovation and co-operation which focus on achieving a non-zero sum (Win: Win) outcome.

Deming's Contribution

Ultimately, the impact of Deming's work lay in its pioneering character. Flood (1993) identifies the main strengths of Deming as a logical, systematic approach. For example, the PDCA cycle; the singling out of management's role as the key to improvement, 94% of problems are created by management; a recognition of the importance of people management issues; instilling leadership; and the acceptance that cultural differences exist and need to be responded to in different ways. For example, a recognition of differences between Japanese and American organisations.

On the other hand, many of Deming's principles are broad in nature and can not be readily implemented, for example, his ideal of joy in work. Whilst accepting the importance of people management and cultural issues within his philosophy, Deming did not draw upon established theories and literature relating to human motivation or leadership. For example, he emphasised the need to move away from management based on extrinsic motivation, to one that valued intrinsic motivation, a realisation already established by Maslow (1943) and Herzberg (1966). Furthermore, studies undertaken to identify motivating factors amongst manual labourers have suggested that intrinsic forms of motivation, such as job content, may not be important to this group of workers (Goldthorpe et al 1968; Weaver 1988). The complexities of human motivation appear to be far greater than Deming appreciated and similarly, the political nature of organisations with its associated conflict and power struggles is not sufficiently addressed. The exhortation to "drive out fear" and to "break down barriers between departments" appears to be unrealistically easy to achieve.

JOSEPH M. JURAN

Juran was another notable invitee to Japan in the 1950s whose lectures contained a strong management theme. Unlike Deming, whose work developed to include management responsibility, Juran used this as a starting point. He argued that at least 85% of failures in organisation are the fault of systems controlled by management. Fewer than 15% of problems were worker related. Juran expanded upon this by contrasting management by control/inspection with a prevention or "Breakthrough".

TABLE 3.7 BREAKTHROUGH MANAGEMENT

Control Approach	Breakthrough Approach
Attitude - Present performance is good enough or at least cannot be improved	Attitude - Present level is not good enough and can be improved upon
Objective - Maintain performance at this level	Objective - Do something about it
Plan - Identify and eliminate short term departures from the usual performance	Plan - Seek solutions which identify and eliminate obstacles which prevent this

Source: cited in Collard (1989)

Juran argued that short term pressures had been created by a lack of breakthrough which in turn resulted from attempts to overcome problems via the treatment of symptoms rather than by tackling the underlying causes. The notion of quality, therefore, began to move beyond a simple tool driven mechanism for improving product quality, towards creating a new philosophy of organisation management which could deliver sustained business performance.

Central to Juran's approach was the belief that quality did not happen by accident but that it must be planned. This, together with quality control and quality improvement, formed the "Quality Trilogy", a concept derived from financial management.

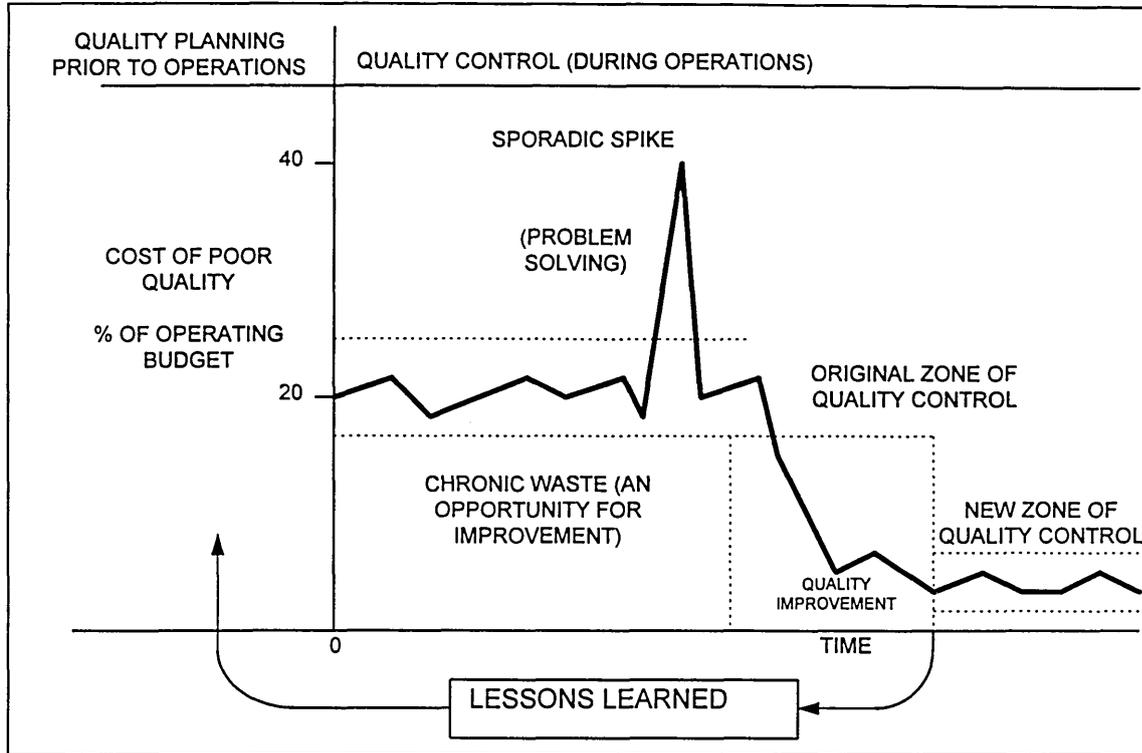
TABLE 3.8 QUALITY AND FINANCE PARALLELS

Trilogy Processes	Financial Processes
Quality Planning	Budgeting
Quality Control	Cost and expense control
Quality Improvement	Cost reduction and profit improvement

Source: Juran (1986)

Juran stressed that those organisations which followed the Trilogy would outperform those which did not, in the same way that those which have used the above financial approach had outperformed those that had not.

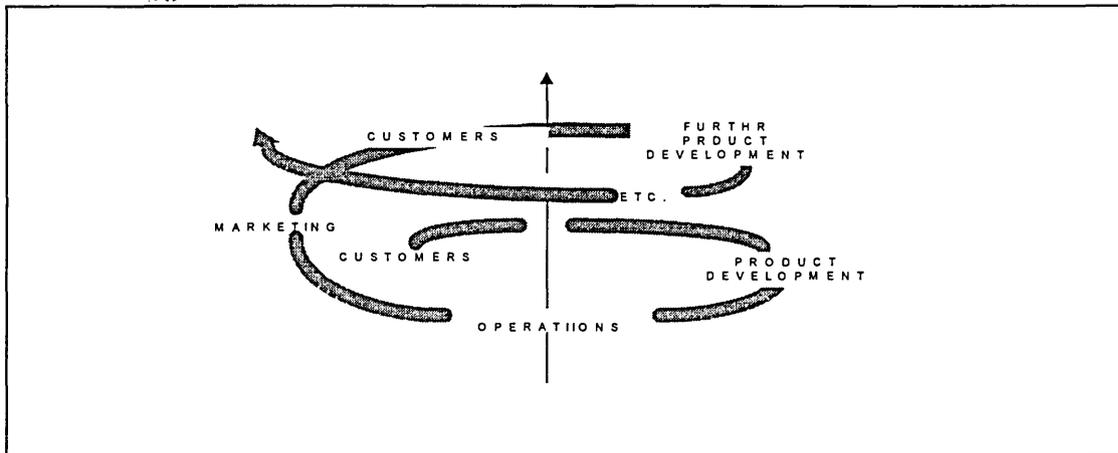
FIGURE 3.6 JURAN'S QUALITY TRILOGY VIA A CONTROL CHART



Source: Juran (1988a)

The importance of the customer was emphasised by Juran who identified and distinguished between external and internal customers whose needs must be met. This was encapsulated in his "Quality Spiral" and "Quality Planning Road Map".

FIGURE 3.7 THE QUALITY SPIRAL



Source: Bendell (1989)

TABLE 3.9 QUALITY PLANNING ROAD MAP

- (1) Identify who are the customers
- (2) Determine the needs of these customers
- (3) Translate those needs into our language
- (4) Develop a product which can respond to those needs
- (5) Optimise the product features so as to meet our needs as well as customer needs
- (6) Develop a process which is able to make the product
- (7) Optimise the process
- (8) Prove that the process can produce the product under operating conditions
- (9) Transfer the process to operations

In order to arrive at a position to be able to make full use of the road map however, an organisation needs to follow 10 steps to quality improvement.

TABLE 3.10 JURAN'S 10 STEPS TO QUALITY IMPROVEMENT

- (1) Build awareness of the need and opportunity for quality improvement - this requires leadership
- (2) Set specific goals for improvement
- (3) Organise to ensure goals are set and a process established to meet them
- (4) Provide training for everyone including top management since they are at the root of most quality problems
- (5) Carry out projects to solve problems
- (6) Report progress
- (7) Give recognition
- (8) Communicate results
- (9) Keep score
- (10) Maintain momentum by making continuous improvement part of the regular systems and processes of the organisation

Juran was more controversial in his belief that there was an economically optimum point for quality being at odds with Crosby's (1979) assertion that quality is free. Juran argued that most organisations operated below the optimal quality level, whilst implying that a trade off existed between costs and quality (Juran and Gryna 1993).

His greatest contribution lay in the emphasis on the customer, conceptualised in terms of internal and external customers (Juran 1988a); in the stress he placed on management involvement and commitment; and in his recognition that there are no short cuts to quality

ARMAND V. FEIGENBAUM

In 1956, Armand Feigenbaum published Total Quality Control in which quality was considered an issue whose concern ought not be limited to production but which should permeate and involve all departments throughout the whole of an organisation.

Total Quality Control is an effective system for integrating the quality development, quality maintenance, and quality improvement efforts to the various groups in an organisation so as to enable production and service at the most economical levels which allow full customer satisfaction (Feigenbaum 1956).

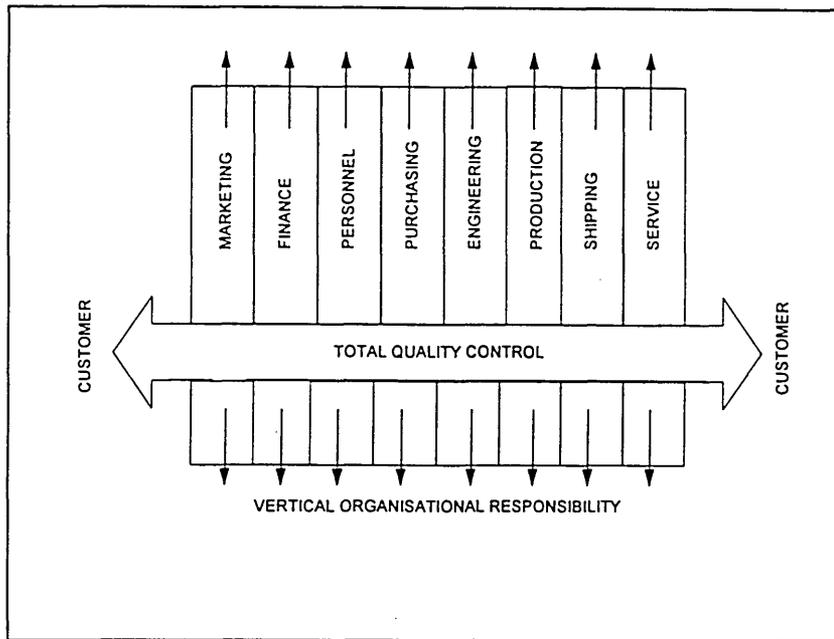
Feigenbaum talked of the "industrial cycle" as an ongoing sequence of activities involved in bringing products from conception to the market. He was keen to point out that the customer was both the start and the end point of this cycle. In between there were many people and functions who had a role to play and the responsibility needed to be shared.

Feigenbaum's approach might be considered as a four stage management tool:

- (1) Setting quality standards
- (2) Appraise conformance to standards
- (3) Acting when standards are exceeded
- (4) Planning for improvements in the standards

It represented a broadening of the concept of quality control in order for it to enter all phases of an organisation's operations.

FIGURE 3.8 THE SCOPE OF TOTAL QUALITY CONTROL



Source: Adapted from Feigenbaum (1983; 1991)

Feigenbaum (1991) stated that “Quality is in its essence a way of managing the organisation” and that there should be an emphasis throughout the organisation on quality leadership and top to bottom human commitment to quality and productivity. He posited the idea of the "hidden plant"; that every organisation wastes a certain proportion of its capacity through the production of poor quality. Feigenbaum was also the first to advocate using the cost of quality (or non-quality) as a strategic tool to drive the improvement process with the intention of minimising the total cost of quality (see Feigenbaum 1956; 1961). These comprised of:

- (1) **Prevention costs** related to quality planning
- (2) **Appraisal costs** related to inspection
- (3) **Internal failure costs** related to scrap and rework
- (4) **External failure costs** related to product recall, warranties and complaints

Expenditure on prevention activities, as opposed to tackling quality problems with more spending on appraisal activities, could lead to a several-fold improvement in the costs of internal and external failures. Internal and external failures were believed to account for around 65-70% of an organisation’s quality costs and appraisal costs accounted for 20-25%. The equivalent figure for prevention costs, however, probably did not exceed 10% (Feigenbaum 1991).

CHAPTER 4 STRATEGIC QUALITY

QUALITY AS A STRATEGIC TOOL

According to Moore (1992), strategic analysis was concerned with “The determination of how an organisation in its entirety can best be directed in a changing world”. Essentially, the student of business strategy is concerned with those factors which determine business success. Buzzell and Gale (1987) demonstrated that a relationship existed between quality and business results through their Profit Impact on Market Share index (PIMS). They concluded that

In the long run, the single most important factor affecting a business unit’s performance is the quality of its products and services, relative to those of its competitors.

More specifically, Morgan and Piercy (1992), through empirical evidence, offered an argument in favour of a quality driven strategy by highlighting three major areas where it has an effect:

- Manufacturing and operation costs
- Price and perceived quality
- Quality and market share

Manufacturing and operation costs

Evidence exists which supports the view that increased quality can lead to significantly lower manufacturing costs and increased productivity (Deming 1982; Phillips et al 1983; Curtin 1983; Hayes and Wheelwright 1984; Fine 1986; Garvin 1988).

Price and perceived quality

Studies have suggested a relationship exists between price and perceived quality. Higher perceived quality may allow a premium price to be levied but, in addition, price can also act as a powerful indicator of quality, particularly in the absence of other "cues" such as branding and product features (Buzzell and Wiersema 1981; Stokes 1985).

Quality and market share

The PIMS database provided clear evidence of a positive correlation between quality and market share (Buzzell and Gale 1987).

QUALITY AS A MULTI-DIMENSIONAL CONCEPT

A definition of quality provides a starting point from which a quality strategy can be constructed. Numerous commentators have noted the lack of a universally accepted definition of quality and the problems which this might create (see, for example, Joss et al 1993; Pollit 1993; Gaster 1995).

According to Garvin (1984), the many and various definitions of quality could be categorised according to the aspects which each emphasised:

- **The Transcendental Approach** considered quality as “innate excellence”
- **The Product Based Approach** saw quality as a precise and measurable variable where differences in quality amounted to differences in some desired attribute or characteristic
- **The Manufacturing Approach** took quality to mean the degree to which a product met with the design or specification
- **The User Based Approach** defined quality as the ability of a product to satisfy or exceed customer wants.

Clearly the definition of quality would have a significant effect on how it was managed. Crosby (1979), for example, was in no doubt that taking a transcendental approach, or as he put it, holding a “common sense notion of quality”, was unsuitable and undesirable. He stated that “The first erroneous assumption is that quality means goodness, or luxury, or shininess or weight”. As a consequence management became “imbued in the conventional wisdom” and this in turn led to an attitude that quality “... is unmeasurable; that error is inevitable; and that people don’t give a damn about doing good work”

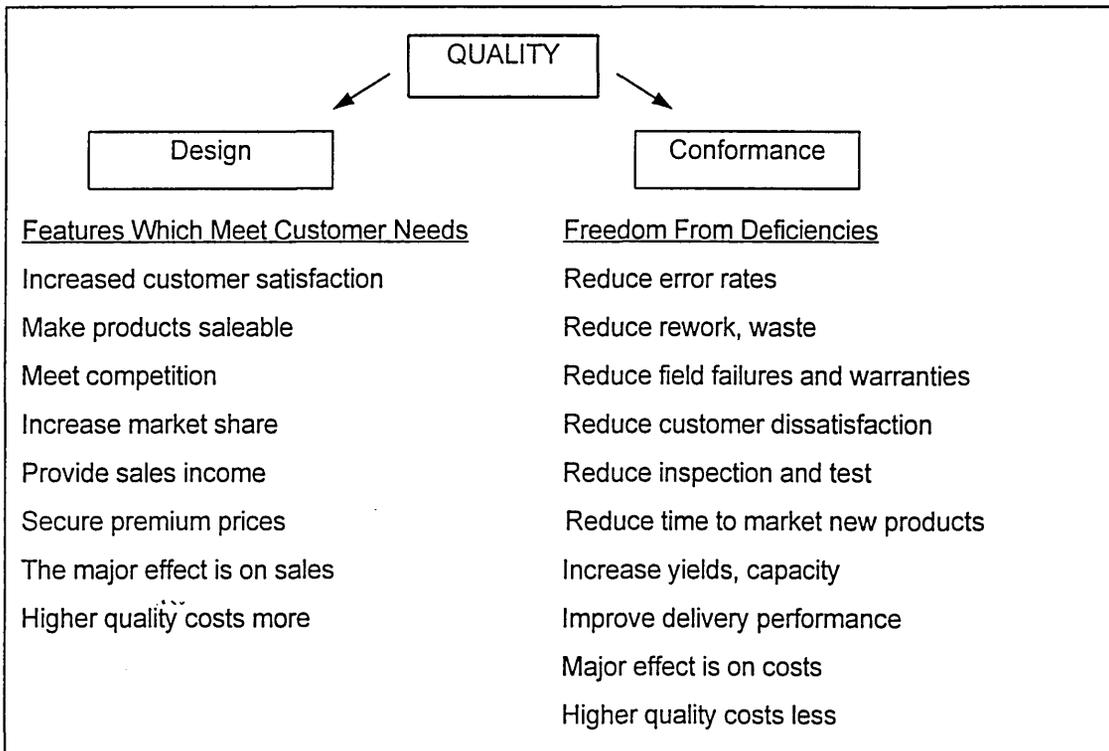
The advantage of defining quality as “conformance to requirements” (Crosby 1979) made quality tangible, measurable and manageable. Quality of conformance, however, satisfied only one of the two broad quality criteria. The other being quality of design. Hence, Juran (1988a) preferred “Fitness for use” as he argued that a product may conform to all the requirements but may not be fit for the use or purpose intended. Finally, Deming (1986) suggested that quality was “A predictable degree of uniformity and dependability at low cost and suited to the market.

It is possible to identify a number of important issues which emerge from these definitions. The first is that quality is a complex and multi-faceted concept (Garvin 1984). As a result, no universally accepted definition of quality exists, although attempts have been made to provide multiple definitions of quality to accommodate the various approaches. Quality consists of elements of both conformance and design and there are financial considerations associated with achieving quality

QUALITY OF CONFORMANCE AND DESIGN

Juran (1988a) considered quality to have separate influencing factors of satisfaction and dissatisfaction. Positive satisfaction accrues from performance and features, that is, design quality. Whilst dissatisfaction stemmed from deficiencies or defects which existed, that is, conformance quality. The strategic planning and implementation of quality, therefore, revolved around these dimensions.

FIGURE 4.1 QUALITY OF DESIGN AND CONFORMANCE



Designing Quality

The work of Garvin (1984; 1987) has provided a means by which the concept of design quality can be presented and understood in a meaningful and manageable way. He proposed that quality has eight dimensions which act as a framework for strategic analysis: performance, features, reliability, conformance, durability, serviceability, aesthetics and perceived quality.

1. **Performance** refers to the primary operating characteristics. These include such factors as size, speed, power and sound.
2. **Features** are the extras which supplement the primary operating characteristics.
3. **Reliability** is a measure of the probability of failure.
4. **Conformance** is the degree to which specifications and standards are met.
5. **Durability** relates to a product's life span; its robustness under operating conditions.
6. **Serviceability** concerns such matters as the frequency, ease, speed, cost and friendliness of service.
7. **Aesthetics** includes appearance, style, class and impression
8. **Perceived Quality** are innate feelings of quality which are often inferred through both tangible and intangible aspects of the product. Reputation is an important driver of perceived quality.

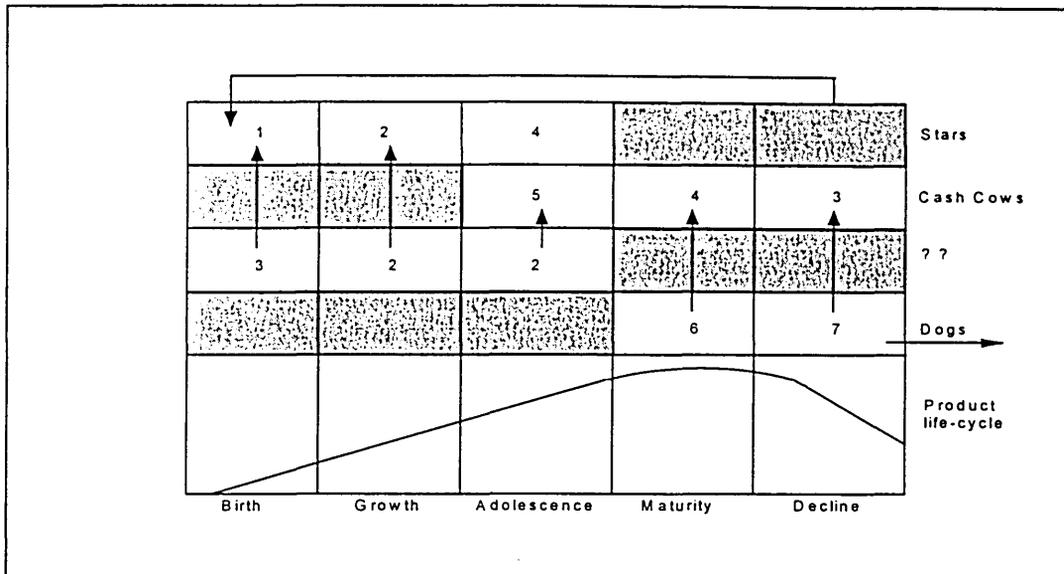
QUALITY AND PRODUCT MANAGEMENT

Strategic quality management was discussed by Walsh (1985) who identified seven pure optimal pure quality strategies:

- (1) set quality standards;
- (2) improve general quality effectiveness;
- (3) develop new quality dimension;
- (4) maintain perceived quality and reduce costs;
- (5) maintain relative product quality;
- (6) breakthrough in quality management;
- (7) reduce quality to “quit”.

These in turn were matched to the product/service life-cycle and portfolio to determine the appropriate strategy to adopt.

FIGURE 4.3 VARIATION OF OPTIMAL STRATEGY WITH MARKET CONDITIONS AND LIFE-CYCLE STAGE



Source: Walsh (1985)

THE ECONOMICS OF QUALITY

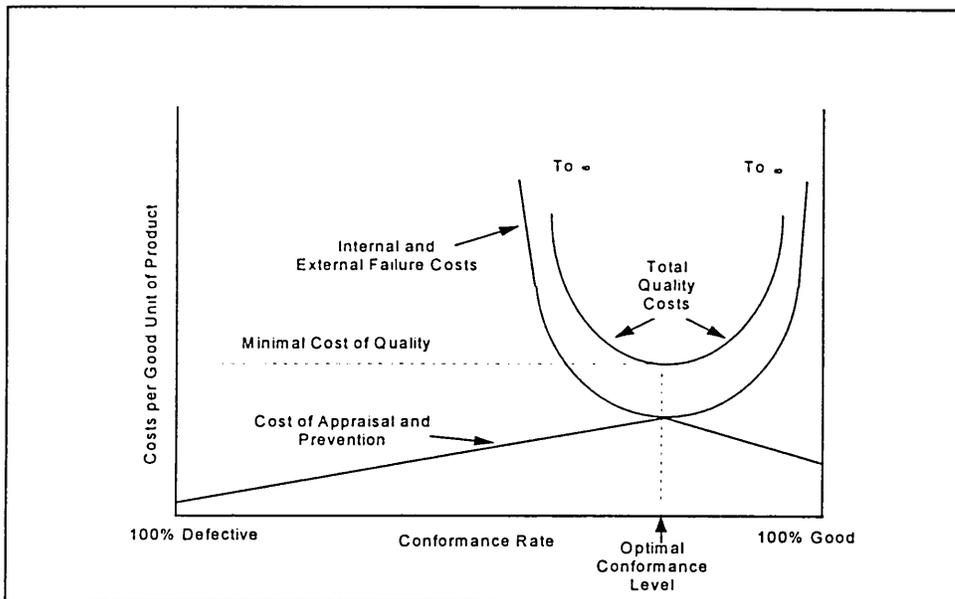
Crosby (1979) declared that there was no such thing as the economics of quality as it was always cheaper to do the job right first time. This assertion underpinned much of Crosby's approach and indeed was embodied in the title of his book Quality is Free. Whilst such a title undoubtedly gave appeal to his approach, it is an issue which is by no means as absolute as Crosby would contend.

Crosby's claim that the only costs of quality were the costs of non-conformance ran counter to the ideas of Feigenbaum (1991) who identified 4 types of quality related costs:

- Prevention
- Appraisal
- Internal Failure
- External Failure

Juran used this framework by which to construct an Economic Conformance Model and to demonstrate the existence of an optimum quality level (Juran and Gryna 1980).

FIGURE 4.2 THE ECONOMIC CONFORMANCE MODEL



Source Juran and Gryna (1980)

Other writers have been in agreement with this model. Quality may be free, but only in the long term was the assessment of Chatterjee and Yilmaz (1993). Meanwhile Hill (1983) demonstrated the use of an optimum level of quality by using a model which plotted quality activities against perceived product value. The model sought to identify a quality level which maximised returns on the trade-off between costs associated with undertaking quality management activities and customer perceptions of product value. The optimum quality level lay at the widest point between the two curves where, in relative terms, costs are low but perceived value is high.

The validity of this model, however, hinged upon several questionable suppositions in that it assumed:

- (a) customers held certain expectations of a product or service which included an allowance for defects.
- (b) non-price factors were only relevant up to a certain position (where satisfaction was met) before price became an overriding factor.
- (c) quality levels were measured using only a single measure; that of percentage of defects.
and
- (d) quality related activities always add to costs.

The model did not explain the complex relationship between price and customer perception of quality. For example, a multiplying effect exists relating to sales attributable to dissatisfied customers which defies objective measurement (Rienzo 1993). Deming's (1986; 1994) concept of "profound knowledge" stated that the most important figures are those which are unknown or unknowable.

THE IMPACT OF GOVERNMENT POLICY

In 1982 the Department of Trade and Industry (DTI) published the White Paper Standards Quality and International Competitiveness (Department of Trade and Industry 1982). In so doing, the Government accepted the importance of quality and the role it could make in improving the industrial performance and competitiveness of British firms.

It suggested that the way forward was through the rigorous adherence to clearly defined standards.

The White Paper was split into 5 sections:

- Section 1 The Importance of Standards in World Markets
- Section 2 Developing an understanding with the British Standards Institute (BSI)
- Section 3 Enhancing the status of the standards of regulatory bodies (for example, The Health and Safety Executive)
- Section 4 Government Purchasing Policy
- Section 5 Quality Assurance and Accreditation

The Government, so the White Paper claimed,

Recognised national and international standards, which reflect requirements of world markets (not just home markets), can help firms design, make and sell products with the quality feature that the customers want.

Furthermore

The principle ways in which government action can enhance the status of standards as an instrument of improving efficiency and the international competitiveness of British firms are:

- (1) Closer co-ordination between the Government and BSI to develop standards of the required quality, commanding respect in world markets
- (2) ... Commitment from the Government to make better use of standards.

In April 1983 the DTI launched the National Quality Campaign. This was not the first time that an attempt had been made to raise quality awareness, Wilkinson et al (1991) remind us of the Right First Time campaign, organised by the British Productivity Council, in the early 1960s. The National Quality Campaign consisted not only of providing advice and publications, concerning certification and quality management produced by the DTI, but also offered financial support to smaller companies to offset consultant's fees.

This was an important development, not simply because it provided quality with a high profile, but also because it had an impact on influencing the quality management approach that British

firms adopted. By 1989 more than 50,000 companies had contacted the DTI for advice and information relating to quality management issues (Lascelles and Dale 1989). In general, this approach a reliance on management consultants to provide advice, both because of their perceived expertise and because companies received financial assistance from the DTI for doing so. Indeed Tuckman (1991) claimed that management consultants had difficulty in selling their services unless they included an element of TQM. In addition, the advice proffered was likely to include an element on achieving BS 5750/ ISO 9000, the nationally and internationally recognised quality standard. (In March 1994 the British Standard BS 5750, the European Standard EN 27000 and the International Standard ISO 9000 were collectively renamed BS EN ISO 9000.)

THE STANDARDS BASED APPROACH

There were several reasons why the pursuit of BS 5750/ ISO 9000 became such an integral part of many organisations' quality approach. To begin with, the 1982 White Paper suggested that adherence to quality standards was the way forward, in compliance, many government departments and agencies began to stipulate that their suppliers achieve BS 5750/ ISO 9000 certification. Secondly, BS 5750 offered a tangible product by which organisations could see what they were getting for their money, namely a quality manual to drive the system and a certificate on the wall. Thirdly, the implementation of BS 5750 could be implemented within the existing organisational context. Advocates of a standards based approach pointed to lower business failure rates amongst BS 5750 registered companies. Further evidence exists to suggest that the achievement of BS 5750 certification may be worthwhile in terms of increased profitability, improved marketing and higher export sales (see PERA International and Salford University Business Services Ltd. 1992).

On the other hand, a range of criticisms have been voiced of a standards based approach to quality management. Some commentators saw problems with the application of the standards, particularly their suitability for implementation by small businesses (see, for example, Small Business Research Trust 1992) Others pointed to deficiencies within the system used to award certificates (see, for example, Haliday 1993). Whilst others voiced concern that BS 5750 had become synonymous with TQM, with some organisations seeing BS 5750 certification as the culmination of their quality improvement activities (see, for example, Dale 1994). Doubts have thus been raised about the ability of a standards based approach to sustain quality improvement activities (Daniels 1992; Waterman 1992).

The different demands required of the two approaches are set out below:

TABLE 4.1 BS 5750 AND TQM

BS 5750	TQM
Standards for doing things right (Efficiency)	Focus on doing the right things right (Efficiency and Effectiveness)
Primary focus on the product/service	Company-wide focus on all functional areas
System driven	Philosophy/management approach
No requirement for employee involvement in improvement	Emphasis on all employees being involved
Goals to meet the standard and pass the audit	No final goal. Self driven pursuit of continuous quality improvement
Low visibility once in place	Company-wide high profile

Source: Gladstone (1993)

Dale (1994), in reporting findings from TQM research undertaken at UMIST, stated that whilst ISO 9000 could be an integral part of a TQM initiative it was by no means a prerequisite; others have reported that BS 5750 and TQM may be seen by some organisations as alternative but viable routes (Fowler et al 1992).

THE TQM APPROACH

It might be concluded that organisations developing a quality strategy are confronted with a bewildering array of conflicting approaches. According to The Economist (1992), the result was shown in “... mounting evidence that the quality programmes of many western companies are failing dismally.” The report pinpointed the adoption of non-TQM approaches as being a major cause of failure.

Having chosen to adopt a TQM approach, however, the confusion facing an organisation does not stop there. Very few definitions of TQM exist and, therefore, there might be uncertainty regarding the full implications of pursuing the implementation of TQM in terms of both what it involved and what it could deliver. None of the trio of leading gurus; Deming, Juran and Crosby, offered a definition of TQM or referred to it in their own approach. Indeed, Deming vehemently sought to distance himself from the term.

In order to overcome this dilemma, several writers have attempted to crystallise the TQM concept into a set of guiding principles and process steps. Hence Collard (1989) defined TQM as

A cost-effective system for integrating the continuous quality improvement efforts in an organisation to deliver products and services which ensure customer satisfaction

stressing that meeting customer needs was the driving force behind quality. Whilst Oakland (1989) preferred:

An approach to improving the effectiveness of organising and involving the whole organisation, every department, every activity, every single person at every level. For an organisation to be truly effective, every part of it must work properly together, recognising that every person and every activity affects and in turn is affected by others.

which placed emphasis on the concept of the internal customer-supplier chain.

Occasionally, writers have attempted to explain TQM by separately defining each of its component parts. Thus, Haigh and Morris (1994) saw TQM as a combination of:

- Total** Organisation wide process involving everyone from post room to board room.
- Quality** Establishing quality goals for each and every element in the process of product or service delivery in order to meet customer needs and expectations first time and on every subsequent occasion.
- Management** Not just commitment of senior management to quality goals but senior management' s active involvement in pursuit of them.

An alternative approach was to highlight the features or characteristics of TQM in order to convey its meaning:

TABLE 4.2 TOTAL QUALITY MANAGEMENT

The Approach	Management Led
The Focus	Customer Satisfaction
The Scope	Company-wide
The Scale	Everyone is responsible for Quality
The Philosophy	Prevention not Detection
The Standard	Right First Time
The Control	Cost of Quality
The Theme	Continuous Improvement

Source: Smith (1989)

Within these features, so called “hard” and “soft” elements have been identified; the former emphasising the systems side of TQM implementation and the latter emphasising people management issues, as organisations seek to formulate the right conditions for TQM to succeed (see, for example, Collard 1989; Wilkinson et al 1991; 1993; Dale and Cooper 1992).

In particular, the softer elements of TQM have attracted a great deal of debate. The issue at stake has been whether TQM represents a culture change, or whether a culture change is necessary before TQM can succeed. Clutterbuck and Crainer (1990) were of the opinion that TQM and culture change were synonymous terms. On the other hand, British Telecom was reported to have introduced TQM as a specific strategy to break down the bureaucratic, administrative culture which was perceived to exist within the organisation and to become more customer orientated. Early accounts of its experience indicated that the administrative culture, far from undergoing a transformation, had in fact imposed itself on the implementation process; thereby reinforcing the existing culture (The Economist 1992).

WHICH APPROACH?

As a philosophy which is still unfolding, a review of the TQM literature reveals a growing realisation that a rigid adherence to the work of one particular guru is not appropriate (see, for example, Jackson 1990). Bendell (1991), suggested that, as each guru had a unique message and contradictions existed between the gurus teachings, so the approach taken needed to be made specific to the organisational context; “rather than follow one particular guru, I strongly advise companies to pick and mix.” (Bendell 1991)

Others, such as Dale and Cooper (1992), advised organisations to start by adopting the teachings of one of the gurus; although their own experience suggested that the process soon moved on to the development of tailored models, using ideas borrowed from each of the gurus, to suit individual circumstances. This advice, therefore, does not appear to be particularly sound. The literature, for example, has identified Crosby's approach as a model which organisations have tended to favour, at least in the initial stages, but has also indicated that organisations only progressed so far by following such an approach. (MacDonald and Pigott 1990; Hawkes 1992; Jones and Macilwaine 1991; Davies and Hinton 1993).

THE CRITICAL SUCCESS FACTORS AND THE BARRIERS TO TQM

Given the difficulties associated with implementing TQM, a number of writer have focused their attention on identifying those factors which are necessary for the successful implementation of TQM (Porter and Parker 1993). McCaskey (1988) referred to managers suffering from “map trouble” where “a map refers to a set of interconnected understandings of what in a given situation is important, and what demands action or attention and what does not.” (McCaskey 1988).

For Reeves and Bednar (1993), a review of the literature identified the following characteristics of successful initiatives, ordered according to the number of citations:

1. Top management commitment
2. Incentives and rewards
3. Long term focus
4. Training
5. Employee commitment and participation
6. Middle managers involvement
7. Vision
8. Reduce turf battles
9. Resources
10. Communication
11. Knowledge

However, as part of a research study to determine the barriers which prevent the implementation of TQM in health care organisations, the researchers discovered that top and middle managers perceived different sets of barriers.

TABLE 4.3 BARRIERS TO THE IMPLEMENTATION OF TQM

Barriers Perceived by Top Managers	Barriers Perceived by Middle Managers
Inadequate knowledge about and understanding of TQM	Sabotage/ lack of support from top management
Unclear definitions of TQM goals, boundaries and authority	Politics/ turf battles
Time required for meetings and problem solving	Lack of resources
Inadequate planning for implementation	Turnover and changes in key personnel
Insufficient rewards	Inadequate/ insufficient training in TQM
	Employees lack of confidence in the programme

Source: Reeves and Bednar (1993)

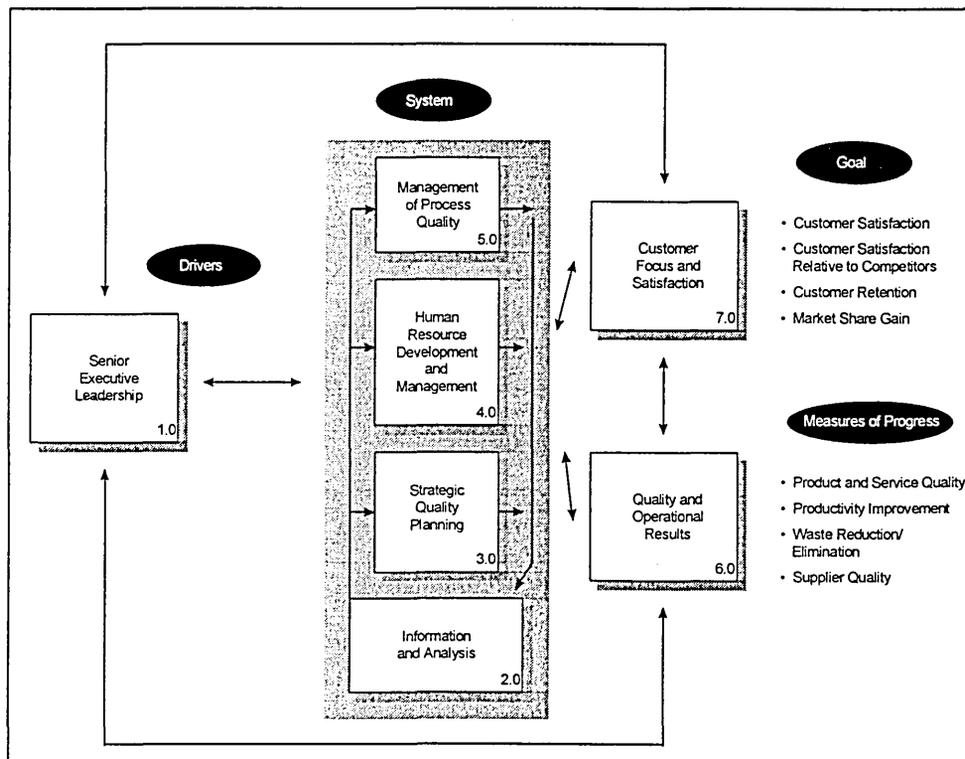
It was clear that whilst top managers were preoccupied by an organisational approach towards TQM implementation, middle managers were more concerned with the practical, operational side of implementation.

THE MALCOLM BALDRIGE NATIONAL QUALITY AWARD

Although standards, such as ISO 9000, have provided organisations with a means by which a quality system can be established, it must be accepted that such an approach may not cover in sufficient depth, the key areas of leadership, quality commitment and customer satisfaction demanded by a TQM philosophy. As organisations have become increasingly aware of the importance of adopting a TQM approach in order to remain competitive, so attention has moved towards developing frameworks for implementing TQM..

One such framework is the American Malcolm Baldrige National Quality Award. It was first presented in 1988 to recognise the achievement of those companies who have excelled at implementing TQM and, as winners, had agreed to share their knowledge with other US businesses. Organisations nominated themselves and were required to submit a highly detailed application form covering their quality practices and performance. Companies which scored well were then visited by a team of examiners who undertook an in-depth assessment of their operations within seven assessment criteria outlined below:

FIGURE 4.4 THE MALCOLM BALDRIGE NATIONAL QUALITY AWARD



Source: Costin (1994)

There are a total of 1000 points available, divided amongst each of the criteria as follows:

TABLE 4.3 MALCOLM BALDRIGE AWARD: EXAMINATION CRITERIA

1.0	LEADERSHIP	Maximum Points 120
1.1	Senior Management	30
1.2	Quality Values	20
1.3	Management System	50
1.4	Public Responsibility	20
2.0	INFORMATION AND ANALYSIS	Maximum Points 60
2.1	Scope of Data and Information for "Management by Fact"	25
2.2	Data Management	15
2.3	Analysis and use of Data for Decision Making	20
3.0	STRATEGIC QUALITY PLANNING	Maximum Points 80
3.1	Planning Process	30
3.2	Plans for Quality Leadership	50
4.0	HUMAN RESOURCE ALLOCATION	Maximum Points 150
4.1	Management	25
4.2	Employee Involvement	40
4.3	Quality Education and Training	30
4.4	Employee Recognition	20
4.5	Quality of Working Life	35
5.0	QUALITY ASSURANCE OF PRODUCTS AND SERVICES	Maximum Points 140
5.1	Design and Introduction of New or Improved Products and Services	25
5.2	Operation of Processes which Produce the Company's Products and Services	20
5.3	Measurements and Standards for Products and Processes	15
5.4	Audit	20
5.5	Documentation	10
5.6	Quality Assurance of Operations and Business Processes	25
5.7	Quality Assurance of External Providers of Goods and Services	25
6.0	QUALITY RESULTS	Maximum Points 150
6.1	Quality of Products and Services	70
6.2	Operational and Business Processes	60
6.3	Quality Improvement	20
7.0	CUSTOMER SATISFACTION	Maximum Points 300
7.1	Knowledge of Customer Requirements and Expectations	40
7.2	Customer Relationship Management	125
7.3	Customer Satisfaction Methods of Measurement and Results	135

The Baldrige prize, however, has not been without its critics. According to Dickson (1992) there has been considerable disquiet about its failure to assess financial performance; its failure to recognise superior product or service quality; its lack of an underpinning philosophy; its over emphasis on management processes, encouraging a belief in the existence of a TQM magic

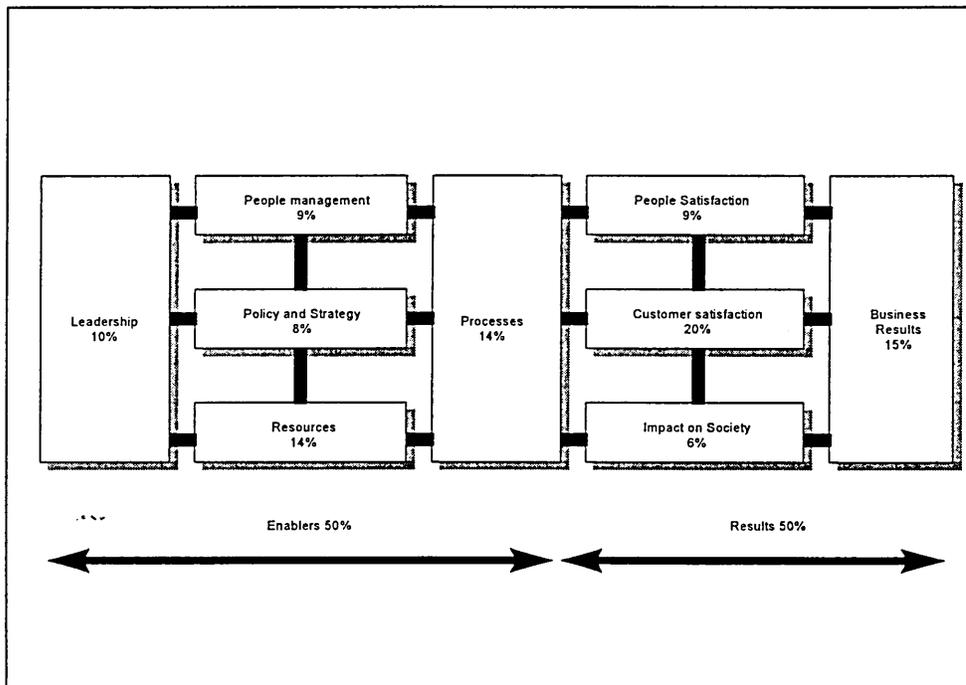
formula; and its misfortune in honouring subsidiaries of major US organisations such as IBM, General Motors and Westinghouse Electric, whose performance s since winning the award have been poor. These criticisms, however, have tended to revolve around the award process itself rather than the use of the Baldrige criteria as a self assessment exercise for quality

THE EUROPEAN MODEL FOR TOTAL QUALITY MANAGEMENT

The European Foundation for Quality Management (EFQM) was established in 1988 by fourteen leading European businesses. Its intention was to accelerate the acceptance of quality as a strategy for achieving global competitiveness and to stimulate quality activity as widely as possible (EFQM 1996).

In 1991, the EFQM launched the European Quality Award, supported by the European Organisation for Quality (EOQ) and the European Commission, the basis of which was the European Model for Total Quality Management, now known simply as the EFQM Model (EFQM 1994).

FIGURE 4.5 THE EFQM MODEL



Source: EFQM (1994)

The European Quality Award has had the advantage of being able to learn from the Baldrige experience. It has included categories for business results and impact on society, and given more weight to people satisfaction. In addition, an emphasis has been placed on the self-assessment aspect of the model (EFQM 1996).

CONCLUSION

With evidence of improved performance, quality is now recognised as a desirable operating strategy. Garvin (1987) analysed the concept in terms of a series of attributes around which products could be built. Similarly Walsh (1985) considered that different quality strategies were required for different products within an organisation's portfolio.

An analysis of the standards BS 5750 and ISO 9000 have shown them to be well known and widely adopted. However, concern has been raised that these standards fall short of the requirements of TQM, moreover, they have their roots in private sector manufacturing and are not directly applicable to other sectors. Consequently, two frameworks, the Malcolm Baldrige Quality Award and the EFQM Model, have provided generic frameworks with which to build a TQM strategy, particularly by providing a means for organisations to undertake self-assessment exercises.

CHAPTER 5 SERVICE QUALITY

INTRODUCTION

According to Deming, people who work in services have a product, it is called service. In his view, there stood no difference between products and services in terms of the implementation of TQM. He called manufacturing the "little q" and both manufacturing and services the "big Q" because he suggested that it was the service side of organisations which added value to products. Nevertheless, the core principles of the TQM philosophy remained the same (Deming 1986).

Understanding the concept of quality within the service sector has been explored along similar lines to that of quality in manufacturing, that is, through an analysis of service design and conformance.

DESIGNING SERVICE QUALITY

Much of the ground work in the above area may be found within the marketing literature. The starting point for defining service quality has been to establish a basis to determine the factors which people use to assess the relative merits of a service. Cowell (1984) has suggested a range of approaches which might be used to provide an understanding of services:

- a) Definitions of services
- b) Characteristics of services
- c) Functions of services
- d) Classifications of services
- e) Conceptual frameworks

DEFINITIONS OF SERVICES

Kotler (1982) defined a service as “ any activity that one party can offer to another that is essentially intangible and does not result in the ownership of anything. Its production may or may not be tied to a physical product.” Whilst Stanton (1981) preferred:

Services are those separably identifiable, essentially intangible activities which provide want satisfaction, and that are not necessarily tied to a product or another service. To produce a service may or may not require the use of tangible goods. However, when such use is required there is no transfer of title to these tangible goods.

On the other hand, Levitt (1972) offered view that “There is no such thing as service industries. There are only industries whose service elements are greater or less than those of other industries. Everybody is in service.”

These definitions raise two important points. Firstly, they suggest that services possess certain characteristics, in particular, that of intangibility, which sets them aside from products. Secondly, Levitt (1972), in highlighting a commonality between products and services, suggested that both products and services are marketed in terms of the benefits and satisfaction they provide. Customer satisfaction goes beyond the tangible aspects of an organisation’s offering.

CHARACTERISTICS OF SERVICES

A series of features, unique to services, has been identified within the literature which, it is suggested, influence how people perceive services.

- Intangibility
- Heterogeneity
- Perishability
- Inseparability

Intangibility

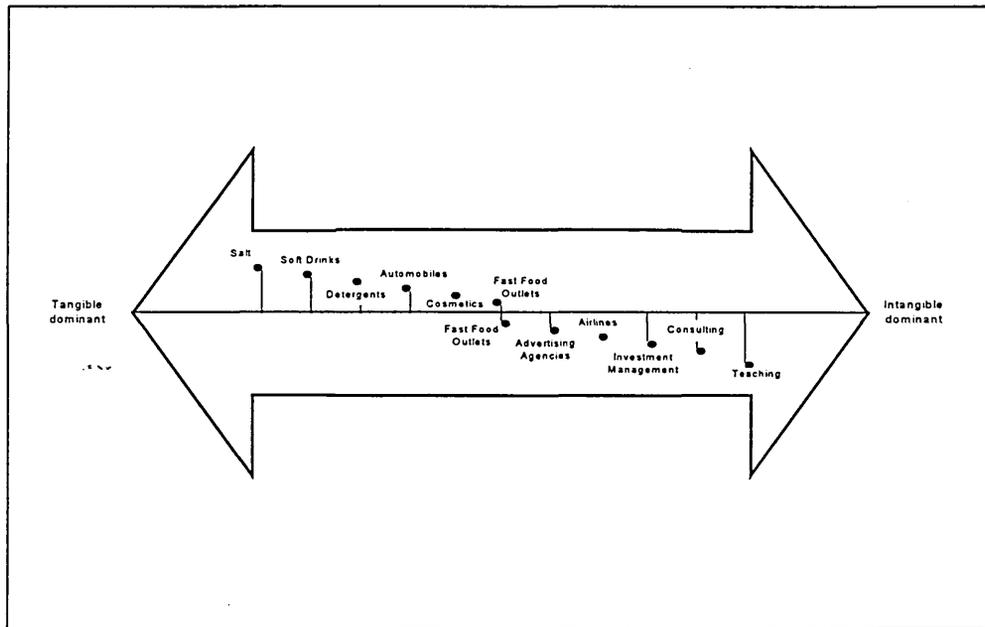
Intangibility was considered by Rushton and Carson (1985) to be the most important factor in determining the approach towards managing services. Services are intangible, they do not possess physical properties and, therefore, cannot be counted, measured, inventoried, tested or verified in advance. A service, and its associated level of quality, cannot be described to an adequate extent either by the provider in terms of what is being offered, or by the prospective customer in terms of what he or she wants. In addition, intangibility makes it difficult to monitor services and determine their relative performances. Crosby (1979), Deming (1986) and Juran (1988) all

emphasised that the need to measure quality was a fundamental part of the management processes.

In exploring the rationale behind consumer purchasing decisions, Nelson (1970) made a distinction between “search” goods and “experience” goods based on the degree of tangibility which each possessed. Search goods were those which the customer could investigate before purchase. Experience goods were those whose attributes could not be evaluated until after purchase. Cars and houses were cited as examples of search goods whilst entertainment and food were more representative of experience goods. Zeithaml (1981) argued that most products would possess both experience and search elements. A similar concept was adopted by Darby and Karni (1973) who referred to “credence” qualities as those aspects of a product or service which were impossible to determine even after consumption because the consumers did not have the necessary knowledge or skill to do so. The writers argued that credence qualities need not necessarily be confined to services. The more complex a good was, the more likely it would be to possess credence qualities.

Shostack (1977) produced a continuum to demonstrate the degree to which goods and services share tangible and intangible elements:

FIGURE 5.1 A GOODS-SERVICE CONTINUUM



Source: Shostack (1977)

Whilst products draw heavily on intangibles, for example, perceived image (see Garvin 1988) to provide a total package, services in turn possess an element of tangibility such as architecture, colours, space, furnishings, brochures etc. to provide physical evidence of their existence and,

therefore, important cues upon which consumers react in making assessments of the quality of service they receive.

Walsh (1991) talked about services possessing both a mental as well as a physical intangibility. He argued that, in some instances, it could be difficult to know whether one was actually receiving a service, for example, within care and protection services, and such a situation could lead to market failure. In the absence of other information which customers could use to base a purchasing decision, or to avoid becoming embroiled in a costly search programme, price was identified as an important quality signal (McConnell 1968; Olander n.d.; Zeithaml 1981).

Heterogeneity

Where services are performances that are carried out for and between individuals, the service is often something unique and, as a consequence, the service will be subject to variation due to the high degree of human involvement. Levitt (1972) advocated automating service delivery in order to create greater standardisation and efficiency. Both the banking and fast food industries have adopted successful strategies of standardising their service operations.

Perishability

Services are perishable. If the service is available and not used, then the service is being wasted yet the service cannot be produced before it is needed. The service life cycle is short and it is not the service which is stored but the customer in the form of queues and appointment schedules.

Inseparability

Services are produced and consumed at the same time being in effect one and the same process. As a result, Walsh (1991) argued that assessments of the relative worth of a service need to be made within the production process, with both producer and consumer working together. The consumer also experiences services at first hand without the benefit of a mechanism which might filter out non-conforming output.

Writers such as Bowen and Schneider (1988), Haywood-Falmer (1988) and Lehtinen and Lehtinen (1982) have explored the role played by the actors involved in the service delivery process and, in particular, the relationship between the provider and the consumer. In many circumstances this interaction has formed the service itself. The identity of personnel involved in assembling a product are not an important concern for most consumers, but in many service situations the performers are of the greatest importance; particularly in the care professions such as health, education and social work.

The role played by the customer is equally important in delivering a service because in consuming a service, the customer can also form part of the production process. Indeed, it has been argued that this is a crucial role to understand, because it is a factor over which management has little control. Consequently, Mudie and Cottam (1993) advocated a strategy of customer education as a means of promulgating a quality service; although they conceded that this was dependent on the willingness of customers to comply and their capacity to comprehend the complexity of the service.

A number of economists, such as Akerlof (1984) and Dingwell and Fern (1987), have predicted market failures if consumers are disadvantaged due to poor information regarding a service. Where consumers are unable to differentiate between what is good and what is bad, then there is no incentive for producers to market quality goods and, suggested Walsh (1991), might provide an incentive to maintain ignorance. However, Ovretveit (1990) highlighted the role professionals play in determining service quality within the internal delivery process, by defining the quality of service to individuals.

THE DIMENSIONS OF SERVICE QUALITY

The work of Gronroos (1984a) has been influential by suggesting that service quality is assessed across two basic elements:

- (1) Technical quality - The outcome
- (2) Functional quality - The process

He argued that technical quality (the outcome) was not necessarily more important. Indeed in certain services it may be difficult to make a judgement on what the outcome should be. Sometimes, this may only become clear in the long term, such as in social work and education, by which time other factors will have had an influence, and so it becomes impossible to state the precise effect. In the event of being unable to judge the technical quality, then the consumer is likely to make an assessment based on functional quality.

Identifying customer wants is undoubtedly a difficult exercise. Teboul (1991) coined the acronym "ikiwisi" (I know it when I see it) to describe the quality assessment process which consumers typically undertake whilst Garvin's (1987) eight quality dimensions provided a framework to understand those features which people consider in assessing the quality.

How a person determined the quality of a product was dependent on the importance the individual placed on each attribute. Garvin (1987) argued that it was not possible, nor indeed desirable, for companies to attempt to maximise the quality level of every attribute. Instead a trade off existed between the different dimensions and companies needed to identify the set of attributes which were important to their customers or target market.

The application of a similar set of attributes to services has been deemed by some commentators as problematical. Haywood-Falmer (1988) warned that whilst most goods could be evaluated using only a few, clearly understood attributes which remained constant over time, services often had many more attributes and were likely to change very quickly. However, this cautionary note has not deterred efforts to identify such attributes.

Sasser, Olsen and Wycoff (1978) suggested that service quality was judged on material, facilities and personnel, Lehtinen and Lehtinen (1982) referred to physical quality, corporate quality and interactive quality, whilst Haywood-Farmer (1988) proposed a service quality model built around the three Ps of Physical Process; People's Behaviour; Professional Judgement.

(1) Physical facilities, Processes and Procedures

Location, layout

Size, decor

Facility reliability

Process flow, capacity balance, control of flow

Process flexibility

Timeliness, speed

Range of services offered

Communication (written)

(2) Peoples Behaviour and Conviviality

Timeliness, speed

Communication (verbal, non-verbal)

Warmth, friendliness, tact, attitude, tone of voice

Dress, neatness, politeness

Attentiveness, anticipation

Handling complaints

(3) Professional Judgement

Diagnosis

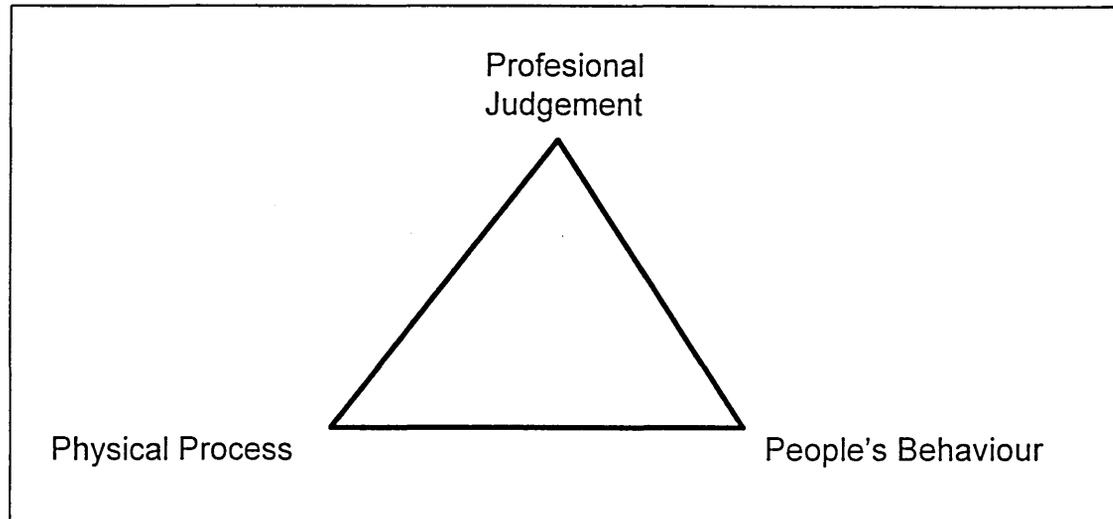
Advice, guidance, motivation

Honesty, confidentiality

Flexibility, discretion

Knowledge, skill

FIGURE 5.2 A MODEL OF SERVICE QUALITY



Source : Haywood-Farmer (1988)

Perhaps the best known of service quality determinants has been provided by Parasuraman et al (1985), detailed as follows:

Reliability involves consistency of performance and dependability. It means that the firm performs the service at the right time first time. It also means that the firm honours its promises:

- accuracy in billing;
- keeping records correctly ;
- performing the service at the designated time

Responsiveness concerns the willingness or readiness of employees to provide service. It involves timeliness of service:

- posting a transaction slip immediately;
- calling the customer back quickly
- giving prompt service (e.g., setting up appointments quickly)

Competence means possession of the required skills and knowledge to perform the service. It involves:

- knowledge and skill of the contact personnel;
- knowledge and skill of operational support personnel
- research capability of the organisation

Access involves approachability and ease of contact. It means:

- the service is easily accessible by telephone (lines are not busy and they don't put you on hold
- waiting time to receive service is not extensive;
- convenient hours of operation;
- convenient location of service facility

Courtesy involves politeness, respect, consideration, and friendliness of contact personnel (including receptionists, telephone operators, etc.) It includes:

- consideration for the consumers property
- clean and neat appearance of public contact personnel

Communication means keeping customers informed in language they can understand and listening to them. It may mean that the company has to adjust its language for different customers; increasing the level of sophistication with a well-educated customer and speaking simply and plainly with a novice. It involves:

- explaining the service itself;
- explaining how much the service will cost;
- explaining the trade-offs between service and cost;
- assuring the consumer that a problem will be handled.

Credibility involves trustworthiness, believability, honesty. It involves having the customer's best interests at heart. Contributing to credibility are:

- company name;
- company reputation;
- personal characteristics of the contact personnel;
- the degree of hard sell involved in interactions with the customer.

Security is the freedom from danger, risk, or doubt. It involves:

- physical safety;
- financial security;
- confidentiality.

Understanding/ knowing the customer involves making the effort to understand the customer's needs. It involves:

- learning the customer's specific requirements;
- providing individualised attention;

- recognising the regular customer.

Tangibles includes the physical evidence of the service:

- physical facilities;
- appearance of personnel;
- tools or equipment used to provide the service;
- physical representations of the service, such as plastic credit card or a bank statement;
- other customers in the service facility.

However, limitations have been identified with this approach.

(1) The attributes were identified as being important amongst a specific set of services, principally financial services. It is likely that different services will have different attributes which are important to them.

(2) There was no weighting of attributes yet it is likely that customers consider some attributes to be more important than others. This was Garvin's (1987) "trade off" argument.

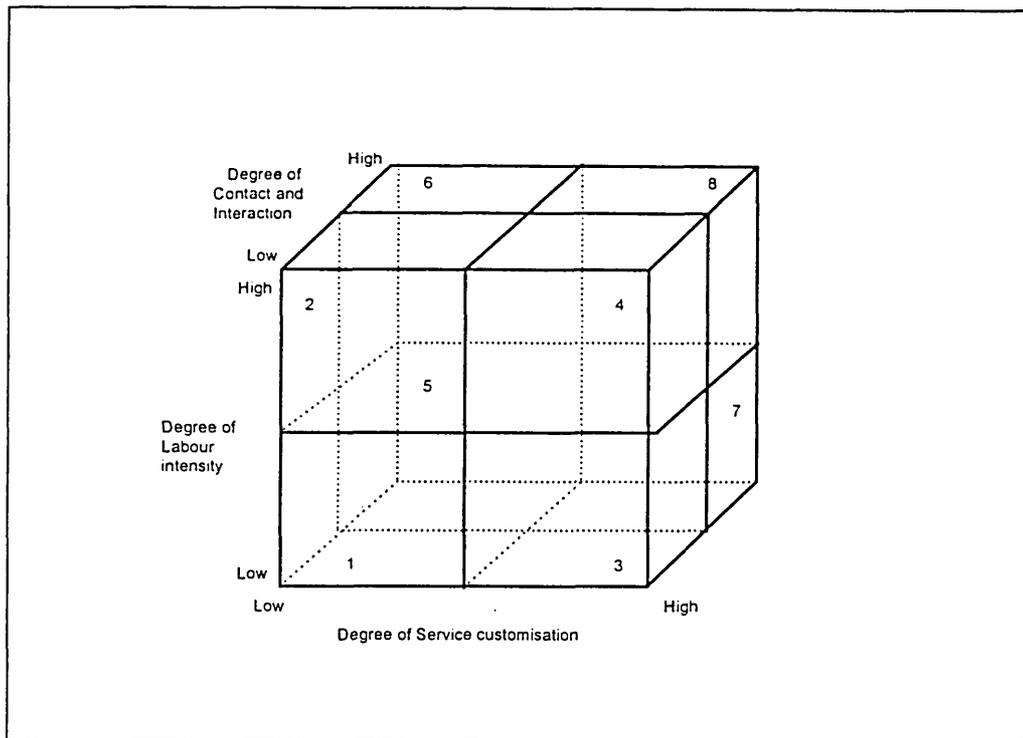
(3) The type and mix of attributes is unlikely to remain static even within the same service

(4) Quality evaluations of services take place at different times, before, during and after the delivery of the service.

(5) Service performance is variable and evaluations do not take account of serious problems which could exist at times of peak demand

(6) Customers do not evaluate services on a set of attributes but rather as a series of incidents they encounter.

Blois (1974) suggested that to be fully effective, generic concepts, theories and approaches needed to be tailored to fit individual circumstances. Service classification schemes, such as that of Haywood-Falmer (1988), have tended to differentiate services along the lines of service delivery rather than service output.

FIGURE 5.3 A THREE-DIMENSIONAL CLASSIFICATION SCHEME

Source: Haywood-Falmer (1988)

Examples of services in each octant are :

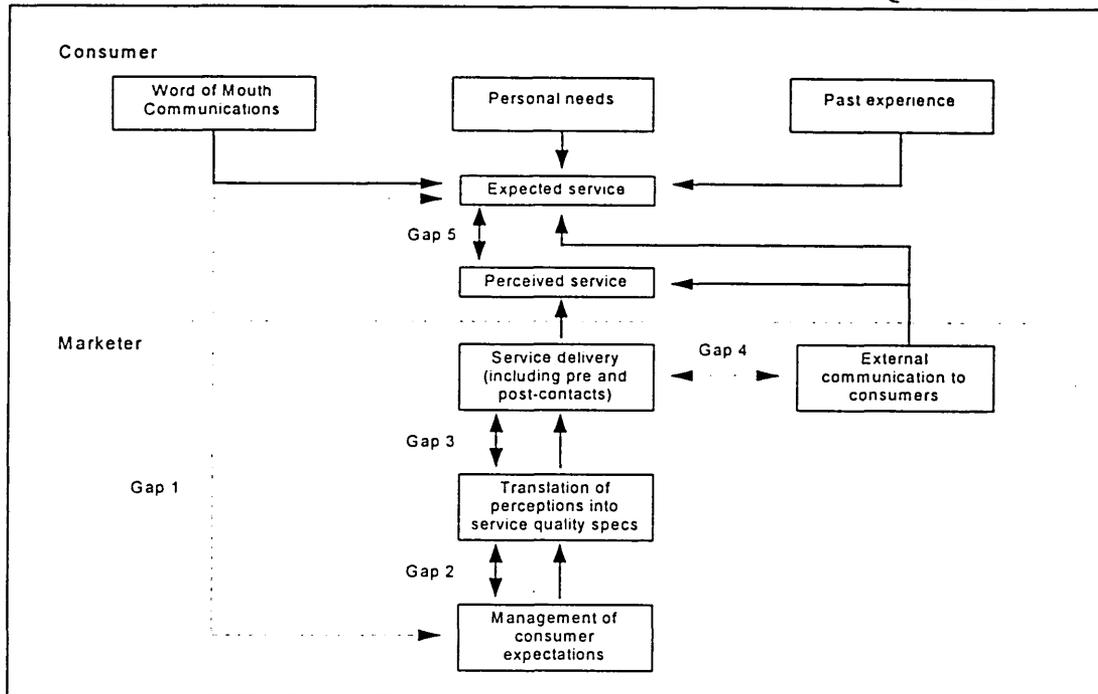
- (1) Utilities, transport of goods
- (2) Lecture teaching, postal service
- (3) Stockbrokers, courier services
- (4) Repair services, wholesaling, retailing
- (5) Public transport
- (6) Fast food, live entertainment
- (7) Charter services, hospitals
- (8) Design services, advisory services, health service

SERVICE QUALITY AND GAP ANALYSIS

Within the literature, numerous authors contended that the evaluation of service quality consisted of a comparison of expectations with performance. (see, for example, Lewis and Booms 1983; Smith and Houston 1982) Extensive research by Parasuraman et al (1985) refined this idea and established a definitive strategic service quality management model. Their general thesis was that

A set of key discrepancies or gaps exists regarding executive perceptions of service quality and the tasks associated with service delivery to consumers. These gaps can be major hurdles in attempting to deliver a service consumers would perceive as being of high quality

FIGURE 5.4 A CONCEPTUAL MODEL OF SERVICE QUALITY



Source : Parasuraman et al (1985)

Perceptions of service quality on the part of the consumer is dependent on the size and direction of GAP 5, which is, in turn, a function of the other identified gaps.

$$GAP 5 = f (GAP 1, GAP 2, GAP 3, GAP 4)$$

The precise nature of this function, however, has not been determined. For example, it has yet to be established whether, or not, one gap is more significant than another, or if the relationship varies from one service to another. Word of mouth, personal needs, and past experience all have an impact on a person's expectations of a service; but it is a fine strategic balance to avoid either over promising or over engineering a service (Morgan and Piercy 1992).

CONCLUSION

Despite the arguments from Deming (1986) and Levitt (1972) that products and services share many similarities, the unique nature of services, in terms of intangibility, heterogeneity, inseparability and perishability, has warranted separate consideration. It has been argued that these features present a challenge to the service quality manager.

Writers have tended to broach the subject from two angles. Some believed that it was possible to adopt a generic approach, and to treated all services as though they shared similar characteristics,

for example, Gronroos (1984a) and Parasuraman et al (1985). Whilst others, for example Haywood-Falmer (1988) have highlighted the fact that different services possess different features and require different management approaches. Even within a service, differentiation has been made between the delivery process and the outcome and, for Gronroos (1984a), this has provided two basis on which people might assess the quality of the service they have received.

The gap analysis model, devised by Parasuraman et al (1985), however, has become one of the most well known conceptualisations of service quality. It has been widely adopted and its potential has been acknowledged by public sector services. (see, for example, Donnelly et al 1995) The issue of quality within the public sector, however, has nevertheless been the subject of an intense debate .

CHAPTER 6 QUALITY IN THE PUBLIC SECTOR

INTRODUCTION

Both Gronroos (1984b) and Garvin (1987) have highlighted the impact of corporate image on customer perceptions, acting as a modifying device between actual outcome and perceived outcome. In effect, the image of the provider organisation can affect the way in which the service is perceived. Public sector organisations are popularly seen as deliverers of poor quality services which create and perpetuate low expectations (Gaster 1995).

As a response to the need to improve performance and reduce costs, prompted by the introduction of government initiatives such as Compulsory Competitive Tendering (CCT), public sector organisations have increasingly been seen to implement some form of quality management. However, attempts to introduce private sector principles and practices have not been without their difficulties. Whilst quality is about meeting and satisfying customer needs, the concept of customers and the notion of consumer choice are not ones which sit easily with the language of the public sector.

CUSTOMERS AND CONSUMERISM: AN ACCEPTABLE CONCEPT ?

A number of writers have highlighted important differences between public and private sector services by considering the customers which each is seeking to satisfy. It has been argued that these differences would fundamentally alter the strategic approach which public sector services adopted (Morris 1988; Johnston 1989; Chapman and Cowdell 1993).

Central to this argument lay the concept of “multiple markets”. It was argued that organisations operating in the public sector faced at least four markets, each of which had an influence on the service provider.

The primary market consisted of the actual users or direct beneficiaries of the service.

The secondary market consisted of those who are in a position to influence the choice of the transaction.

The legitimiser market consisted of those individuals and bodies which existed to ensure that the service was provided in the approved manner, subject to the approved quality standards etc.

The resourcer market included those who were responsible for allocating the resources which were necessary to provide the service which was needed.

Johnston (1989) considered the issue in terms of people's involvement with the operation and defined three types of involvement. There were customers who paid for the service, customers who benefited from the service; and customers who participated in the service. In the private sector this might be, and probably was, one and the same person. In the public sector, the payer, participant and beneficiaries were all likely to be separate individuals or sections of society.

Applying "consumerism" to the public sector continues to be a contentious issue. It might be argued that the free market works as a result of competition between firms responding to the choice exercised by consumers. However, as Stewart and Clarke (1989) argued:

The customer of a public service is not the same as a customer of a service in the market. The customer does not necessarily buy the service; the customer may have a right to receive the service; the customer may be compelled to receive the service; customers may be refused a service because their needs may not meet the criteria laid down.

Furthermore, a conflict of interest was likely to exist between the role of customers as consumers and customers as citizens (see also Gladstone et al 1992). A number of writers have shown concern about the use of consumer, customer, and citizen as synonymous terms because by doing so the distinctive meanings of each is lost, which are used interchangeably within the Citizen's Charter.

Despite the assertion of Connelly (1992) that consumerism has now become an inescapable part of current thinking about the public services, numerous writers have questioned the applicability of consumerism to public services. Government policy, over the last fifteen years, has fuelled the debate concerning whether or not market based reforms are necessary for improving the management of public sector organisations and, consequently, improving the quality of services delivered. These arguments have ranged from ideological criticisms to those concerned with the practicalities of implementing the reforms.

Chandler (1993) warned of the mistaken belief that the terms "consumer", "customer", and "citizen" are interchangeable terms, considering it to be the start of a dangerous process of eroding democracy. The notion of "citizenship" implied a far wider role, conferring on a person a set of rights from and duties to the state, than that of customer or consumer. Elcock (1993) raised similar concern about the move towards consumerism in the public sector and casts doubts as to whether the stated objectives of the reform process can actually be achieved. Others, such as Griffiths (1988), have been more upbeat about the subject, suggesting that there is an ongoing

debate concerning the degree to which the public sector can benefit from the fruits of consumerism.

Connelly (1992) considered the adoption of a consumerist philosophy as a welcome improvement to public service because it focused attention on the needs of the recipient of the service rather than on those of the producer. However, he tempered his argument by stressing the need to distinguish between strong and weak senses of consumerism. The weak sense of consumerism was considered to be a simple, general orientation by public services toward the consumer which would ensure a high level of service provision. The strong sense of consumerism, on the other hand, was one which clearly developed from the world of commerce and was based on the idea that companies provided goods and services and competed for the business of customers whose demands had to be met if they were not to go elsewhere.

Connelly proposed that in either sense, consumerism was a means of improving the quality of service, however, its two forms achieved this end in different ways. Whilst he believed that all public sector services should be open to the weak sense of consumerism, considering it to be almost a moral imperative, the application of the strong sense of consumerism to the public sector should be resisted because it implied an economic doctrine driven by self interest whose conditions were frequently not met in the public sector. As Stewart and Clarke (1987) noted:

The customer of a public sector is not the same as a customer of a service in the market. The customer does not necessarily buy the service; the customer may have the right to receive the service; the customer may be compelled to receive the service; customers may be refused a service because their needs may not meet the criteria laid down.

Under such circumstances, a person's choice would clearly be restricted and, as a result, so too would the operation of a true market. Similarly, Potter (1988) suggested that because consumer theory is associated with squaring the imbalance of power between providers and recipients of goods and services within the market place, there would be difficulty in conceiving a similar shift of power within the public sector. This was as much a question of willingness, on the part of providers to accept a new relationship between themselves and recipients of services, as it was of understanding the nature of the new relationship. However, it did place consumer preferences on the agenda even if ways other than supply and demand had to be found to ensure that decision makers were made aware of these demands.

The implicit guide to the relationship forged by consumerism has been offered in the form of five basic principles, namely; access, choice, information, redress and representation. (Potter 1988; Hambleton 1991).

Access is concerned with decisions about who is eligible to receive the service. There are two issues. The first, is the need to establish clear criteria upon which to base decisions concerning how the service should be rationed. The second is more the notion of accessibility, in the sense that public services are, by and large, bureaucratic organisations the operations of which are more often geared towards their own convenience rather than that of the user (for a discussion on the dysfunction's of bureaucracies see, for example, Merton 1968).

Choice. The exercise of choice is a mechanism by which people can signal their preferences. Where choice exists in the market, consumers can influence the behaviour of providers by selecting those goods and services which meet their requirements. The provision of public services, however, involves redistributing cost and benefits within society and, therefore, individual consumer choice cannot be the sole basis upon which to make such decisions. As a result, the element of choice has frequently been limited within the public sector. The consumerist approach argues that where consumers cannot directly choose between service providers, then other mechanisms must be found to take into account people's preferences because the power of choice compels services to become sensitive to the needs of its users. Performance measures are one way of taking users' views into account if their interests are brought into the evaluative process.

Information. People need to receive information about services if they are to make effective choices. (see, for example, Walsh 1991)

Redress satisfies two requirements. One is the means by which people's grievances can be settled equitably. The other is to act as a feedback mechanism which can highlight problems in the operation of the service.

Representation literally means consumers' views should be represented to decision-makers at all points in the system where decisions are made concerning their interests.

These principles may be contrasted with the more explicit requirements of the Citizens Charter, which was launched by the government in 1991. This specified four aims of quality, choice, standards, and value, defined as follows:

- Quality - A sustained new programme for improving the quality of public services
- Choice - Choice wherever possible between competing providers is the best spur to quality improvement

- Standards - The citizen must be told what service standards are and be able to act where the service is unacceptable.
- Value - The citizen is also a tax-payer; public services must give value for money within a tax bill the nation can afford.

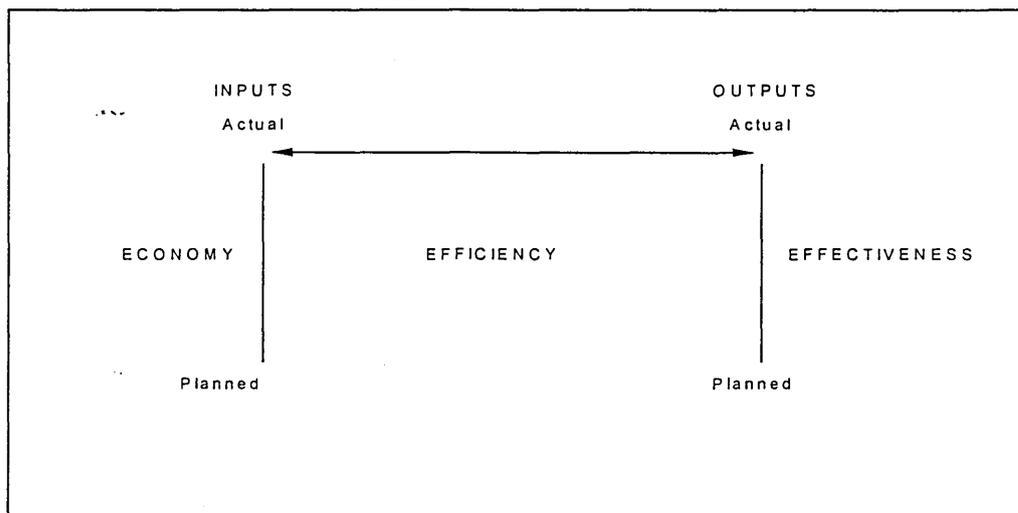
Whilst there appears to be a degree of commonality between the two sets of principles, both acknowledge the need to provide choice, information and mechanisms for redress, there are clearly differences as well. The most obvious being that whilst the principles of consumer theory present the consumer with active involvement, the Citizen's Charter provides the user with a more passive role in the service delivery process.. Rather than redress the balance between the provider and user (Potter 1988), the principles of the Citizen's Charter continue to favour the provider in this power struggle.

THE CONCEPT OF VALUE FOR MONEY

The concept of value-for-money is probably the oldest measurement of quality. This was implicit within Deming's (1986) definition of quality "a predictable degree of uniformity and dependability, at low cost and suited to the market". The product or service not only had to be made at a minimum cost to the producer, but it also had to match people's requirements including their purchasing power.

For providers of services, the concept of value-for-money is frequently conceptualised in terms of Economy, Efficiency and Effectiveness (3Es).

FIGURE 6.1 DISTINCTIONS BETWEEN ECONOMY, EFFICIENCY AND EFFECTIVENESS



Source: Metcalfe and Richards (1990)

Metcalf and Richards (1990) highlighted the limitations of the concept. Firstly, there was an overall tendency for a trade-off to exist between the three Es, for example, the most effective services were often not be the most economic. Secondly, it was likely that the overall service would comprise of a number of subsidiary services and that the respective three Es in each of these services might not complement each other. Thirdly, it was suggested that a fourth E of Equity was needed in order to provide a measure of the impact of the overall impact of the service on society as a whole (see Selim and Woodward 1992).

Hinton (1993) found, from preliminary research into quality management practices in public sector organisations in North West England and North Wales, that the value-for-money philosophy may be being eclipsed by purer approaches to quality in the form of TQM. He proposed that the reasoning behind this was twofold. Firstly, unlike value-for-money, TQM was consumer rather than producer led and secondly, TQM provided a motivational boost for staff who would find they were able to relate to the concept and this provided the possibility of culture change to transform an organisation into a dynamic, responsive unit.

PROVIDER-LED PUBLIC SERVICES

A number of reasons have been proposed why public services tend to be provider led. For example, Pollit (1990) argued that public services are dominated by professionals who believed that they, rather than users, are in the best position to assess quality levels because users frequently do not possess the skills with which to judge the technical aspects of the service. Where quality initiatives have been introduced they have tended to take the form of customer care programmes which emphasised the relationship, or functional aspect of a service (Pollit 1990). Customer involvement in these circumstances, however, remained minimal, reduced to being notified that a complaints procedure existed should the standard of service fall below that determined by the provider (Pollit 1990).

Attempts to improve the quality of their services have not always caused public sector organisations to demonstrate a commitment to quality. As Joss et al (1993) reported, many NHS reforms, such as the establishment of Trust hospitals and the process of health service contracting between purchasers (District Health Authorities and GP Fund Holders) and providers (hospital units), have diverted attention away from quality to the extent that some within the NHS considered quality to have been superseded.

WHAT KIND OF SERVICES ?

In her discussion of the power imbalance which exists between users and providers of public services, Potter (1988) suggested that whilst consumer theory had much to offer public sector organisations as a conceptual framework, it did not stipulate what sort of services were required. Several writers, however, have turned their attention to this matter, Ovretveit (1990) identified three aspects to delivering quality in health care services:

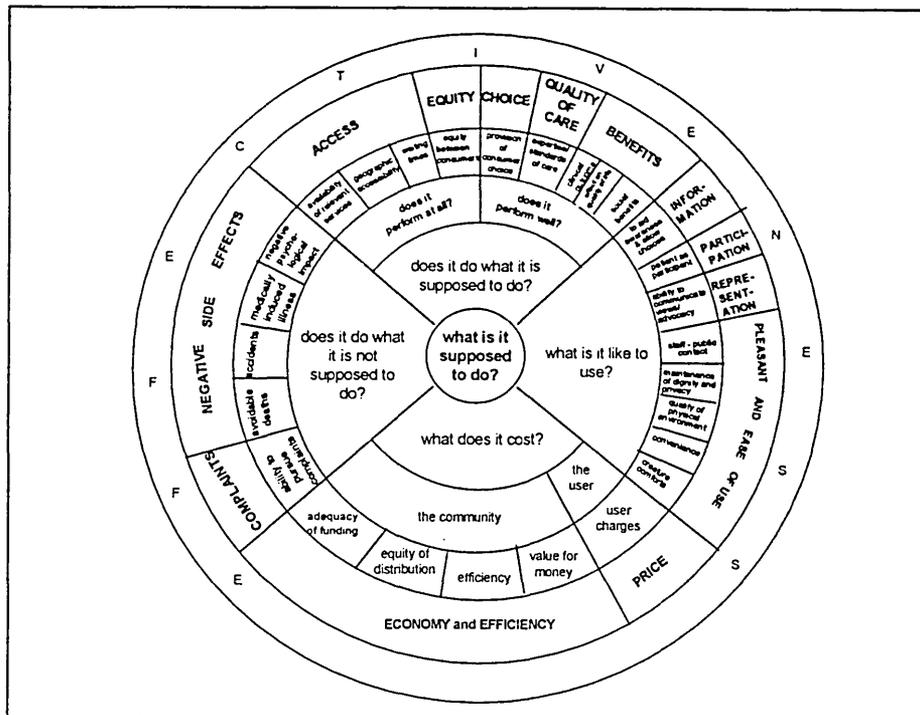
- (a) Customer Satisfaction
- (b) Professional Assessment
- (c) Process Quality,

Customer Satisfaction

The use of checklists has become an important mechanism by which consumer preferences may be articulated within a commercial setting. The SERVQUAL technique devised by Parasuramen et al (1988) is one example of such, a checklist. However, the researchers acknowledged that the technique required modifying to make it more relevant to other service settings.

Within the public sector stress is placed on the wider social aspects of the service, thus, Maxwell (1984) discussed the application of quality to health care in terms of accessibility, appropriateness, relevance to need, social acceptability, equity, efficiency and effectiveness. The model provided by Healey and Potter (1987) suggested that checklists take account of the multiple interest groups which exist for public services.

FIGURE 6.2 EVALUATING HEALTH SERVICES: THE CONSUMER CRITERIA



Source: Healey and Potter (1987)

The use of checklists however is not without its critics. Following research into service quality in public and private enterprises in the UK, Ovretveit (1992) identified six factors which illustrated the fact that customers perceive quality on a range of different basis. These included:

- Service quality was not just customer's perceptions. Professional definitions of quality might need to be recognised as did legal requirements, such as health and safety regulations.
- Thresholds. Most customers became aware of an aspect of a service only if some aspect of it was particularly good or bad.
- Valued attributes were an ordered hierarchy, and change with competition. Once a service performed well on one set of factors another set became more important. The presence of the first order set was taken as given. In competitive markets, one time luxury features would come to be expected and a pre-requisite for market entry.
- Service was a process and, therefore, perceptions held before, during and after service delivery carried different levels of importance depending on the service. In some services, for example, personal services, the final expectation might be less important than perceptions during delivery.
- Customers took part in service production and their perceptions related to their interactive experience. Service deliverers could elicit expectations and modify unrealistic ones.

Practice within public sector organisations, however, has indicated that the full range of perceptual bases upon which service quality is judged is not taken into account. For example, Kogan, Henkel, Joss and Spink (1991) found that most customer satisfaction surveys in the NHS were carried out on a post-hoc basis.

Professional Assessment

Just as a non-mechanic may rely on a professional mechanic in order to deliver the necessary quality of work when his or her car is serviced, so Walsh (1991) highlighted the particular difficulties of users and providers assessing service quality in a health care setting. Patients might not understand a great deal about the course of treatment they are receiving, nor the outcome which can be expected, but when radically new treatments are being used; neither might fully understand. A professional input is needed to evaluate the quality of the overall service outcome, and in an interactive environment such as health care, to modify expectations if necessary. (see Ovretveit 1992)

Process Quality

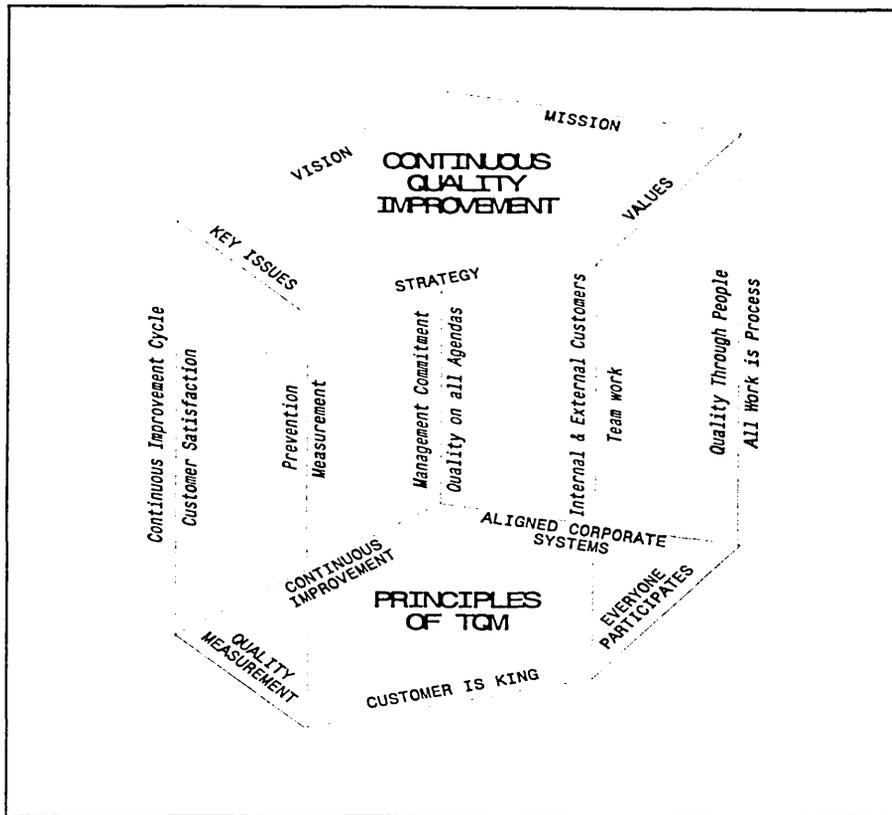
Ovretveit (1992) argued that customers do not evaluate services solely according to the service outcome but as a series of incidents which together form the service. The overall success of the service will, therefore, depend on the design and operation of a service which uses resources in the most effective way to satisfy customer requirements.

TQM IN THE PUBLIC SECTOR

The apparent difficulties in reconciling the principles of TQM with the operating environment of the public sector has not prevented attempts to make the concept accessible and applicable. Generally, these fall into two broad categories; generic models and specific models.

Generic models focus on the universal suitability of TQM by drawing together all its various strands. For example, Haigh and Morris (1995) have offered a model which emphasises the need to link the macro, underlying tenets of TQM with the micro, operational components.

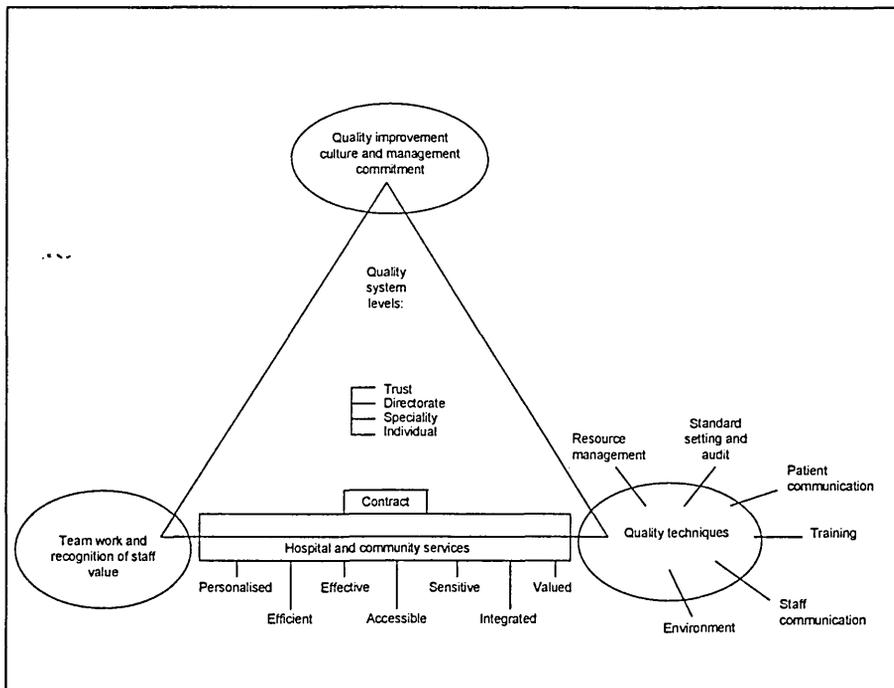
FIGURE 6.3 A GENERIC MODEL OF TQM



Source: Haigh and Morris (1995)

On the other hand, Koch (1992) has devised a specific model of TQM for health care:

FIGURE 6.4 A TQM MODEL FOR HEALTH CARE



Source: Koch (1992)

CONCLUSION

The public sector is faced with a set of complexities concerning the issue of quality which have been the source of heated debate. Public sector organisations have been characterised as bureaucratic, unresponsive and dominated by professionals who resent the challenge to their right to define quality (Pollit 1990; Walsh 1991). On the other hand, it has been suggested that the adoption of private sector management techniques has created a move towards a “new public management” (Hood 1991).

The implications of this move has received much attention, particularly with regard to the language of quality. The definition of quality is not limited to the meeting of customer needs but incorporates social values such as equity with a focus on improving access, choice, information, redress and representation. Yet, despite its unique nature, the pressure to deliver quality services has created an interest in the implementation of TQM within the public sector, none more so than in the NHS.

CHAPTER 7 THE NATIONAL HEALTH SERVICE

The search for an organisational solution to the NHS's problems can best be understood as policy making under constraints, where the ideal was often seen as the enemy of the feasible: the politics of second best. (Klein 1989)

THE CREATION OF THE NATIONAL HEALTH SERVICE

In order to provide the context for the research, it is important to be aware of the history of the National Health Service (NHS), to understand its initial objectives and how these were translated into health policy, and to consider the concerns of the various interest groups.

Prior to the creation of the NHS, health care in Britain was provided through a varying mix of state insurance, private insurance and, at the last resort, free care which gave everyone access to at least some form of medical treatment at the expense of widely differing quality (Klein 1989). Whilst it was generally agreed that changes to the existing system were needed, particularly regarding the co-ordination and funding of services, there was much discussion and debate concerning their shape and form.. For example, the Dawson Committee, set up in 1919, recommended providing a comprehensive system of hospital and primary care. The Royal Commission on National Health Insurance reporting in 1926, the 1937 Sankey Commission on voluntary hospitals and the British Medical Association reports of 1930 and 1938, each put forward their own proposals (Ham 1993).

The Beveridge Report on Social Insurance and Allied Services of 1942 offered perhaps the most influential set of proposals. Amongst its recommendations for reforming the social security system were calls for a national health service. This, along with the Labour victory in the General Election of 1945, led to the National Health Service Act of 1946 and the establishment of the service on 5th July 1948.

Whilst Klein (1989) described this event as “The transformation of an inadequate, partial and muddled patchwork of health care provision into a neat administrative structure.” Ham (1993) suggested that this administrative structure was more a reflection of the possible rather than the desirable, representing the outcome of protracted negotiations between the different interested parties and saddled with the legacy of its predecessors’ history. In particular, he highlighted the

power of the medical profession in winning important concessions in the lead up to the establishment of the service. These concessions included the retention of the independent contractor system for GPs; the option of private practice and access to pay beds in the NHS for hospital consultants; large salary increases for those consultants receiving distinctions under a new system of awards; a major role in the administration of the Service at all levels; and success in resisting local government control. It became clear that subsequent changes to the operation of the NHS would also need to be endorsed by the medical profession if these were to be successful.

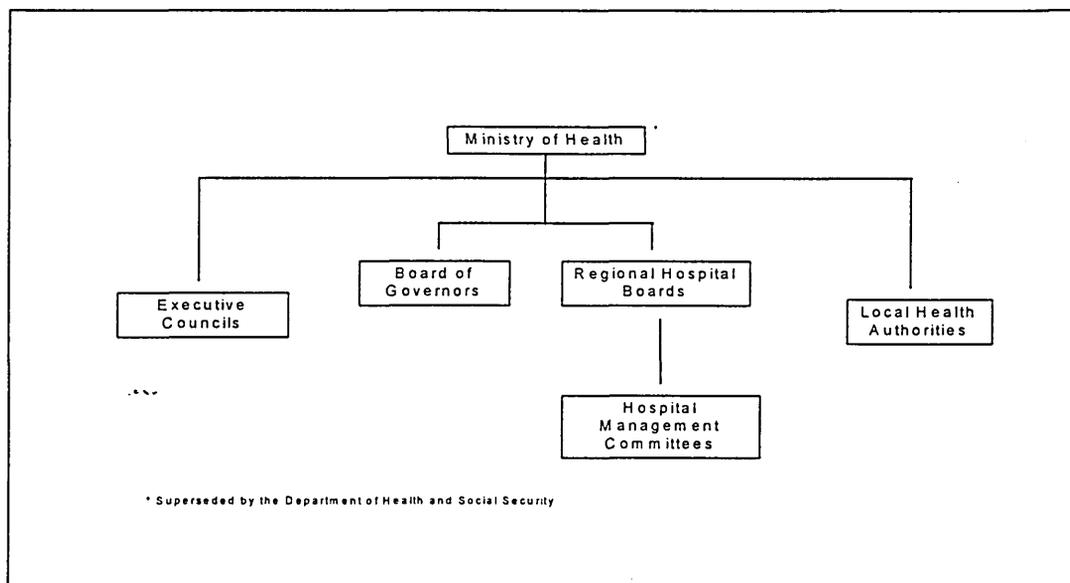
The Structural Arrangements

Much of the debate dominating the establishment of the NHS was concerned with its structure.

{The general organisation and supervision of services} comprises the main activities and responsibilities of the Regional Boards. It is under this head that the boards will operate as the bodies responsible to the Minister for what may be termed the strategy of the services of their area, for reviewing and assessing the resources of the service, planning the best use of them and determining the contribution to be made by each hospital or group, working out developments of the service and giving general oversight to the operations of the Hospital Management Committees" (Ministry of Health Circular RHB (48) 2)

The original structure of the NHS is depicted as follows:

FIGURE 7.1 THE STRUCTURE OF THE NHS, 1948-74



Source: Ham (1993)

The Ministry of Health was responsible for the Service's central administration and for the provision nationally of all hospital and specialist services. First fourteen and then fifteen Regional Hospital Boards (RHBs) were established to administer the management of hospitals along with some four hundred Health Management Committees (HCBs). The elite teaching

hospitals were administered by Boards of Governors who were directly responsible to the Ministry of Health.

Executive Councils were responsible for administering the service provided by general practitioners, dentists, opticians and pharmacists. These councils were appointed jointly by local professionals, local authorities and the Ministry of Health. However, they could not be regarded as management bodies; their role being simply to administer the contracts for the service providers listed above, maintain lists of local practitioners, and to handle patient complaints.

Local Health Authorities were the county and borough councils and were chiefly responsible for administering environmental and personal health services. These included maternity and child welfare clinics, health visitors, health education, vaccination and immunisation, and ambulances. However, this represented a marked reduction in the range of services provided by local authorities who had previously been responsible for the management of hospitals.

Within the general consensus of the need for a national health service, Klein (1989) identified two distinctive strands. The first was a rational, paternalistic stance whose concern lay with overcoming the general muddle, inefficiency and incompetence of the existing health care system rather than one of overcoming social injustices. The second was an institutional approach which considered health care to be a public good rather than an individual right.

Although it is tempting to consider the birth of the NHS as triumph for socialist values, it was as much an outcome of the attempts to provide a practical solution to a recognised problem and, thus, in Eckstein's (1958) opinion the creation of the NHS represented a victory for a "radically managerial ideology".

The debate over structure appeared to have been chiefly focused on the administrative machinery employed rather than policy issues taken for granted. However, in so doing, and coupled with the adoption of a management solution, a number of concerns were not addressed at the time which have remained unresolved throughout the service's existence. Dilemmas which have been neatly chronicled by Klein (1989) as:

- (1) How to reconcile government acceptance of the principle of national responsibility for the health care system with the desire to avoid a centralised service actually operated by the NHS.
- (2) What, therefore, should the exact balance be between central and local government, between bureaucratic control from the centre and freedom at the periphery?

(3) Public accountability and professional participation in decision making. Medical professionals sought representation on policy making.

(4) How to integrate hospital and general practitioner services.

HEALTH POLICY AND PRIORITIES, 1948 - 1979

The NHS was founded upon the principal assumption that a backlog or "fixed quantity of illness" existed in the population which the introduction of a health service, free at the point of use, would gradually reduce. The argument followed that as the health of the population improved so the cost of the service would fall. Unfortunately, the premise was based on a false assumption. Predicting demand for health care proved to be impossible and even in the areas of dentistry and ophthalmology, the numbers requesting replacement dentures and spectacles were grossly underestimated as people rushed to take advantage of the free service. Furthermore, the concept of quality of care appeared to be compromised. Professional perfectionism was not compatible with the public financing of the NHS and not for the first time the issue of rationing resources was raised.

Funding the NHS

Concerns over the rising cost of the service led to the appointment of the Guillebaud Committee of Enquiry (1953):

to review the present and prospective cost of the National Health Service; to suggest means, whether by modifications in organisation or otherwise, of ensuring the most effective control and efficient use of Exchequer funds as may be made available; to advise how, in view of the burdens on the Exchequer, a rising charge can be avoided while providing for the maintenance of an adequate Service; and to make recommendations.

The report concluded, however, that there was little evidence of inefficiency or extravagance in the NHS. Indeed the Committee demonstrated that in real terms, the cost of the service had actually fallen from 3.75% of Gross National Product in 1949-50 to 3.25% in 1953-54. It further suggested that more money, not less, should be spent on the service.

If the 1950s could be described as a period of consolidation, then the years 1960-75 were about "technocratic change". Efficiency emerged as an ideology with policy aimed at squeezing as much health care as possible out of a limited input of resources (Klein 1989). The emphasis was on achieving greater efficiency through the application of rational planning where techniques such as cost-benefit analysis, PPB (Planning, Programming, Budgeting) and PAR (Programme, Analysis and Review) flourished.

The move reflected a general trend across the whole of the public sector at that time. In its review of the Civil Service, the Fulton Committee's (1968) concern lay with devising ways of producing a more professional corps; one which was more managerial, more numerate and more specialised than the traditional generalist. Likewise, a year later the Radcliffe-Maud Royal Commission (1969) into Local Government was preoccupied with the problem of devising authorities large enough to employ a wide variety of qualified staff.

This period in the history of the NHS was also notable for the emergence of three key problems. The first concerned the lack of integration between the various parts of the service. The Guillebaud Committee (1956) highlighted the gulf which existed, for example, between GPs and hospital consultants. There was also growing disconcertion with the poor quality of care provided to particular patient groups, especially mental patients and the elderly (see, for example, Robb 1967; Ely Report 1969). These, in turn, highlighted a third problem; the administrative control of the NHS.

In the early 1960s, the Porritt Committee, which consisted of leading members of the medical profession, published a report suggesting that health services should be unified and placed under the control of area bodies (Porritt Committee 1962). The fundamental weakness of the original structure of the NHS was seen as an administrative separation of hospital, GP and Local Authority health services. However, given that the structure of the NHS represented political expediency rather than administrative logic, it made it difficult to present an alternative.

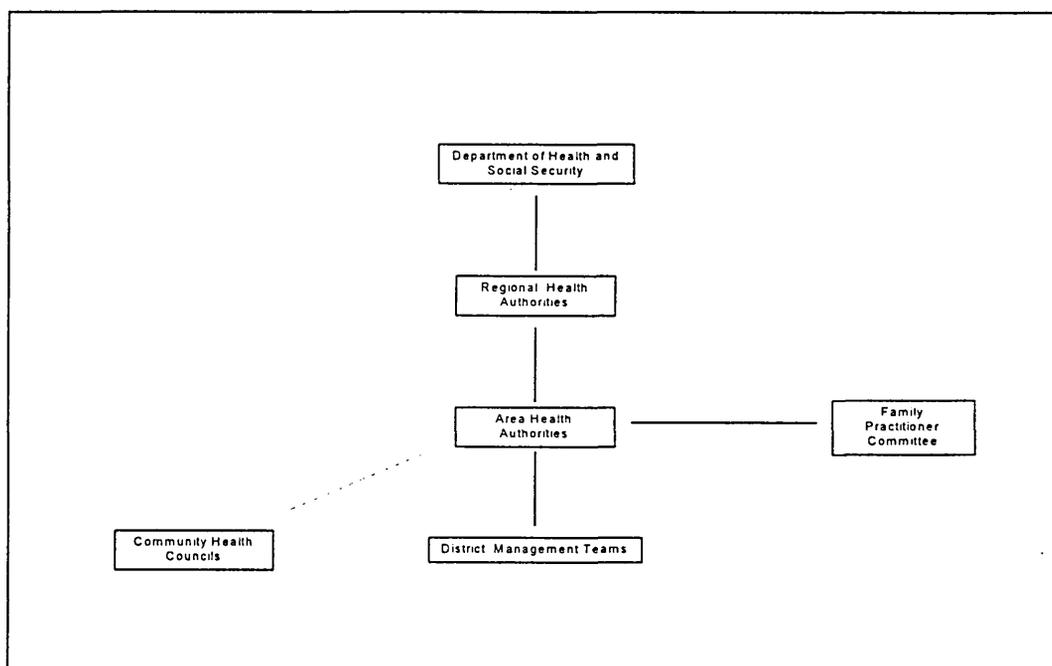
Allsop (1984) argued that the problems of integration would have been avoided if the responsibility for the Service had been placed under local authority control yet, although both Labour and Conservative parties agreed in principle that this would be the ideal solution, neither would entertain the proposal as a possible policy option. (Klein 1989) This was partly the result of a demonstration of power by the medical profession with its long standing hostility towards local government control, and partly a question of mechanics, as it would have required fundamental changes to both the organisation of local government and its ability to raise finance.

Towards Restructuring

In 1968, the Labour Government published a Green Paper inviting comments on the proposal to make the administration of the NHS in England and Wales the responsibility of forty to fifty area health boards. A second Green Paper published by the same government in 1970, increased this number to ninety and which would constitute the main unit of local administration. It was also proposed to have regional health councils which would be responsible for planning activities and 200 district committees as a forum for local participation.

Even with a change of government, there was a high degree of continuity in proposals for the restructuring of the NHS. Within the final proposals laid down in the National Health Services Act 1973 and which came into force on 1 April 1974, Regional Health Authorities took on the role of "executive agencies". Larger Area Health Authorities were divided into districts, each run by a team of officers managing on a consensus basis. In addition, professional advisory committees were to exist at each level to provide expert opinion.

FIGURE 7.2 THE STRUCTURE OF THE NHS, 1974-82



Source : Ham (1993)

The 1974 reorganisation was intended to achieve a number of objectives. Firstly, it attempted to unify the NHS by bringing together all those services previously administered by Regional Hospital Boards, Hospital Management Committees, Boards of Governors, Executive Councils and Local Health Authorities. Secondly, it attempted to improve co-ordination between health authorities and local government services with the new Area Health Authorities sharing broadly the same boundaries as those of the local authorities providing the service. Thirdly, the reorganisation was intended to promote better management of the service with clear lines of accountability upwards to the Department, and responsibilities and task structures downwards to the health authorities. These functions and duties were embodied in the Management Arrangements for the Reorganised National Health Service in England (Department of Health and Social Security 1972); the so called "Grey Book".

The Impact of the New Structure

The new structure did not prove to be as successful as was envisaged and attracted a great deal of criticism. Richard Crossman, the Minister for Health in the previous Labour administration and responsible for the 1970 Green Paper on restructuring, described it as "overly managerialist and excessively bureaucratic" (Crossman 1973). The reorganisation had failed to address the lack of integration between hospital and primary care services. Indeed there was a widespread feeling that the increase in administrative tiers was making it difficult to establish good working relations throughout the service. (Ham 1993). In addition, the restructuring carried a high cost both financially and in terms of low staff morale (Brown 1979).

Several factors were found to have led to this situation. To begin with, the process of implementing the new structure was a lengthy one, taking over two years to complete and many staff found it difficult to adapt to the changes. This was in direct contrast, however, to the preparatory stages where arrangements were rushed through in order to meet the 1 April 1974 deadline, a situation which precluded proper discussions about the impending changes from taking place. Levitt and Wall (1992), for example, noted that although the "Grey Book" contained a number of proposals which could have been altered through consultation, they were considered to be set in stone in the minds of many people.

There was also dissatisfaction amongst the medical professions. In setting up the NHS in 1948, Aneurin Bevan remarked that as far as he was concerned, he had "stuffed their mouths with gold" in order for them to accept his proposals (Abel-Smith 1964). This time there were no such concessions leading to discontent, particularly over government plans to phase out "pay beds".

The Royal Commission

Concern over the country's poor economic performance at the time, cast doubts about the ability to adequately fund the NHS in the future (Bacon and Eltis 1978). This, coupled with an outbreak of industrial action taken by various groups of health service workers, prompted the government to set up a Royal Commission in 1976. Its remit was "to consider in the interests of patients and those who work in the National Health Service, the best use and management of the financial and manpower resources of the National Health Service".

The Commission took three years to complete its review reporting its findings in July 1979. The report stated that "we were appointed at a time when there appeared to be widespread concern about the NHS", but concluded that "it would be difficult to argue that there is widespread inadequacy in the NHS". However, it did criticise NHS management, stating that there were too

many tiers, too many administrators of all disciplines, a failure to make swift decisions and a consequent waste of money (Royal Commission on the National Health Service 1979).

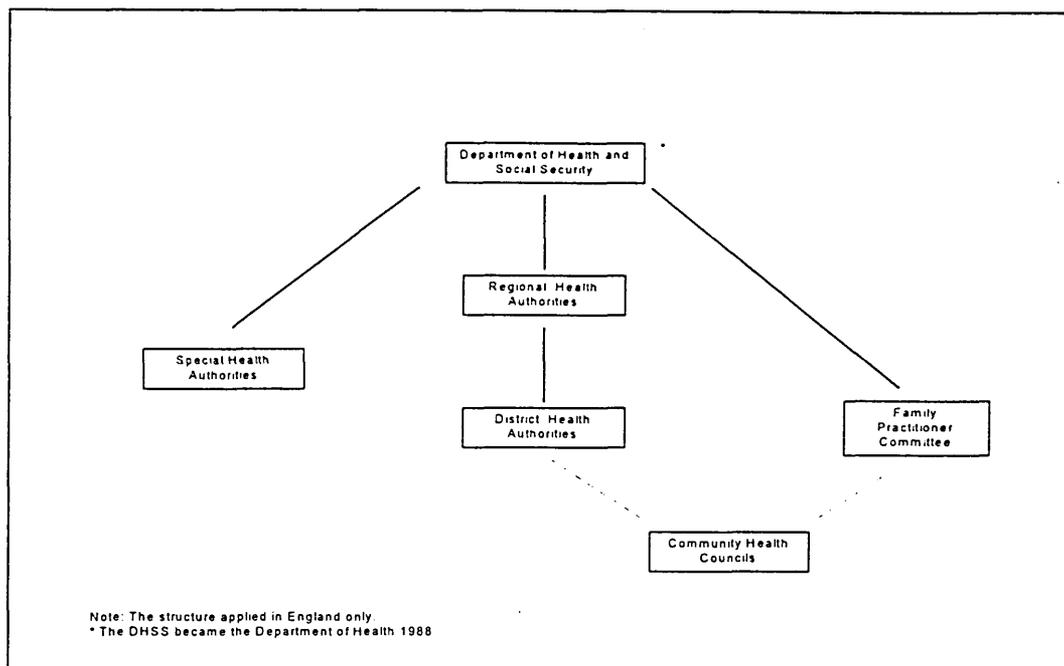
These problems could be traced back to the 1974 restructuring and its failure to realise the objectives set. In unveiling the new structure, Sir Keith Joseph, the Secretary of State for Health and Social Security, claimed it would provide "Maximum delegation downward, maximum accountability upward". However, the reorganisation did little to ease the tension which existed between the centre and the periphery. The Commission accepted that one tier of administration should be removed, but warned that structural changes could not be considered a panacea for all the administrative ills facing the NHS.

HEALTH POLICY AND PRIORITIES SINCE 1979

The Conservative Government, elected in May 1979, stated it would "make better use of what resources are available" and would "simplify and decentralise the service and cut back bureaucracy" (Conservative Party 1979). It responded to the Royal Commission's report by drafting a consultative document, Patients First, which endorsed much of its recommendations (Department of Health and Social Security 1979). The Government's final decision was published in July 1980 and announced that Area Health Authorities would be abolished and that 192 District Health Authorities would be established in England to combine the functions of existing areas and districts. With the intention that "the closer decisions are taken to the local community and to those who work directly with patients, the more likely it is that patients needs will be their prime objectives. (Department of Health and Social Security 1980).

In line with this, Community Health Councils would remain in existence but their functions would be reviewed. Significantly, Family Practitioner Committees were retained and became free floating bodies, which all but admitted defeat in the task of embracing GPs into mainstream health planning. The central problem of reconciling central funding with local autonomy, however, was left unresolved by the new model. Although, the Government's decision to fallback on restructuring the service was something of a surprise, given both the lessons of 1974 and the findings of the Royal Commission, it heralded the onset of the most radical programme of innovation since the NHS was established (Carroll and Wilson 1993).

FIGURE 7.3 THE STRUCTURE OF THE NHS, 1982-1991



Source: Ham (1993)

The Griffiths Inquiry

Shortly after the new structure came into effect on 1 April 1982, the Secretary of State for Social Security appointed a small team under the leadership of Sir Roy Griffiths, the Deputy Chairman and Managing Director of Sainsburys. The Government was concerned with the deficiencies of the system of consensus management within the health service, in particular, lengthy, poor quality decision-making and the lack of clear lines of accountability. The inquiry team was to privately advise the Secretary of State on how these weaknesses may be overcome. (Levitt and Wall 1992).

The findings of the Griffiths team were unequivocally accepted by the Government and predictably sounded the death knell for consensus management. It argued that the weaknesses of the NHS arose because the Service lacked a clearly defined management structure:

Absence of this general management support means that there is no driving force seeking and accepting direct and personal responsibility for developing management plans, securing their implementation and monitoring actual achievement. It means that the process of devolution of responsibility, including discharging responsibility to the Units is far too slow (Griffiths NHS Management Inquiry 1983).

Accordingly, Griffiths recommended that general managers be appointed at each of the Regional, District and Unit levels of the NHS. These managers would then be responsible for improving the efficiency and effectiveness of the organisation.

The Report also hinted at the need for the NHS to adopt a more strategic focus at its centre. At government level, it advocated the setting up of a Health Service Supervisory Board with a

Management Board accountable to it. The Supervisory Board would be responsible for determining policy; the overall objectives and direction of the health service; for approving the overall budget and resource allocation; for making strategic decisions; and for monitoring performance. It would be made up of the Secretary of State who would chair the board, the Minister of State (Health) the Permanent Secretary of the DHSS, the Chief Medical Officer and the Chairman of the Management Board. The Management Board would be responsible for implementing these policies; for giving leadership to management in the NHS; for controlling performance; and for achieving consistency and drive over the long term. (Levitt and Wall 1992).

Whilst the introduction of general management throughout the NHS, and the wholesale changes of operation at the DHSS, were arguably the principle outcomes from the Griffiths Inquiry, there were a number of additional recommendations worthy of note. These included the introduction of tighter systems of control, which built upon the recently introduced systems of performance indicators. The concept of management budgets was also floated, along with a recommendation that the previously "ad hoc" Treasury scheme of "efficiency savings" be adopted on a formal basis, and was renamed "cost improvement programmes". Finally, Griffiths argued that NHS managers needed to become more consumer orientated but stopped short of offering specific advice on how this might be achieved. (Pollit et al 1991).

The Impact of the Griffiths Recommendations

It is not intended to provide an in-depth critique of the Griffiths Report nor to comment extensively on its subsequent impact. (for such a discussion see, for example, Pollit et al 1991). Nevertheless, it is important to consider the widespread debate generated both within and outside the service following its publication.

To begin with, criticism was made for its lack of rigorous research. For example, Klein (1989) points to the fact that the enquiry team consisted of only four people who took just six months to complete the review. There was no formal recording of evidence, and indeed its main findings were laid down in a letter rather than a conventional report. Furthermore, the Griffiths rejection of consensus management was questioned by Ham (1993) who argued that the large number of disparate occupations within the NHS made it necessary to seek agreement with those affected by decisions and it was not possible to function independently as Griffiths had implied.

Opposition MPs were also suspicious of the informal reporting methods and the initial disinclination on the part of the Secretary of State to publish the letter. His defence was that the changes could take place within existing arrangements and would, therefore, not affect the

constitutional position of Parliament, Ministers, or the Health Authorities. Although not for the first time, speculation was fuelled that the NHS was about to be privatised.

The Secretary of State, however, positively welcomed the findings of the Griffiths Inquiry and sought to implement them immediately, with general managers appointed by the end of 1985, firstly at Regional and then at District and Unit level (Department of Health and Social Security 1984).

The impact of the Griffiths Report appears to have been mixed. Best (1987) reported that the basis on which general managers were appointed, that is, short-term contracts, individual performance review (IPR), and performance related pay (PRP), was instrumental in bringing about a more purposeful style of management. However, other research indicated more patchy success (Pollitt et al 1991). Regions experiencing better results were frequently those which had previously enjoyed sound relations under consensus management which further undermined the Griffiths critique and vindicated Hunter's (1984) argument that there was a great deal of merit in the existing consensus management system. General management had not by itself improved relations between the different elements of the NHS and tensions between managers and the medical professions remained.

More practical problems reflected the overriding concern with financial matters at the expense of other important issues, such as developing a long-term strategy and focusing on quality of care. The greater strategic focus advocated by Griffiths did not materialise. The Supervisory Board met only on rare occasions and the Management Board failed to provide either the strong central management influence needed or the force to transmit a corporate vision through the NHS. (Pollitt et al 1991)

Of more significant relevance was the failure of the Griffiths recommendations to appreciate the political setting in which the NHS operates; a recurring theme throughout the history of the NHS.

The complex political nature of the NHS led Klein (1989) to conclude that it has always been easier to introduce policy means into the NHS rather than achieve policy objectives. Pollitt et al (1991) suggested that at the root of the problem was an attempt to reduce complex political questions to structured rational solutions. Ultimately, change brought about by the Griffiths recommendations was slow and uneven.

The Prime Ministerial Review and Working for Patients

The years following the introduction of general management were notable for the increasing concern shown by the Government towards the financing of the Service. By 1987-88, cumulative

under-funding since 1981-82 had reached £1.8 billion (Kings Fund Institute 1988) and, consequently, many health authorities were forced to take drastic action, such as the temporary closure of wards and the cancelling of non-urgent admissions, to keep within spending limits.

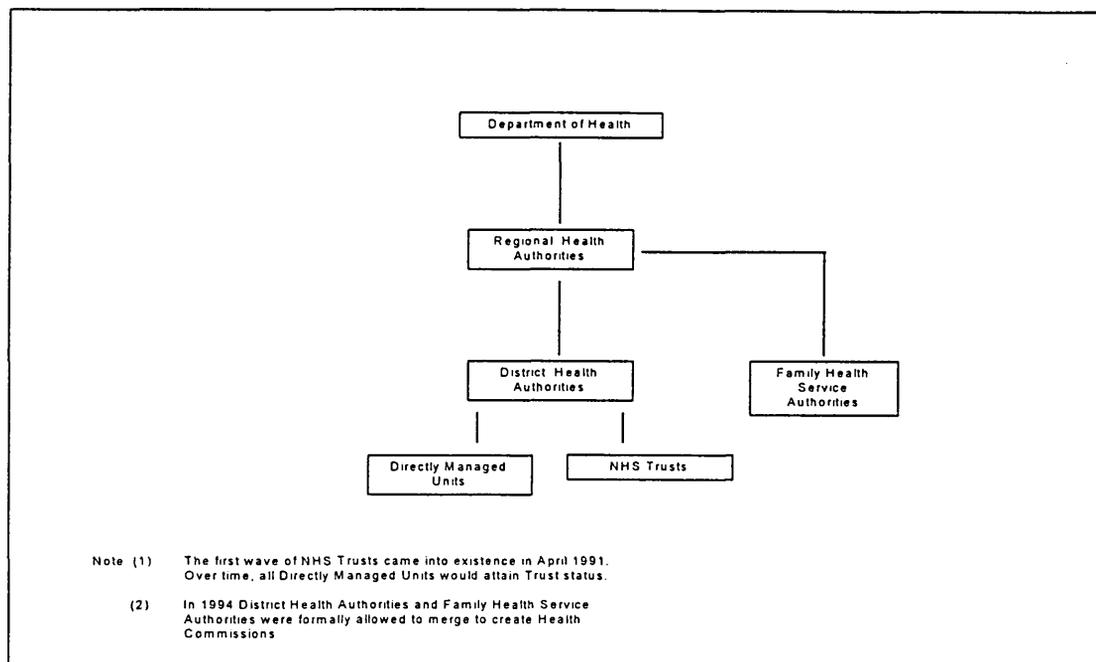
The Government's response to the so called "funding crisis" was to initiate a Prime Ministerial Review in January 1988. Initially, this concerned itself with reviewing alternative means of financing the Service despite the fact that in the early 1980s a working party, comprising representatives from the DHSS and the Treasury, had concluded that it was unfeasible to change the system. (Fowler 1991). It was no surprise, therefore, when the focus moved away from how to generate additional resources towards how to make better use of existing resources.

The Review culminated in the publication of the White Paper Working for Patients in January 1989 (Department of Health 1989). Whilst the existing principles of funding the NHS were to be preserved, the White Paper outlined wholesale changes for the delivery of health services. Essentially, responsibility for purchasing and providing health care services was to be separated creating conditions for competition between service providers. Its main proposals were:

- To allow hospitals to apply to the Secretary of State for self governing status. If granted, it would enable a hospital to set the pay and conditions of their own staff.
- To oblige the remaining hospitals to compete for patients by separating their 'provider' role from the 'purchasing' role of the health authority. Health authorities would set contracts for specific volumes of particular services and hospitals would bid for these.
- To encourage larger general practices to hold their own budgets, which would be used to purchase a defined range of services for their patients from hospitals.
- That regional, district and family practitioner management bodies will be reduced in size and reformed on business lines, with executive and non-executive directors.
- To extend arrangements of medical audit so that every district, henceforth, has a medical audit committee.
- To give the Audit Commission responsibility for undertaking 'value for money' audits of health authorities.
- To appoint more consultants and in other ways ensure patients enjoy reduced waiting times and improved appointments systems.
- To give every consultant a more detailed, locally negotiated job description than had been customary in the past. Also, to modify the criteria for consultants' distinction awards, so that henceforth "consultants must demonstrate not only their clinical skills but also a commitment to the management and development of the Service".

- To create two new bodies at the centre; a policy board to determine strategy, objectives and finances of the NHS and a Management Executive to deal with all operational matters, including monitoring within the strategy set by the monitoring board.

FIGURE 7.4 THE NHS INTERNAL MARKET



Source Ham (1993)

The Impact of Working for Patients

Butler (1993) considered the White Paper to be a natural progression from the introduction of general management. Certainly, it may be contextualised within the Government's plans to free the NHS of its "undesirable" characteristics; these being its bureaucratic structure, its domination by professionals and its reliance on central funding (Morgan and Everett 1991). If the root cause of the problem was the existence of a monopolistic bureaucracy, then the answer was to replace it with a model of the free market (Mackintosh 1992).

Nevertheless, the provisions set out to establish an internal market in the NHS attracted much criticism. Burke and Goddard (1990) argued that the costs involved in supporting this "quasi-market" would lead to overall inefficiency. They referred to the work of Williamson (1975) who argued that the "transaction costs" incurred by maintaining, negotiating, writing, monitoring and enforcing contracts increased when it was difficult to value goods and services, and where there was a lack of trust between the contracting parties.

Transaction costs could be split into "ex ante" costs associated with negotiating, drafting and safeguarding an agreement, and "ex post" costs that arise from monitoring activities carried out to

check compliance with the agreed terms and, if necessary, in resolving disputes. Under certain conditions, it was possible to conclude that transaction costs would be substantially higher in a market structure than in a bureaucratic one. Typical conditions were small numbers of contracting parties, a high degree of complexity/uncertainty, transaction specific investment, bounded rationality, and opportunism, all of which prevailed within the NHS.

Whilst the overall intentions of the White Paper were:

to give patients, wherever they live in the UK, better health care and greater choice of the services available and greater choice of the services available [and to produce] greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences (Department of Health 1989).

Hayek (1960) recognised a need for the NHS to embrace participation by the public and employees in the making and control of policy; and a number of commentators queried the extent to which this has taken place. Paton (1993), for example, cast serious doubts on whether either true devolution had taken place and whether the "significant centralist strand" underpinning the White Paper fitted with the principles of a free market operation. The managerial and clinical relationship was now defined by the contracting process governed by directives issued by the NHS Management Executive. Thus, contracts had to include explicit specifications relating to cost, quantity and notably quality with the White Paper stressing that

A quality Service - which provides not only clinical excellence but also makes patients feel valued - requires a quality management and organisation. (Department of Health 1989)

Although shrewd general managers, anticipating the direction that the NHS was taking, had already embarked on implementing some form of quality system (see Ledwith and Vilroy 1988), Mackintosh (1992) argued that the arrangements for the contracting process could actually discourage the parties involved to pursue improved quality. Providers might be inclined to withhold information on the grounds that it was "commercially sensitive" (Keen 1994) reducing the scope for different providers and purchasers to learn from each other (Stewart and Walsh 1992). In addition, there would be practical difficulties associated in obtaining information on costs and the effectiveness of treatments needed to effectively drive the contracting process (Raftery and Stevens 1994).

Keen (1994) speculated whether the distance that providers, in particular, seemed keen to maintain between themselves and purchasers would increase or diminish over time. Research by Bennet and Ferlie (1996) suggested that the emerging contractual process in the NHS had diverged from the competitive, market forces model implicit within the White Paper. Instead,

contracting had taken the form of a relational process with purchasers generally seeking to facilitate more co-operation.

The Impact on Quality

The focus on quality seemed to be directed towards the so called "soft" areas of customer care. In his speech to the National Association of Health Authorities in June 1989, its chairman, Martyn Long, spelt out initial areas where attention should be focused:

- a good appointment system
- prompt treatment
- pleasant surroundings
- smiling faces
- good information
- high standard of cleanliness
- high calibre professionals
- high calibre support staff

More directive influence came in 1991 with the launch of the Patient's Charter. The initiative was part of the broader Citizen's Charter movement intended to "raise quality, increase choice, secure better value, and extend accountability." (The Citizen's Charter: Raising the Standard 1991)

The above aims were to be achieved mainly through the publication of standards and results. The Charter, however, has been heavily criticised from several quarters. The emphasis on publishing performance standards does not, by itself, provide a mechanism to increase participation. Indeed the Charter stated that people need to be informed of what standards are available and, therefore, may be expected.

THE NHS AND TQM

In 1989 the Department of Health gave approval for the implementation of TQM across 17 health authorities. The following year it made £7.5 million available to 23 TQM pilot sites. (see, for example, Joss et al 1994; Blades 1992; Brooks 1992) The NHS Directorate in Wales stated that TQM was the recommended quality approach:

TABLE 7.1 TOTAL QUALITY MANAGEMENT

- Total
 - A key element of overall policy objectives
 - With clear leadership from the top
 - Two-way communication involving all staff
 - Supported by training to involve staff and fulfil their potential
- Quality
 - Meeting needs and expectations
 - Customer centred
 - Valuing people and individuals
 - With agreed measurable standards of performance of performance for all aspects
 - Reinforced by robust and reliable processes
 - So that standards are achieved consistently
- Management
 - An integral part of working practice
 - Monitoring evaluated and reviewed regularly
 - Continuously improving

Source: NHS Directorate in Wales (1990)

TQM would not only lead to improved quality and customer satisfaction, but with estimates of the cost of poor quality accounting for 20-25% of total costs in manufacturing companies and 40% in service industries, this would represent savings of between £6-11 billion in the NHS (Blades 1992).

Beyond this initial interest, however, there has been little official concern for implementing TQM within the NHS. According to the Quality Team, who are responsible for co-ordinating quality improvement efforts across the NHS, the decision to implement TQM was a matter for individual sites (NHS Management Executive: Quality Team 02.02.94). Nevertheless, EL (93) 54 Priorities and Planning Guidelines 1994-95 stipulated that:

NHS authorities and Trusts should demonstrate an organisational-wide approach to quality through the development of quality improvement strategies which should be made explicit in business plans, specify continuously reviewable standards for services, and require changes arising from audit to be implemented

The emphasis clearly remained on quality improvement, however, it appeared that there was now no favoured approach.

CONCLUSION

The aim in setting up the NHS was to reconcile national accountability with local autonomy (Klein 1989). The period from its creation in 1948 to the first reorganisation in 1974 was characterised by the dominance of the medical professions in the decision making process, by concerns with the cost of running the Service, and the rise of technocratic managerialism with its emphasis on rational planning and the efficient use of resources. This reached its zenith with the restructuring of the NHS in 1974 and which, in turn, heralded the period of consensus management as an attempt to bring together doctors, nurses and administrators.

Government policy since 1979 has seen a radical transformation in the way the NHS is run, through the introduction of general managers and the creation of an internal market for health care services. The move towards a quality focused approach has been closely associated with this transformation, but whilst TQM has been a much vaunted approach, it remains uncertain exactly how much popularity it has enjoyed throughout the entire NHS and how successful it has been.

The problems which have consistently plagued the NHS have demonstrated the difficulties involved in managing an organisation unique in its complexity. As Klein (1989) observed, when dealing with the NHS, it has frequently been easier to implement policy means, than to achieve policy aims.

CHAPTER 8 ANALYSIS OF RESEARCH RESULTS: QUALITY ACTIVITIES

RESPONSE RATES TO THE QUESTIONNAIRE

A total of 103 District Health Authorities (DHAs) existed in England at the time the questionnaire was circulated. A rationalisation process was taking place within the health care purchasing function, however, which resulted in the merger of a number of DHAs. Thus, during the period of this research, the number of DHAs fell from 103 to 98. Although further mergers were being planned, the population size was taken to be 98 for the purposes of this analysis.

The questionnaire elicited the following response rates from the DHAs.

TABLE 8.1 QUESTIONNAIRE RESPONSE RATES

Region	Number of DHAs in Region	Numbers of responding DHAs	Response rate (%)
West Midlands	14	11	78.6
Northern and Yorkshire	15	6	40.0
South Thames	14	8	57.1
Anglia and Oxford	9	4	44.4
Trent	7	5	71.4
North Thames	10	6	60.0
North West	17	11	64.7
South and West	12	8	66.7
Total	98	59	60.2

A further eight questionnaires were sent to each of the Regional Health Authorities (RHAs) in England and were returned by Northern and Yorkshire RHA, South Thames RHA, North Thames RHA, Anglia and Oxford RHA and West Midlands RHA.

From the following data, it became possible to determine a profile of non-respondents. Two DHAs returned the questionnaire unanswered but provided documentation regarding their quality management activities. A further two DHAs refused to answer the questionnaire claiming that they were inundated with questionnaires and that it was not possible to reply to them all. One RHA felt unable to reply because it had only recently been created following the merger of two smaller RHA and, therefore, held that it could not provide any meaningful

information. The indications were that non-respondents were not at an advanced stage of implementing a quality management initiative.

TABLE 8.2 THE FREQUENCY DISTRIBUTION OF COMPLETED QUESTIONNAIRES

Region	Frequency	% of sample	Response rate (%)
West Midlands	11	18.6	78.6
Northern and Yorkshire	6	10.2	40.0
South Thames	8	13.6	57.1
Anglia and Oxford	4	6.6	44.4
Trent	6	10.2	71.4
North Thames	5	8.5	60.0
North West	11	18.6	64.7
South and West	8	13.6	66.7
Total	59	100	62.0

There was no obvious explanation for this distribution of responses. Nevertheless, it should be noted that national statistics will be influenced to a greater extent by those DHAs in the West Midlands and the North West and to a lesser extent by those in Anglia and Oxford. However, the figures are also broken down on a regional basis in order to provide a more detailed picture of the activities taking place.

POSITION OF RESPONDENTS

The position of respondents provides information concerning the level at which quality is being addressed within DHAs and the possible content of quality initiatives. Dalley et al (1991) discovered that quality initiatives in hospitals managed by DHAs were likely to reflect the background of the person or persons responsible for the implementation process.

The findings were as follows for each of the regions:

CHART 8.1 WEST MIDLANDS

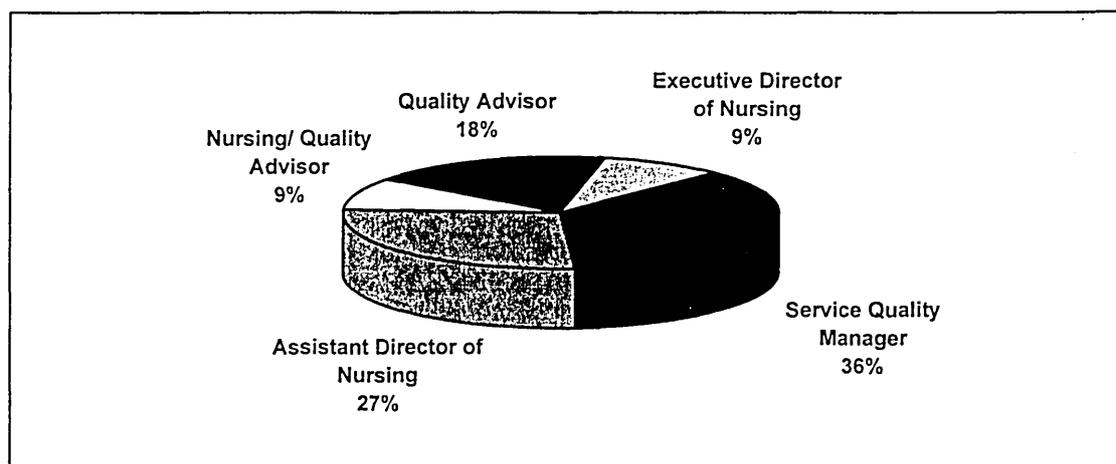


CHART 8.2 NORTHERN AND YORKSHIRE

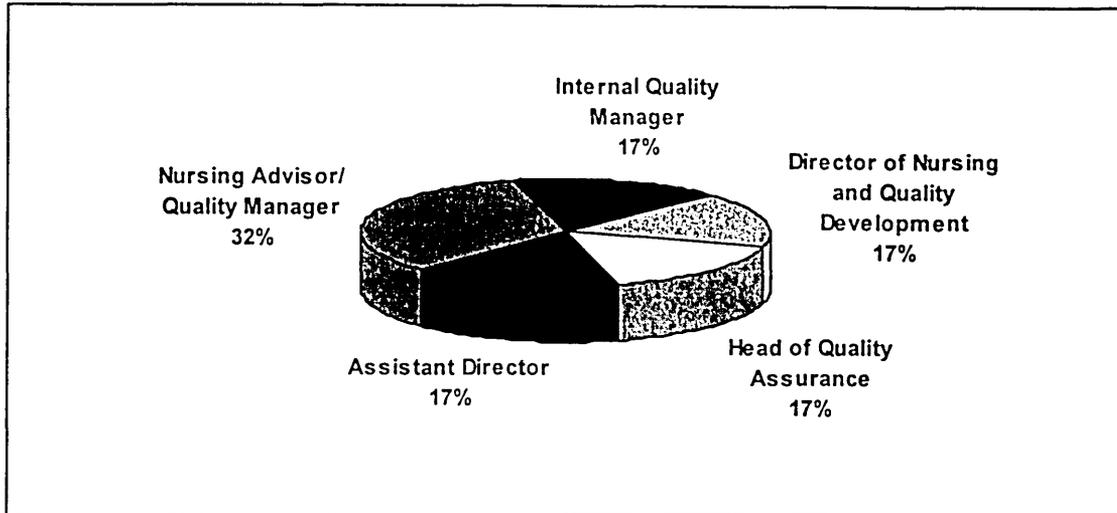


CHART 8.3 SOUTH THAMES

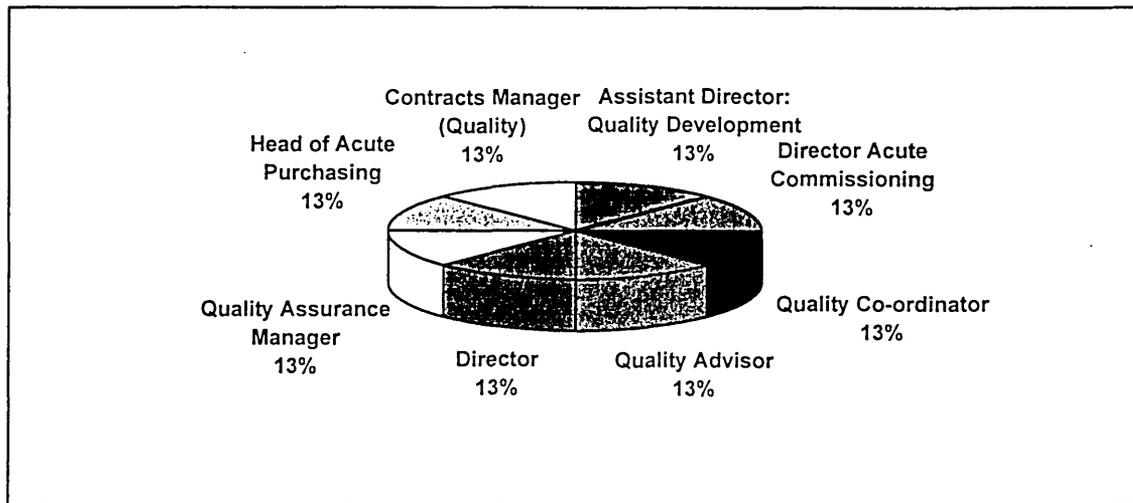


CHART 8.4 TRENT

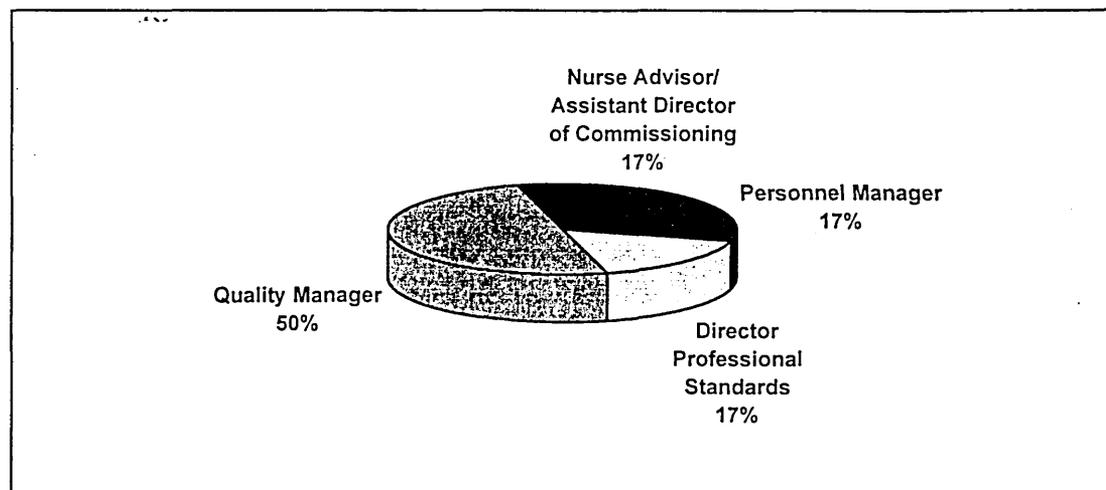


CHART 8.5 ANGLIA AND OXFORD

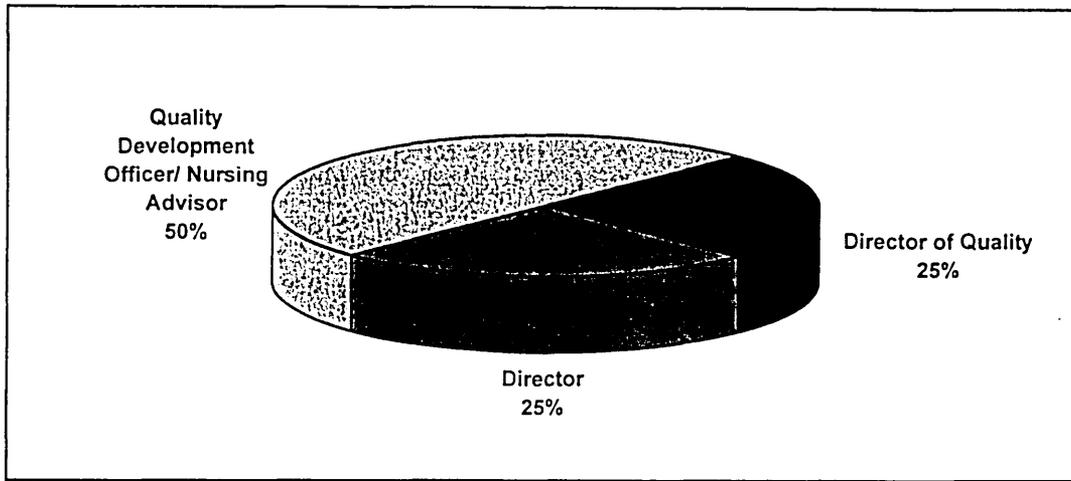


CHART 8.6 NORTH THAMES

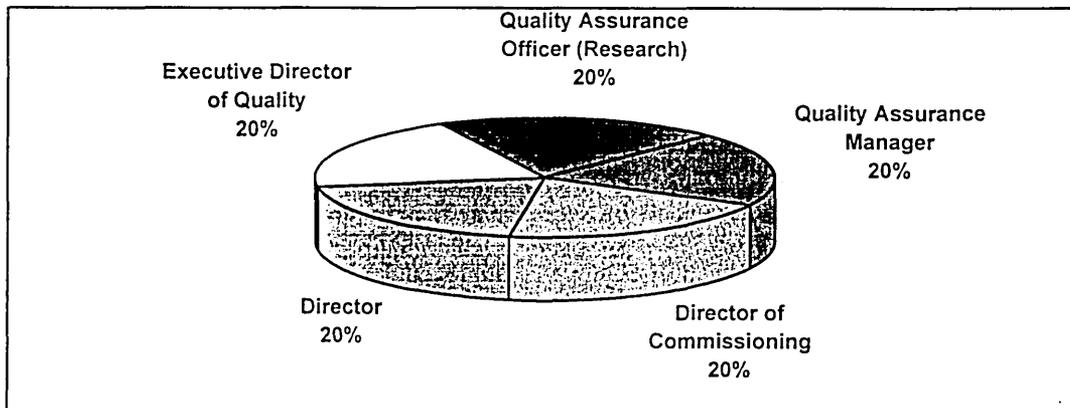


CHART 8.7 NORTH WEST

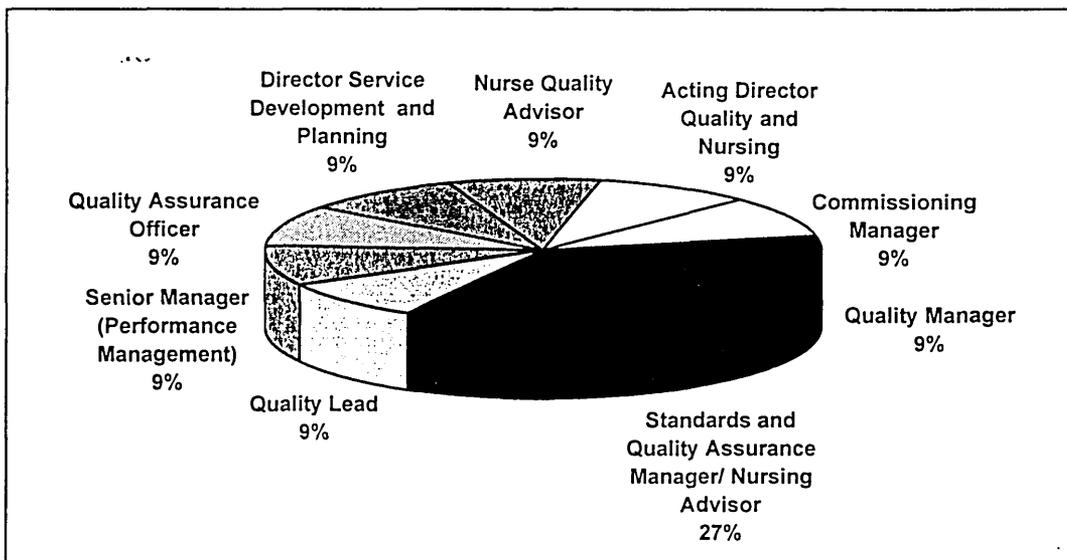
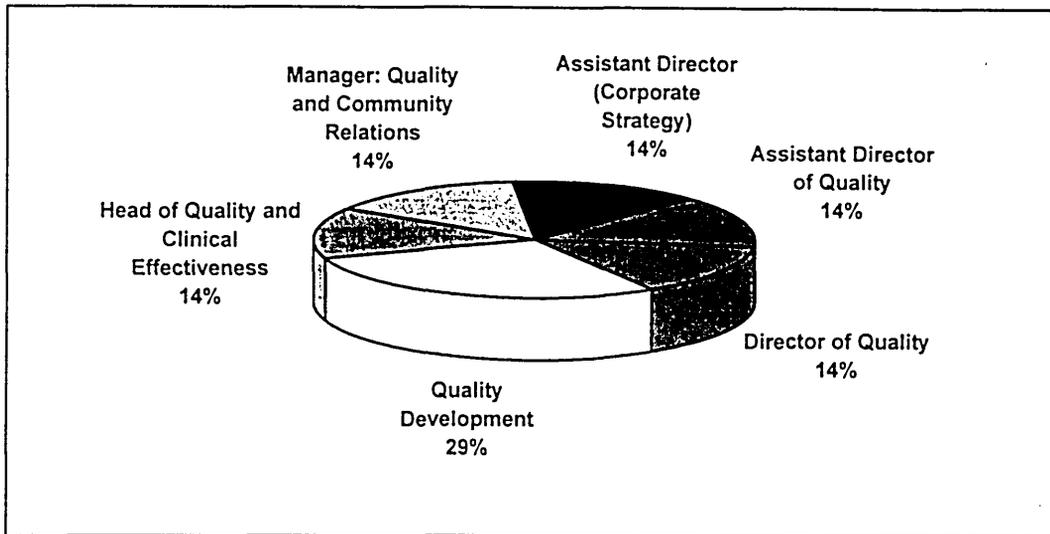


CHART 8.8 SOUTH AND WEST



Respondents filled a wide variety of positions where responsibility for quality was accorded to whichever department was seen as most appropriate rather than a uniform approach being adopted by all DHAs. This would suggest that different DHAs held different understandings of quality and also suggested that the management of quality was taking place on an 'ad hoc' rather than an holistic basis.

As can be seen, quality was frequently an additional responsibility of the post holder and, rather more importantly, in many cases appeared as a secondary responsibility. So, whilst 64% of respondents carried a responsibility for quality within their job title, only 42% were responsible solely for quality. There would appear to be a reluctance to treat quality as an issue deserving attention in its own right. Dalley et al (1991) noted that a substantial number of NHS quality leads came from those with a nursing background. The current findings showed that there continued to be a link with nursing with 18.6% of respondents having a nursing role either wholly (3.4%) or in conjunction with quality (72.7%). The quality initiatives being implemented, therefore, continued to be influenced by the nursing profession.

In terms of job grades, 35.6% of respondents held a position at Director or Assistant Director level and were, therefore, in a position to shape the overall quality policy of the DHA. However, there were clear regional differences. Within the North Thames Region, 60% of respondents held Director or Assistant Director positions compared with 18% in the North West Region. Given the need for senior management commitment to TQM, it would be expected that TQM initiatives would be more successful in those DHAs where responsibility

for quality was held at Director level than in those DHAs where the responsibility was vested in those lower down the organisation. Indeed, further findings revealed that the highest percentage of DHAs implementing TQM was situated in the North Thames Region compared to the North West Regions where there were no recorded incidents of DHAs implementing TQM. However, when the positions of respondents from those DHAs implementing TQM were considered:

TABLE 8.3 POSITION OF RESPONDENTS AT TQM SITES

Position of Respondents at TQM Sites
<ul style="list-style-type: none"> • Assistant Director: Corporate Strategy • Personnel Manager • Quality Assurance Manager • Commissioning Nursing Advisor • Executive Director of Quality and Community Relations • Assistant Director of Quality • Nurse Advisor and Assistant Director of Quality • Quality Development Advisor • Internal Quality Manager • Quality Assurance Officer (Research)

It can be seen that only 40% of these sites indicated a responsibility for quality at director level. Furthermore, only one of the three DHAs implementing TQM in the North Thames Region reported a responsibility for quality at director level. A respondent's position could not be taken as an indication of the adoption of TQM, although support from senior management is of course necessary.

DETERMINING A QUALITY STRATEGY OR MISSION STATEMENT FOR QUALITY CARE

81.4% of respondents stated that they had been involved in determining a quality strategy or mission statement for health care. Of these, 52.5% stated that Providers had been involved in the process, 18.6% stated that other DHAs had had an input and 10.2% said that the RHA was involved in the process. None of the DHAs stated that the NHS Executive was involved in the process. The results according to Region are as follows:

CHART 8.9 WEST MIDLANDS

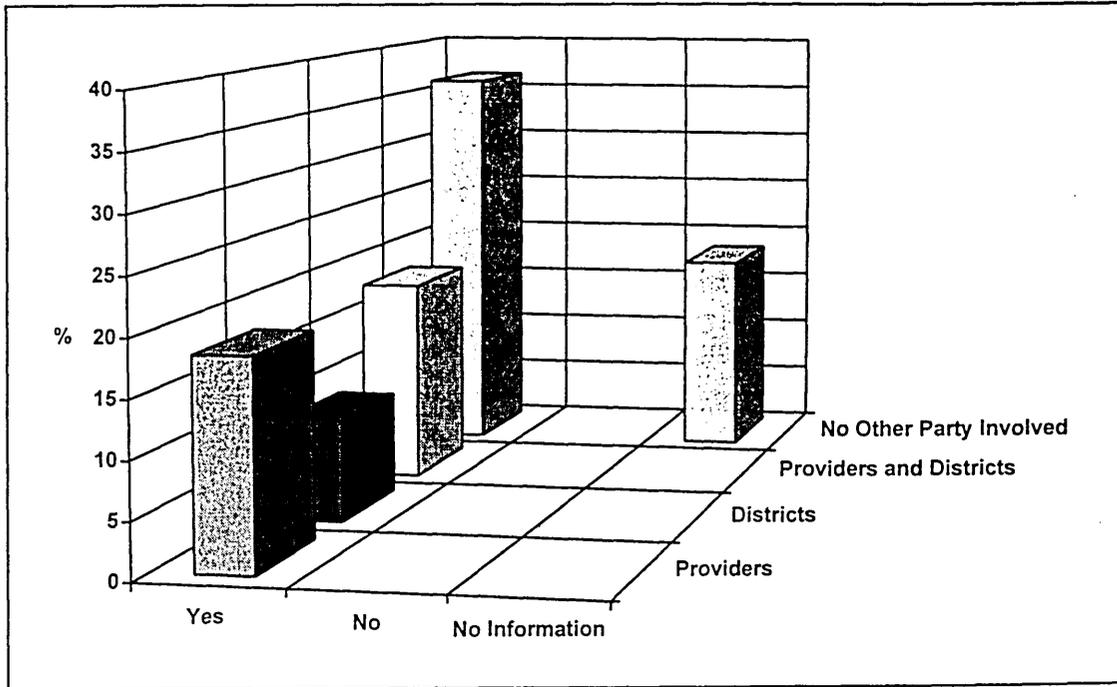


CHART 8.10 NORTHERN AND YORKSHIRE

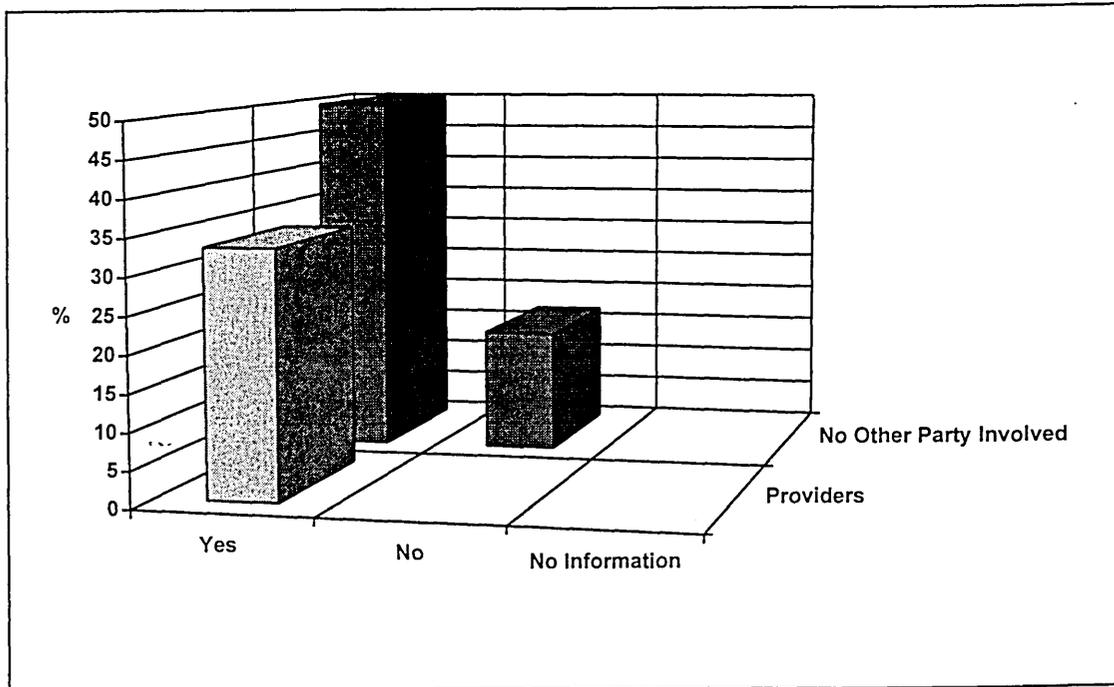


CHART 8.11 SOUTH THAMES

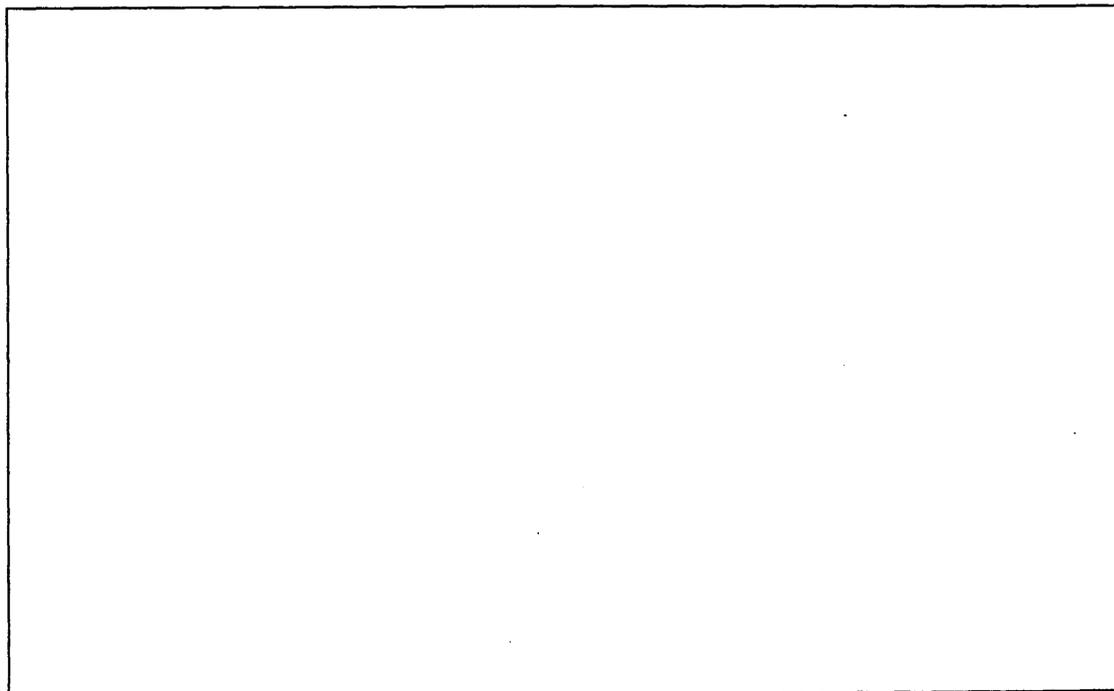


CHART 8.12 ANGLIA AND OXFORD

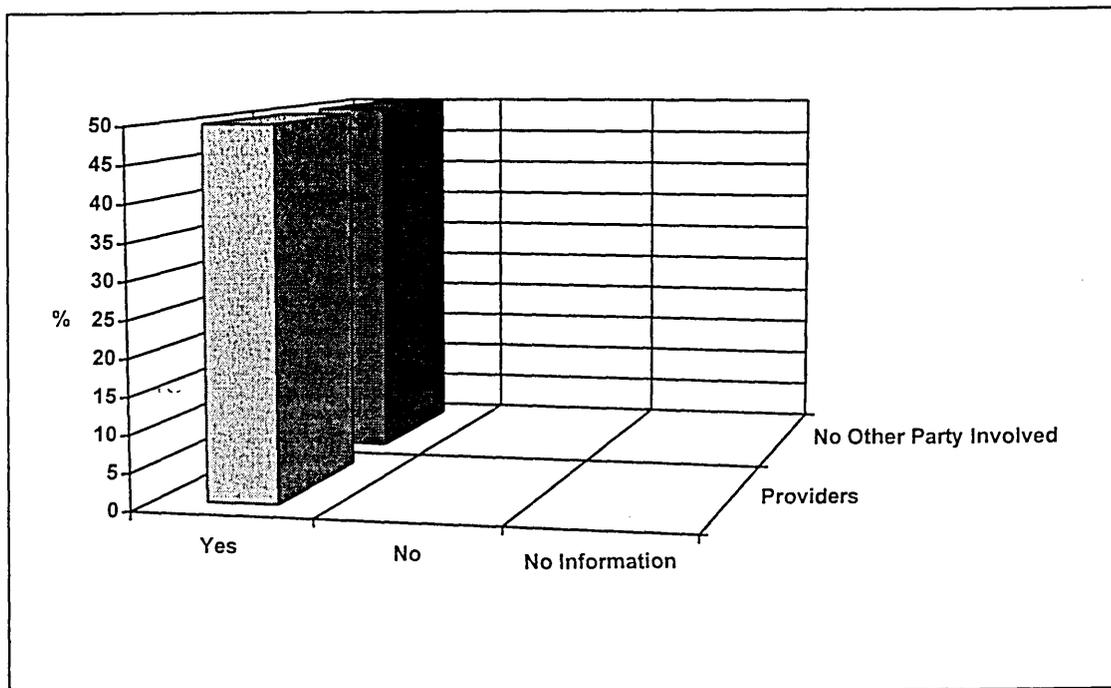


CHART 8.13 TRENT

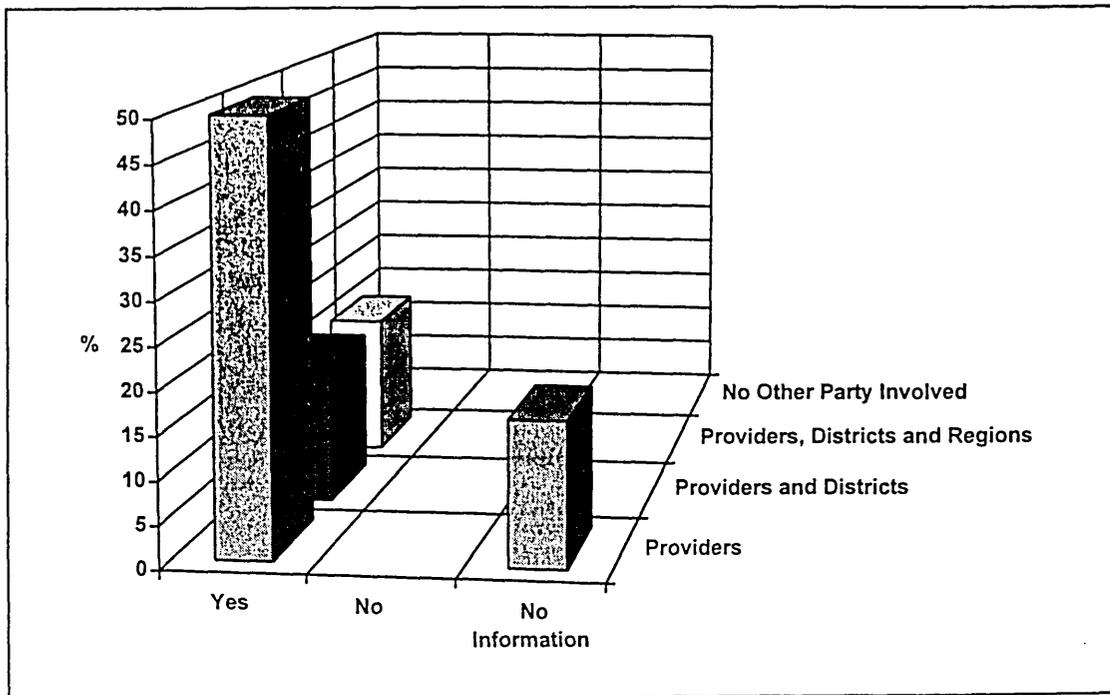


CHART 8.14 NORTH THAMES

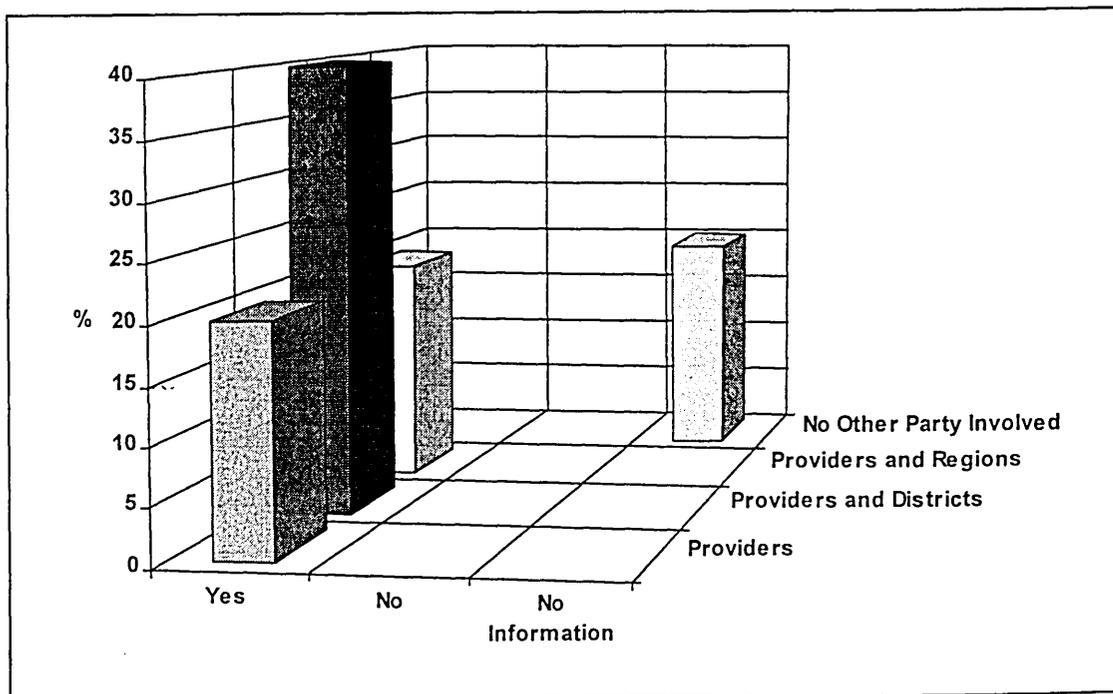


CHART 8.15 NORTH WEST

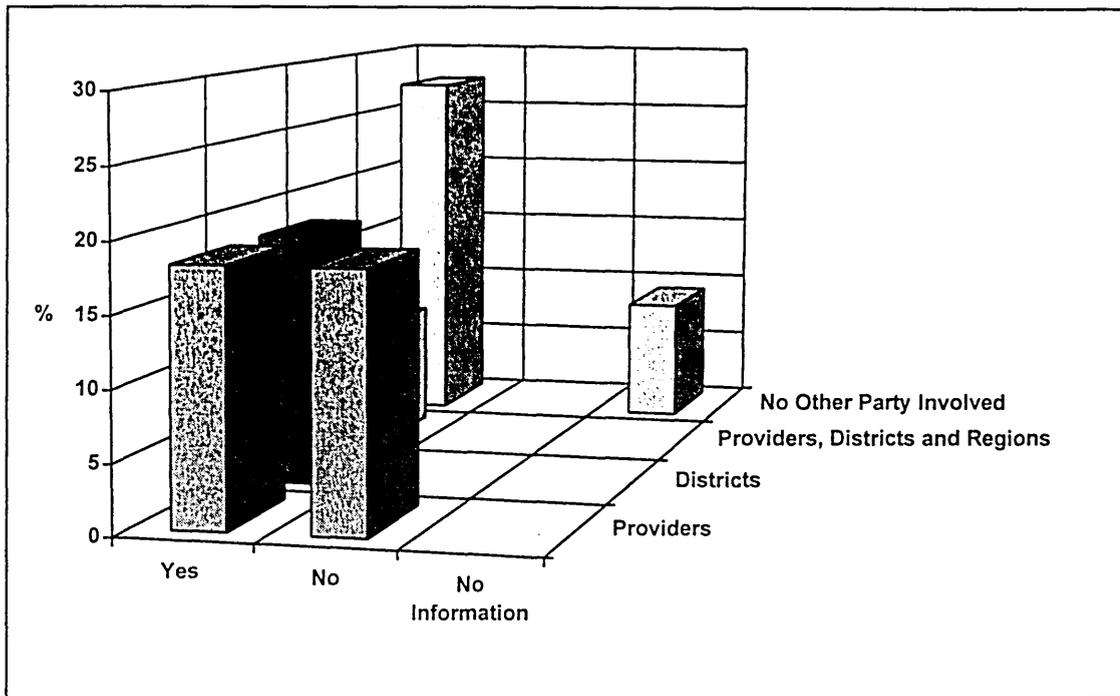
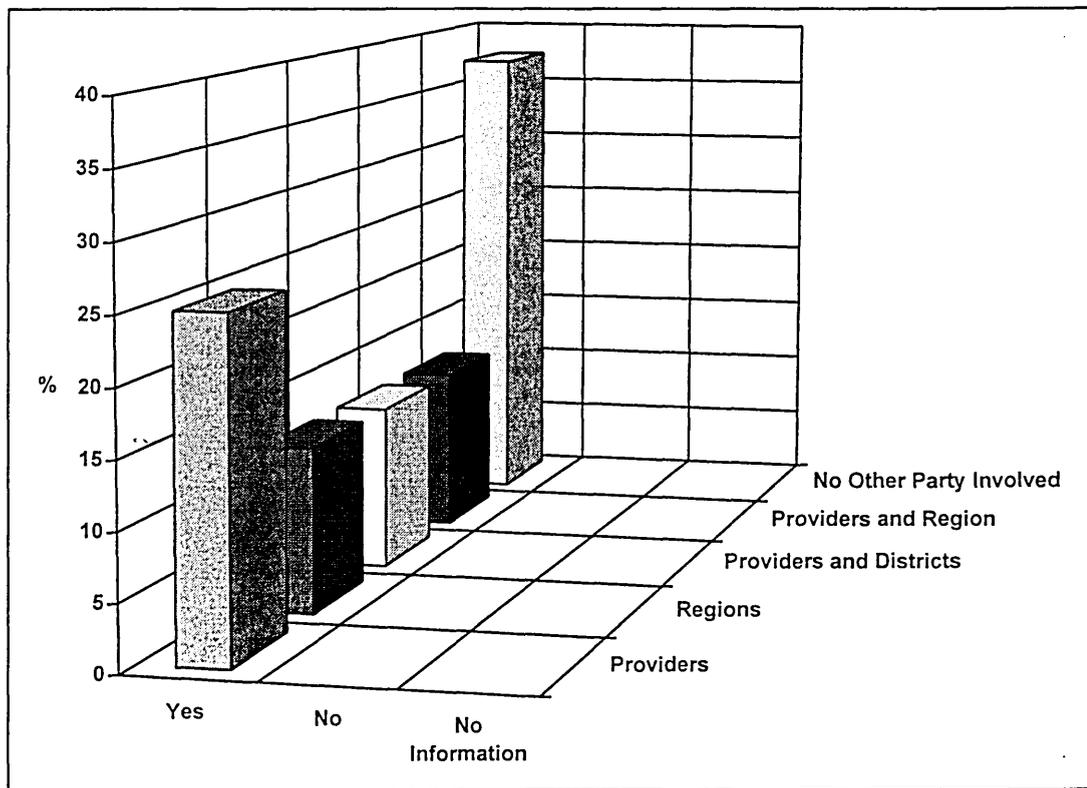


CHART 8.16 SOUTH AND WEST



Over 80% of respondents in most regions had been involved in determining a quality strategy or mission statement, although South Thames and North West had a lower percentage of DHAs which have been involved. Overall, 41% of DHAs had drawn up a quality strategy without the

involvement of other parties. Only in the Trent and North Thames Regions had all respondents reported the involvement of at least one other party. Thus, a substantial proportion of DHAs in the country had attempted to devise a quality strategy without an input from other parties within the health care delivery chain.

The North West Region recorded the lowest percentage of DHAs (63.6%) involved in determining a quality strategy. Two thirds of those DHAs which had not undertaken this activity stated that they were aware of Providers being involved in such work. In comparison, 81.6% of DHAs in the West Midlands had developed a quality strategy or mission statement. However, 44.4% of DHAs in this Region had conducted the activity by themselves compared to 28.6% in the North West. More strikingly, in the South Thames region, 83.3% of the DHA which had determined a quality strategy or mission statement were doing so on their own.

These findings suggested that considerable regional differences existed. In particular, the relationship between Purchasers and Providers. There is little evidence of a concern for internal quality management issues, as much of the content of the quality strategies is focused on the demands made of Providers. For example, a comparison can be made between the South and West, and Anglia and Oxford Regions. Both have been created via the merger of two smaller RHAs, yet they remain small in comparison to some of the other regions being comprised of 11 and 9 DHAs respectively and serving a largely rural population.

In both of these Regions, all the DHAs involved in the research indicated that they had determined a quality strategy or mission statement for health care. However, whilst those DHAs in the South and West Region stated that a variety of parties had been involved in the process, those in Anglia and Oxford stated that either they had undertaken the activity alone or only in conjunction with Providers. A quarter of those respondents in the South and West Region reported an input from the RHA. These findings suggest that either more information is forthcoming from other parties in the South and West Region, or at least there is more awareness of information. Wessex RHA, a forerunner of South and West RHA, had developed guidelines for both Providers and Purchasers to demonstrate an organisation-wide approach to quality management. The Anglia and Oxford RHA have also been working towards producing TQM training material but this has clearly yet to feed through to Purchasers in that Region.

DETERMINING A DEFINITION OF QUALITY

Overall, 61% of DHAs had been involved in determining a definition of quality in health care. Of these, 37.3% stated that Providers had been involved, 11.9% indicated the involvement of neighbouring DHAs, 8.5% suggested that the RHA had played a role and four 6.8% declared that the NHS Executive had an input. The figures may be broken down regionally as follows:

CHART 8.17 WEST MIDLANDS

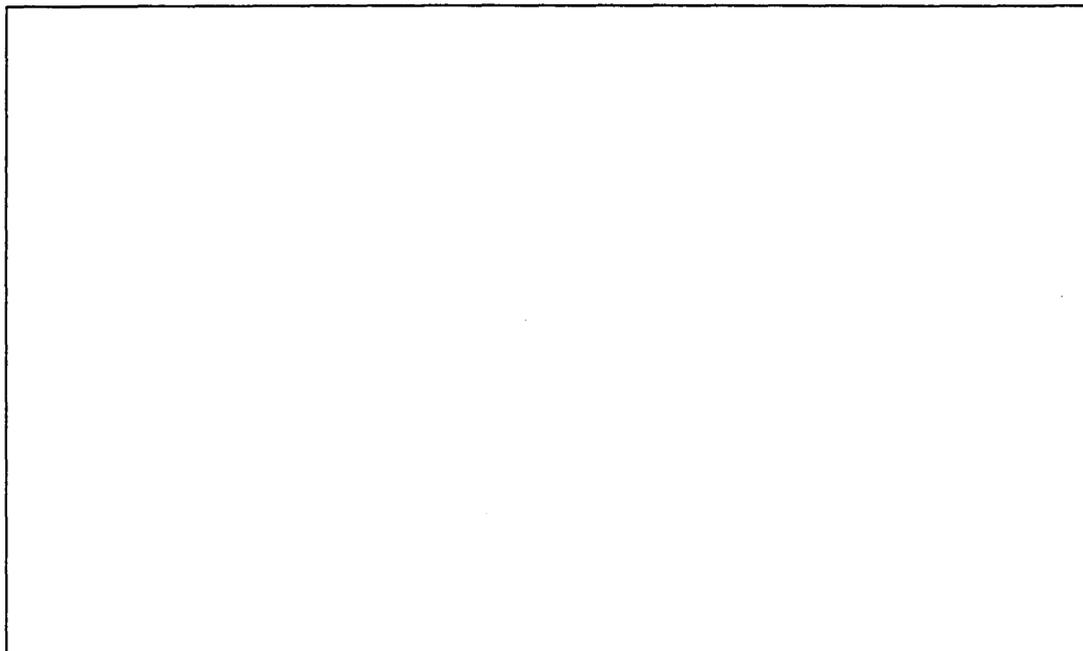
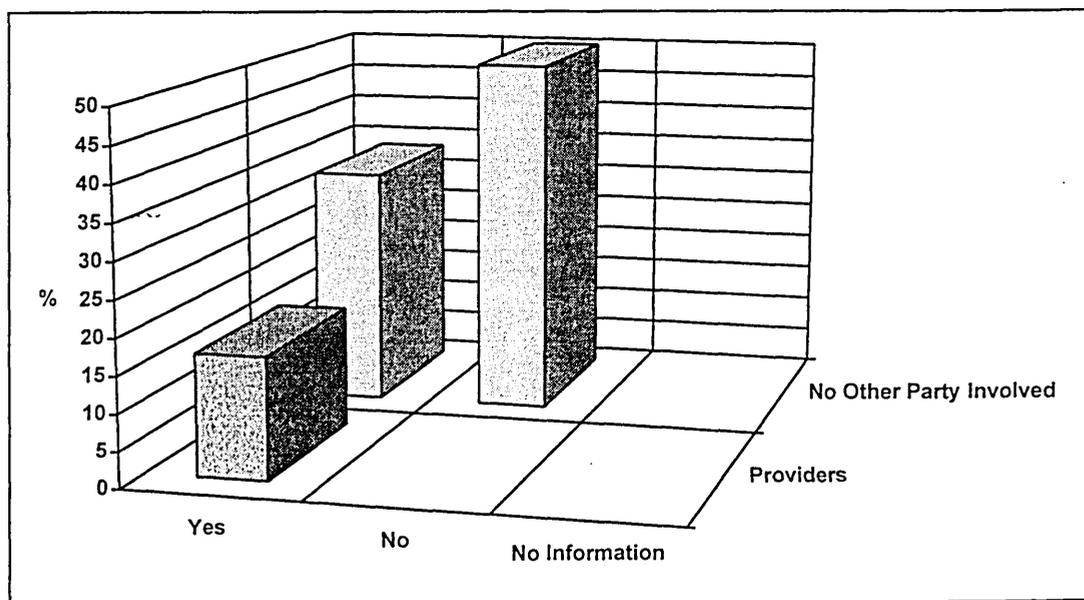


CHART 8.18 NORTHERN AND YORKSHIRE



Chapter Eight Analysis of Research Results: Quality Activities
CHART 8.19 SOUTH THAMES

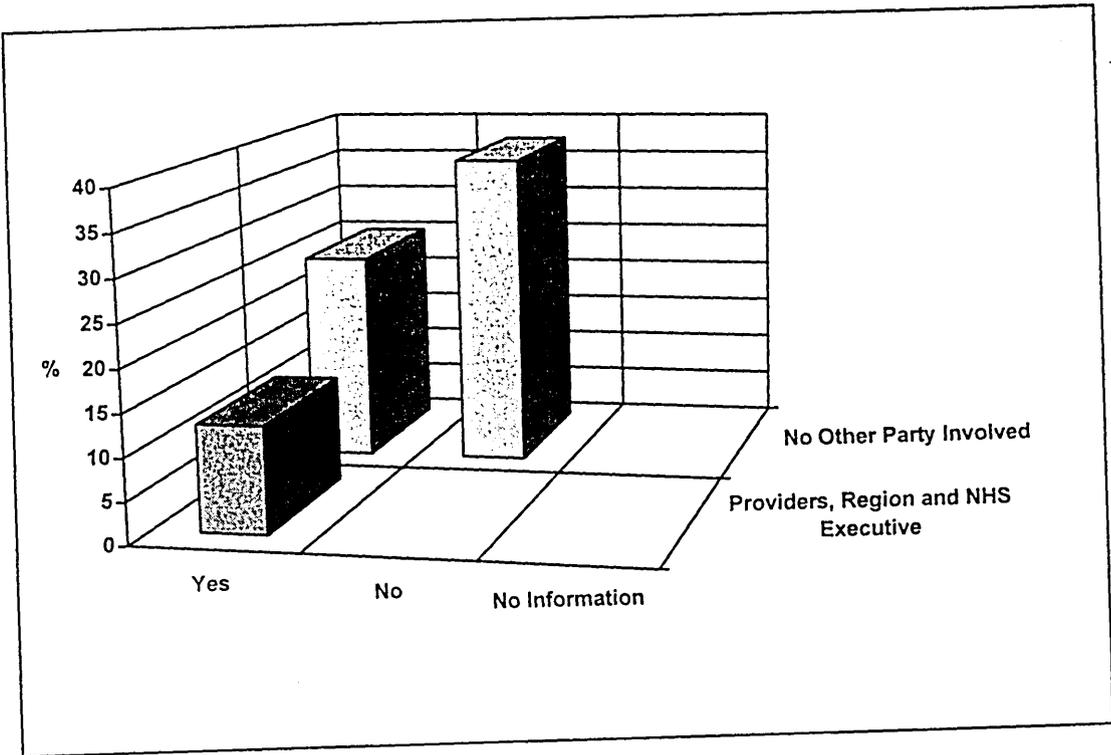


CHART 8.20 ANGLIA AND OXFORD

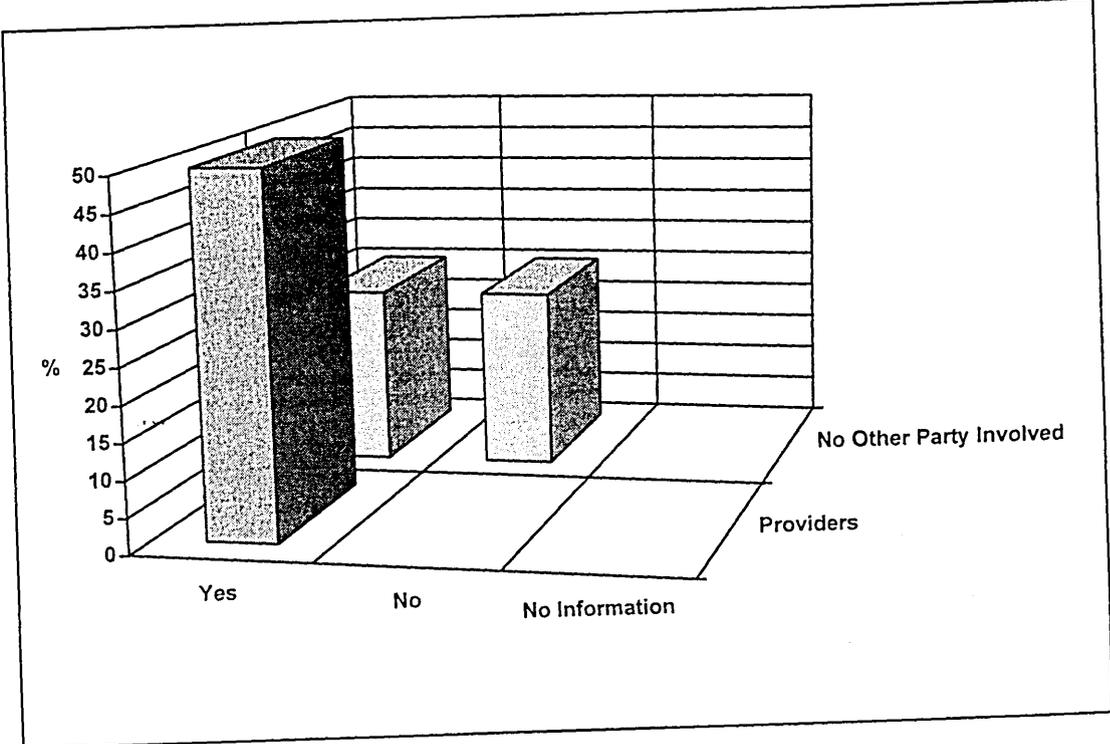


CHART 8.21 TRENT

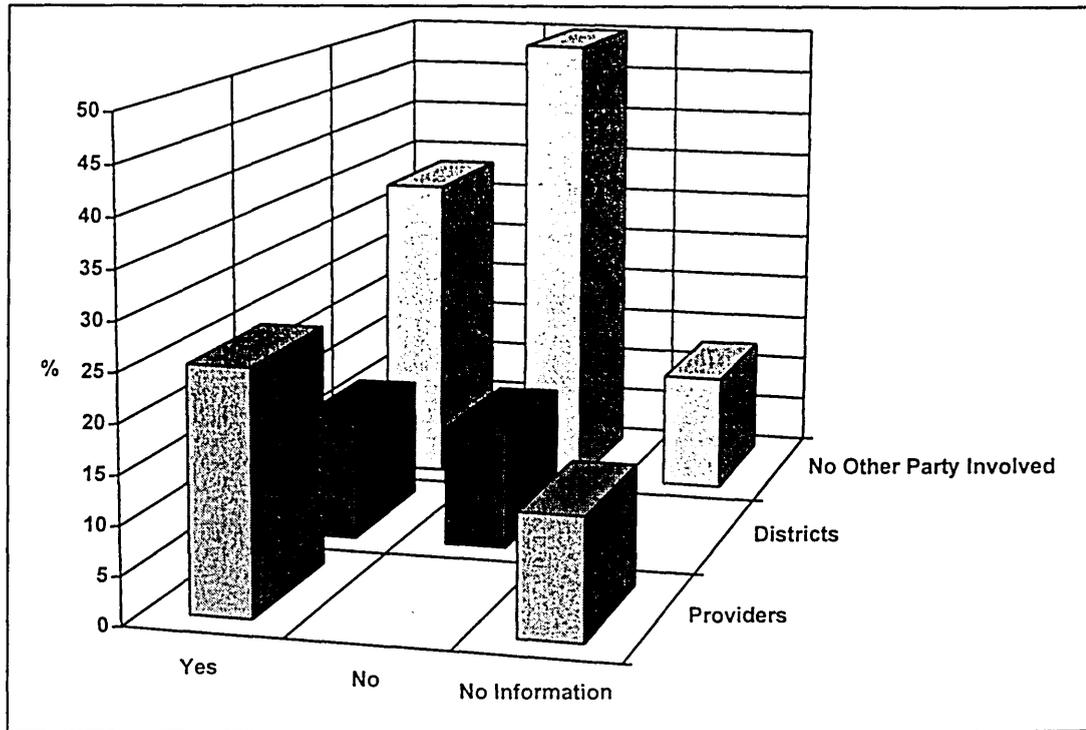


CHART 8.22 NORTH THAMES

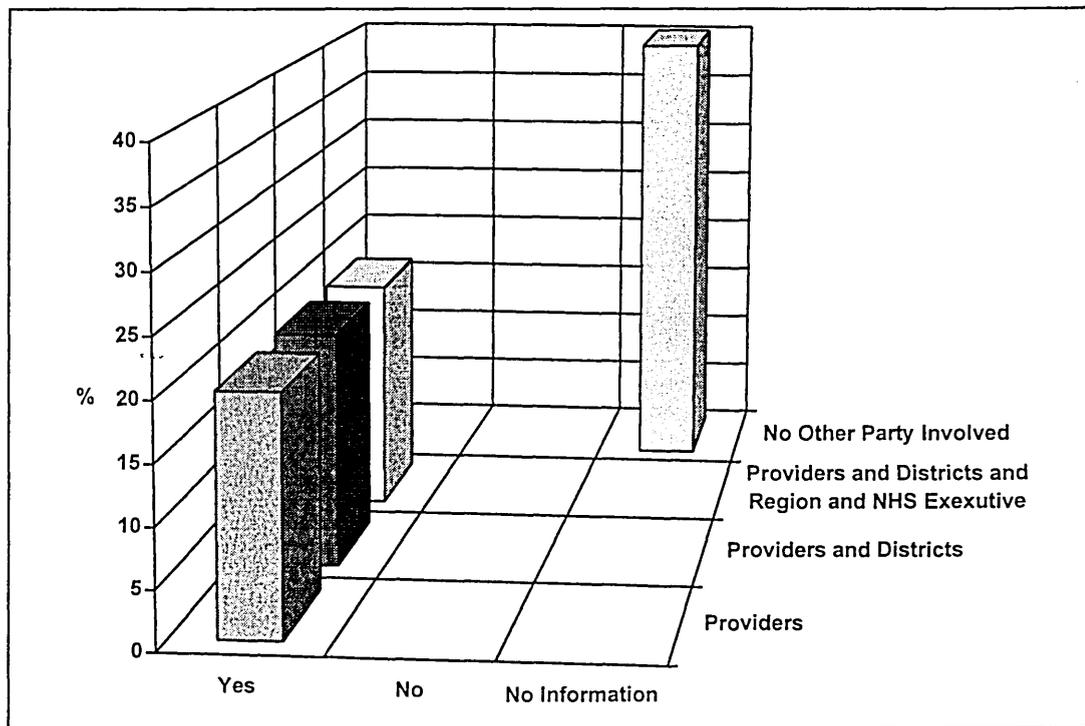


CHART 8.23 NORTH WEST

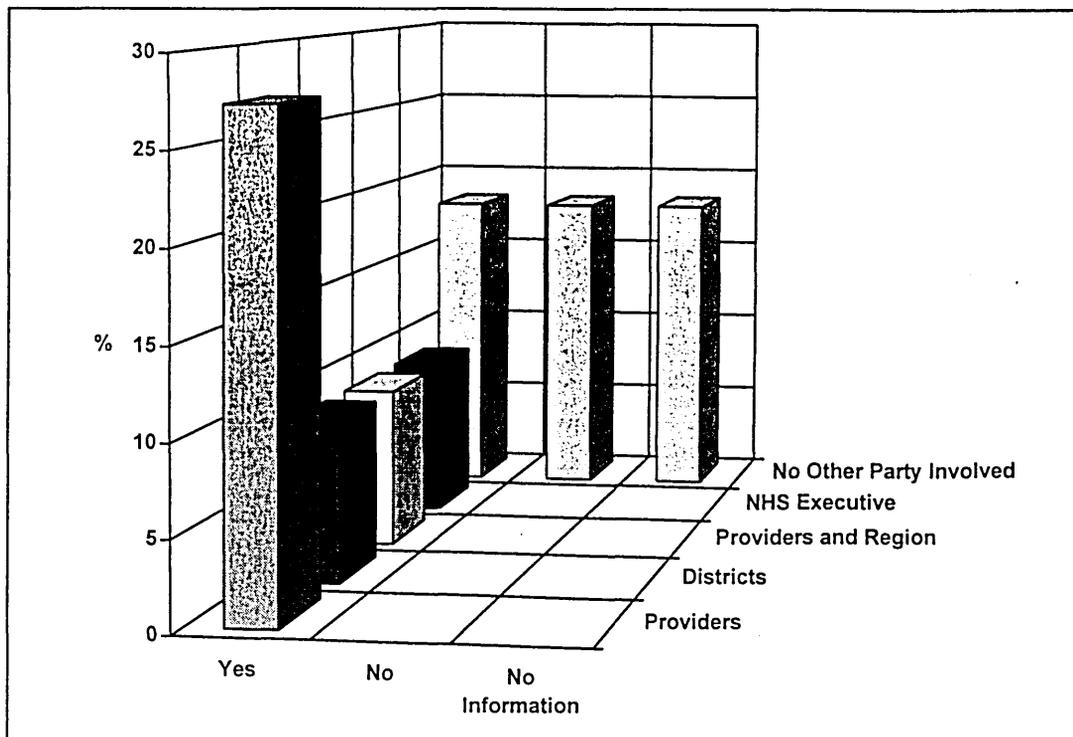
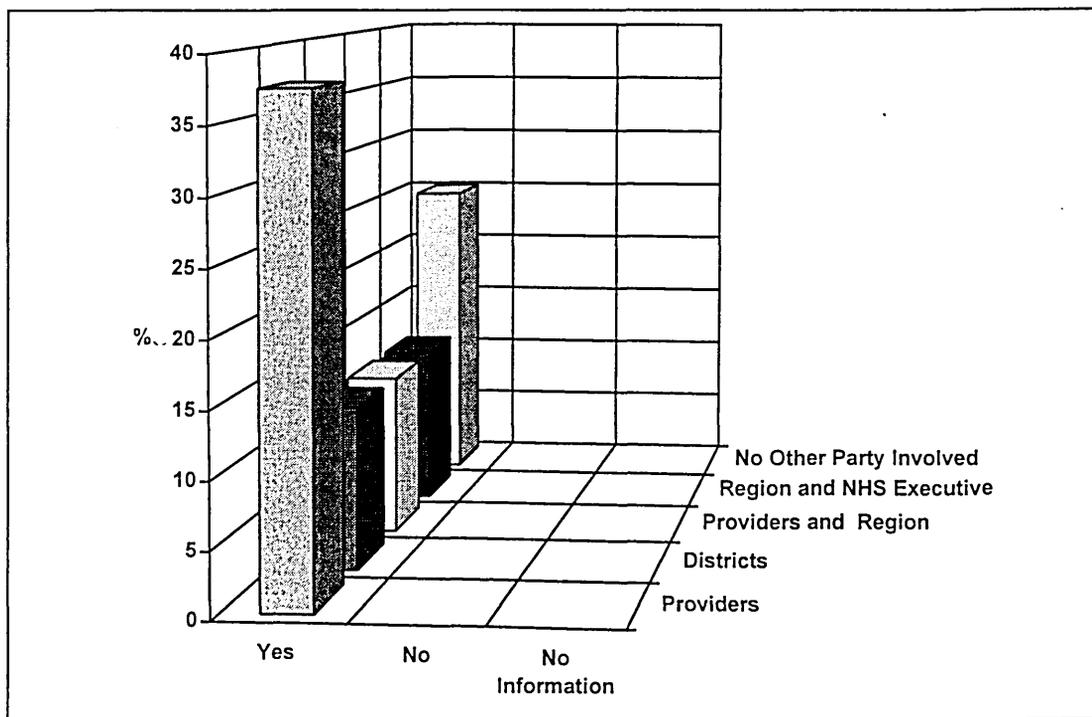


CHART 8.24 SOUTH AND WEST



The South and West Region recorded the highest number of DHAs undertaking this activity. All the respondents in this Region stated that they had determined a definition of health care

quality. However, a number of different parties had been involved in undertaking this activity. The involvement of the RHA featured once again, at the expense of the involvement of Providers. Where other parties had been involved in carrying out activities, these tended to be the RHA and the NHS Executive. Indeed, the South and West Region exhibited a greater number of DHAs involving these two parties across the range of quality related activities than appeared to occur in other Regions. The inference being that the RHA and the NHS Executive were perceived to offer more direction and guidance than, for example, neighbouring DHAs. At the other extreme, those DHAs in the Northern and Yorkshire Region which had determined a definition of quality for health care, had done so solely with their Providers or by themselves. Similarly in the South Thames Region, there appeared to be little involvement with neighbouring DHAs regarding this activity. Two thirds of respondents in this region had also determined a definition by themselves and the remainder suggested involvement had come from the RHA and the NHS Executive.

The findings indicated that, on the whole, DHAs were happy to adopt a generic definition of health care provided by the RHA or NHS Executive. There were, however, low numbers of DHAs which had undertaken this activity and few other parties taking a lead in this area. The low participation rate for this activity could be accounted for by the fact that there is no requirement, for DHAs to determine a definition of quality despite the warnings from Bounds et al (1994) that an underlying cause of TQM failure was that managers did not understand the concept of quality and defined it too narrowly. Few discussions of quality could take place without a concise definition of the concept.

DETERMINING THE SERVICE QUALITY NEEDS OF PATIENTS

In order to comply with the requirements of the purchasing process, contracts between Purchasers and Providers must specify quality levels. Determining the service quality needs of patients is, therefore, a fundamental part of the activities of a DHA and consequently a high participation rate was expected.

Overall, 89.9% of DHAs indicated that they had been involved in this activity. Of these, 91.5% recorded the involvement of Providers in the process, 28.8% registered the involvement of neighbouring DHAs, 20.3% registered the involvement of the RHA and 11.9% registered the involvement of the NHS Executive. The figures for each of the regions were as follows:

CHART 8.25 WEST MIDLANDS

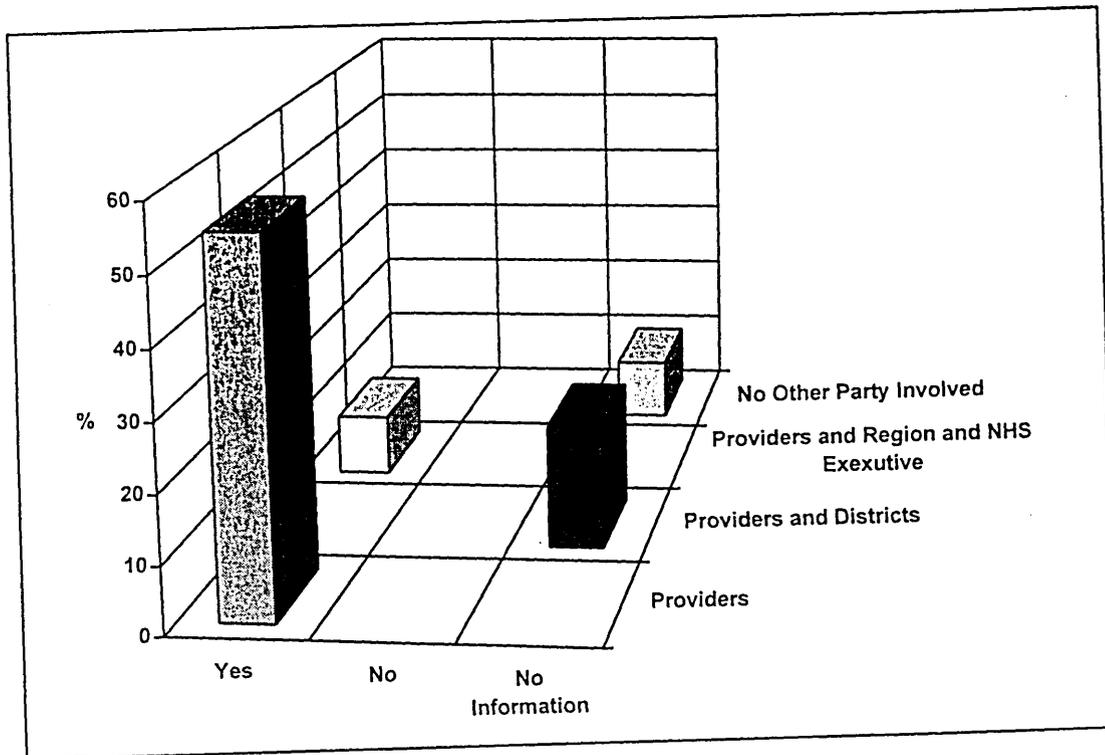


CHART 8.26 NORTHERN AND YORKSHIRE

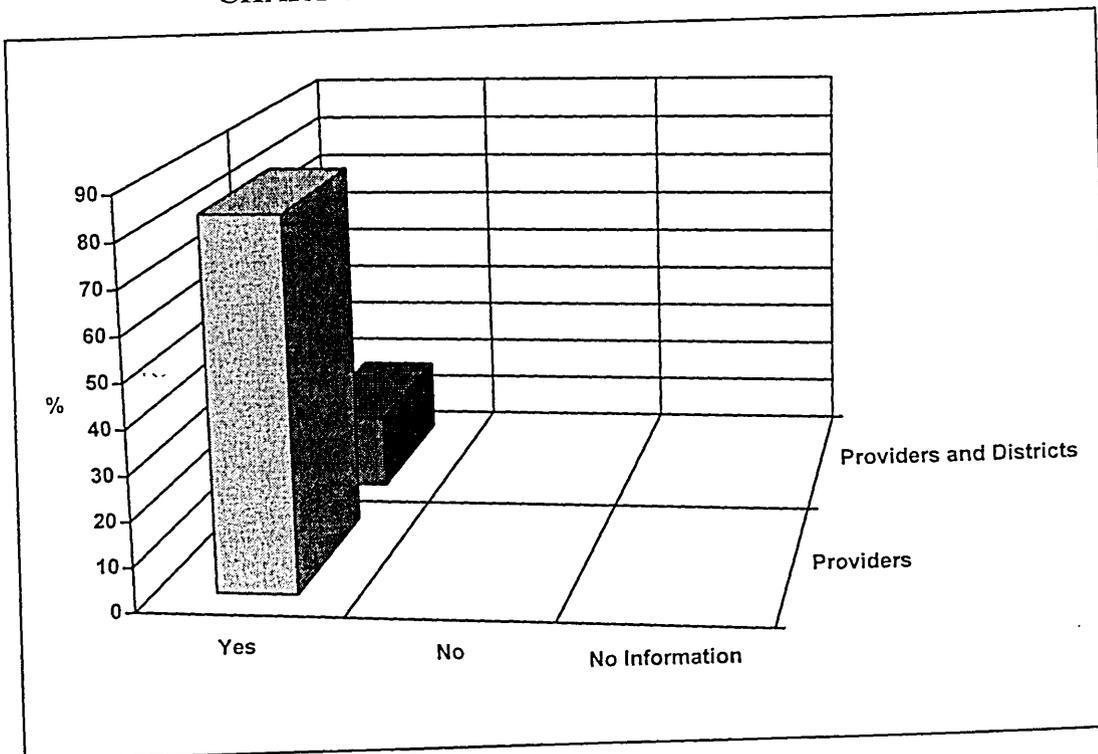


CHART 8.2 SOUTH THAMES

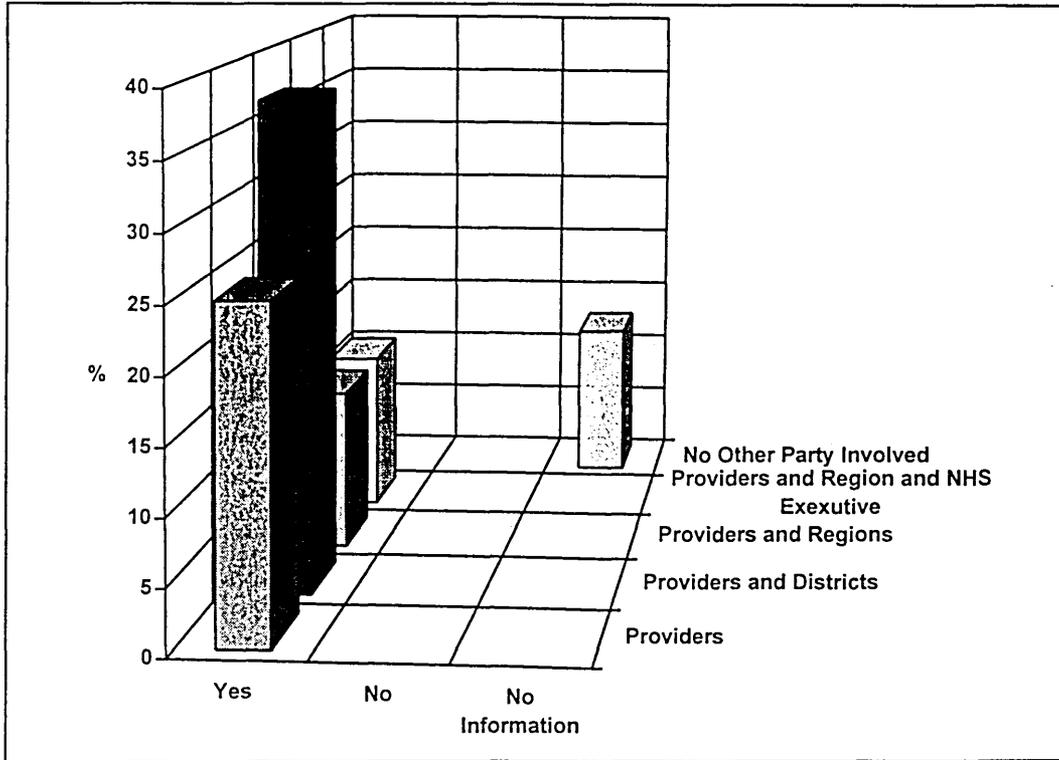


CHART 8.28 ANGLIA AND OXFORD

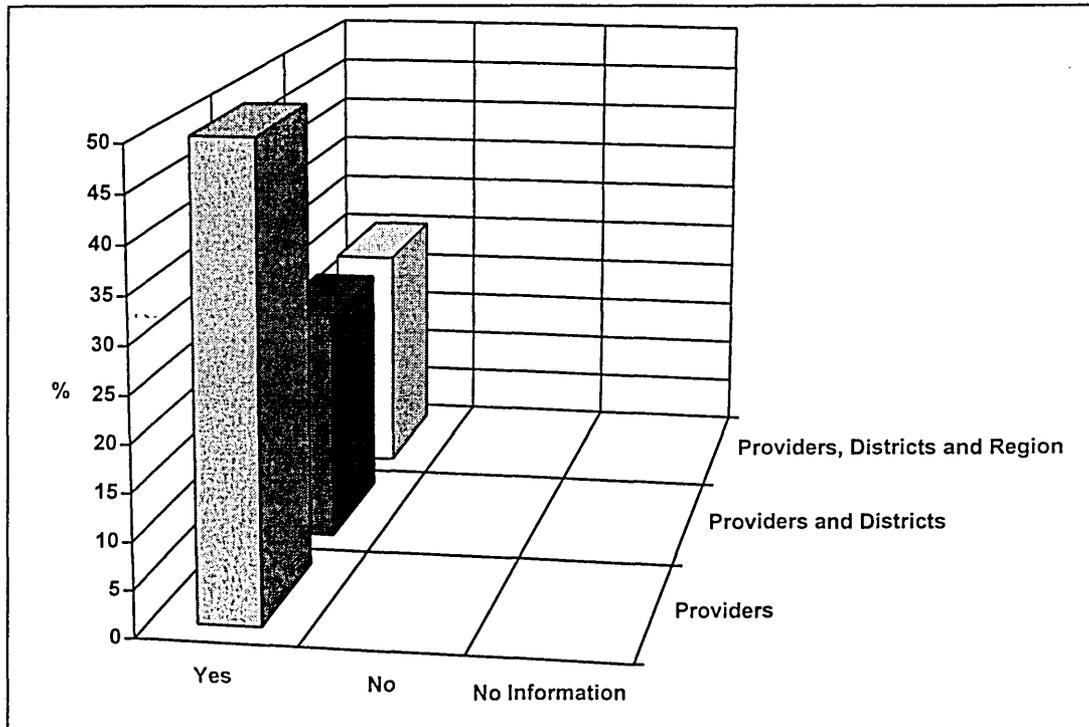


CHART 8.29 TRENT

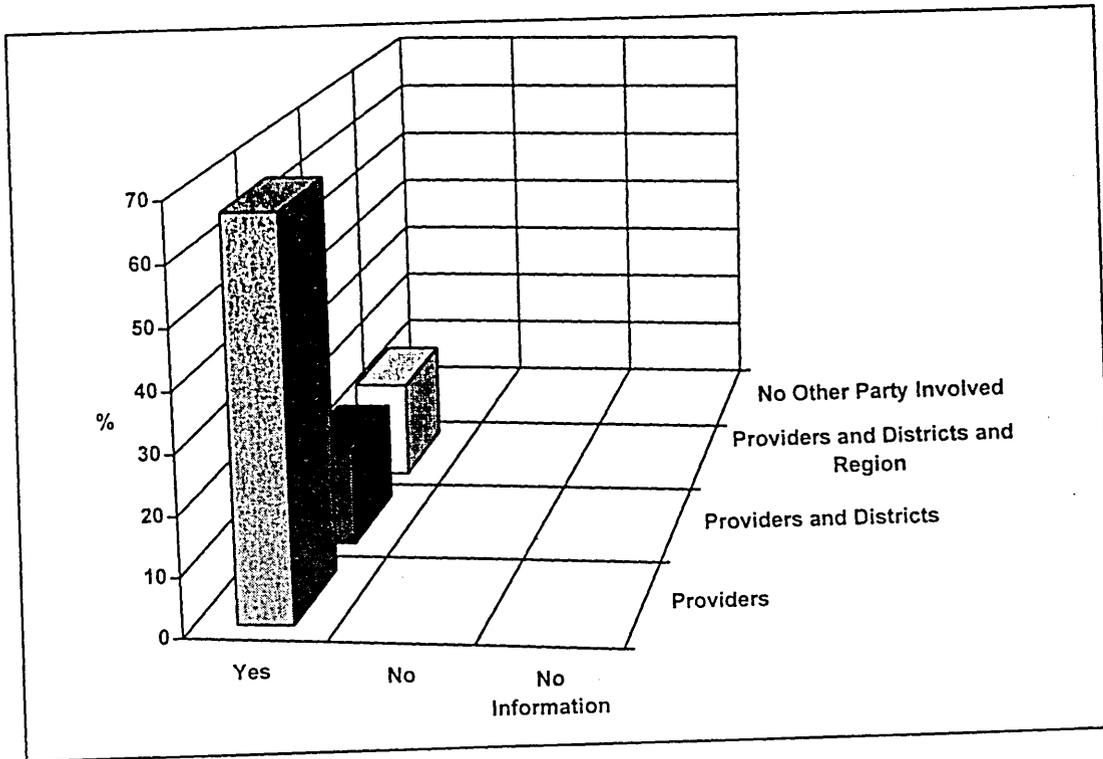


CHART 8.30 NORTH THAMES

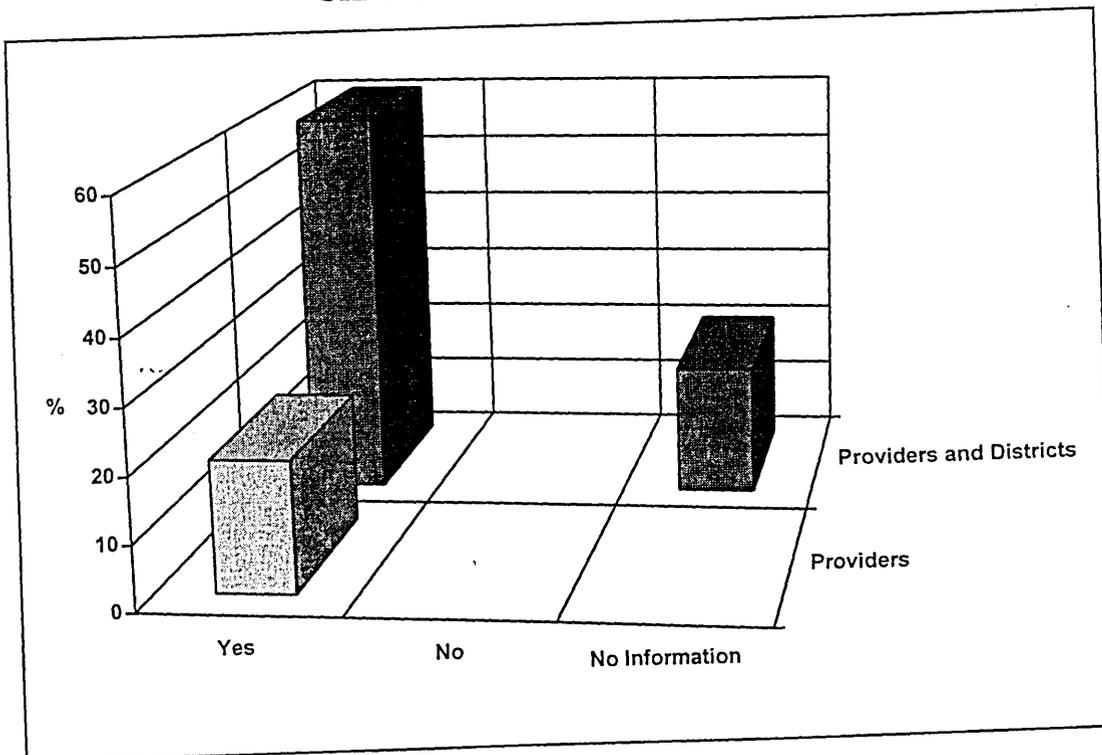


CHART 8.31 NORTH WEST

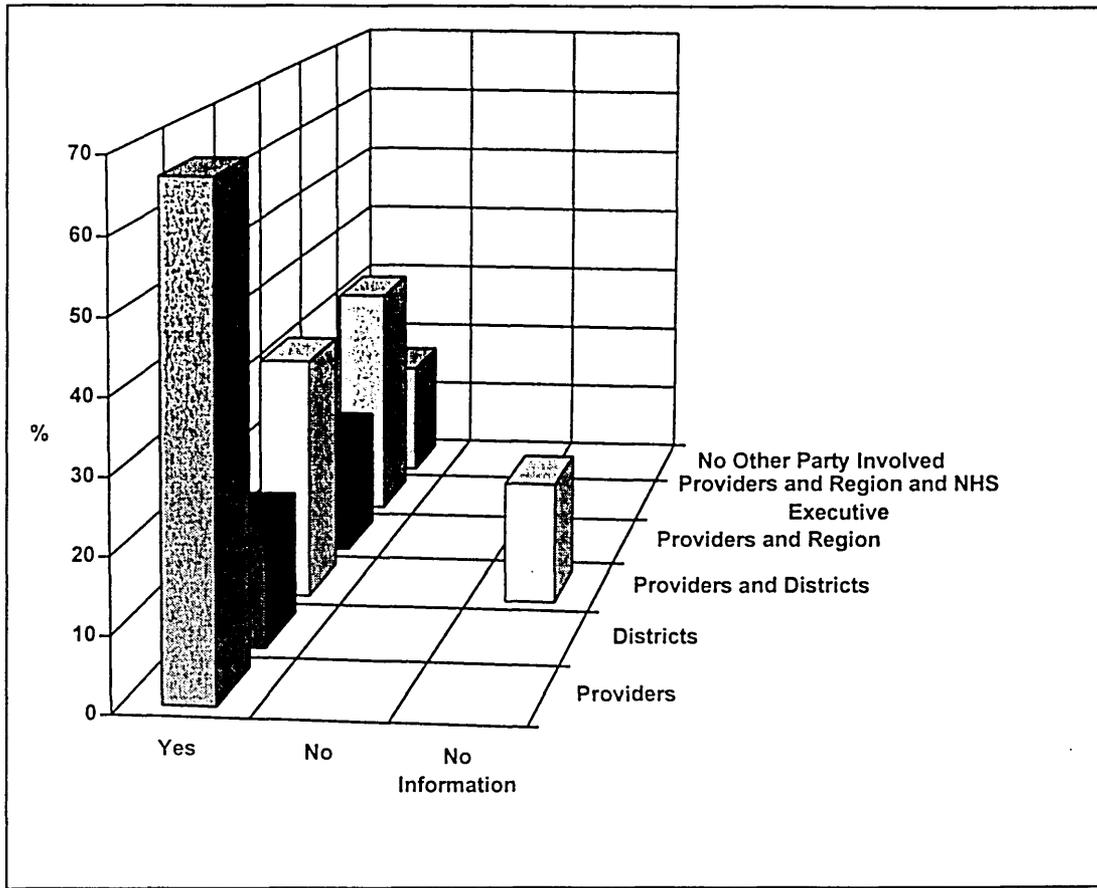
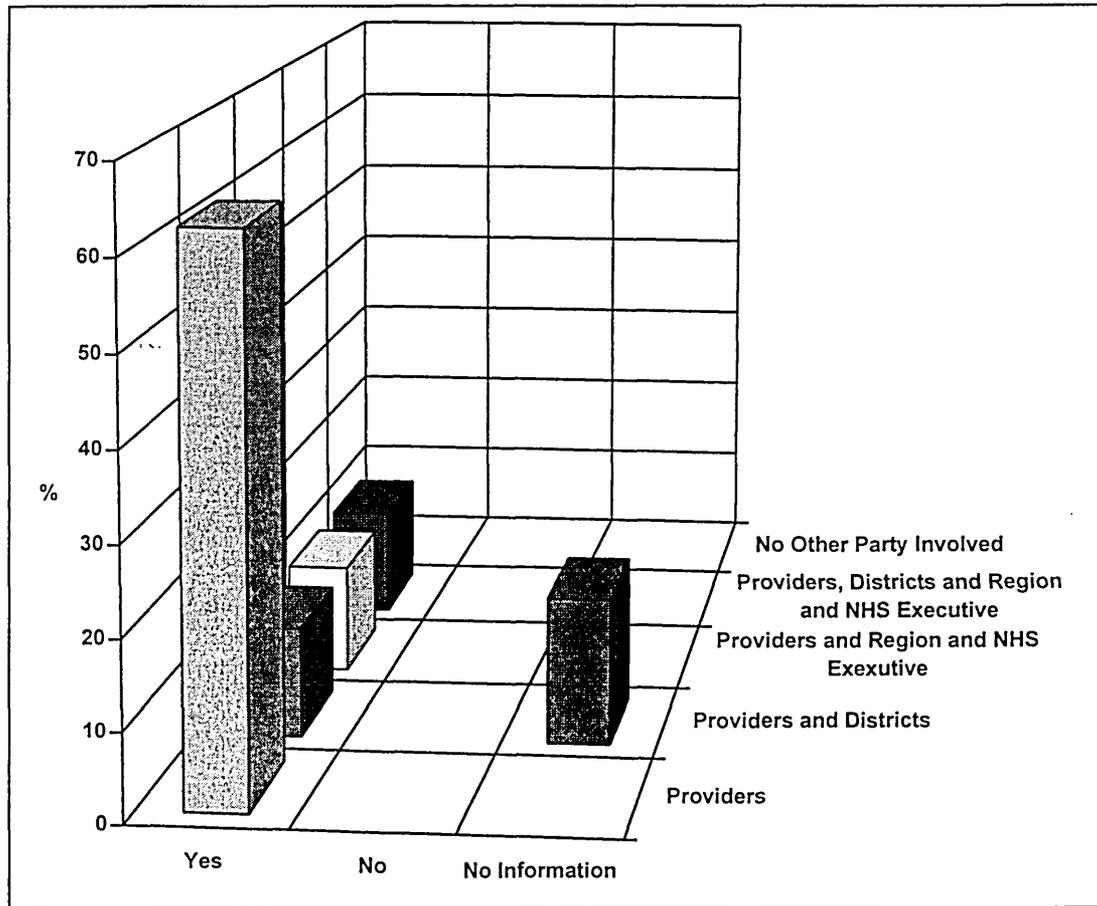


CHART 32: SOUTH AND WEST



The results revealed that all the DHAs in three Regions: Northern and Yorkshire, Anglia and Oxford and South and West, had undertaken work to determine the service quality needs of patients. However, there were differences between the Regions with respect to the parties involved. When asked to indicate which other parties had been involved in the process, those DHAs within the Northern and Yorkshire Region recorded only the involvement of Providers and neighbouring DHAs. Whilst in Anglia and Oxford and South and West, the RHA and the NHS Executive had been involved.

In the Trent Region, just one DHA indicated the involvement of neighbouring DHAs. This result was surprising not least because of the existence of the South Yorkshire Quality Network within the Region. The objective of the South Yorkshire Quality Network was to harmonise the purchasing strategies of the four DHAs located within this county, however, only one questionnaire was received from a DHA within this network and it did not acknowledge the involvement of any other DHAs for any of the activities listed. It would appear that the activities of this quality network did not extend to determining the needs of patients but consisted in imposing joint requirements on Providers.

DETERMINING HOW A QUALITY STRATEGY SHOULD BE IMPLEMENTED

This question was related to Question 1(a) "Determining a Quality Strategy or Mission Statement Health Care" and therefore a similar pattern of responses was expected to emerge.

Overall, 76.3% of respondents stated that they had been involved in determining how a quality strategy should be implemented. This is compared to 81.4% of DHAs who had determined a quality strategy or mission statement for health care. Consequently, slightly fewer DHAs had actually determined the implementation process compared to those responsible for drawing up a strategy. The conclusion reached was that DHAs felt there was a greater need to have a quality strategy in place, in order to demonstrate an organisation-wide commitment to quality, than to determine the fine details of how it would be implemented.

In determining the implementation of the quality strategy, 72.9% of DHAs had involved Providers, 16.9% had involved neighbouring DHAs, 11.9% had involved the RHA and 5.1% had involved the NHS Executive. These results can be compared to the breakdown of responses provided for Question 1(a) where 52.5% of DHAs stated that they had involved Providers in the process, 18.6% said that other DHAs had an input and 10.2% said that the RHA shared in the process. None of the DHAs stated that the NHS Executive was involved in the process. These results suggested that Purchasers were more likely to receive an input from

other parties at the implementation stage rather than during the drafting of the strategy. The results according to Regions were as follows:

CHART 8.33 WEST MIDLANDS

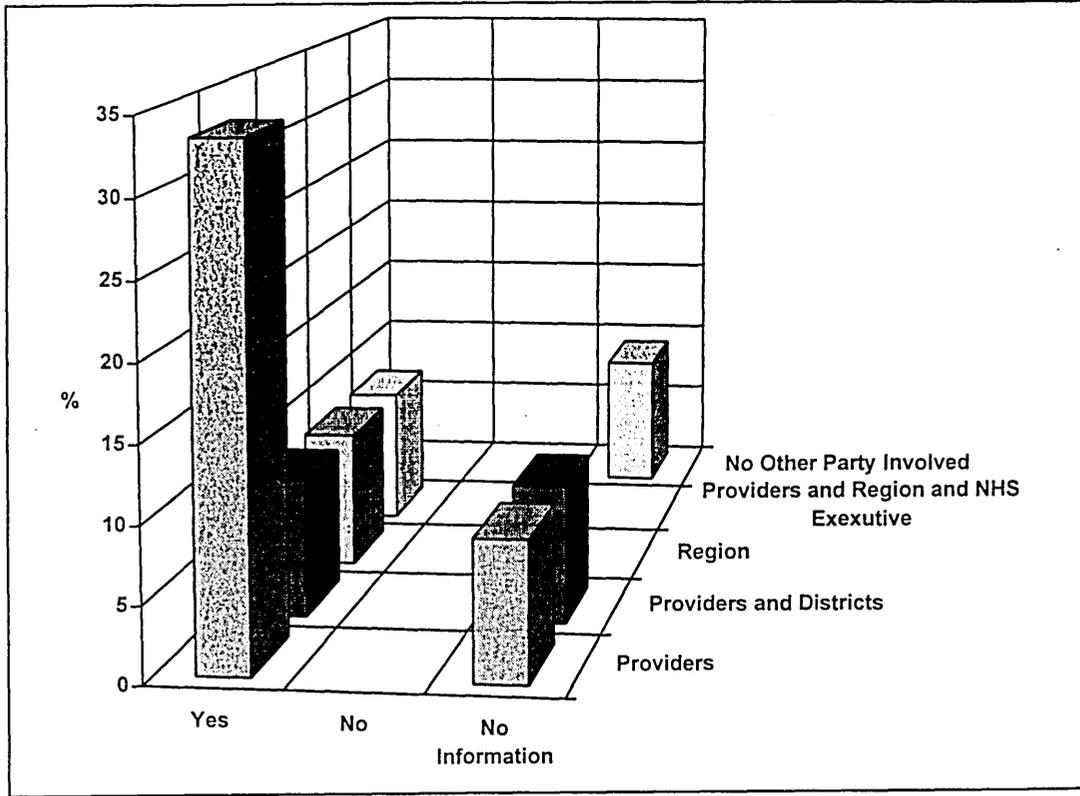


CHART 8.34 NORTHERN AND YORKSHIRE

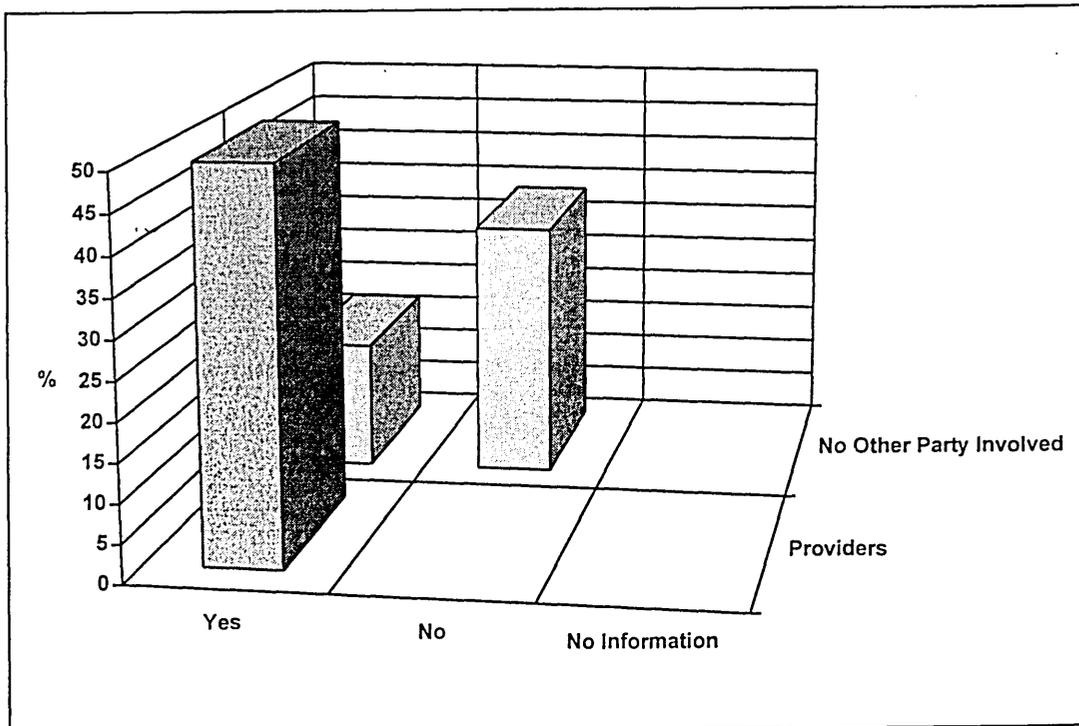


CHART 8.35 SOUTH THAMES

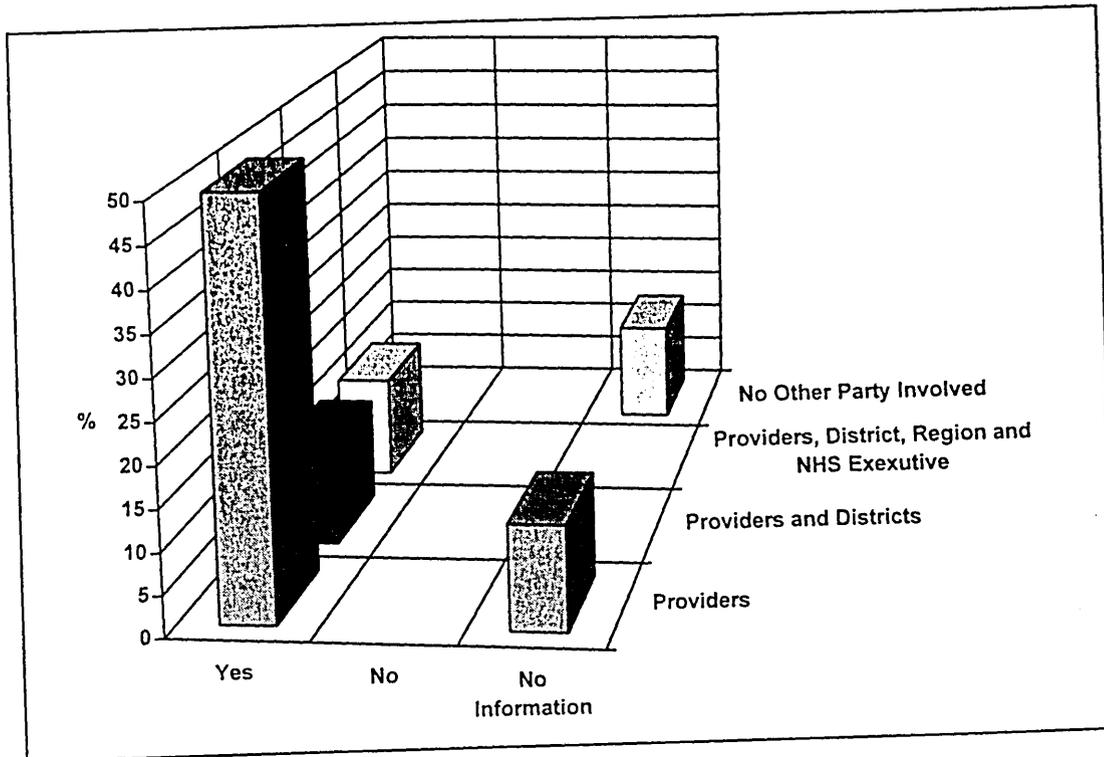


CHART 8.36 ANGLIA AND OXFORD

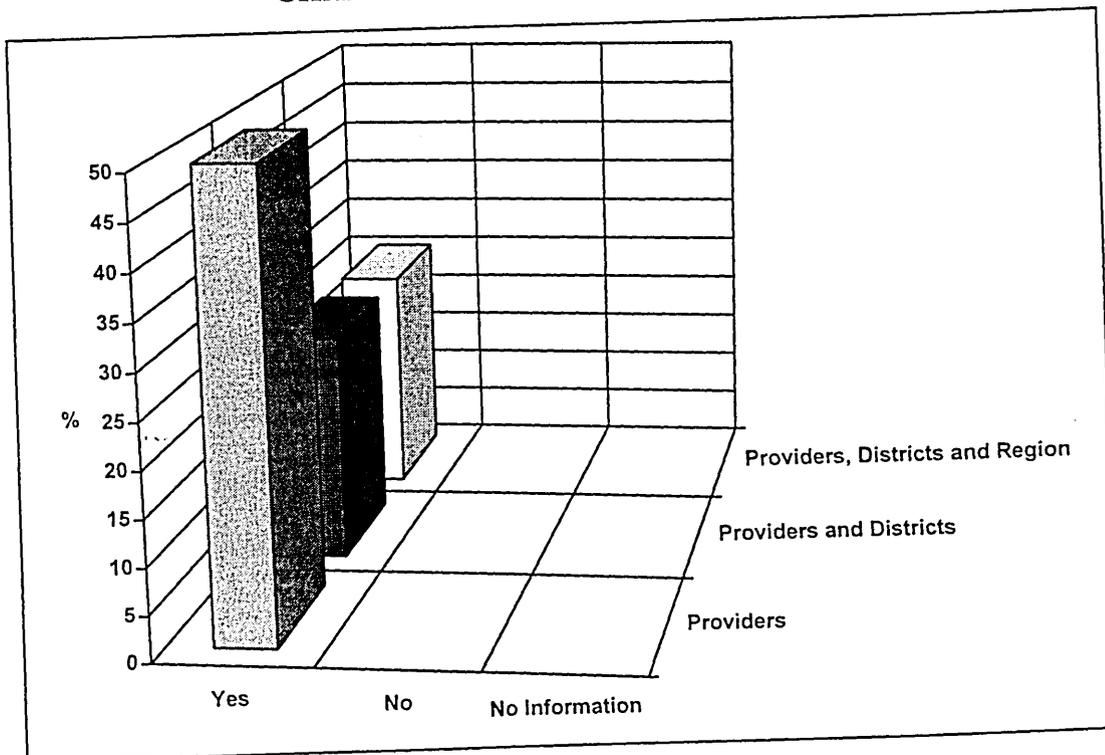


CHART 8.37 TRENT

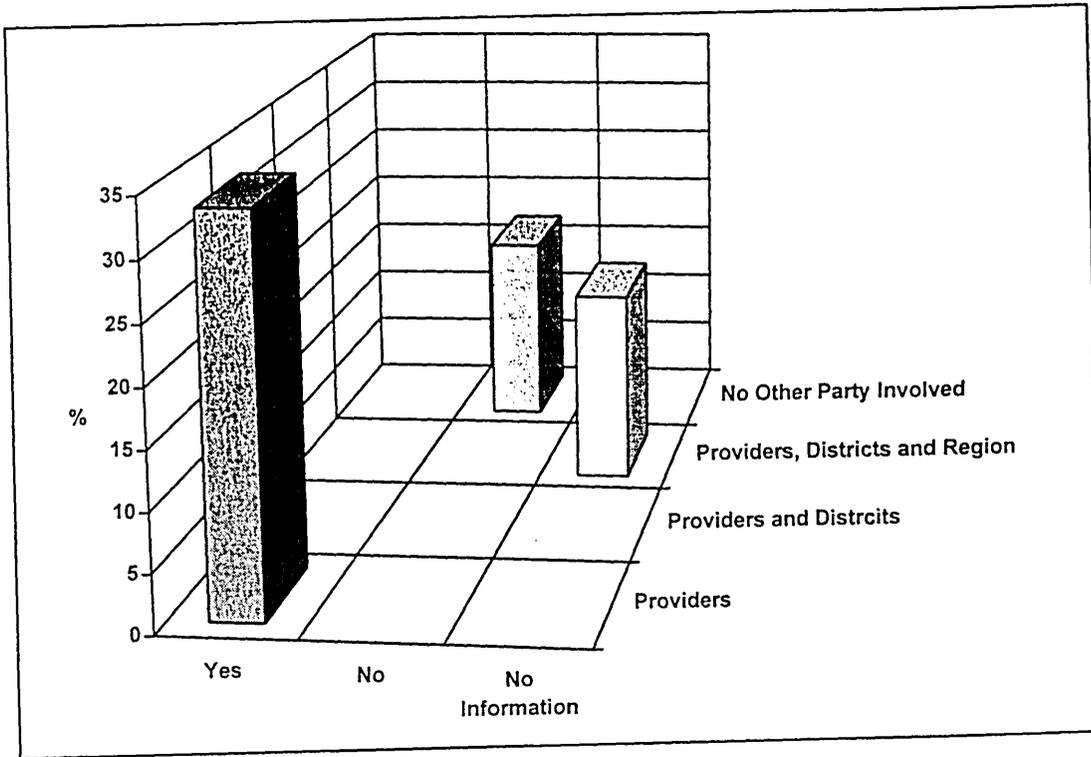


CHART 8.38 NORTH THAMES

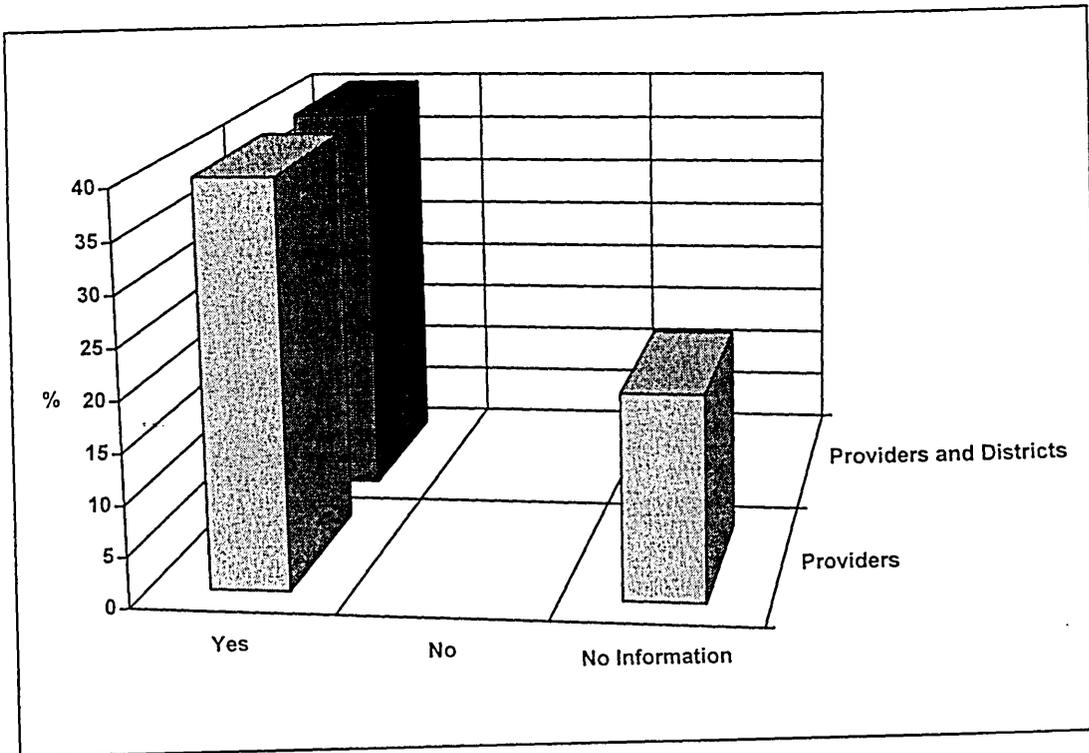


CHART 8.39 NORTH WEST

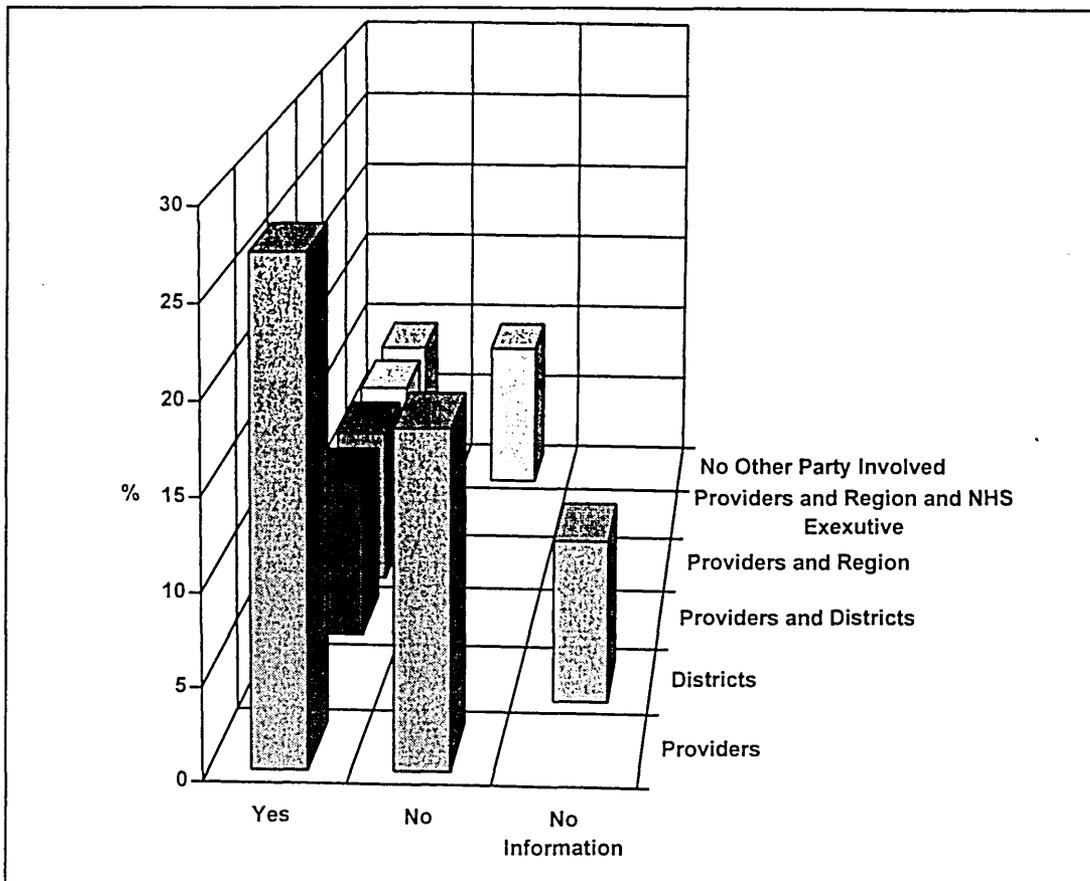
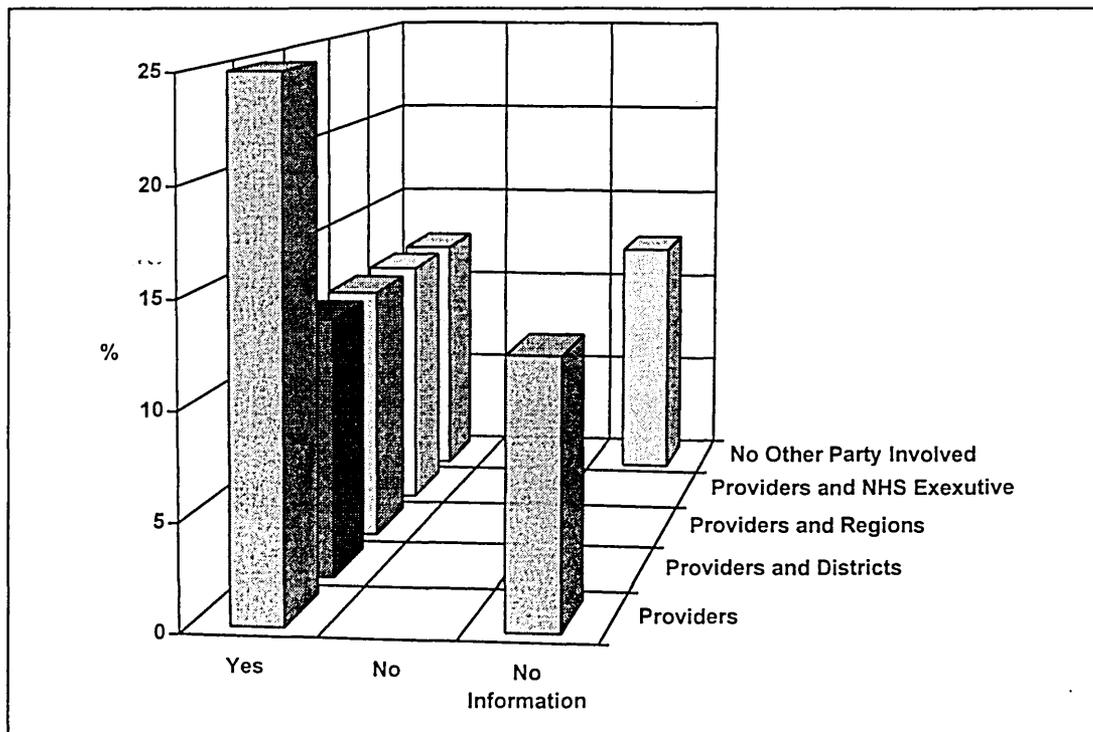


CHART 8.40 SOUTH AND WEST



It was found useful to compare these results with the results from Question 1(a). All the DHAs within the South and West Region stated that they had been involved in determining a quality strategy or mission statement, however, only 75% had determined how this strategy should be implemented. In addition, 37.5% of these DHAs had determined a quality strategy with the involvement of their Providers only, but, this figure dropped to 16.6% at the implementation stage. This may be contrasted with the experience of DHAs in the West Midlands Region where 44% had determined a quality strategy with the involvement of just their Providers whilst 62.5% involved Providers alone during implementation. Clearly, different processes were being employed by the DHAs in the two Regions. The South and West Region would appear to be in the better position as result of involving their Providers at an earlier stage. In addition, the involvement of the RHA and the NHS Executive might have been seen to add greater legitimacy to the quality strategies devised by the DHAs in this Region.

More DHAs in the South Thames Region were found to be involved with determining how to implement a quality strategy than had actually devised a quality strategy. This could be accounted for by those DHAs who had not determined a quality strategy for their own organisation but were involved in implementing a strategy initiated by other parties, particularly Providers. Overall, there was more involvement with Providers at the implementation stage and less involvement from other DHAs and RHAs. Equally significant were the numbers of DHAs undertaking this activity alone. For example, 83.3% of DHAs involved in determining a quality strategy in the South Thames Region were doing so without the involvement of other parties, whilst this had dropped to 14.3% at the implementation stage. This pattern was repeated in the Northern and Yorkshire Region where 60% of those DHAs which had determined a quality strategy had done so without the involvement of other parties, yet, this dropped to 25% at the implementation stage, but the trend was less marked in the West Midlands, North West and South and West Regions. Clearly, whilst it was possible to devise a quality strategy without the involvement of other parties, its implementation needed the co-operation of other parties, particularly Providers. In contrast, the North Thames Region stood alone where each DHA registered the involvement of another party in both determining a quality strategy and determining how it should be implemented and, therefore, might be expected to be further advanced than DHAs in other Regions.

A significant factor in the equation was the role RHAs. Their involvement in quality management activities was quite significant and might have indicated the degree to which a quality strategy became incorporated into the corporate contract between the DHA and the RHA. Interviews with Service Quality Managers at those DHAs implementing TQM suggested that the involvement of the RHA does not go much beyond this point.

DETERMINING THOSE FACTORS WHICH SHOULD BE USED TO ASSESS THE QUALITY OF PROVIDERS

Despite the fundamental nature of the above activity in the process of delivering quality health care it would have been surprising to witness a DHA which had not been undertaking this work. Overall, 88.1% of DHAs indicated that they were involved in determining what factors should be used to assess the quality of Providers. Of those DHAs who were undertaking this work, 84.7% stated that Providers were also involved in the activity, 32.2% indicated that neighbouring DHAs were involved, 27.1% indicated that the RHA was involved and 16.9% stated that the NHS Executive was involved. On a Regional Basis the results were as follows:

CHART 8.41 WEST MIDLANDS

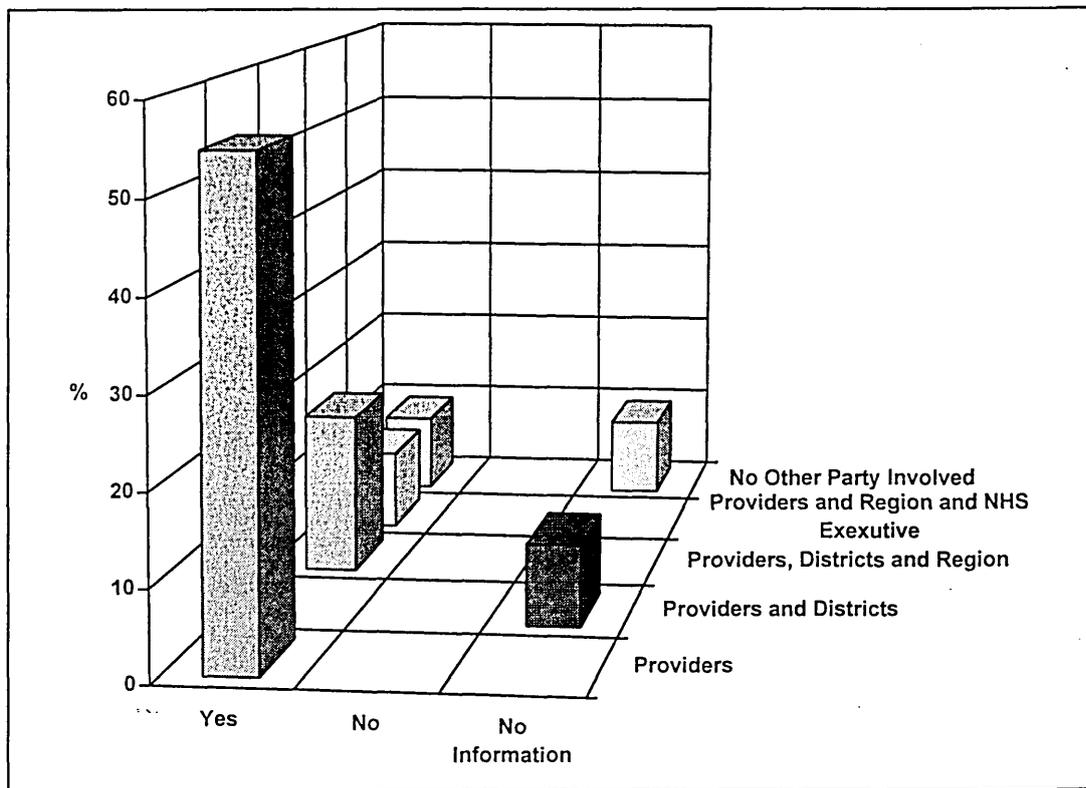


CHART 8.42 NORTHERN AND YORKSHIRE

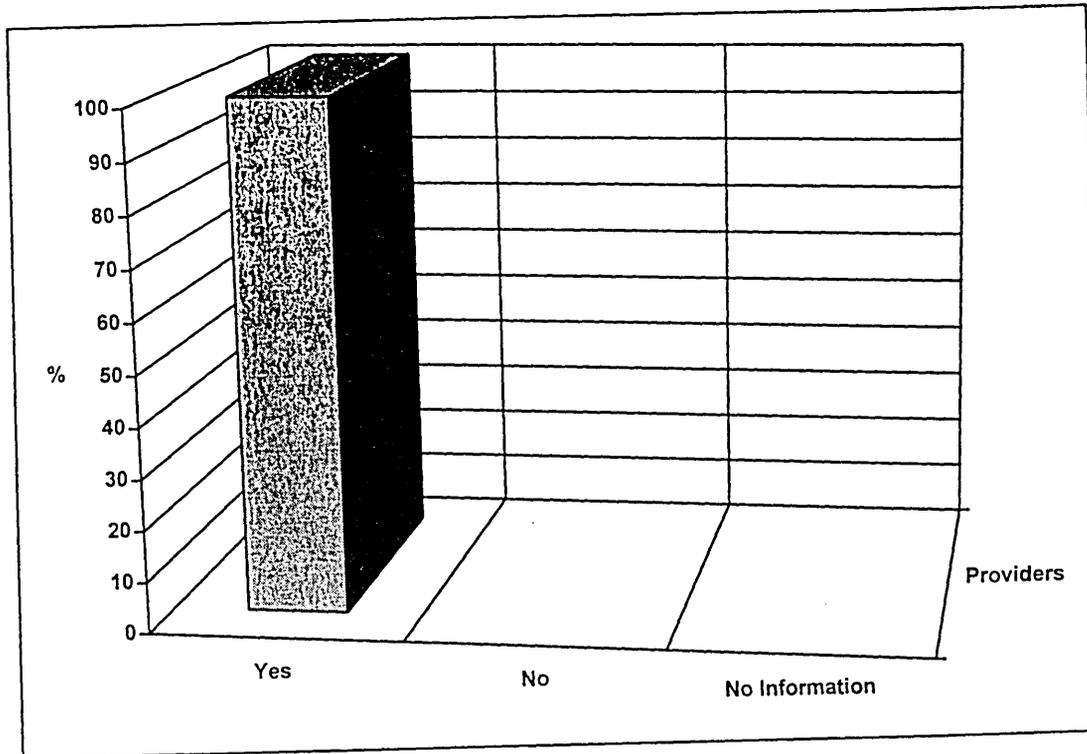


CHART 8.43 SOUTH THAMES

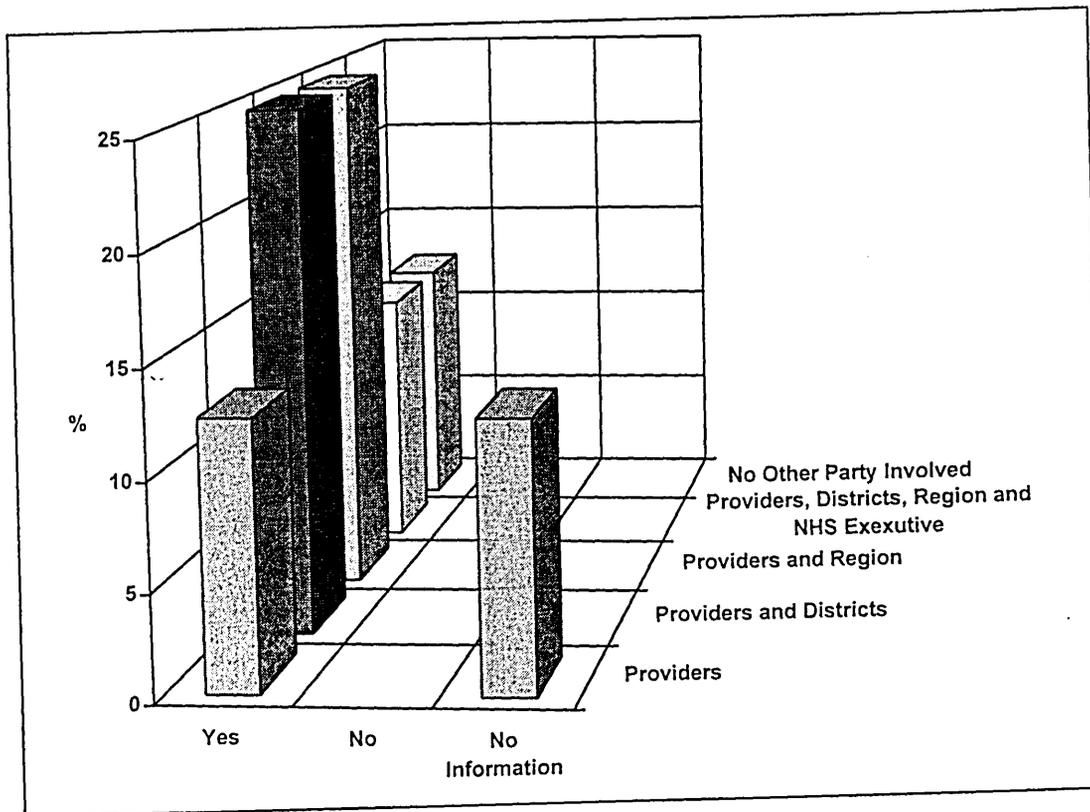


CHART 8.44 ANGLIA AND OXFORD

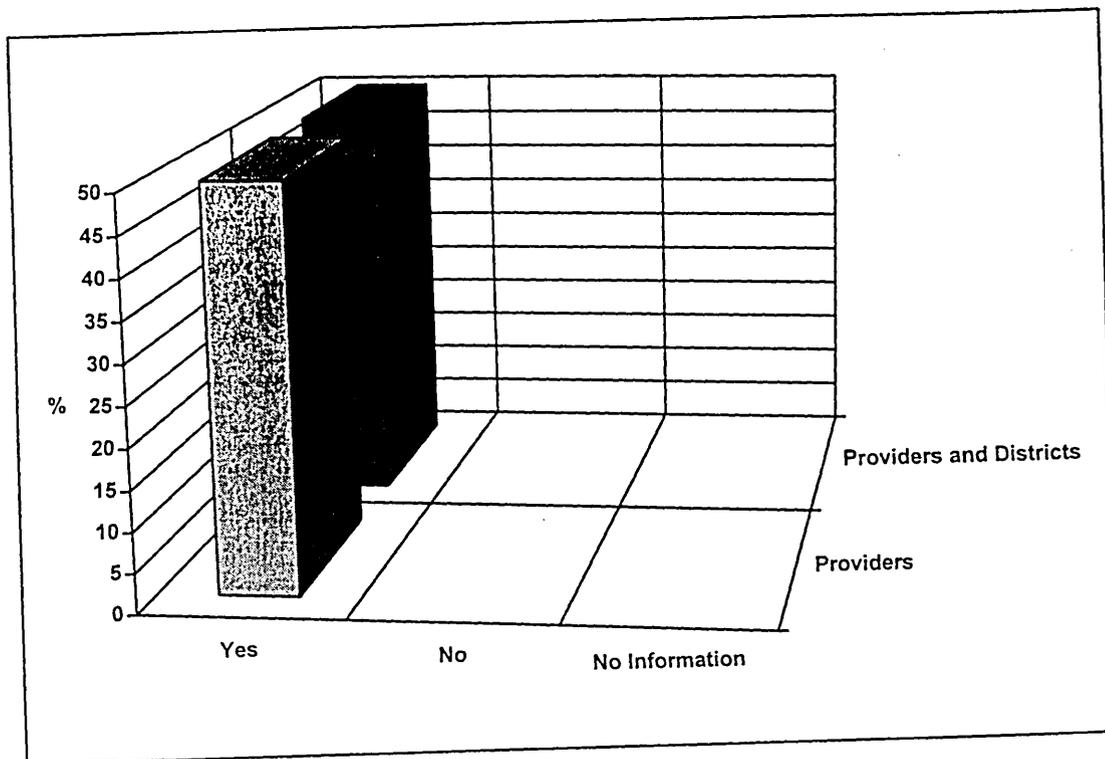


CHART 8.45 TRENT

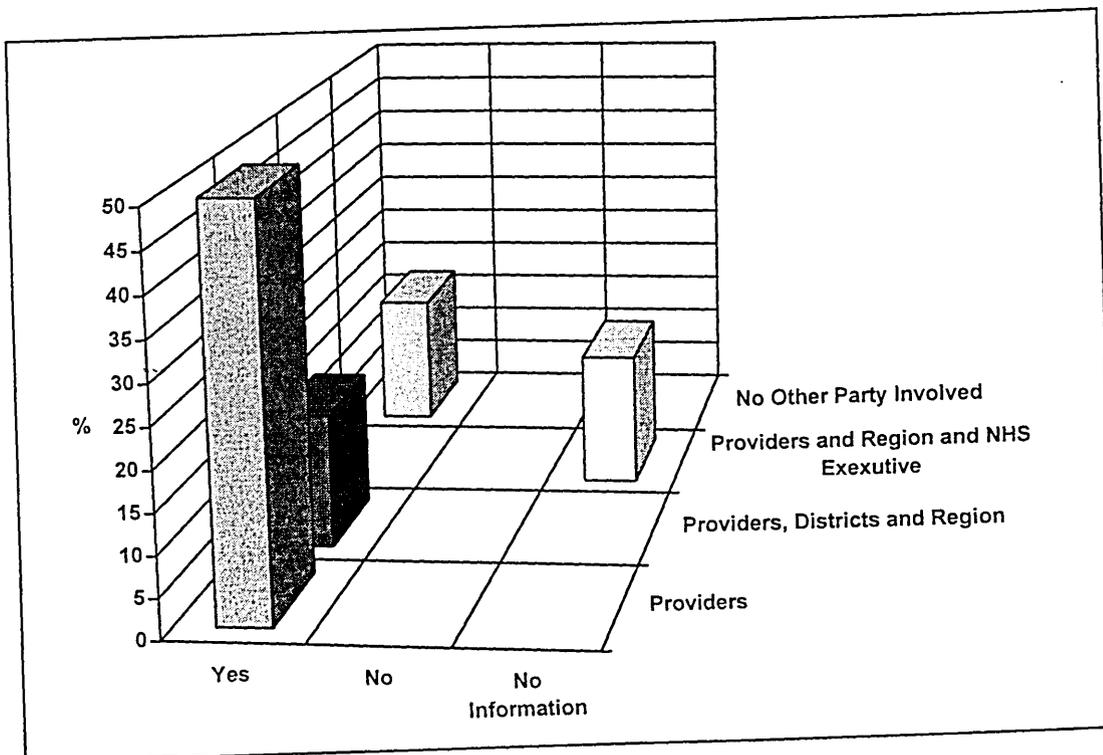


CHART 8.46 NORTH THAMES

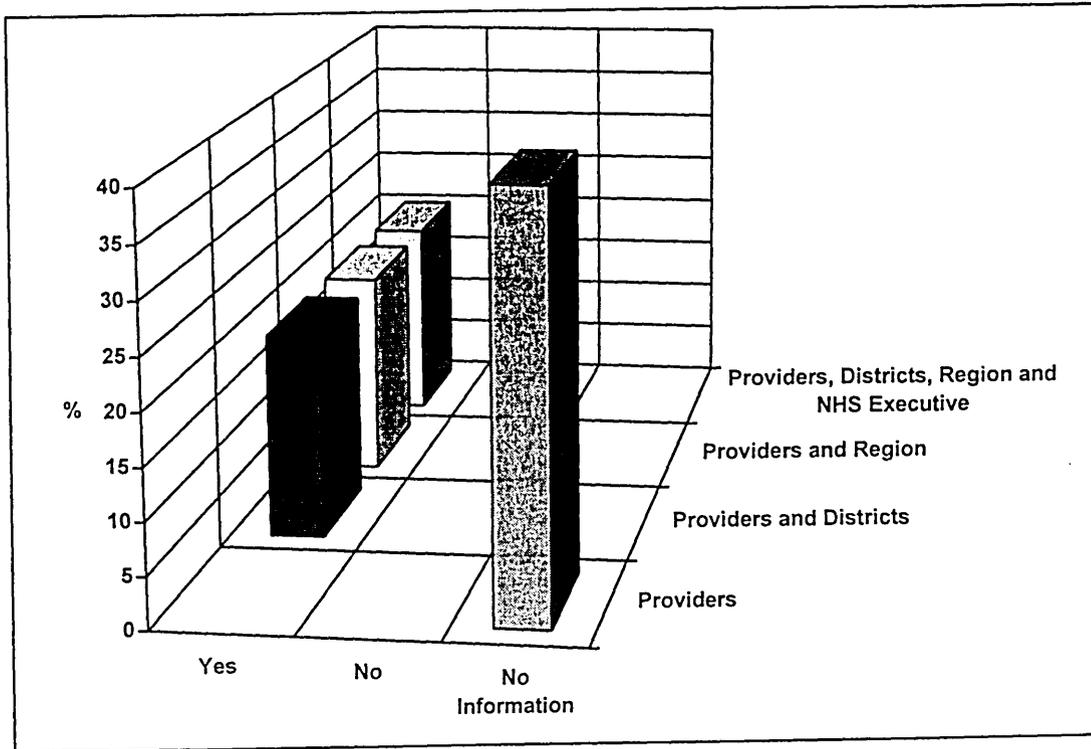


CHART 8.47 NORTH WEST

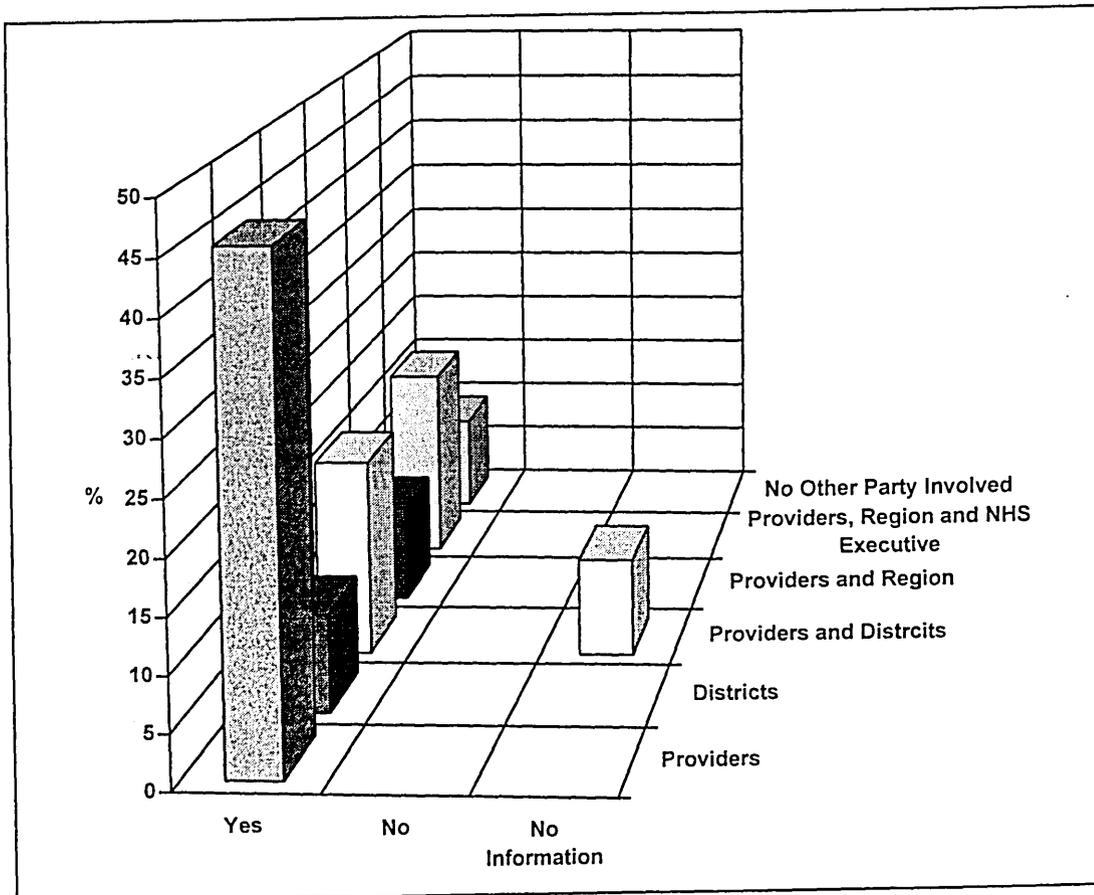
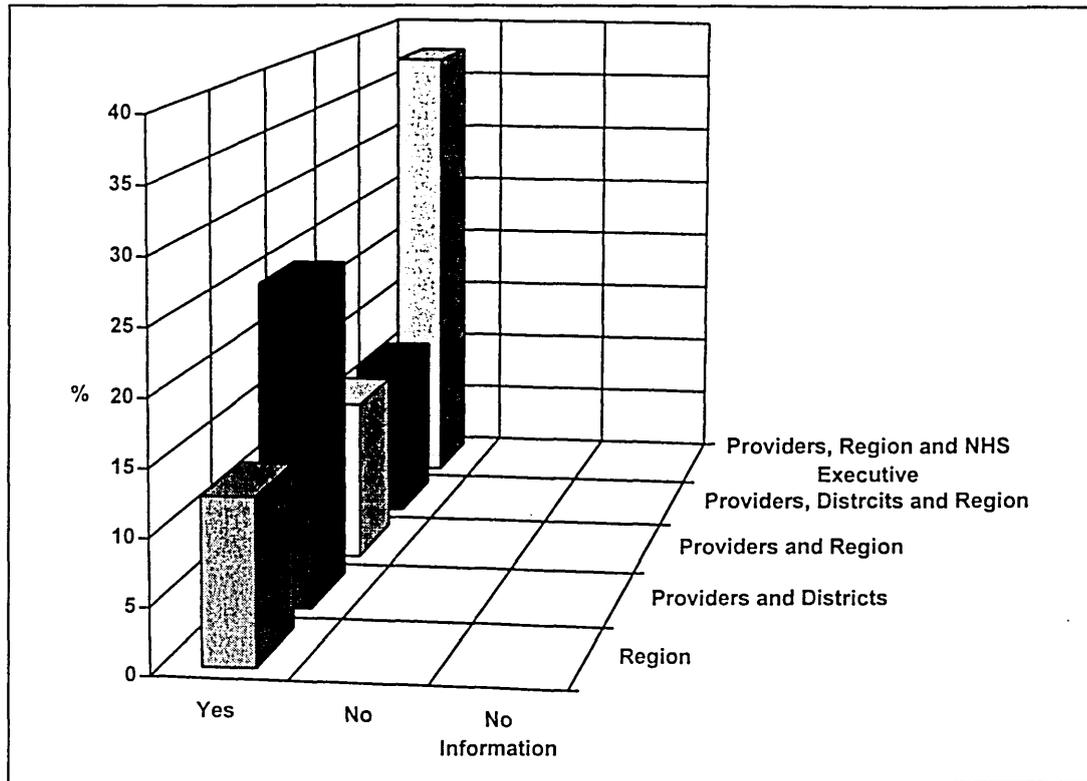


CHART 8.48 SOUTH AND WEST



All the DHAs in the Northern and Yorkshire, Anglia and Oxford and South and West Regions stated that they had been involved in determining what factors should be used to assess the quality of Providers. If the quality of Providers was taken as a measure of how well Providers met the needs of their patients, then it might be expected that the responses given for determining the needs of patients would closely match those for determining the quality of Providers and this proved to be the case. There were differences, however, regarding the involvement of other parties.

A comparison of the above mentioned Regions revealed that all the DHAs in the three Regions reported the involvement of Providers for both activities. In Northern and Yorkshire, only Providers were involved in determining the criteria used to assess the quality of Providers. Whilst in the South and West, all the DHAs stated that Providers had been involved in determining the quality needs of patients of which 62.5% registered only the involvement of Providers. However, in determining what factors should be used to assess the quality of Providers, all the DHA registered the involvement of at least one other party in addition to Providers. In Anglia and Oxford, all the DHAs registered the involvement of Providers for both activities, however, whilst one registered the involvement of Providers, neighbouring DHAs and the RHA when determining the quality needs of patients, the RHA was not involved

in determining the factors used to assess the quality of Providers. In the North Thames Region, all DHAs which indicated that they were involved in determining the factors to be used to assess the quality of Providers stated that neighbouring DHA were involved. One third of the DHA in this region stated that only neighbouring DHAs had been involved.

The findings suggest that, on the whole, more interest was taken across the different parties of the NHS of patient's needs rather than the ability of Providers to meet these needs. The high incidence of involvement amongst neighbouring DHAs indicated the existence of joint purchasing arrangements agreed amongst DHAs. These might not necessarily correspond to patient's requirements and, therefore, did not represent a move towards improving health care quality.

DETERMINING HOW THE QUALITY OF PROVIDERS SHOULD BE MEASURED

Having determined what criteria should be used to determine the quality of Providers, the research dictated that thought needed to be given to how these criteria should be measured. For example, waiting times are frequently used as an indicator of service quality, however, not all Providers measured waiting times on the same basis and not all DHAs will place the same importance on waiting times when assessing the relative quality of their Providers.

Overall, 86.4 % of DHAs stated that they had been determined how the quality of Providers should be measured, 86.4% stated that Providers had been involved, 30.5% indicated that neighbouring DHAs had been involved, 27.1% stated that the RHA had been involved and 15.3% said that the NHS Executive had been involved. The regional differences were as follows:

CHART 8.49 WEST MIDLANDS

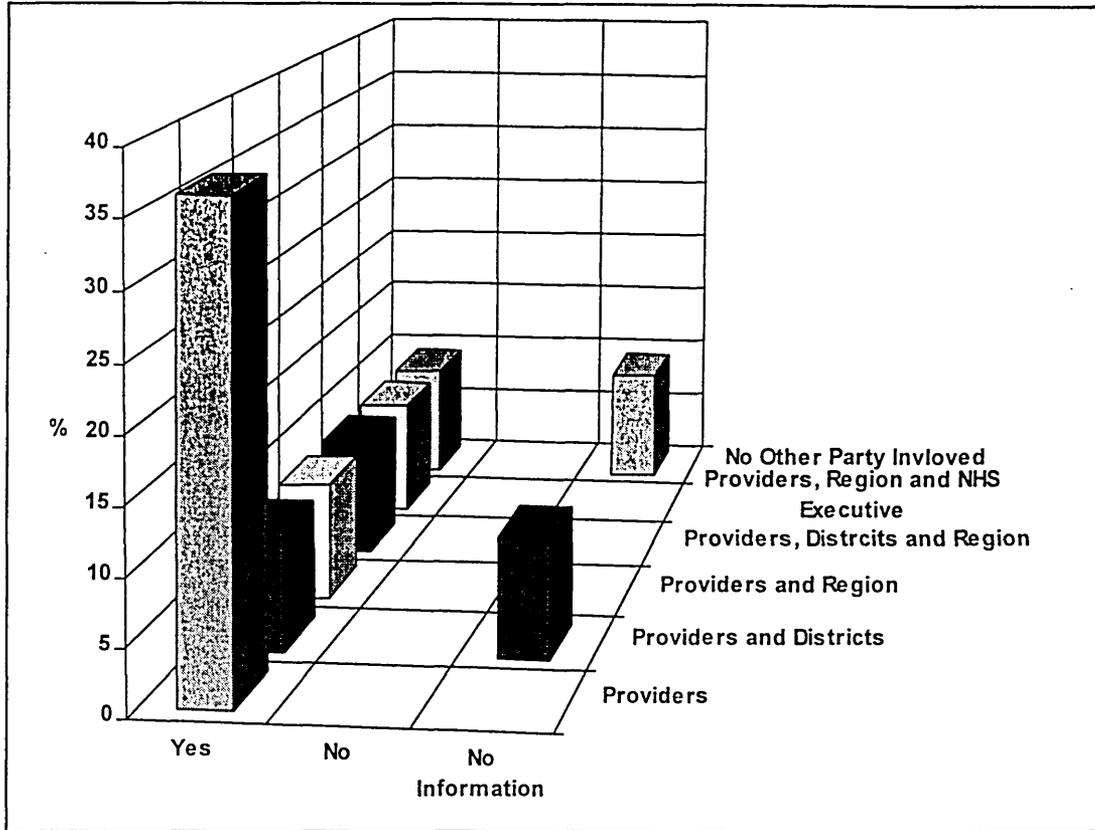


CHART 8.50 NORTHERN AND YORKSHIRE

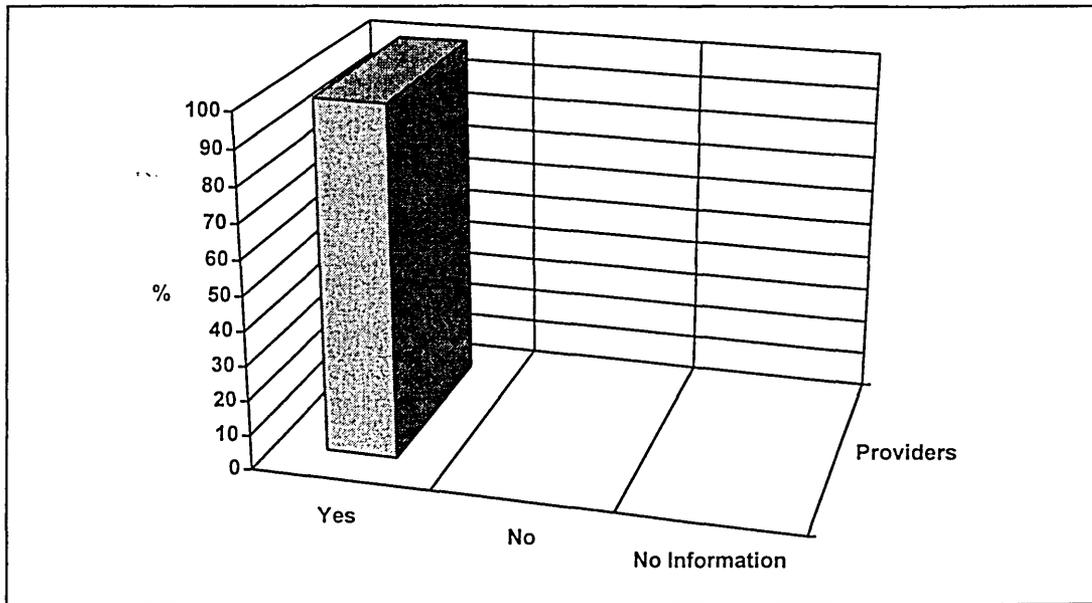


CHART 8.51 SOUTH THAMES

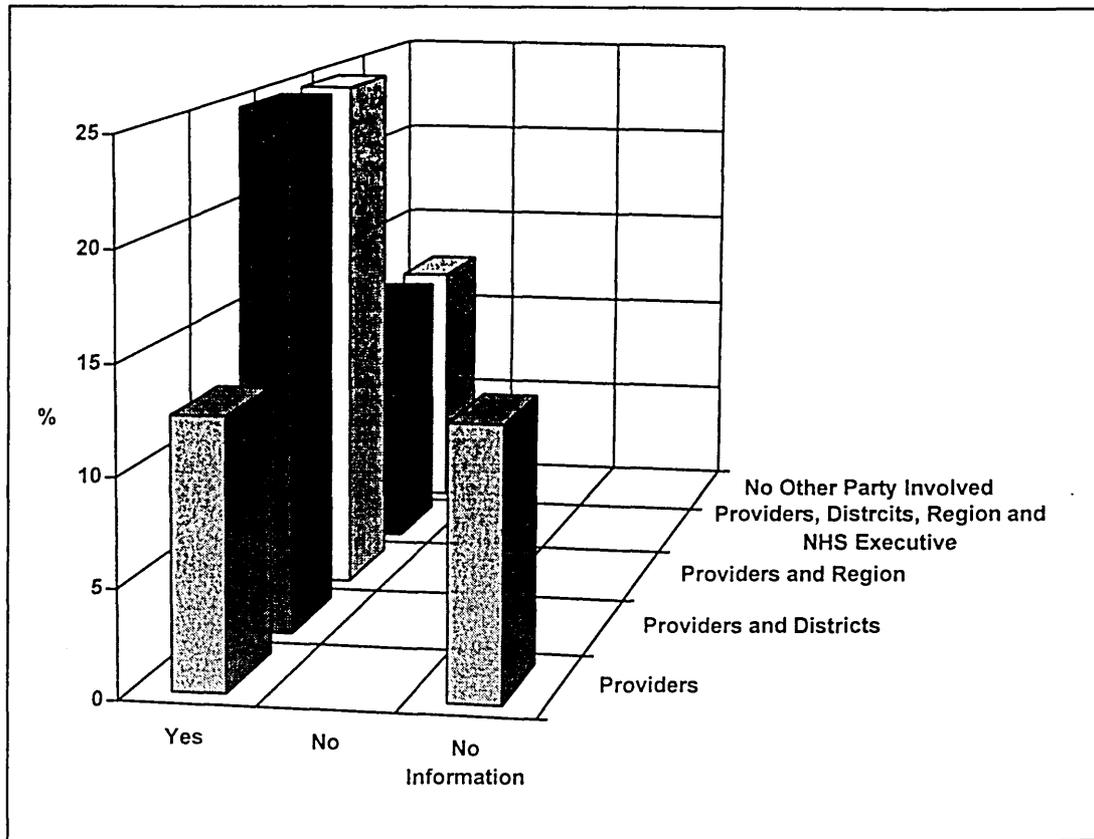


CHART 8.52 ANGLIA AND OXFORD

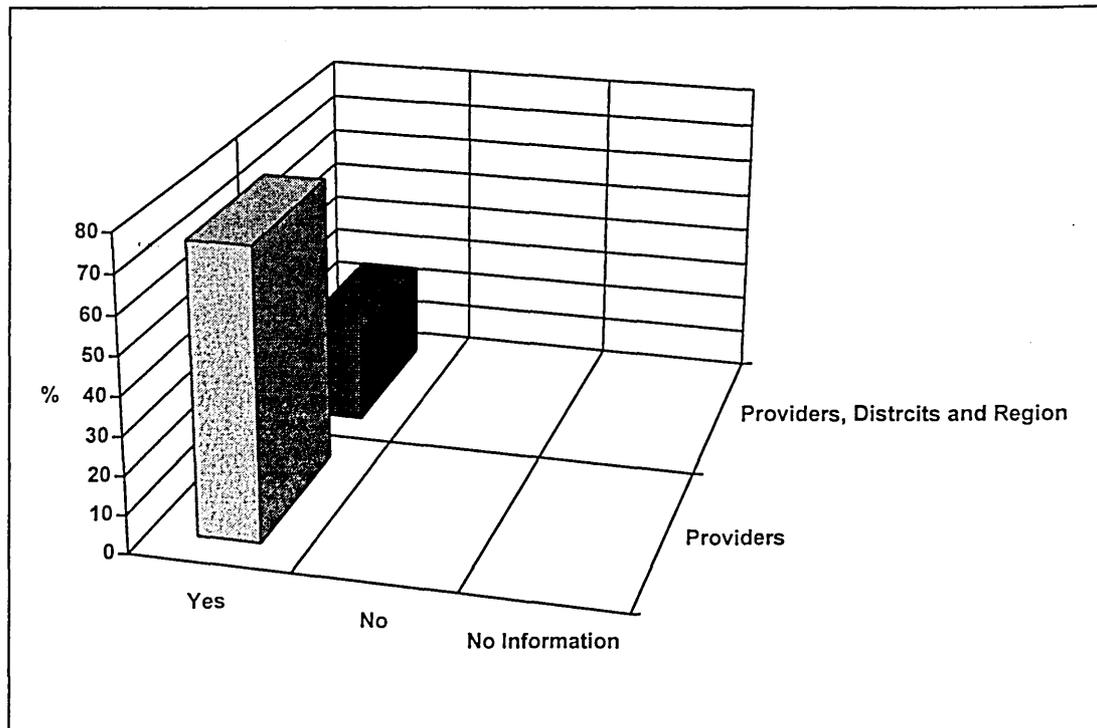


CHART 8.53 TRENT

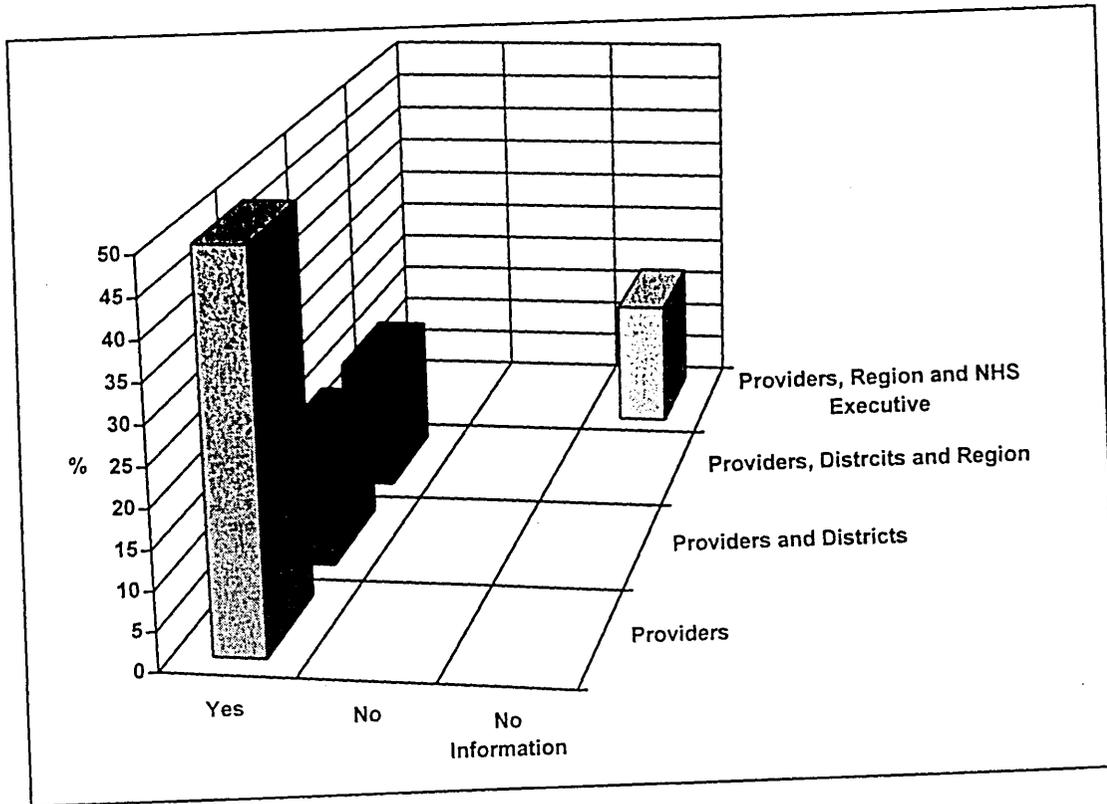


CHART 8.54 NORTH THAMES

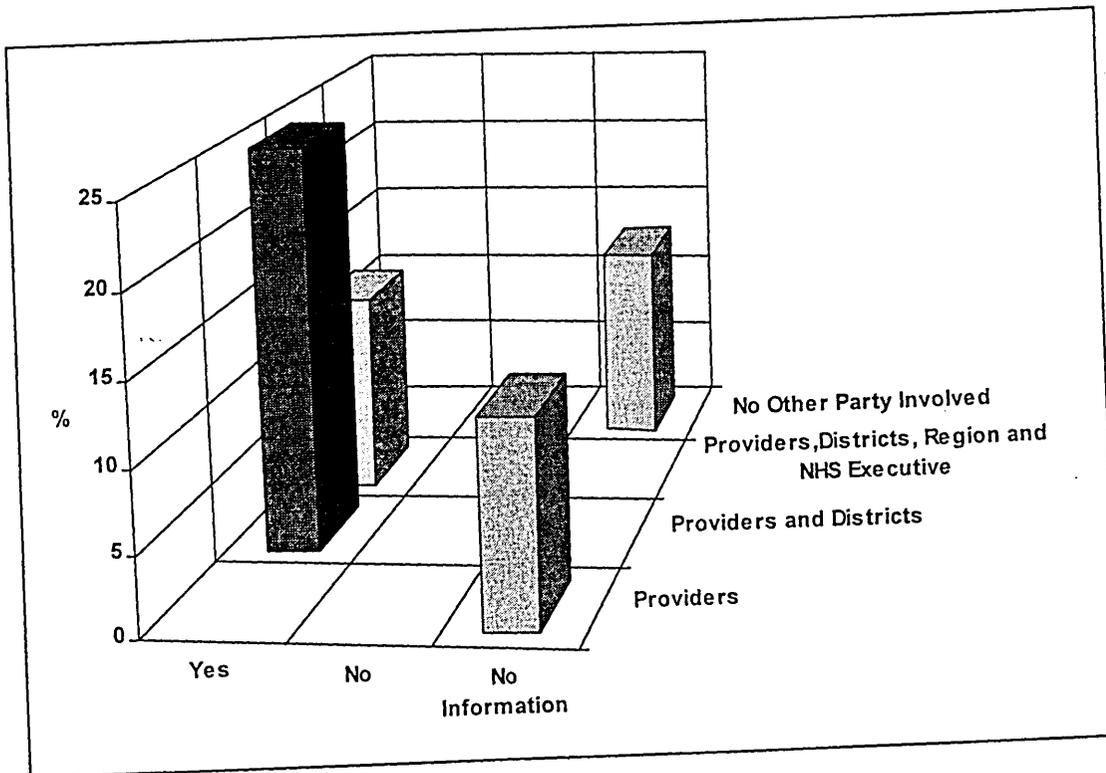


CHART 8.55 NORTH WEST

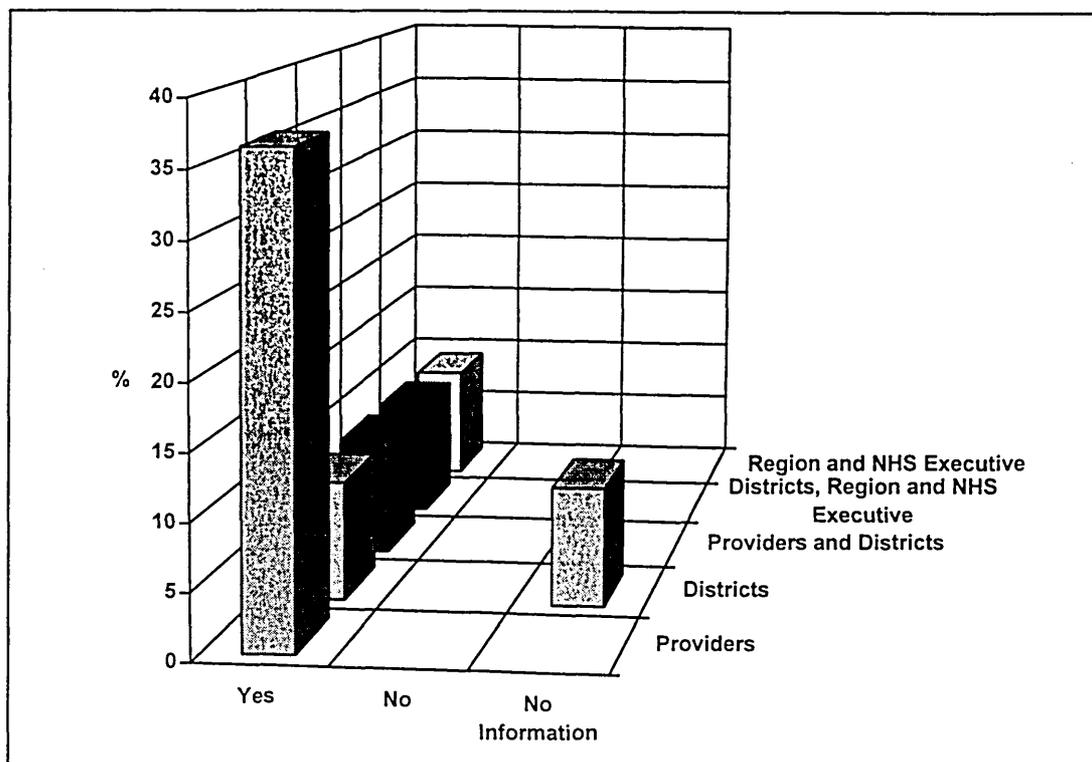
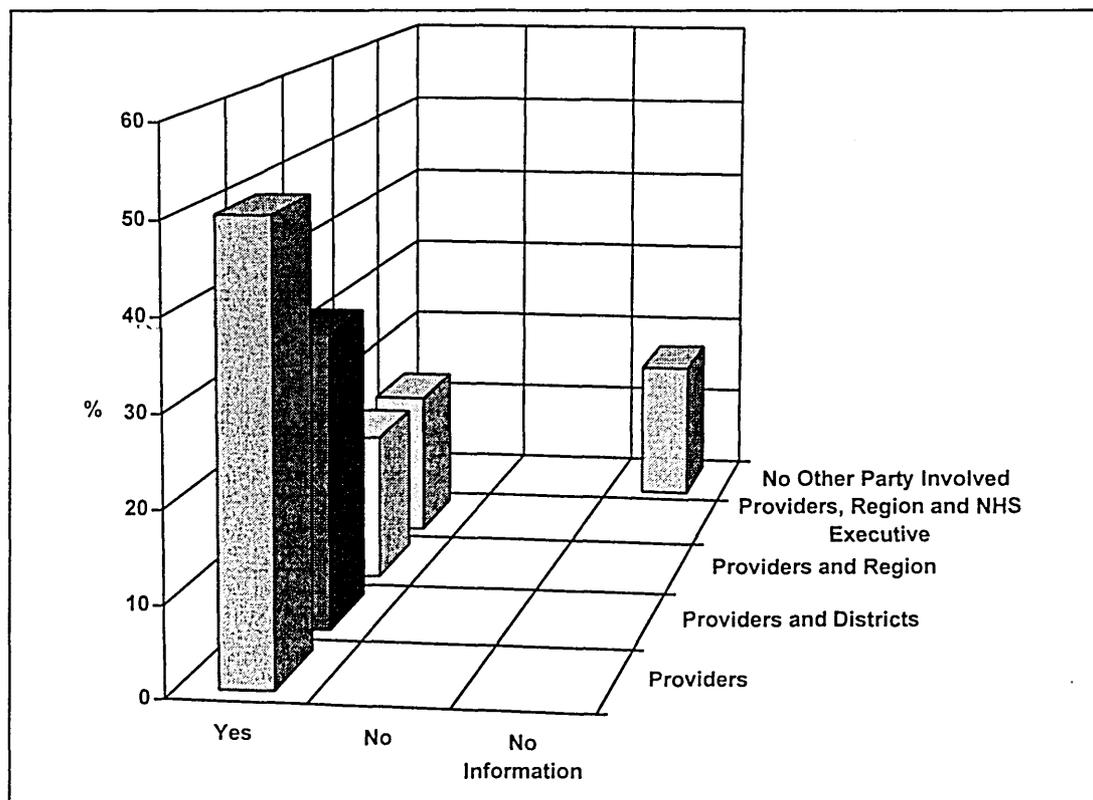


CHART 8.56 SOUTH AND WEST



As expected, the responses were similar to those for determining what factors should be used to assess the quality of Providers. There were, however, significant differences. Within the West Midlands Region, one DHA recorded only the involvement of Providers when determining how these factors should be measured but registered the involvement of Providers and the NHS Executive when determining the factors to assess the quality of Providers. Similarly in the South and West Region, 42.8% of DHA reported only the involvement of Providers when determining the basis for measuring the quality of Providers yet all of the DHAs reported the involvement of other parties when determining the criteria upon which provider quality would be assessed.

This pattern, however, was reversed in the North West Region where two DHAs who had involved only Providers when determining the factors for assessing provider quality, had involved the RHA and the NHS Executive in determining how these factors should be measured. In Trent Region, one DHA which had determined the factors to be used for assessing provider quality without the involvement of other parties did register the involvement of Providers when determining how these factors should be measured.

The involvement of the RHA and the NHS Executive in these activities was due to the perception amongst DHAs that these bodies were responsible for ensuring adherence to the requirements of the Patient's Charter and the issuing of related directives. This guidance was frequently superficial in nature and whilst, for example, statements might be issued referring to areas of health care to be addressed these stopped short of stating the mechanisms to be employed in order to meet these requirements.

DETERMINING HOW THE DHA SHOULD MANAGE THE QUALITY OF ITS OWN ACTIVITIES

This activity was undertaken by 74.6% of DHAs and was therefore the second least carried out activity, the lowest (61%) was determining a definition of quality for health care.

Further analysis revealed that 13.6% recorded the involvement of Providers, 13.6% indicated the involvement of an RHA, 8.5% indicated the involvement of the NHS Executive and 5.1% stated that other DHAs had been involved. This left 45.4% who did not indicate the involvement of another party in carrying out this work. On a regional basis the results were as follows:

CHART 8.57 WEST MIDLANDS

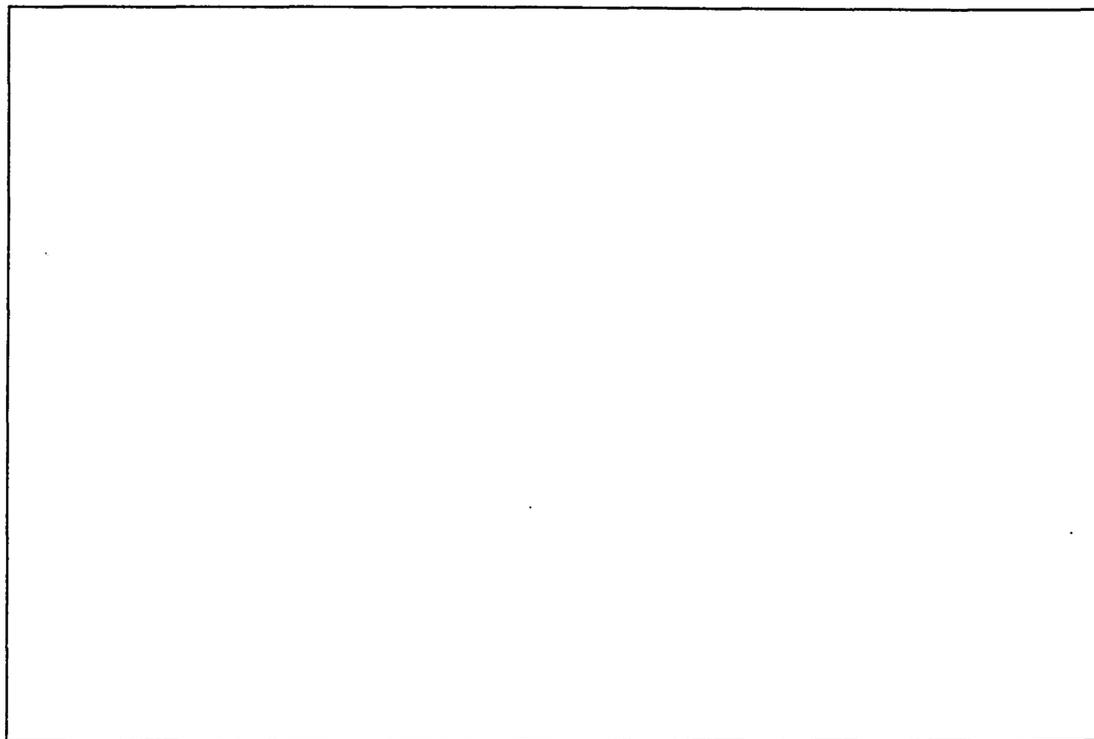


CHART 8.58 NORTHERN AND YORKSHIRE

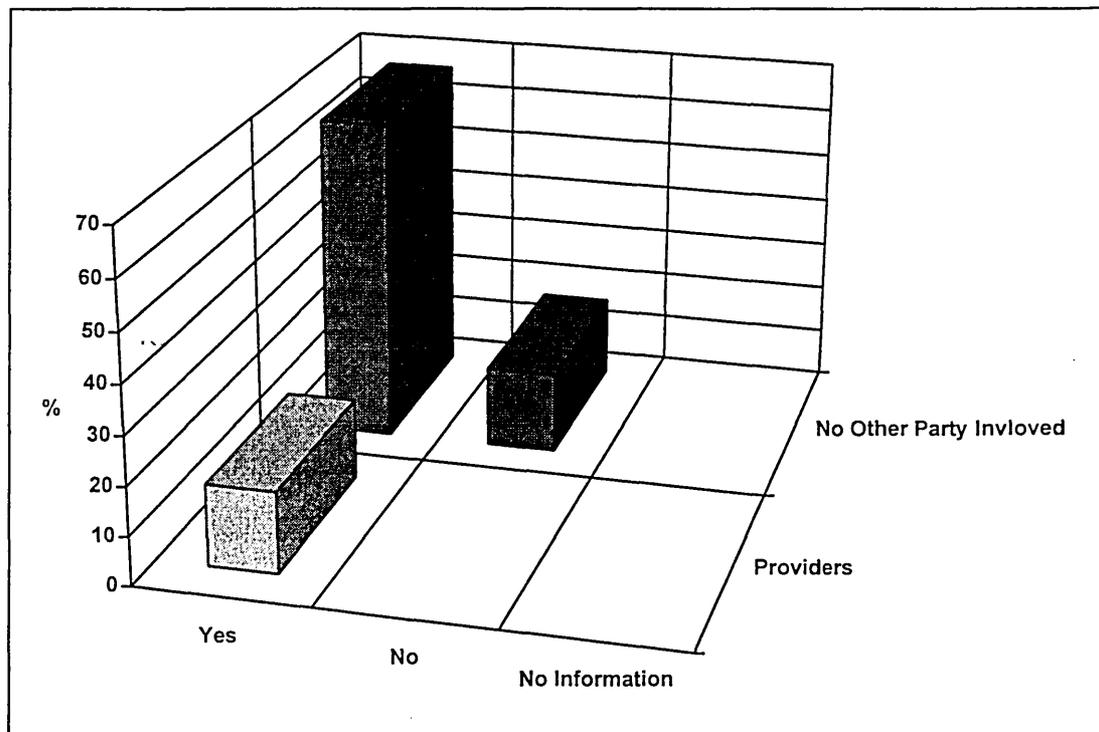


CHART 8.59 SOUTH THAMES

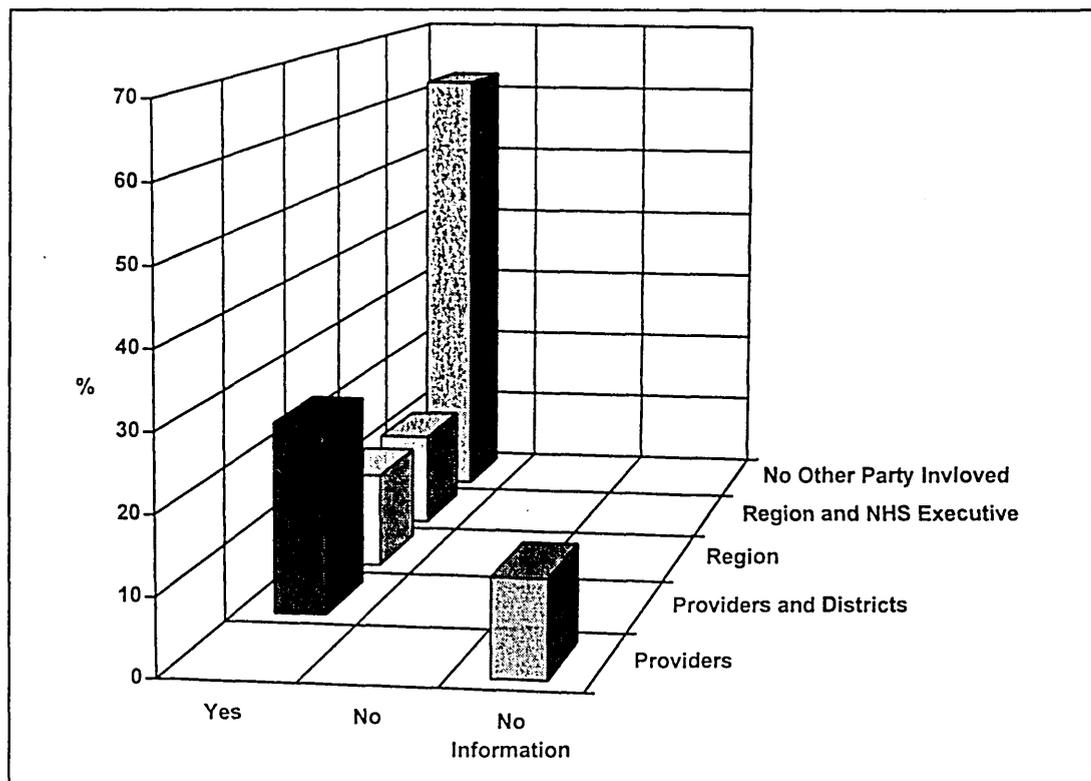


CHART 8.60 ANGLIA AND OXFORD

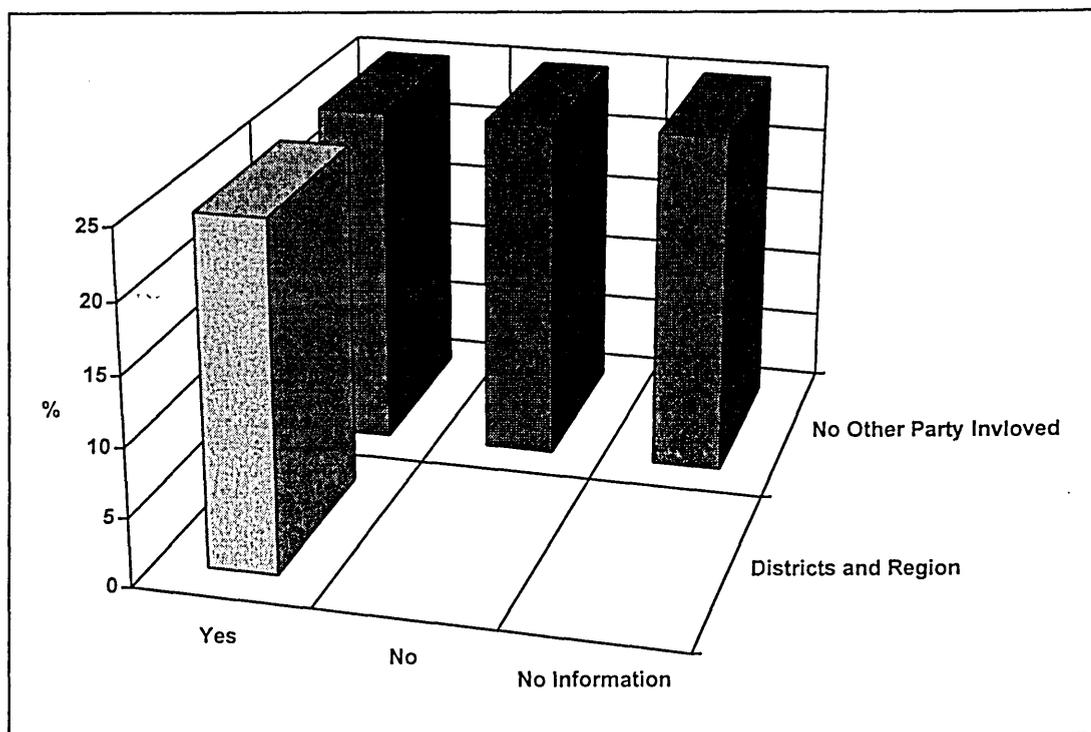


CHART 8.63 NORTH WEST

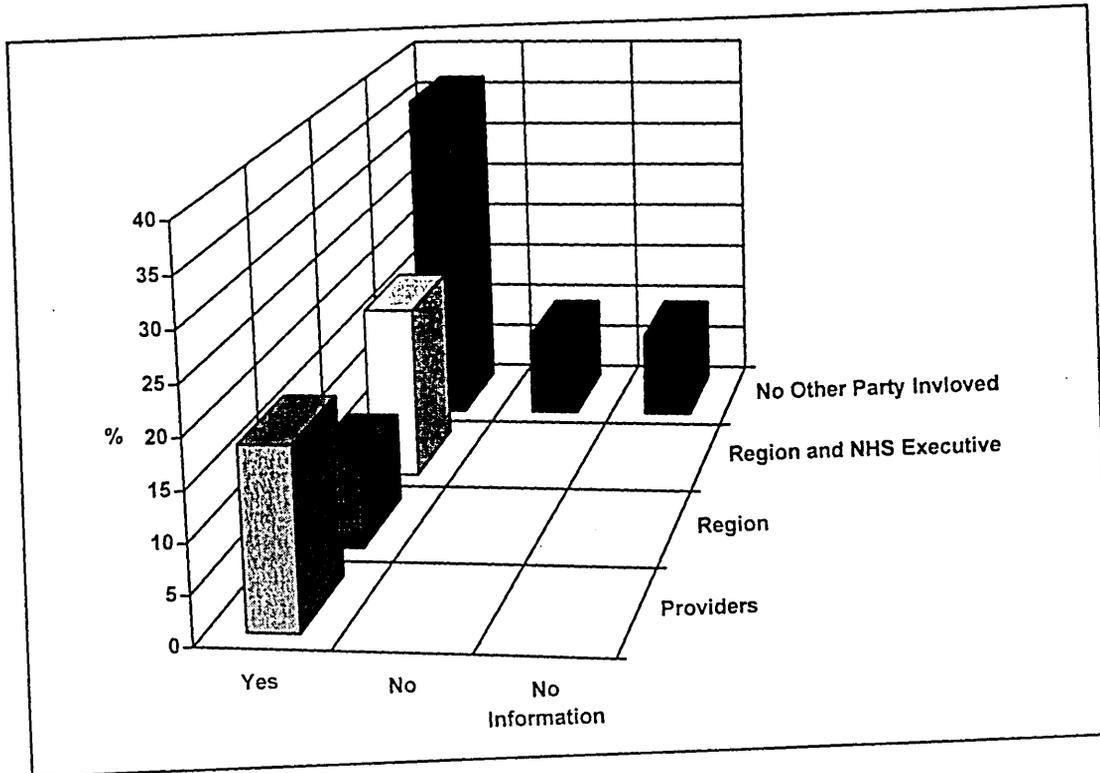
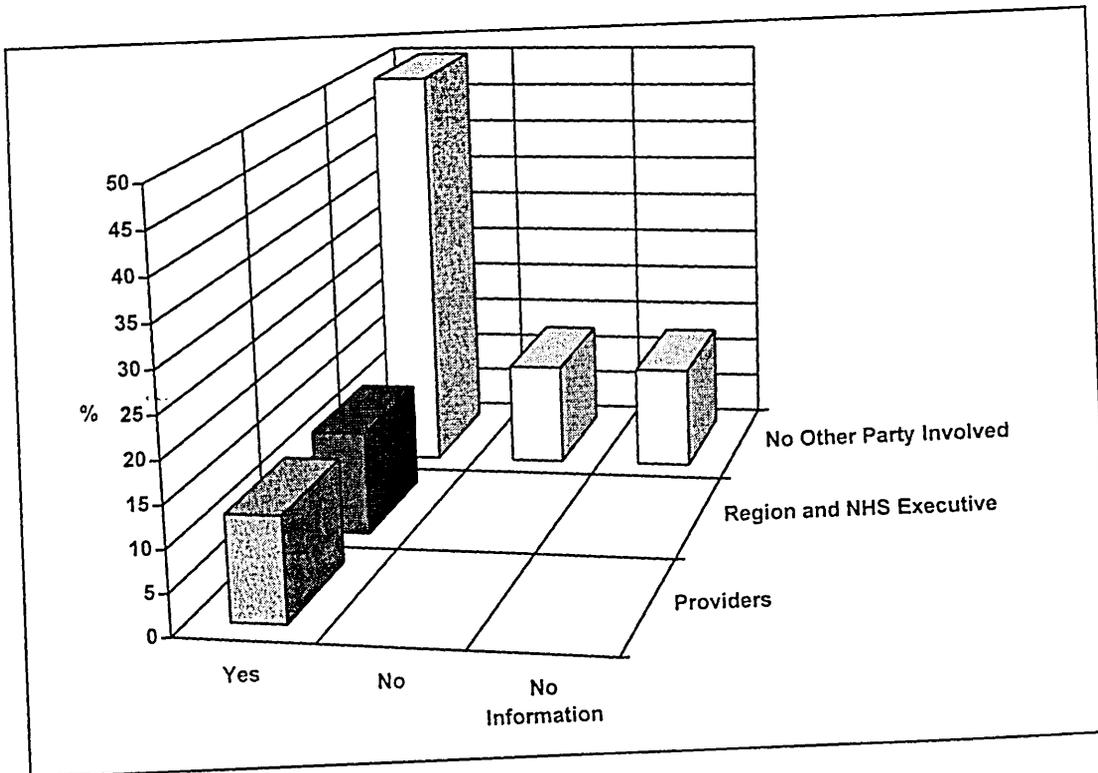


CHART 8.64 SOUTH AND WEST



The results revealed that all the DHAs within the West Midlands Region had carried out this activity without the involvement of another party and this pattern was repeated elsewhere. Only five DHAs across all the Regions recorded the involvement of Providers.

When these figures are compared with the responses made for determining a quality strategy or mission statement then the West Midlands, Anglia and Oxford, Trent and South and West Regions all recorded lower numbers of DHAs involved in determining how they should manage their own quality activities compared to those involved in determining a quality strategy. In South Thames and North West Regions, the opposite was true. There was no difference in the Northern and Yorkshire and North Thames Regions, however, these two regions recorded over 75% of DHAs determining how they should manage the quality of their own activities without the involvement of other parties.

Levels and patterns of activity varied for each quality related activity. Determining the service quality needs of patients registered the highest numbers of DHAs involved and determining a definition of quality for health care the least. The DHAs in Northern and Yorkshire recorded the narrowest range of other party involvement, with six out of the seven activities, recording the involvement of Providers alone, whilst simultaneously displaying the greatest degree of congruence in responses. In contrast the DHAs in the South and West identified at least four combinations of other party involvement in six out of the seven activities. Activity levels were highest for those activities which formed part of the requirements of the Patient's Charter and lowest for those which did not. Although there was a high percentage of DHAs which had been involved in determining a quality strategy for health care there were significantly fewer who had taken this to encompass how the DHA should manage its own quality management activities. This latter activity registered the lowest involvement by parties other than the DHA itself and suggested that little attention had been paid to this activity and few sites were taking a lead.

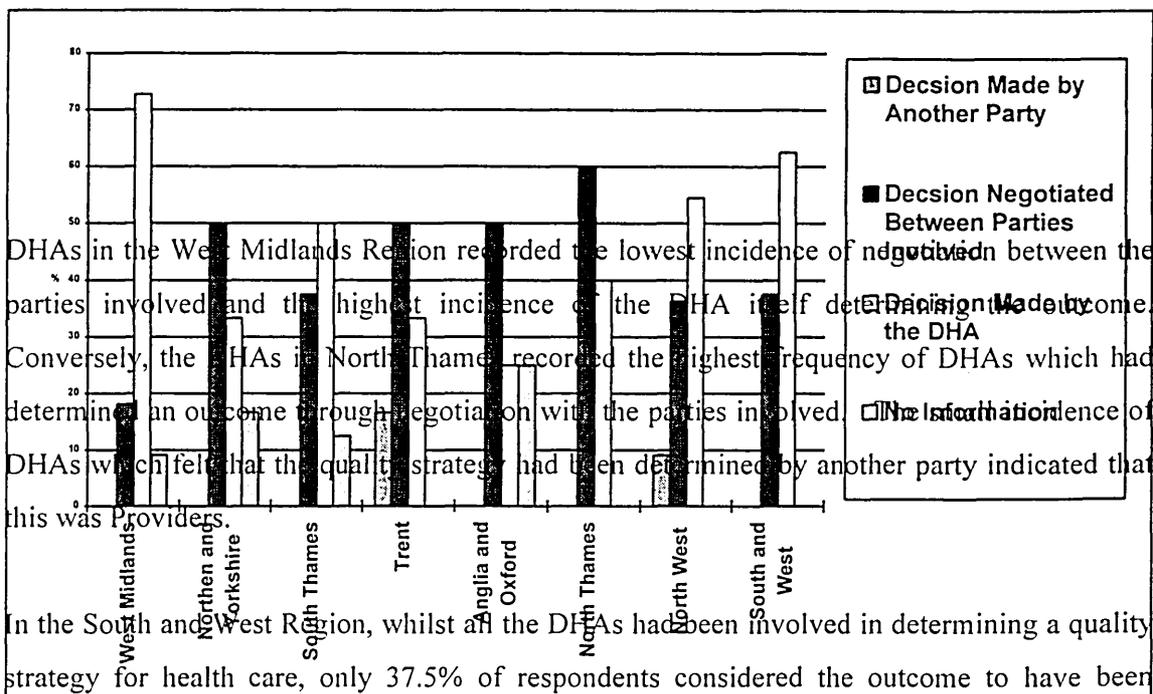
HOW THE OUTCOME FOR EACH ACTIVITY WAS DETERMINED

Preliminary interviews with Service Quality Managers at DHA level suggested that providing a quality health service was achieved through a process of negotiation between Purchasers and Providers to decide what could be achieved and at what cost. In order to assess how widespread was this practice and which activities it covered, DHAs were asked to consider how each of the activities listed in Question 1 were carried out.

Determining A Quality Strategy Or Mission Statement For Health Care

Overall, 50.8% of respondents claimed that the DHA itself had determined the outcome, 40.7% stated that the outcome had been determined through negotiation with the other parties involved, and 3.4% stated that the outcome had been determined for the DHA by another party. On a Regional basis the results were as follows:

CHART 8.65 DETERMINING A QUALITY STRATEGY OR MISSION STATEMENT FOR HEALTH CARE



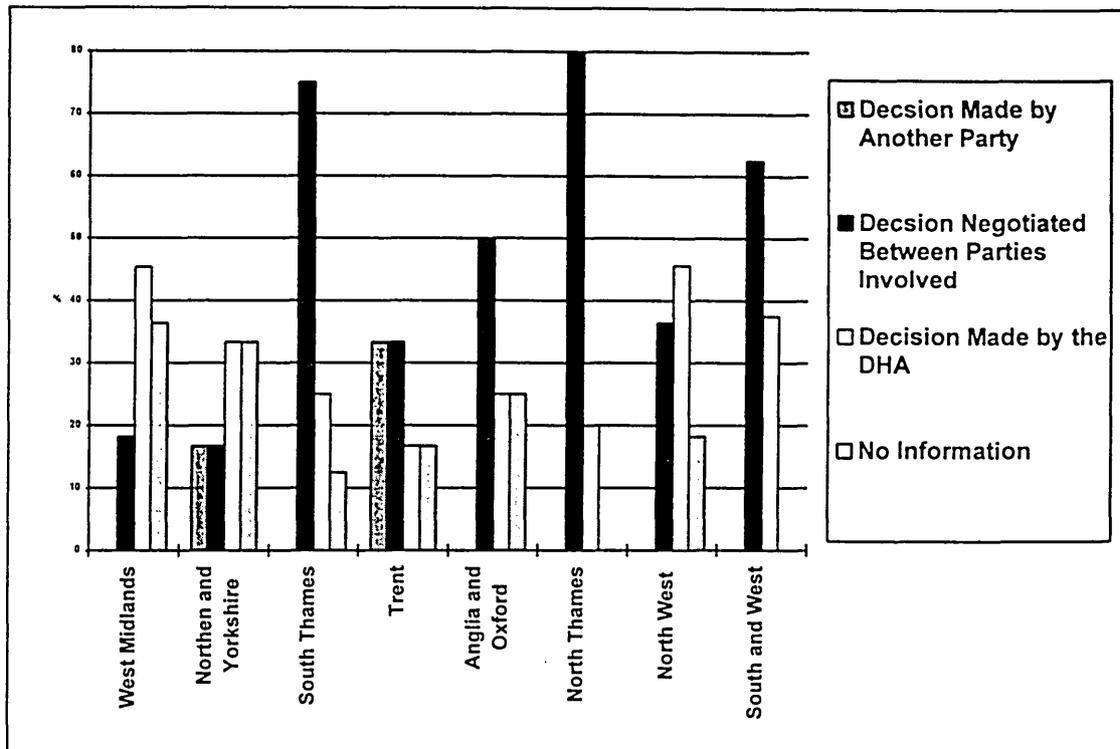
DHAs in the West Midlands Region recorded the lowest incidence of negotiation between the parties involved and the highest incidence of the DHA itself determining the outcome. Conversely, the DHAs in North Thames recorded the highest frequency of DHAs which had determined an outcome through negotiation with the parties involved. The incidence of DHAs which felt that the quality strategy had been determined by another party indicated that this was Providers.

In the South and West Region, whilst all the DHAs had been involved in determining a quality strategy for health care, only 37.5% of respondents considered the outcome to have been achieved through negotiation. The remaining 62.5% considered the outcome to have been determined by the DHA itself. In those cases where the involvement of the RHA was recorded, irrespective of other parties involvement, then the outcome was more likely to be judged as being determined by another party. Where Providers or other DHAs were involved, then the outcome was arrived at through negotiation providing further evidence of the powerful lead being exerted at Regional level in this area.

Determining A Definition Of Quality For Health Care

This activity was carried out by the least number of DHAs. However, the following table show how the DHAs considered a definition of quality for health care:

CHART 8.66 DETERMINING A DEFINITION OF QUALITY FOR HEALTH CARE



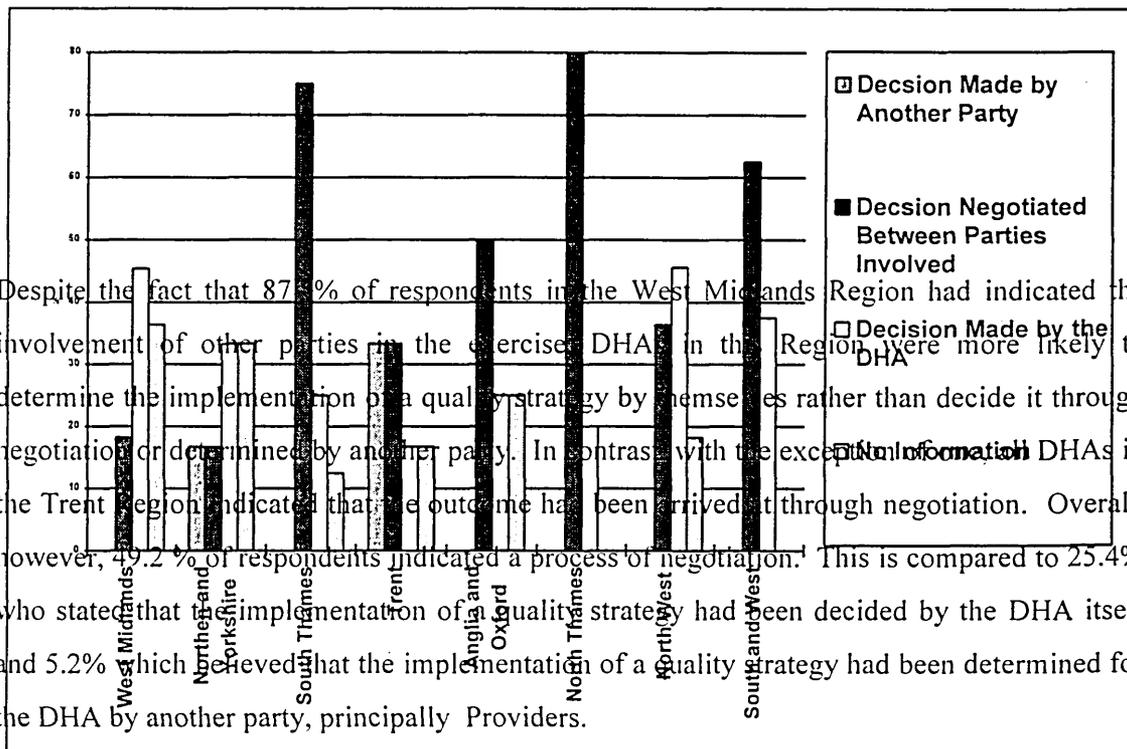
The two Regions displaying the largest number of DHAs which had arrived at a definition of quality for health care were North Thames and South and West. All the DHAs in the South and West had stated that they had undertaken this activity with the involvement of a variety of different parties. A definition of quality for health care was an issue more open to negotiation than deciding upon a quality strategy, reflecting the importance of both agreeing upon a definition of quality and upon the different opinions of what constitutes quality in health care.

Overall, there was higher incidence of negotiated outcomes where Providers were involved, 71.4% of negotiated cases involved Providers. Only three cases involved Providers where a definition of quality was determined by the DHA and only one case involved Providers which had determined a definition of quality for the DHA.

Determining How A Quality Strategy Should Be Implemented

This activity registered the highest number of "yes" responses. In evaluating how the outcome was achieved, 54.3% of respondents claimed that the implementation of a quality strategy had been determined through a process of negotiation with the parties involved. The results were as follows:

CHART 8.67 DETERMINING HOW A QUALITY STRATEGY SHOULD BE IMPLEMENTED

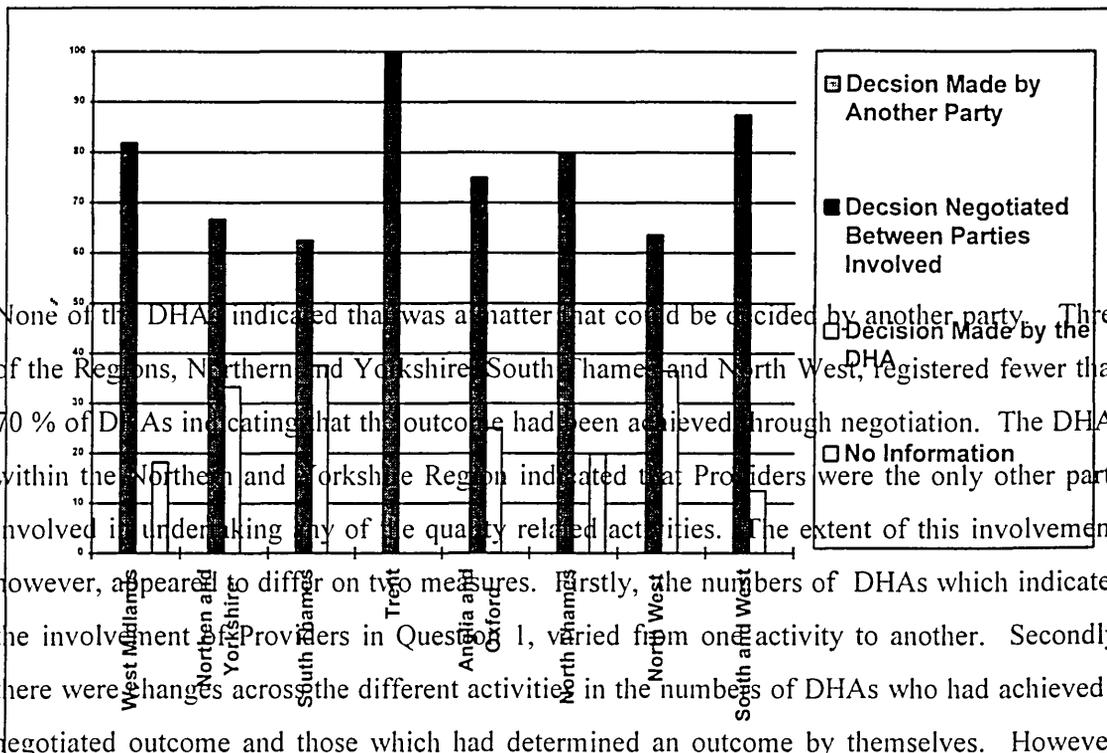


Despite the fact that 87.5% of respondents in the West Midlands Region had indicated the involvement of other parties in the exercise, DHAs in the Region were more likely to determine the implementation of a quality strategy by themselves rather than decide it through negotiation or determined by another party. In contrast with the exception of one DHA in the Trent region indicated that the outcome has been arrived at through negotiation. Overall, however, 49.2% of respondents indicated a process of negotiation. This is compared to 25.4% who stated that the implementation of a quality strategy had been decided by the DHA itself and 5.2% which believed that the implementation of a quality strategy had been determined for the DHA by another party, principally Providers.

Determining Which Factors Should Be Used To Assess The Quality Of Providers

Overall, 88.1% of DHAs had determined what factors should be used to assess the Quality of Providers. An overwhelming 76.3% of DHAs indicated that this had been done through a process of negotiation.

CHART 8.68 DETERMINING WHICH FACTORS SHOULD BE USED TO ASSESS THE QUALITY OF PROVIDERS

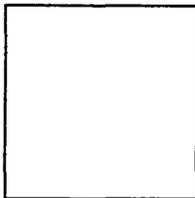


None of the DHAs indicated that this was a matter that could be decided by another party. Three of the Regions, Northern and Yorkshire, South Thames and North West, registered fewer than 70 % of DHAs indicating that the outcome had been achieved through negotiation. The DHAs within the Northern and Yorkshire Region indicated that Providers were the only other party involved in undertaking any of the quality related activities. The extent of this involvement, however, appeared to differ on two measures. Firstly, the numbers of DHAs which indicated the involvement of Providers in Question 1, varied from one activity to another. Secondly, there were changes across the different activities in the numbers of DHAs who had achieved a negotiated outcome and those which had determined an outcome by themselves. However, there does not appear to be a direct relationship between the two measures. Whilst the numbers of DHAs who stated that Providers had been involved differed, there was no marked trend emerging which related to how the outcome was achieved.

Determining How The Quality Of Providers Should Be Measured

The results for determining how the quality of providers should be measured +were as follows:

CHART 8.69 DETERMINING HOW THE QUALITY OF PROVIDERS SHOULD BE MEASURED



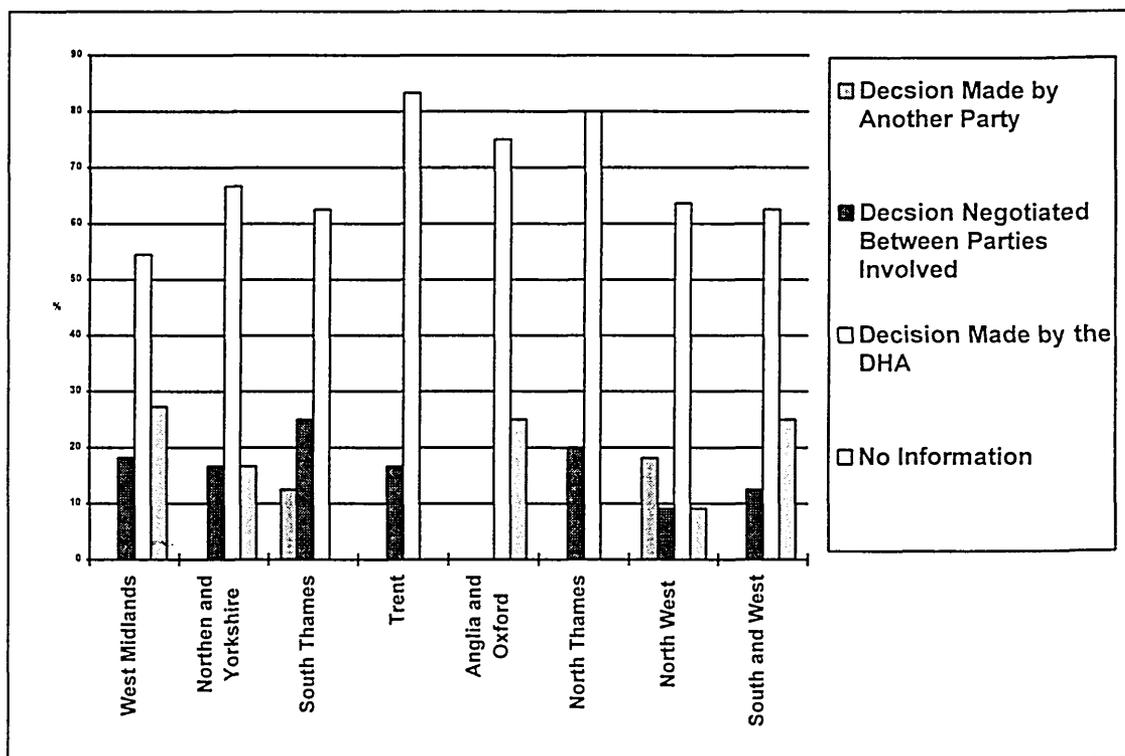
Four Regions registered no difference between determining what factors should be used to assess the quality of Providers and how these factors should be measured.. However, four of the Regions employed different methods to arrive at an outcome. Two recorded an increase and two recorded a decrease in negotiated outcomes.

Deciding How The DHA Should Manage The Quality Of Its Own Activities

Given the relatively high percentage of DHAs (45.4%) which had claimed that no other party had been involved in this activity it is not surprising that most DHAs responded that the DHA itself had determined how it should manage the quality of its own activities.

Interestingly, three DHAs indicated that managing the quality of their own activities had been determined for them by another party. Closer examination revealed that one DHA was determined by Providers without the DHA being involved at any stage. Another which had undertaken this activity believed that the RHA had determined how the DHA should manage the quality of its own activities for them. The third reported that the DHA had been involved in the process but a combination of the NHS Executive and the RHA had decided an outcome for them.

CHART 8.70 DECIDING HOW THE DHA SHOULD MANAGE THE QUALITY OF ITS OWN ACTIVITIES



CONCLUSION

There were relatively few cases of DHAs (2.3%) which considered that decisions had been made for them regarding the quality related activities. Of these, only 0.8% stated that they had been involved in the particular activity in question. Two out of the three cases where an outcome was determined for the DHA by another party concerned the DHA's approach to managing its own quality. In addition, both occurred in the North West Region which, along with other evidence, suggested that DHAs in this Region played a relatively passive role in the delivery of a quality health service.

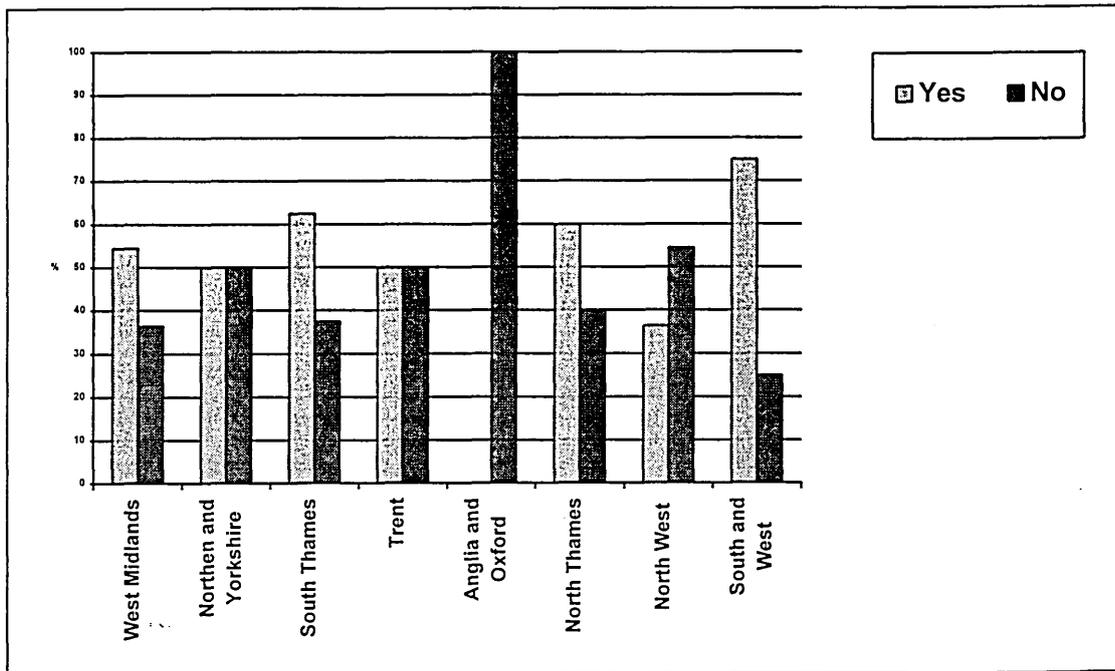
The evidence suggested that individual DHAs treated each activity as an individual event rather than as a series of interrelated activities warranting the involvement of other levels of the NHS. On the other hand, this assumes that such involvement was forthcoming from other parties.

CHAPTER 9 ANALYSIS OF RESEARCH DATA: MEASUREMENT

MEASURING AND MONITORING QUALITY AT DHA SITES

Measurement lies at the heart of the improvement process and is, therefore, fundamental to any quality improvement process. The results revealed, however, that only 50.8% of DHAs were measuring and monitoring the quality of their own activities.

CHART 9.1 DOES THE DHA MEASURE AND MONITOR THE QUALITY OF ITS OWN ACTIVITIES?



Only South Thames, North Thames and South and West Regions had more than 60% of DHAs measuring and monitoring the quality of its own activities. In the North West Region only 36.4% of DHAs were doing so. Yet the figures reveal that 81.8% of the DHAs in the North West Region had determined how to manage the quality of their own activities. Indeed, the results from both the North Thames and South Thames Regions also showed that 80% and 87.5% of DHAs respectively had determined how to manage the quality of their own activities. Thus, figures of 60% and 62.5% for these two Regions would also indicate that some DHAs had taken only the most basic of steps to implement a quality management system.

EL (93) 116 "Achieving Organisation Wide Approach to Quality", recommended that Purchasers and Providers should work in partnership to ensure that standards are set by negotiation with managers, clinicians and other health care professions and, furthermore, that these standards be dynamic, measurable, revisable and incorporate audit and research results with systems developed to ensure effective monitoring of key performance indicators. The realisation that measuring and monitoring quality improvements should form an integral part of a quality improvement process does not appear to have been adopted by a significant number of DHAs. There are several reasons what this might have been the case. Firstly, DHAs might have interpreted the EL in such a way that action on their part should be focused on ensuring that Providers have such systems in place. Reading through the Quality Strategies of many DHAs adds further weight to this argument with most DHAs seeing themselves as a policing agent. Secondly, DHAs might have considered that the implementation of the above recommendations was a low priority, after all, there was no evidence that the NHS Executive were taking much of a lead in terms of implementing their own recommendations.

Four out of the five RHAs which responded to the questionnaire stated that they were measuring and monitoring the quality of their own activities through:

- Quarterly conferences looking at the quality of RHA performance management, internal review meetings and feedback sessions, external "lessons learned" conferences with Purchasers and Providers.
- Own performance management arrangements with the executive and on specific events and initiatives by "customer feedback" e.g. seminar evaluation forms.
- Corporate management performance programme and contract, covers all activities.

In discussing the measurement of management effectiveness, Drummond (1993)- argued that in order to identify whether words and action match, the most pertinent question to ask is "What has been done?" with the implication being that a lack of detail corresponds to a lack of action. The impression from the above findings is one of a lack of rigorous, systematic processes.

One RHA provided a copy of its Regional Strategic Framework which listed the Region's strategic intent and priorities for the year 1994/95, whilst undoubtedly forming an integral part of the Region's priorities and action plan, there was only one reference to a monitoring mechanism and that existed in the acute care sector.

Those DHAs which had stated that they were measuring and monitoring the quality of their own activities were doing so by the following means:

TABLE 9.1

West Midlands
<ul style="list-style-type: none"> • BS 5750 standards, Internal quality circle, Lead officer identifies compliance to BS 5750 and lead TQM development • Programme begun Summer 1994, initial development of quality in relation to - Management commissioning, contract monitoring, purchaser staff training. • Audit, Departmental standards • Internal audit - telephonist and administrative support • Peer review - Kings fund - all areas of commissioning • BS 5750 accreditation and audit • Regular individual performance reviews, Kings Fund Organisational audit will be implemented covering all activities.

TABLE 9.2

Northern and Yorkshire
<ul style="list-style-type: none"> • Partly through quality systems approach i.e. documentation, Through protocols and through performance management of the DHA/FHSA business plan. • By the development of a Commission's Charter which will explain explicit standards against which continuous quality improvement can be measured, although the charter is only at the developmental stages at present. • Communication groups, organisational slice groups, responses to complaints - times - outcomes

TABLE 9.3

South Thames
<ul style="list-style-type: none"> • Participation in formal peer review process at Kings Fund • Yes, but against Regional criteria as part of performance management • Performance review against objectives Departmental Audit (finance, data, etc.), corporate contract and annual evaluation. No formal accreditation system used. • The Health Authority has an internal organisational quality strategy which addresses our philosophy, valuing our staff and organisation wide standards. Standards include responses to letters and phone calls, confidentiality, training, name badges, attendance at team briefings, following corporate image guidelines and presentations. • All aspects of corporate business through review of organisations and individual objectives (which are linked), monitoring of specific standards (handling of ECRs, complaints etc.) use of noon-executive groups (e.g. audit)

TABLE 9.4

Trent
<ul style="list-style-type: none"> • TQM, IPR, Investors in People • Complaints handling, Quality co-ordination group established, communication group established, Assess against Health Improvement Priorities, Public Health annual report and strategy plans. • Organisational development structures, performance management reviews, Individual performance review.

TABLE 9.5

Anglia and Oxford
No measures taken by any of the DHAs in this Region

TABLE 9.6

North Thames
<ul style="list-style-type: none"> • We monitor our achievements to the production of quality review visits. We have conducted internal reviews of communication etc. • We monitor how we handle complaints • We have been subject to peer review by all Purchasers • Complaints monitoring and 6 monthly audits • Performance management being developed as a regular reporting tool to DHA

TABLE 9.7

North West
<ul style="list-style-type: none"> • Performance management, monitoring objectives, organisational audit • Early stage yet - looking at TQM approach using the "Lakeview" approach • Audit using Deardon Management Framework, Investors in People • Corporate contract, purchaser plan, performance management initiatives

TABLE 9.8

South and West
<ul style="list-style-type: none"> • An area under development. Action to date includes: Plan, consultation, customer surveys, involvement in development of purchaser audit, Corporate Programme, progress monitoring, value for money studies • DHA had ensured that all staff attended a four day quality improvement course. Quality council in existence with problem solving teams operating to key issues. Quality council in existence with problem solving teams operating to target key issues. Directorates encouraged to produce own quality indicators e.g. response times to letters, telephone calls, process times for reports etc. • Contract for action - the corporate agenda, internal standards, self assessment peer review across all activities • Complaints handling, ECR procedure - carried out through performance monitoring • All activities - through standards document, quality plans and quality forum activities • Complaints processing response times etc., GP feedback

It is clear from these statements that DHAs had only a very loose understanding of how quality could and should be measured and monitored. Many were merely statements of intent or attempted to address the issue through existing mechanisms or competing initiatives, for example, Investors in People.

DETERMINING A QUALITY STRATEGY

One DHA pointed to a "...quality strategy which addressed a philosophy, valuing of staff and organisation-wide standards, responses to letters and phone calls, confidentiality, training, name badges, attendance at team briefings, following corporate image guidelines and presentations." This response typified the ad hoc nature of many quality initiatives with little detail of how the different elements fitted together to form a cohesive whole. No replies were received which linked measuring and monitoring quality with customer needs. Even complaints handling mechanisms appeared to be more concerned with improving the efficiency of dealing with complaints rather than on identifying and resolving the root cause of problems.

Crosby (1984) stated that quality has four absolutes: the definition, the system, the standard, and the measurement. At least 40% of DHAs, however, had either not defined quality or had not attempted to measure or monitor the quality of their own activities and 27.1% of respondents had neither a quality strategy nor were measuring and monitoring the quality of their own activities. Split on a Regional basis the figures were as follows:

CHART 9.2 WEST MIDLANDS

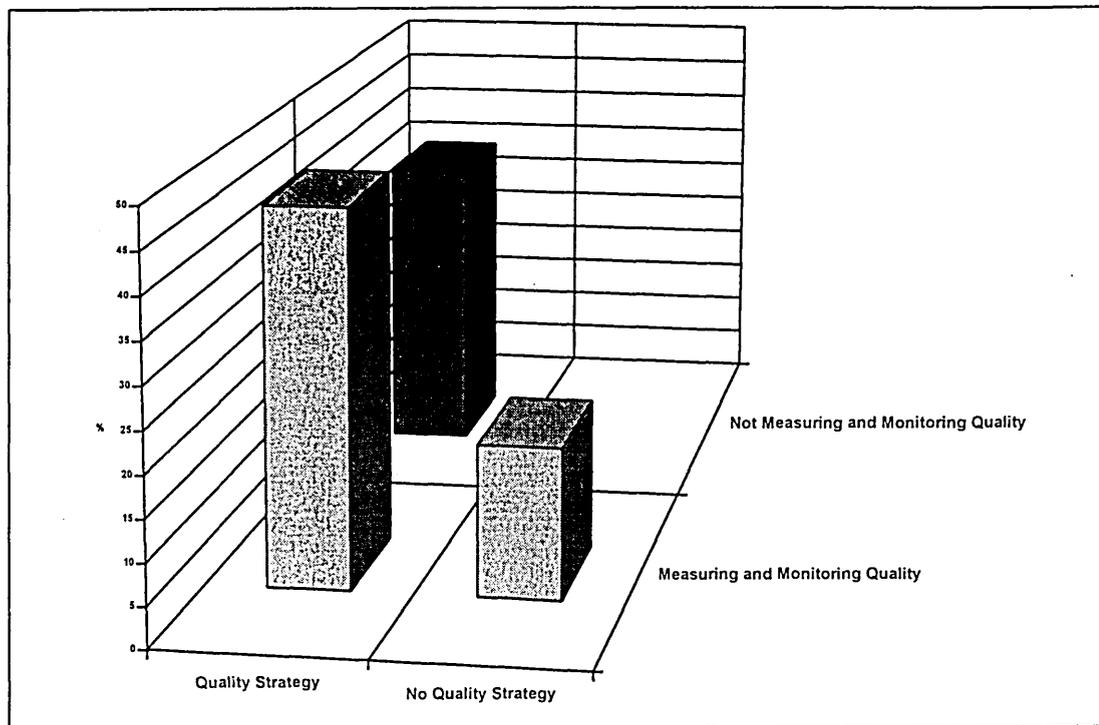


CHART 9.3 NORTHERN AND YORKSHIRE

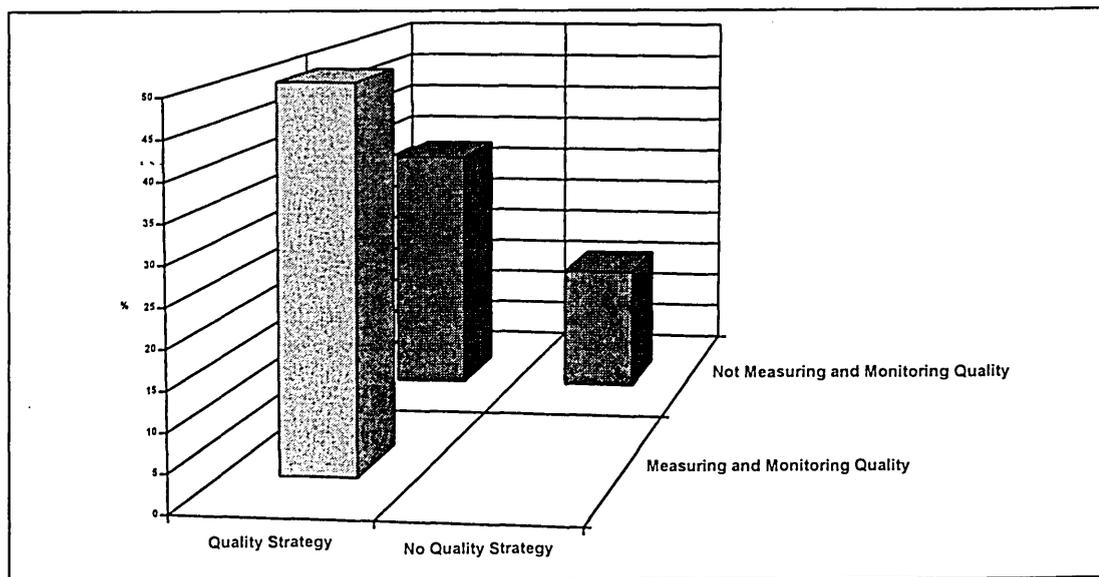


CHART 9.4 SOUTH THAMES

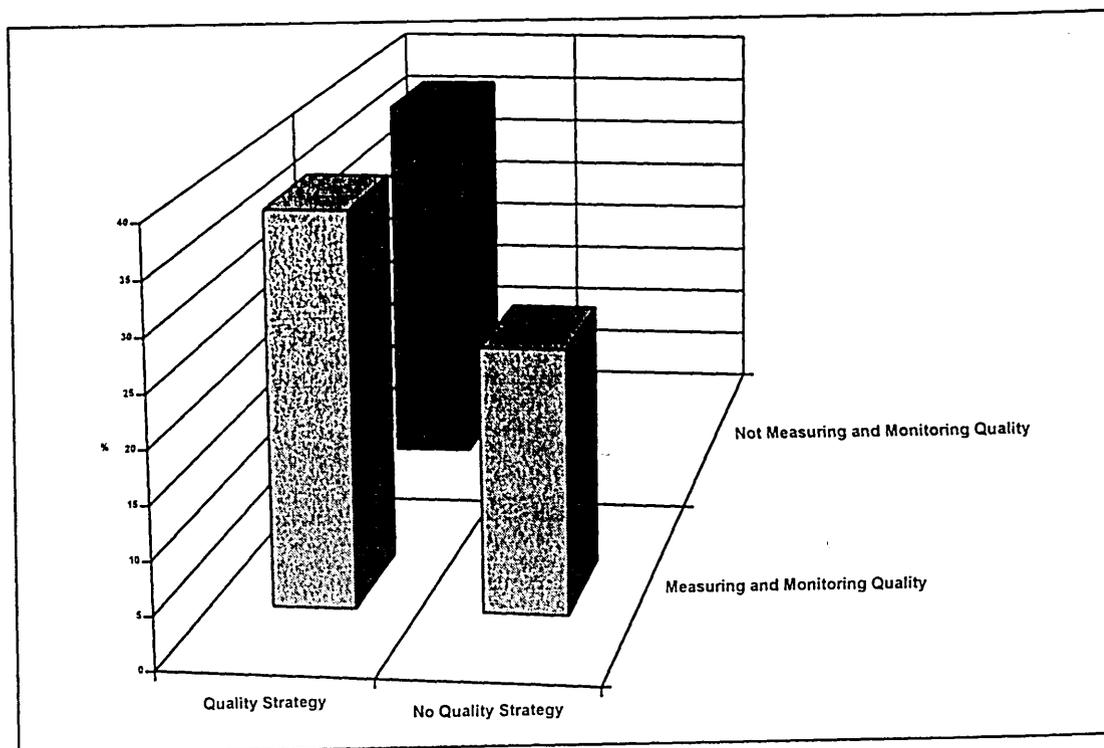


CHART 9.5 TRENT

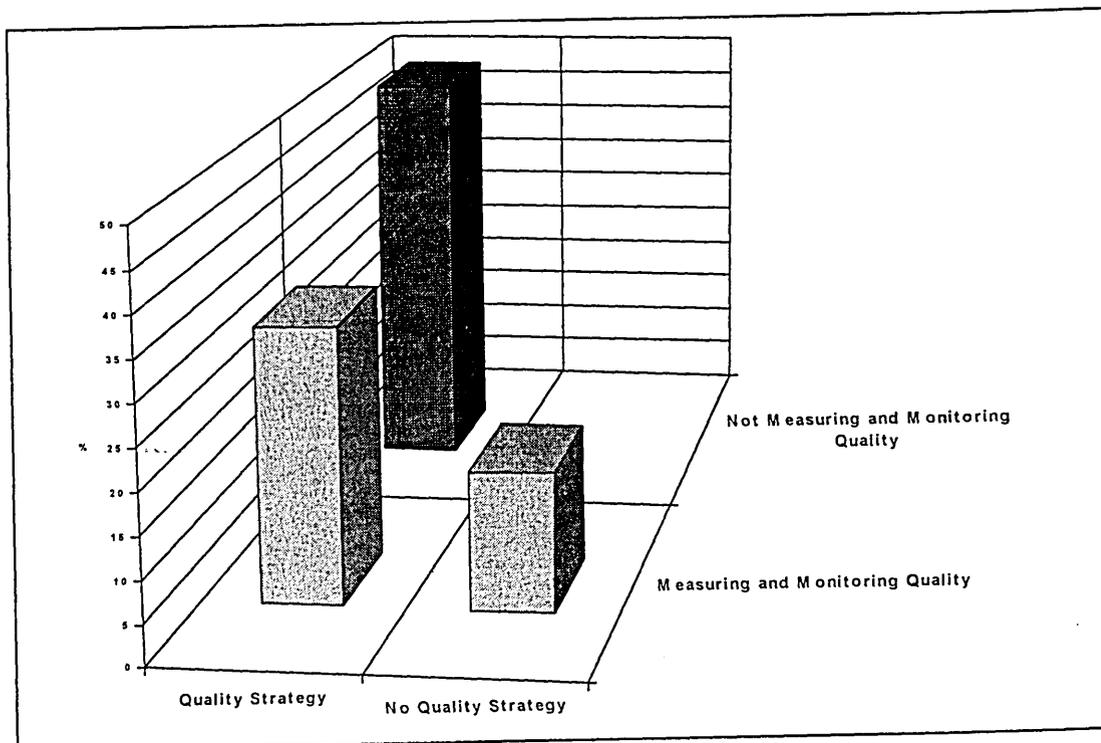


CHART 9.6 ANGLIA AND OXFORD

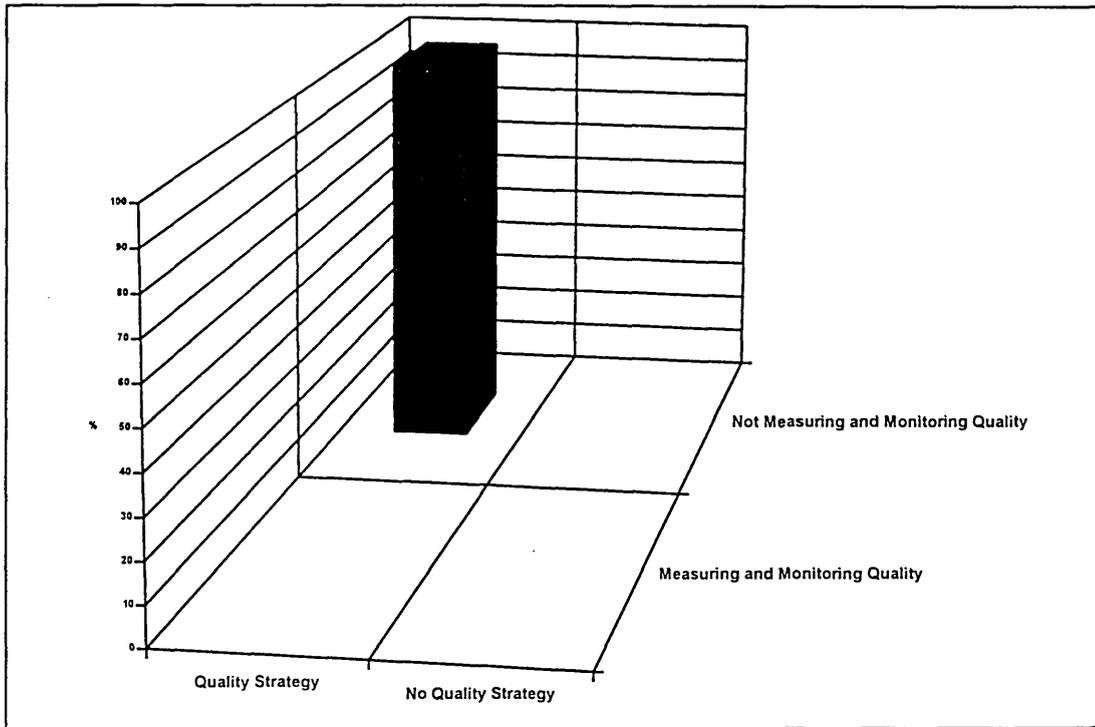


CHART 9.7 NORTH THAMES

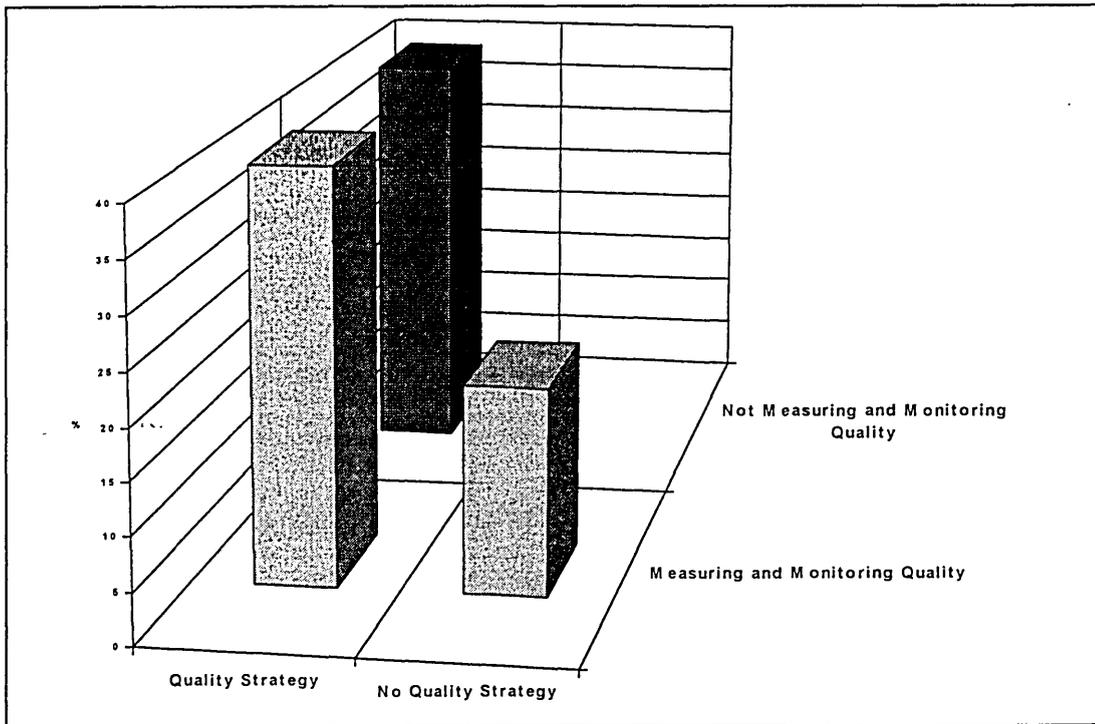


CHART 9.8 NORTH WEST

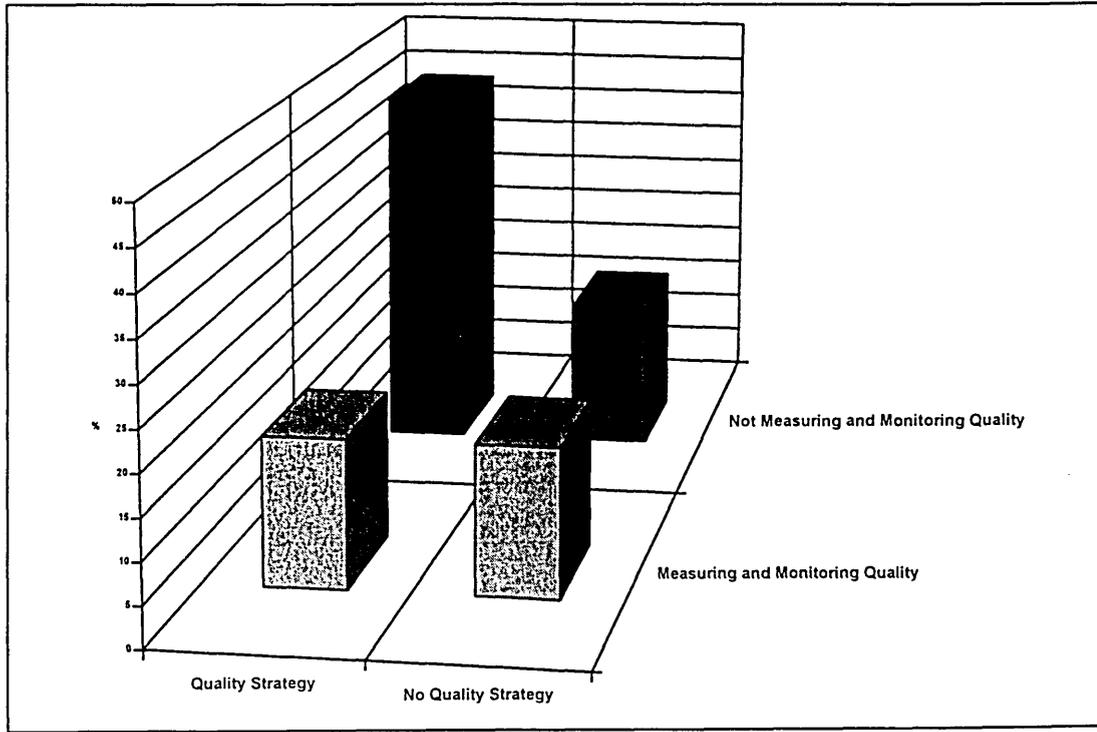
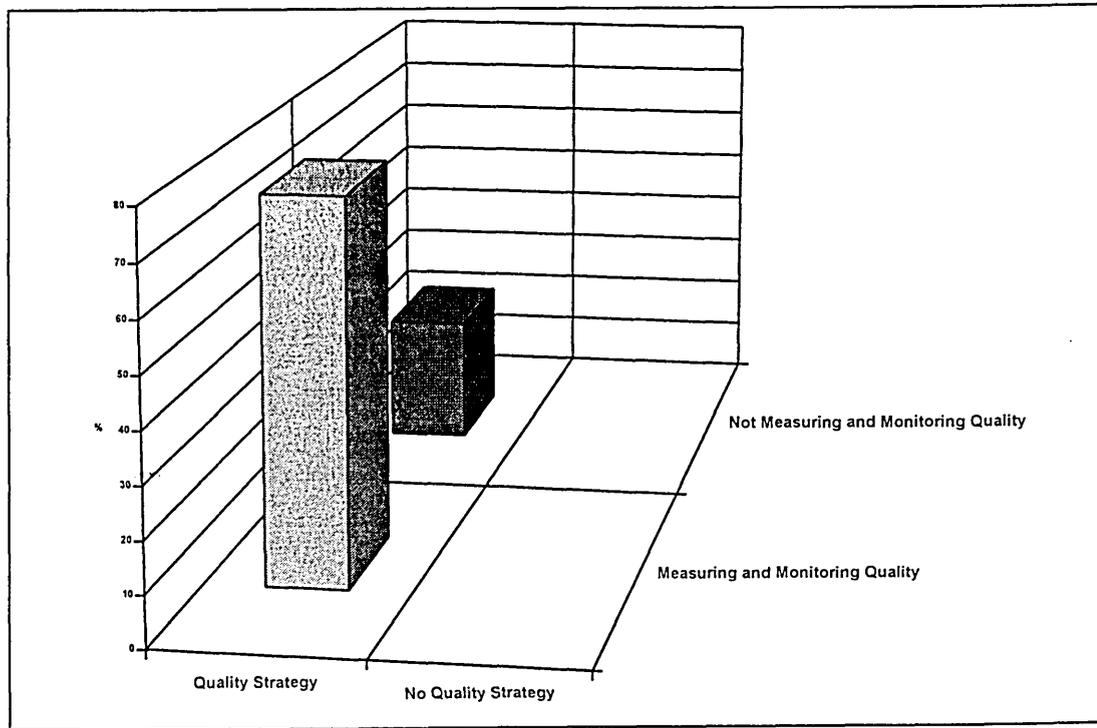


CHART 9.9 SOUTH AND WEST



The results identified the DHAs in the South and West Region as being more likely to have determined both a quality strategy and a system to measure and monitor the quality of their own quality than DHAs in other Regions. The situation in the South and West contrasts with that in the North West where only 18.2% of the DHAs possess both a quality strategy and a

system to measure and monitor quality. The North West Region also stands out as the Region with the highest percentage of DHAs which possess neither a quality strategy nor measure and monitor the quality of their own work. Meanwhile, Anglia and Oxford Region, where all the DHAs claimed to have determined a quality strategy, did not record a single DHA which was measuring and monitoring their own quality.

DETERMINING A DEFINITION OF QUALITY

CHART 9.10 WEST MIDLANDS

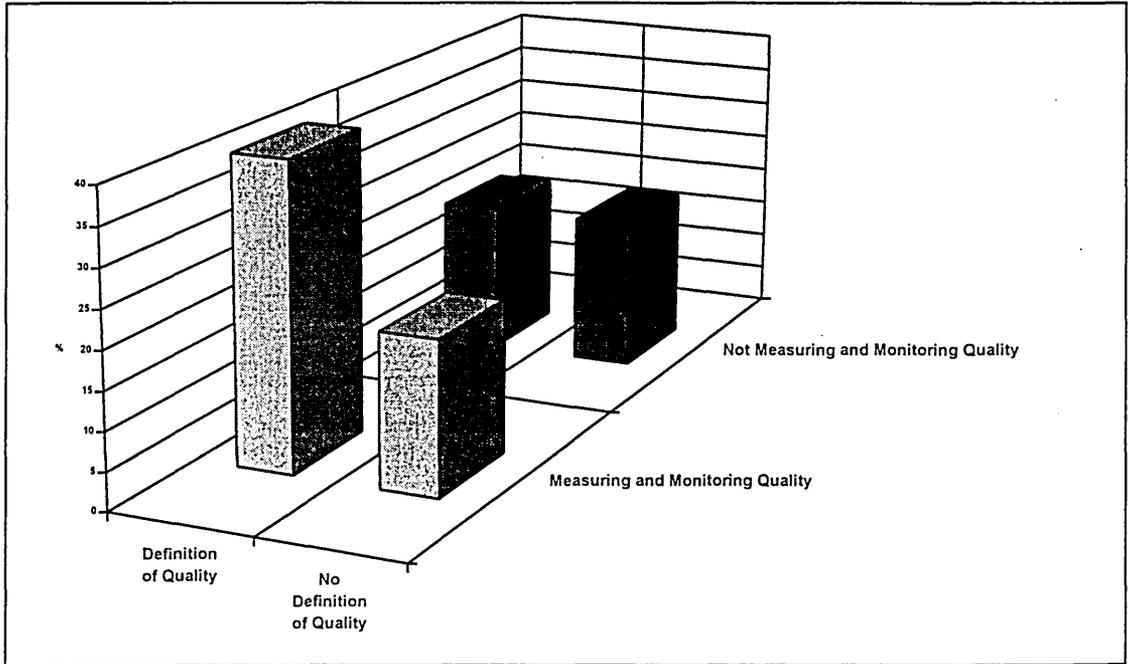


CHART 9.11 NORTHERN AND YORKSHIRE

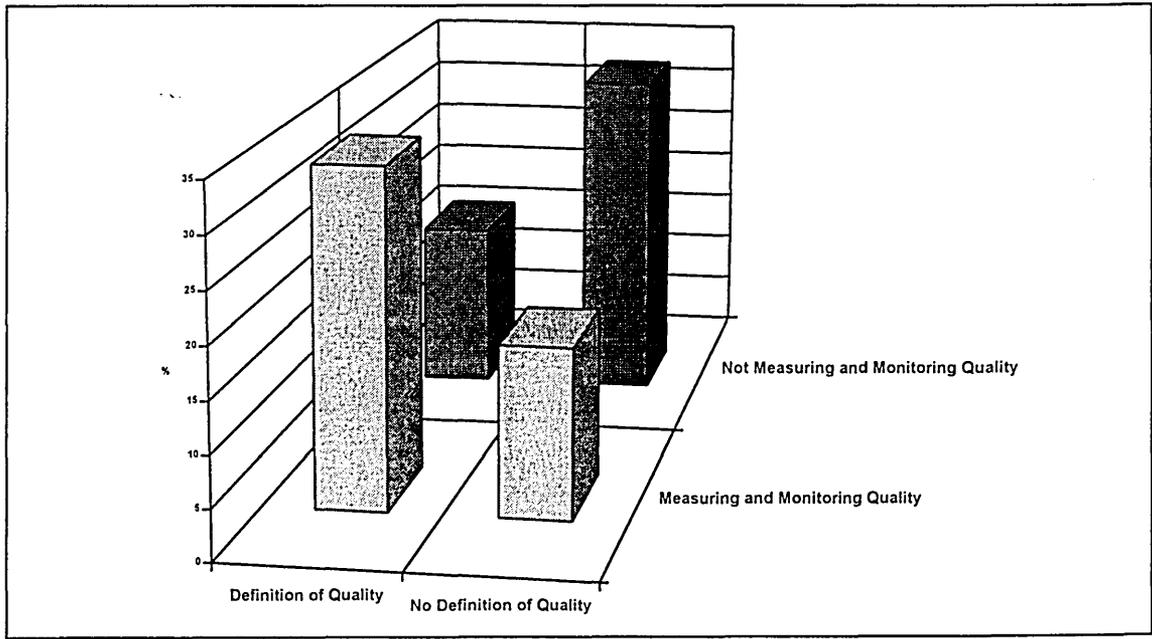


CHART 9.12 SOUTH THAMES

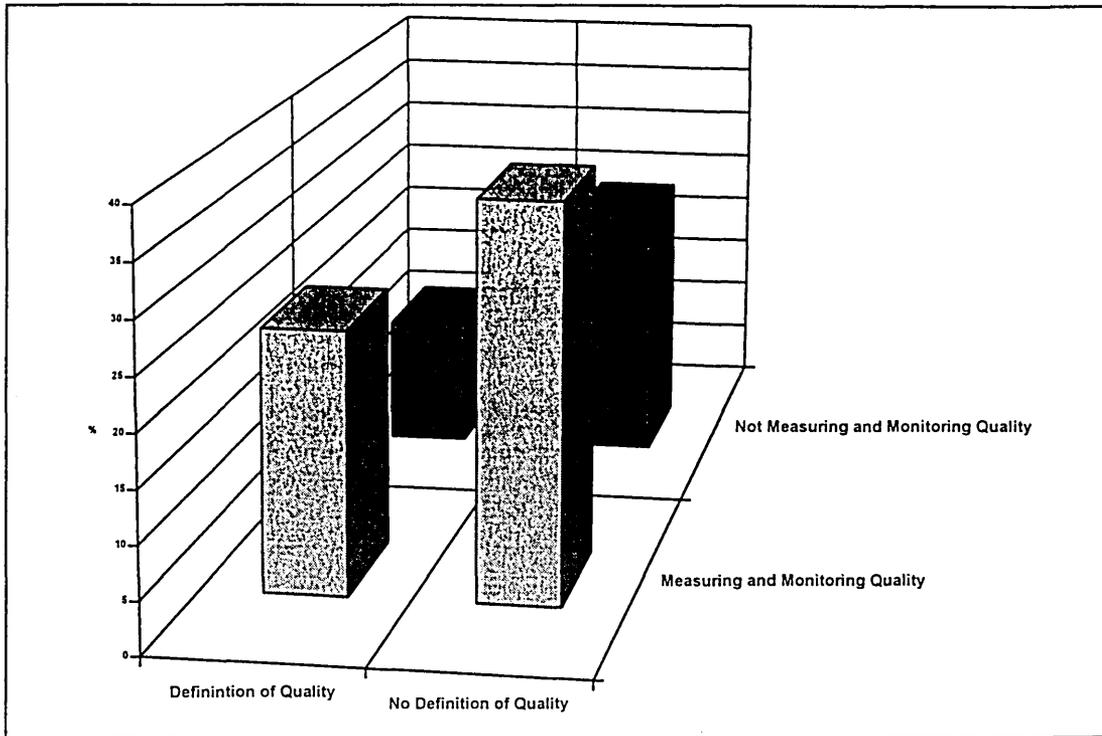


CHART 9.13 TRENT

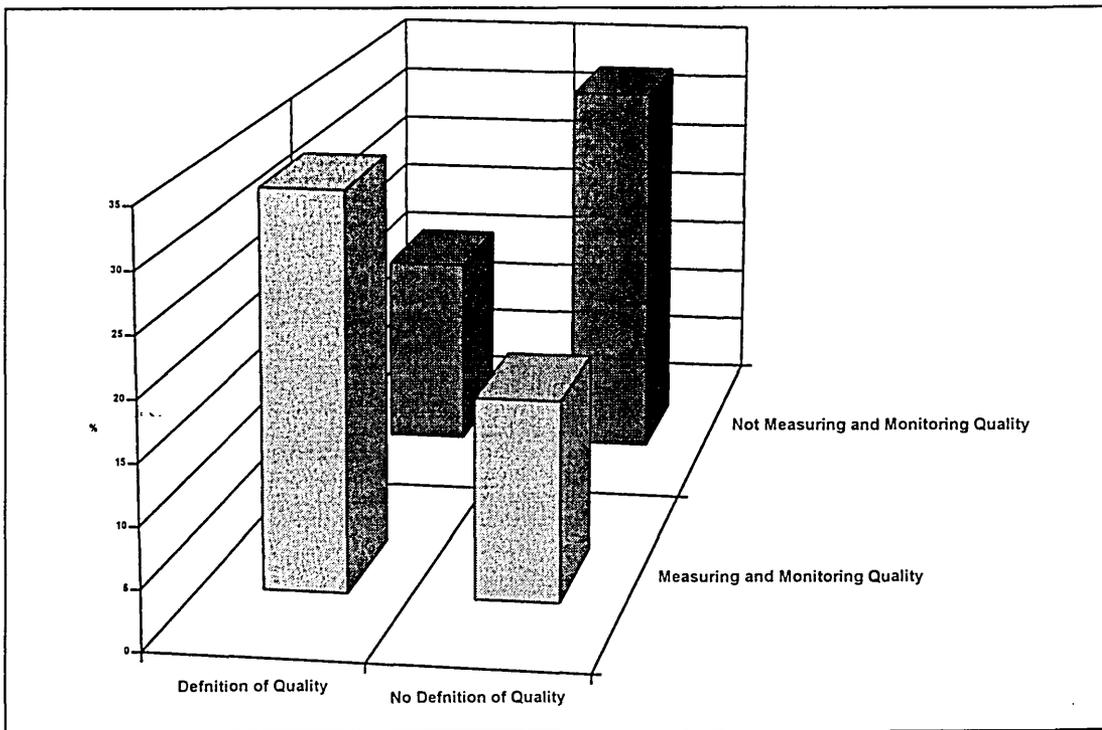


CHART 9.14 ANGLIA AND OXFORD

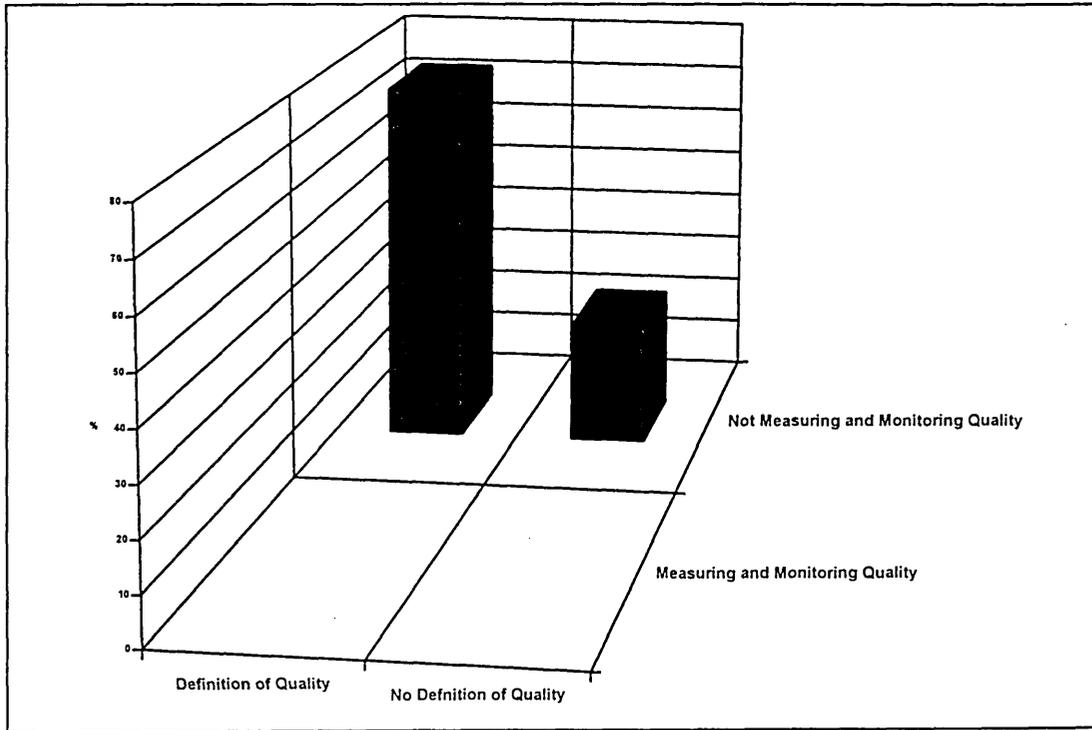


CHART 9.15 NORTH THAMES

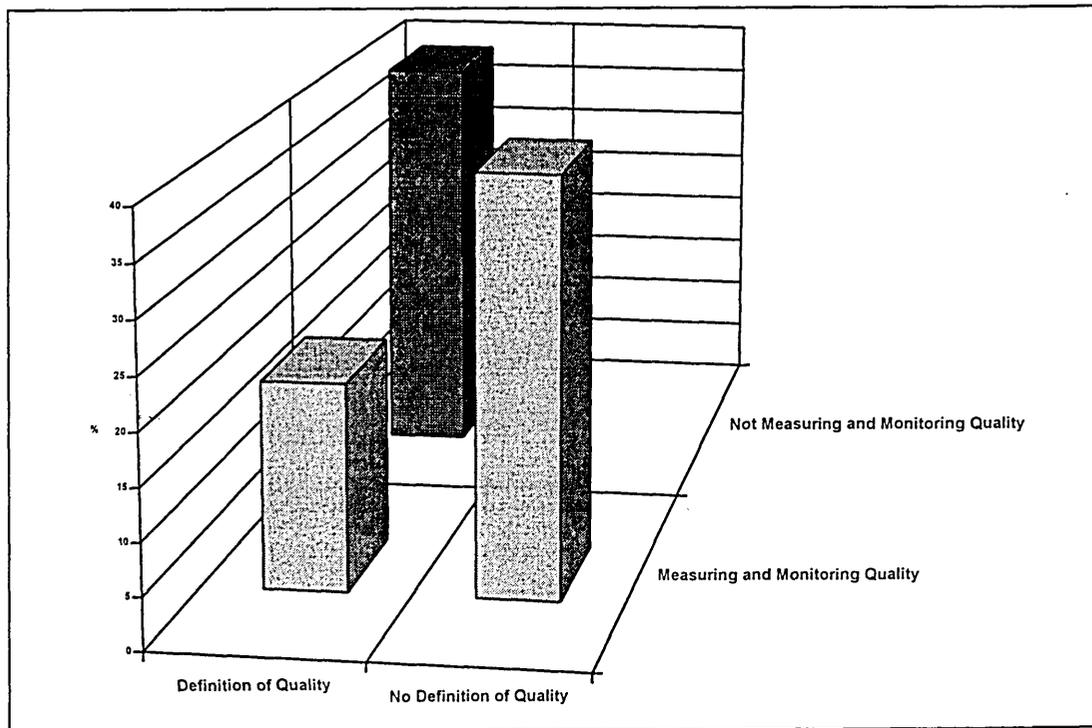


CHART 9.16 NORTH WEST

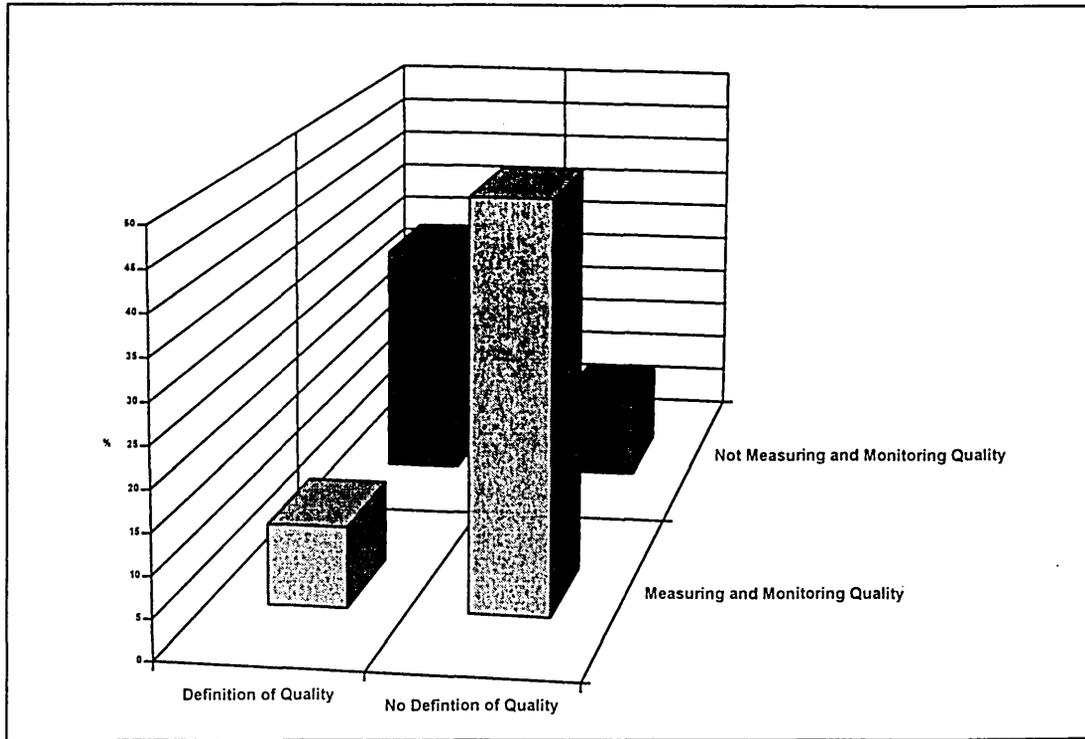
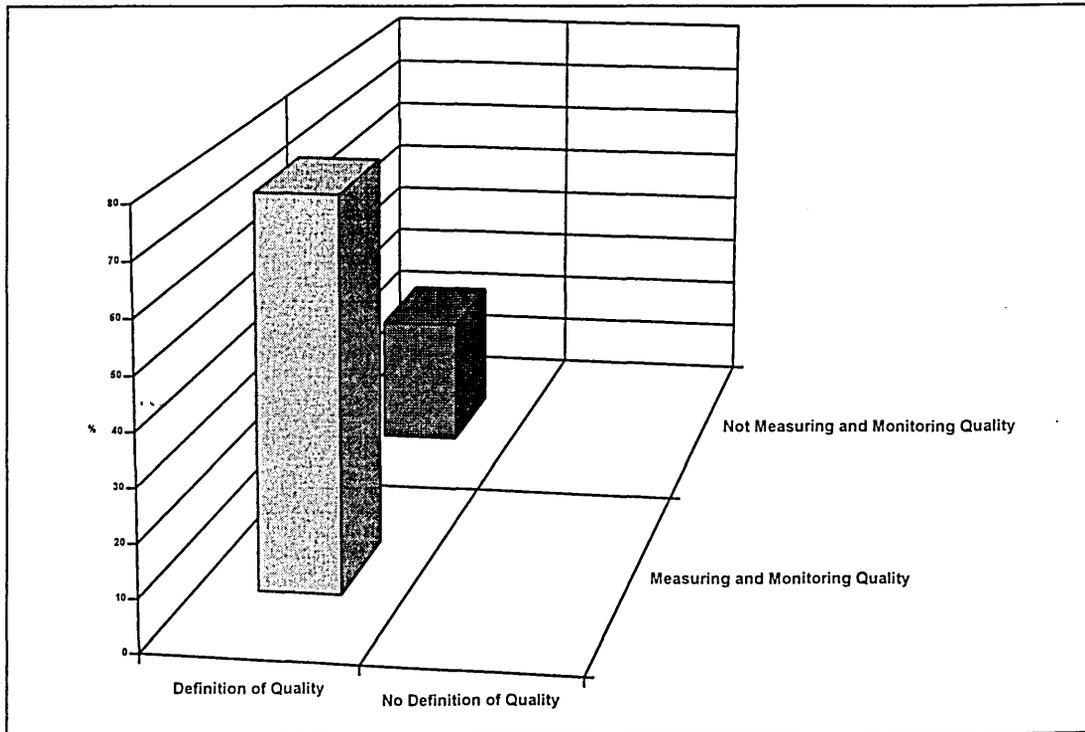


CHART 9.17 SOUTH AND WEST



The numbers of DHAs which have taken steps to measure and monitor the quality of their own work remain the same, irrespective of the activities which have taken place. Differences

exhibited within the same Region are, therefore, due to the activities which have been undertaken.

DETERMINING QUALITY NEEDS OF PATIENTS

CHART 9.18 WEST MIDLANDS

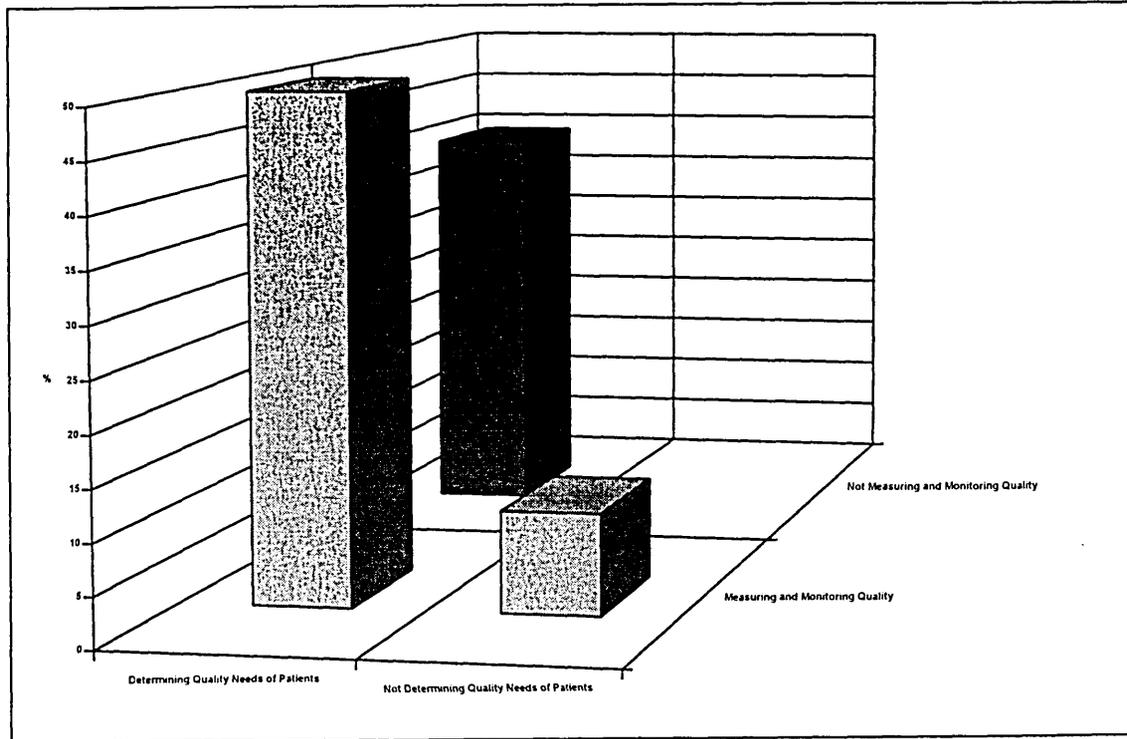


CHART 9.19 NORTHERN AND YORKSHIRE

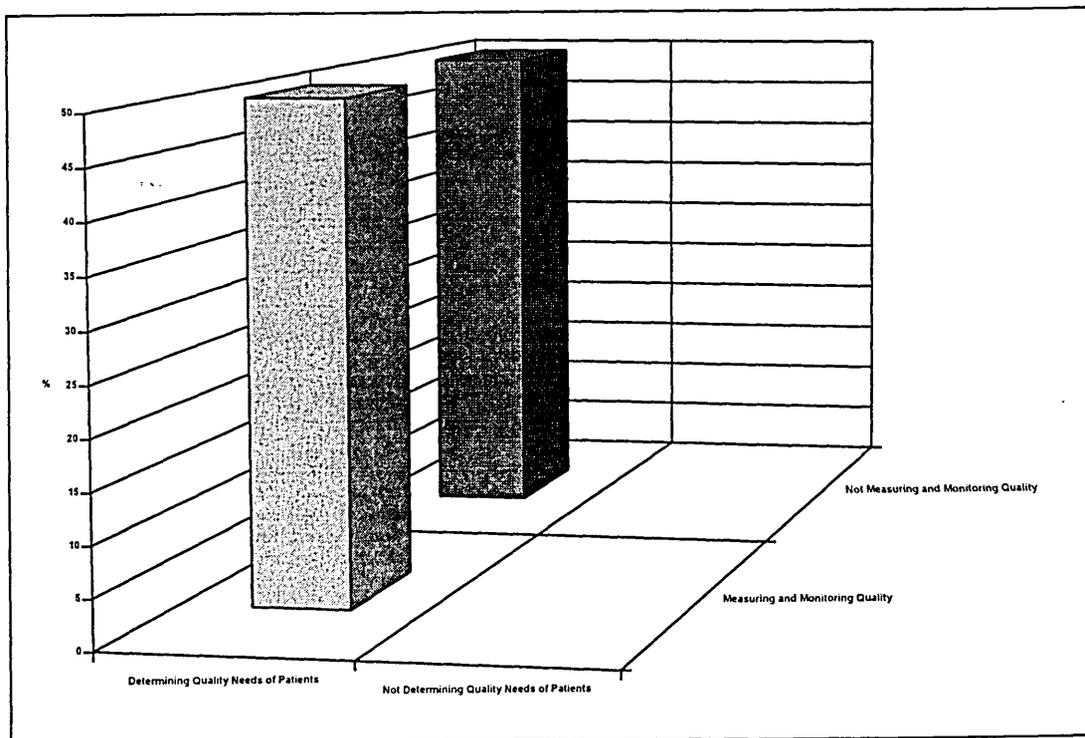


CHART 9.20 SOUTH THAMES

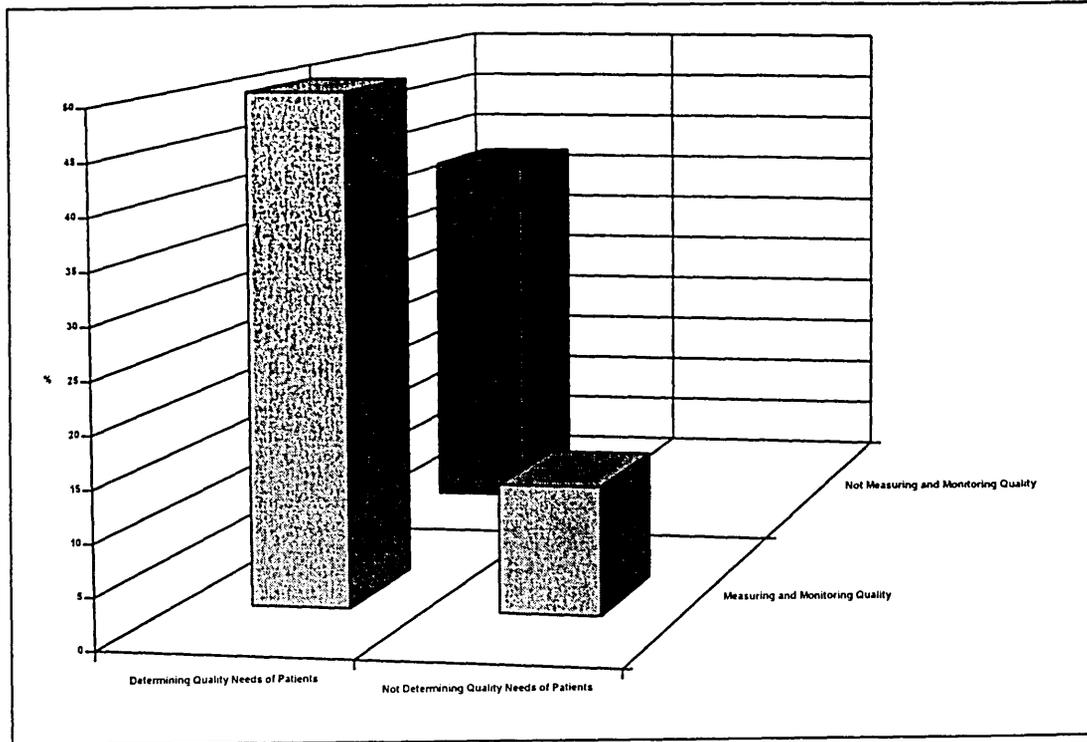


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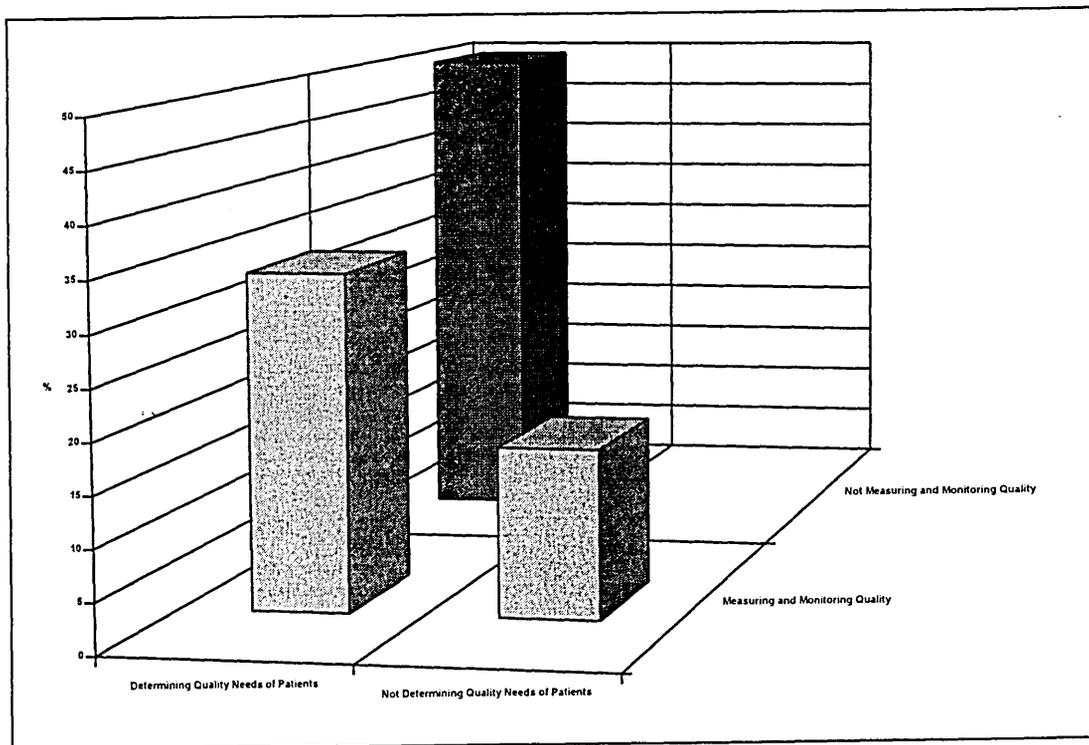


CHART 9.22 ANGLIA AND OXFORD

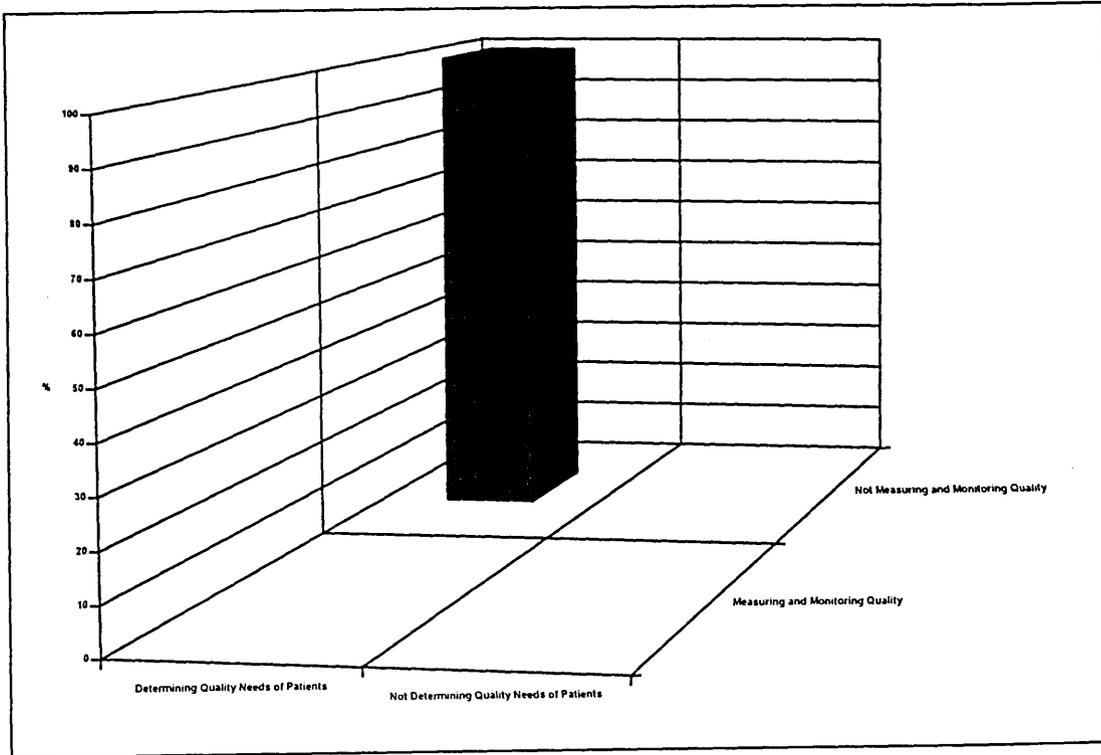


CHART 9.23 NORTH THAMES

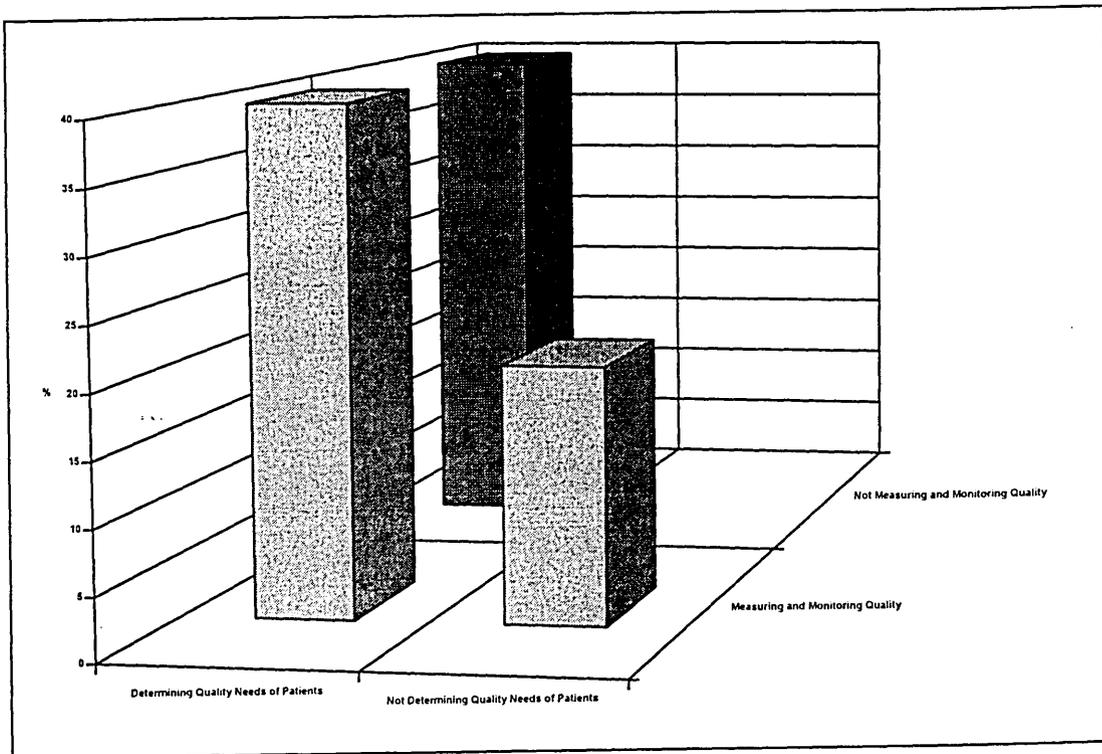


CHART 9.24 NORTH WEST

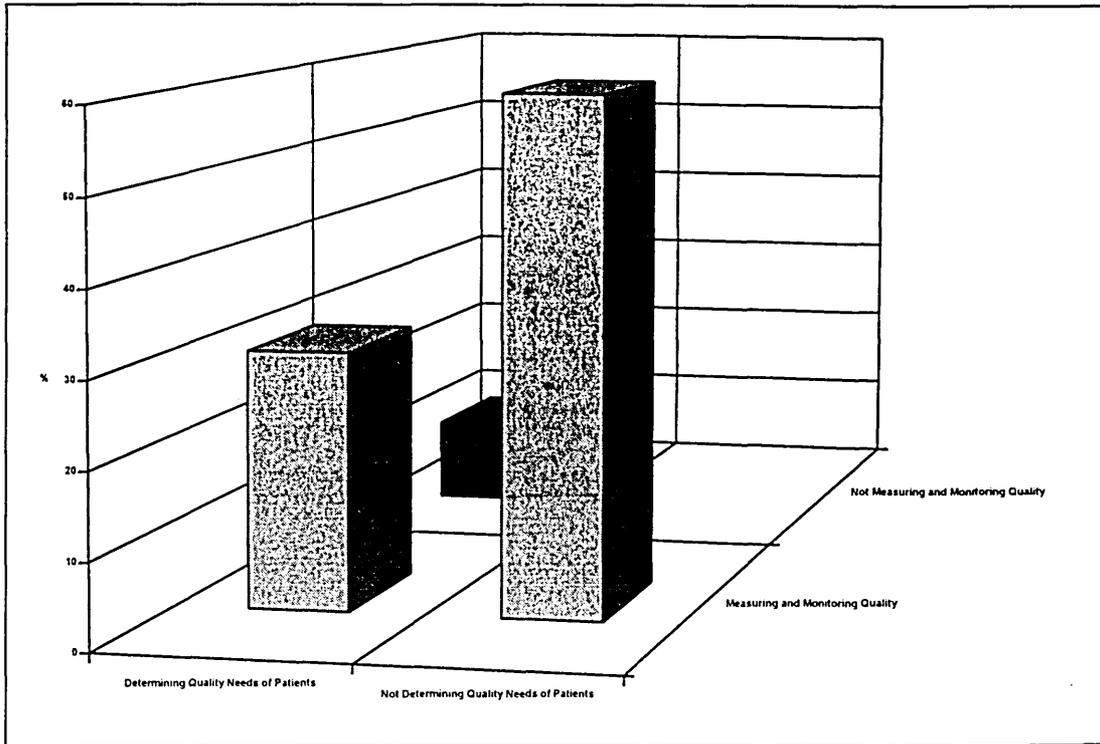
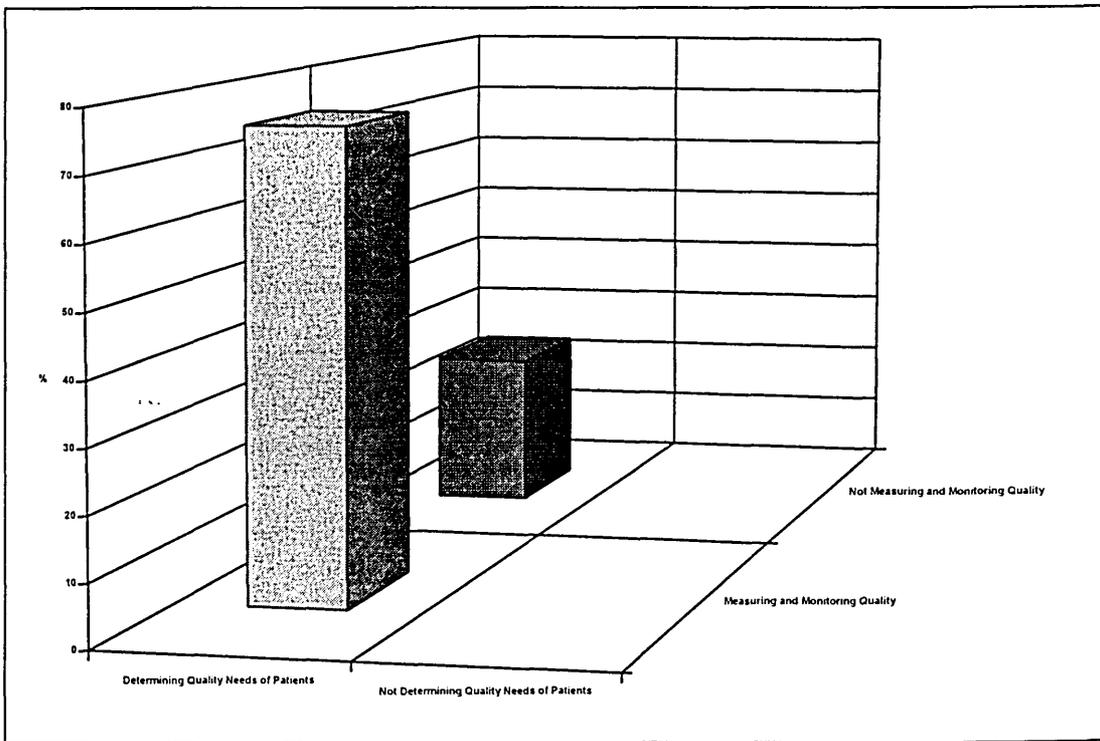


CHART 9.25 SOUTH AND WEST



DETERMINING THE IMPLEMENTATION OF A QUALITY STRATEGY

CHART 9.26 WEST MIDLANDS

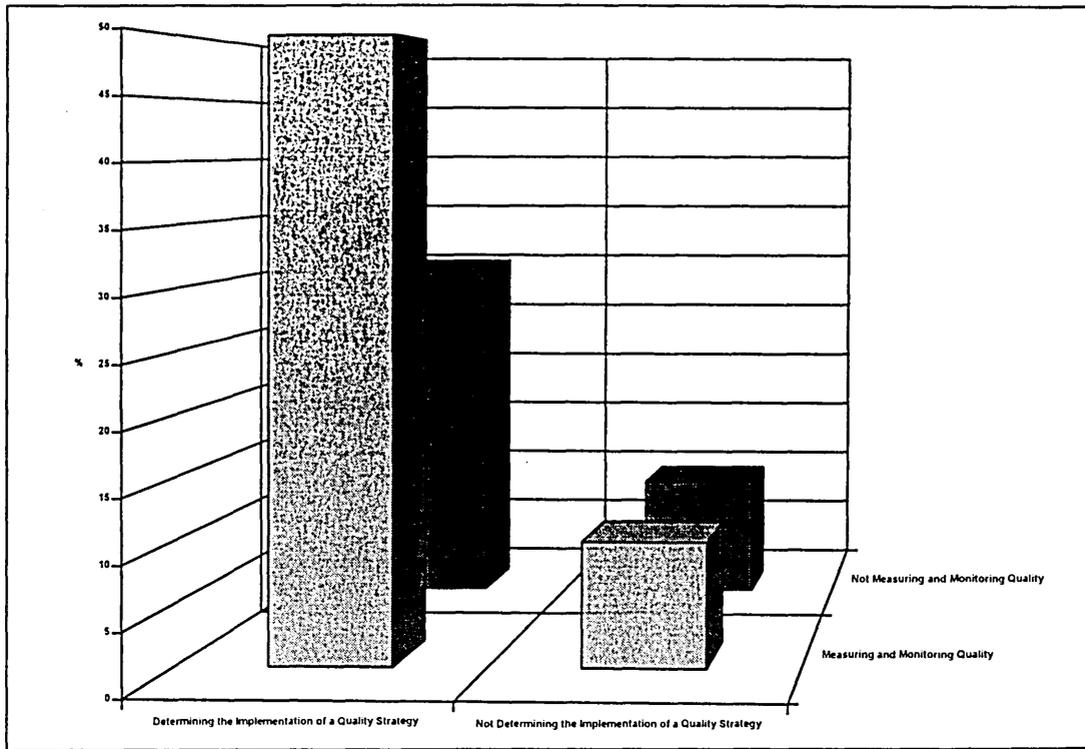


CHART 9.27 NORTHERN AND YORKSHIRE

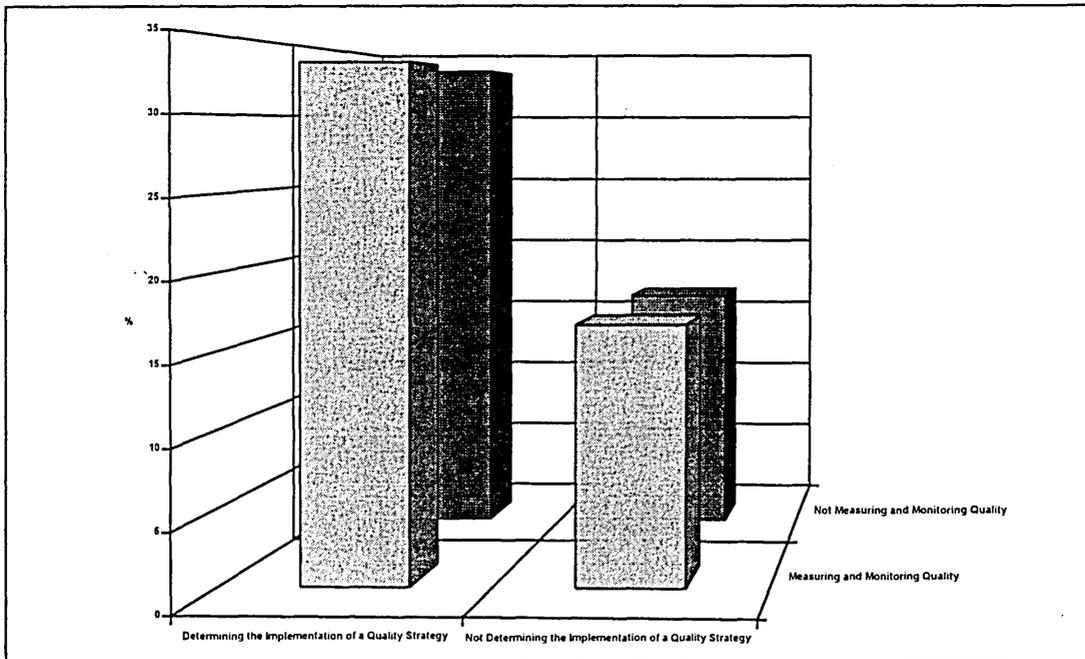


CHART 9.28 SOUTH THAMES

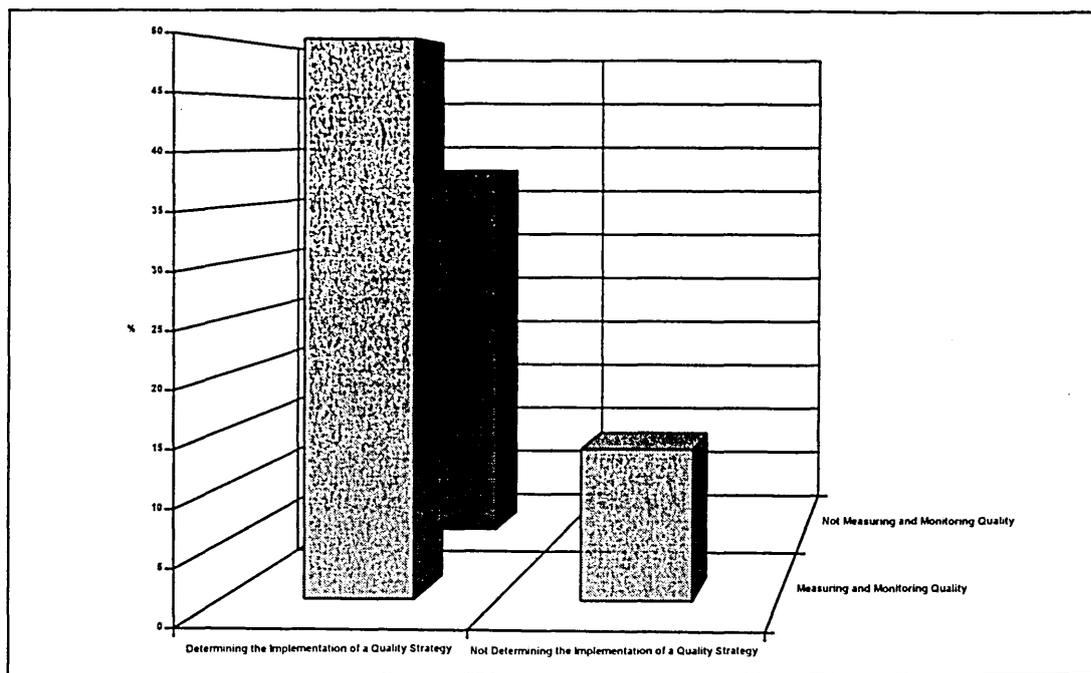


CHART 9.29 TRENT

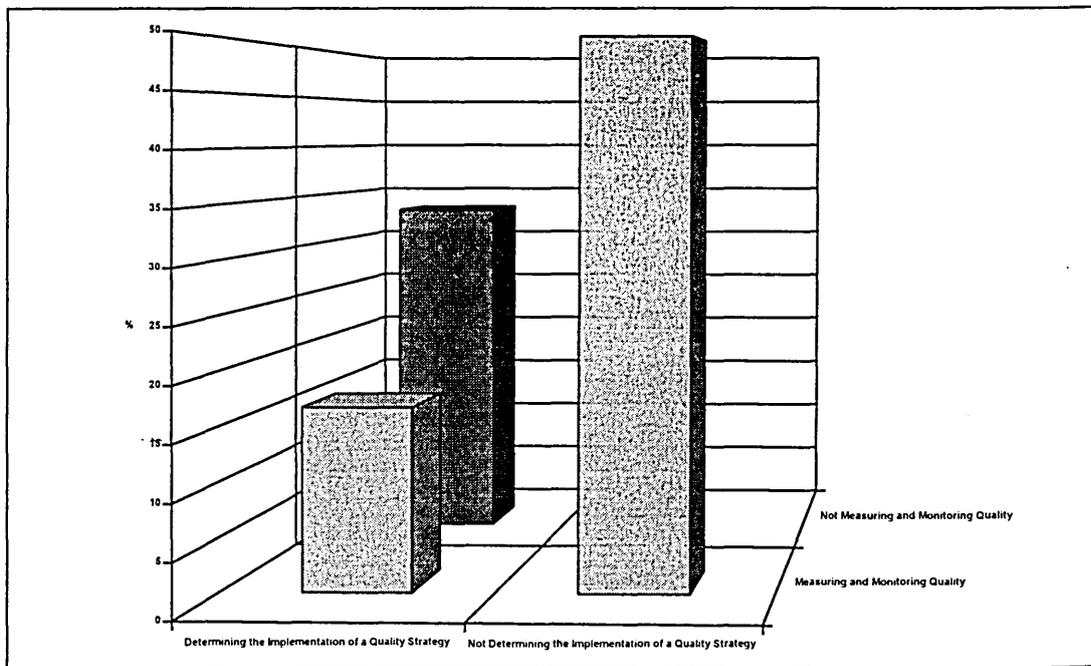


CHART 9.30 ANGLIA AND OXFORD

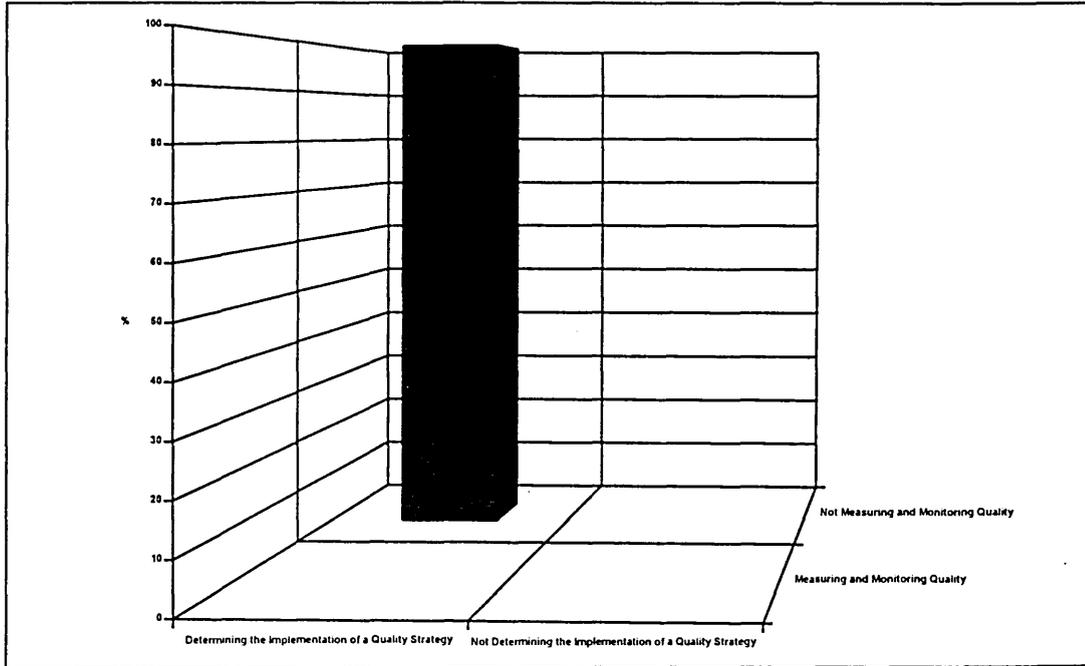


CHART 9.31 NORTH THAMES

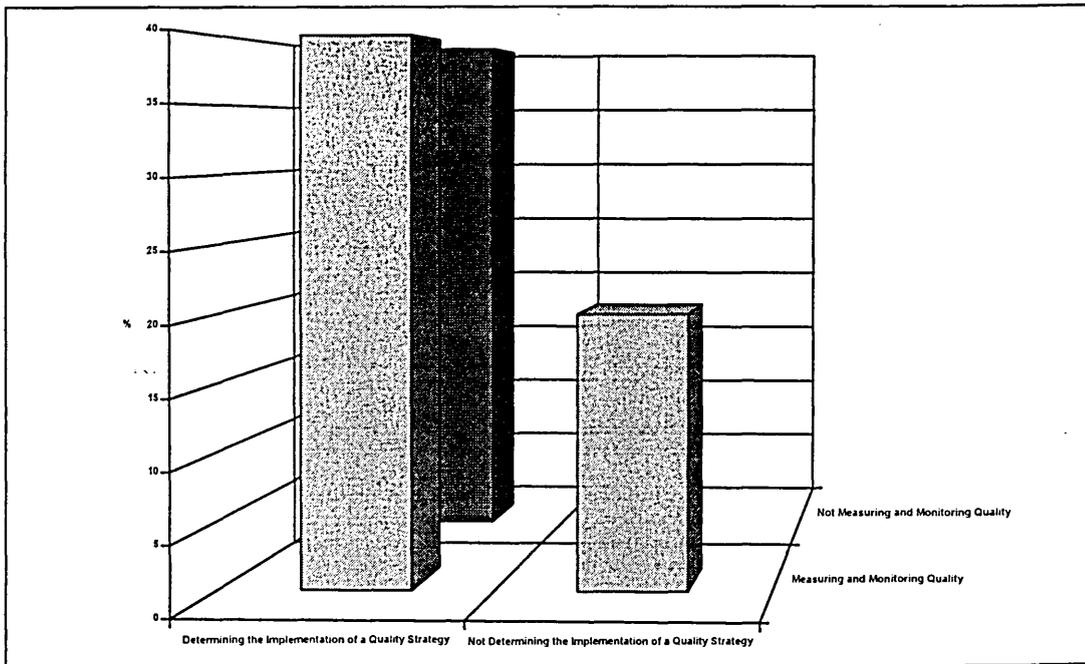


CHART 9.32 NORTH WEST

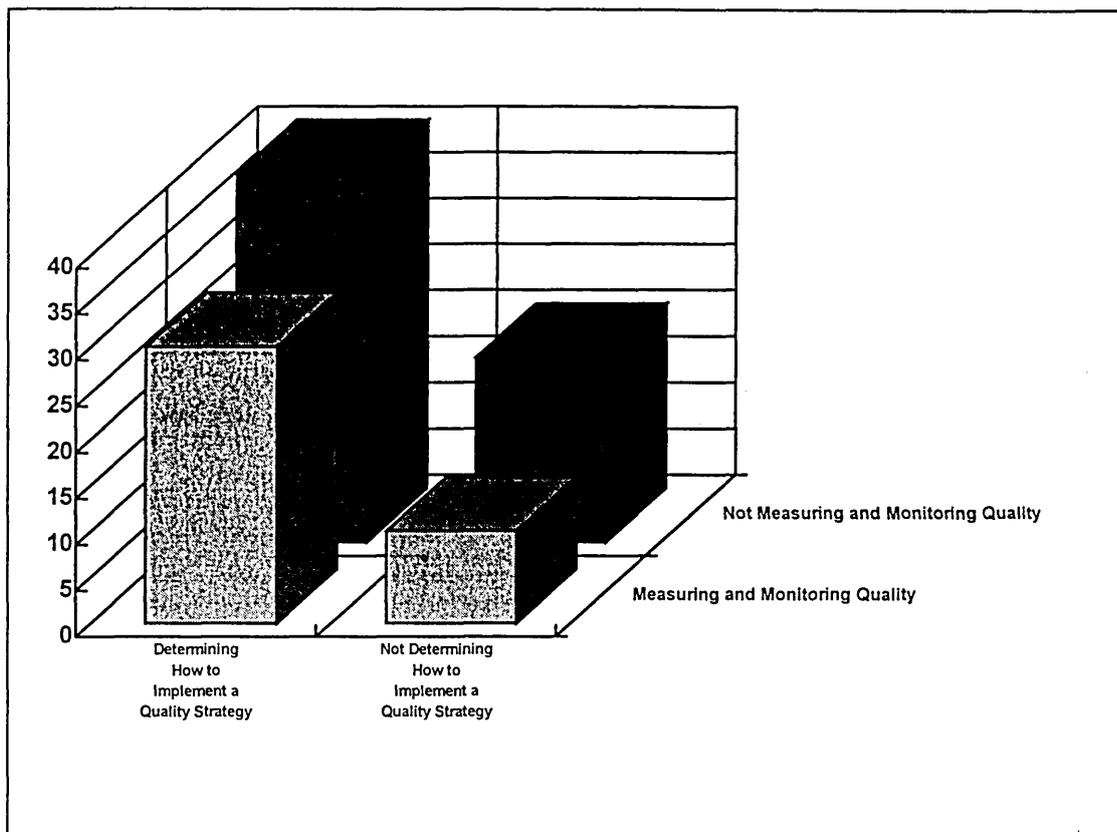
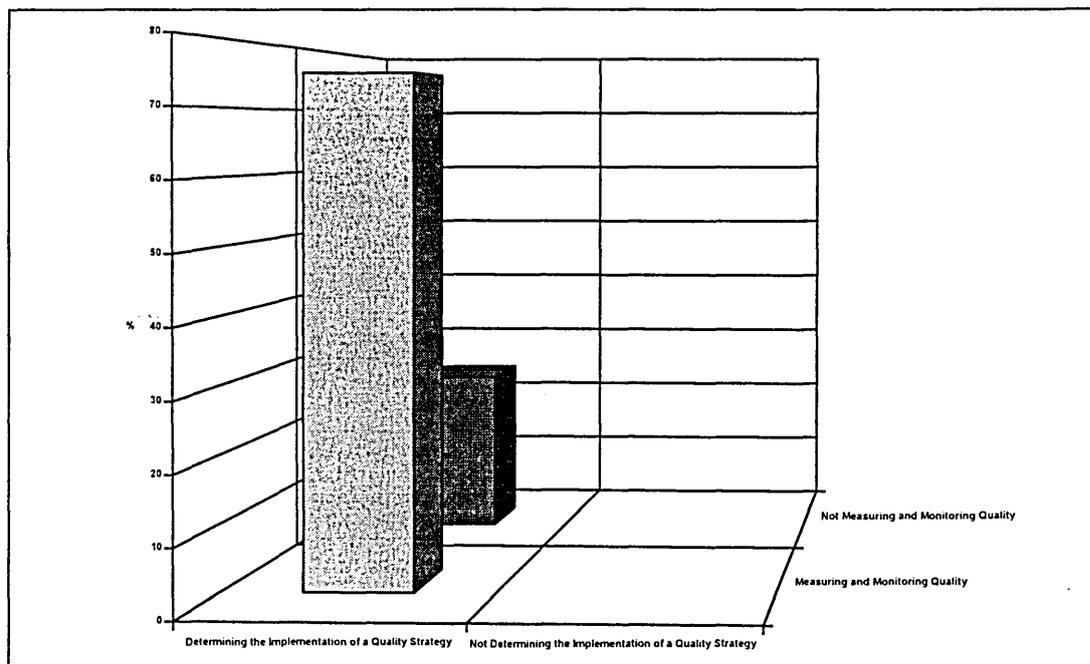


CHART 9.33 SOUTH AND WEST



DETERMINING THE FACTORS USED TO ASSESS THE QUALITY OF PROVIDERS

CHART 9.34 WEST MIDLANDS

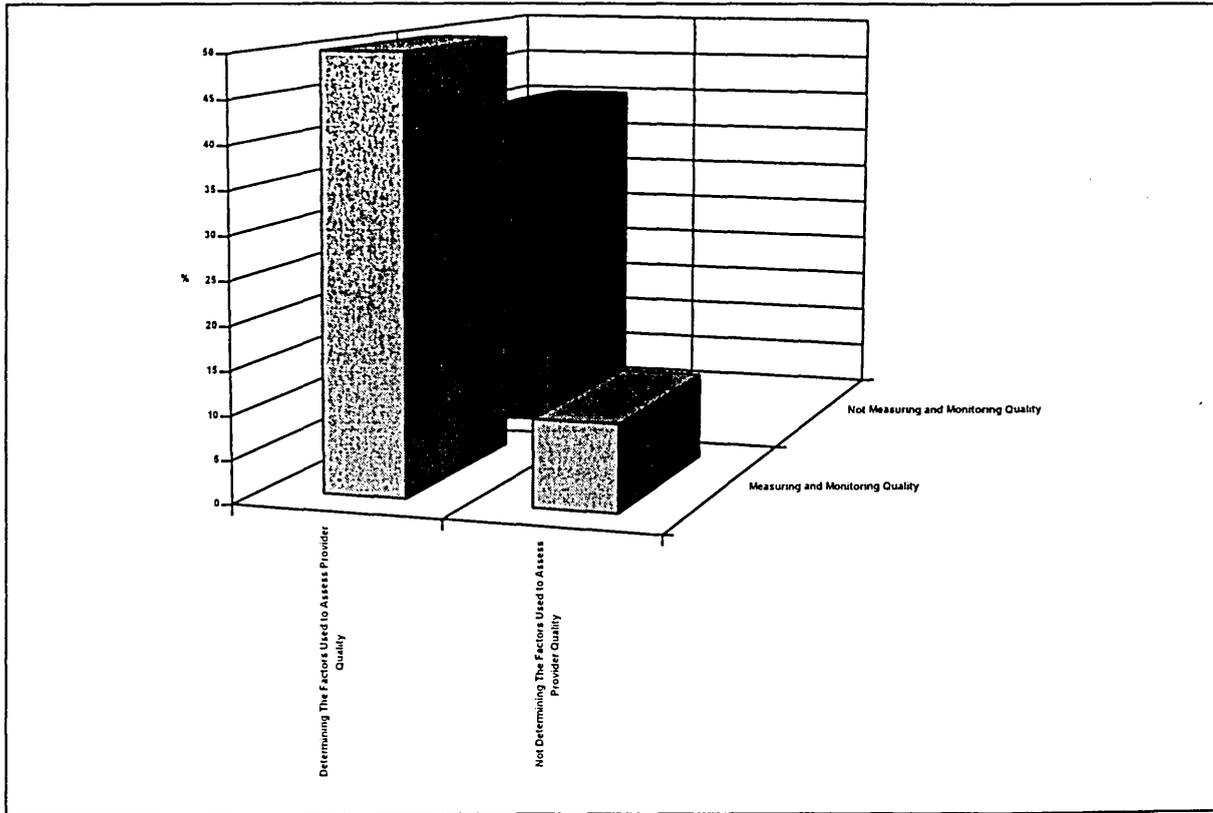


CHART 9.35 NORTHERN AND YORKSHIRE

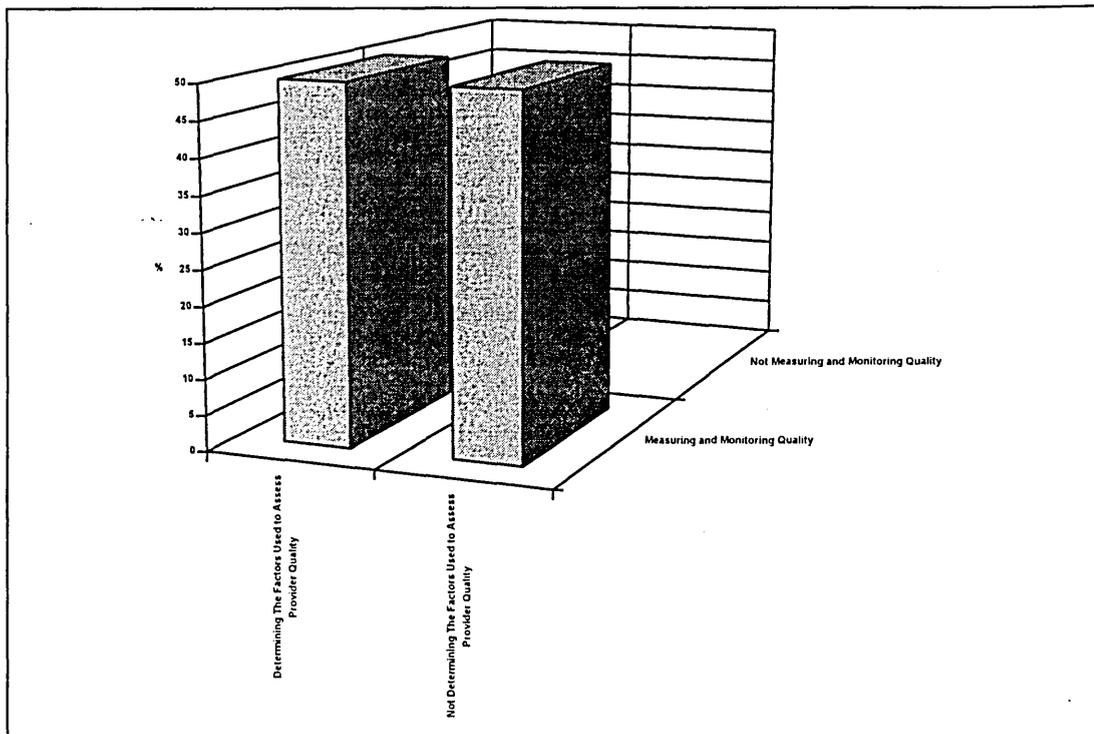


CHART 9.36 SOUTH THAMES

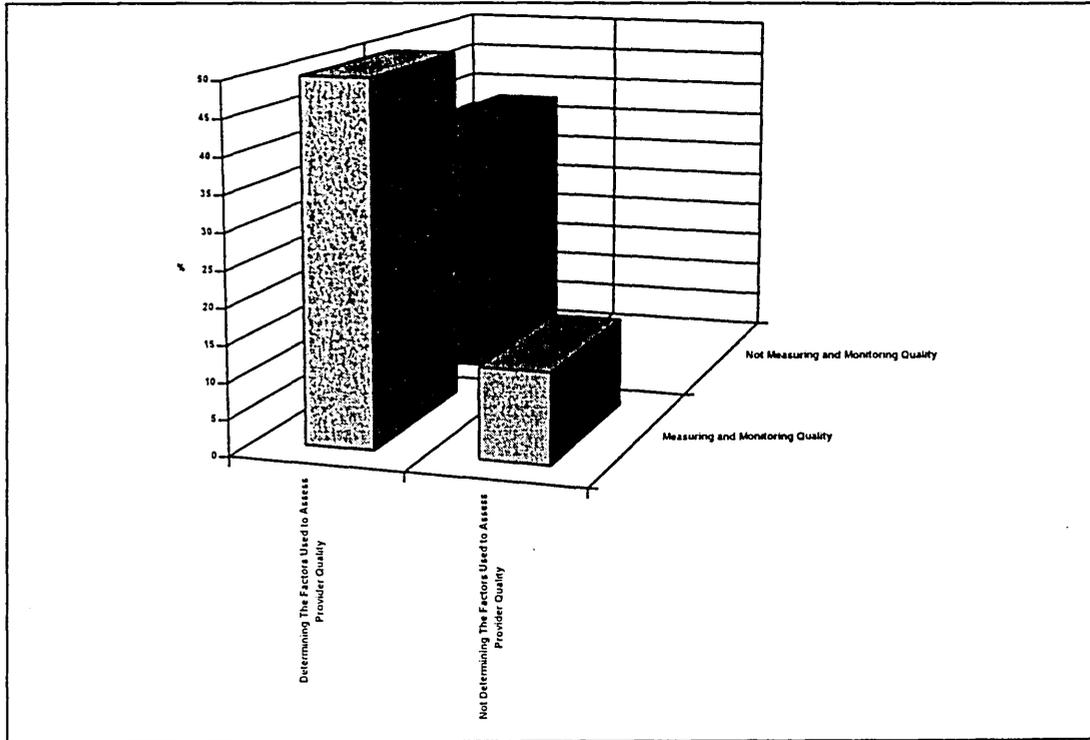


CHART 9.37 TRENT

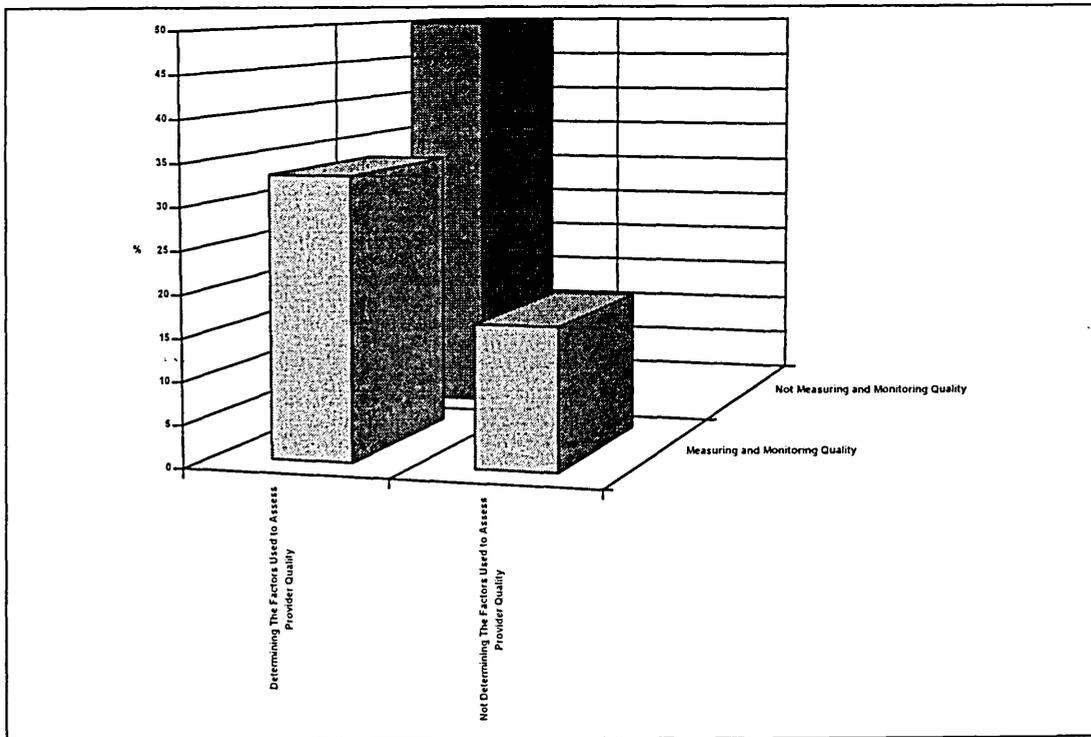


CHART 9.38 ANGLIA AND OXFORD

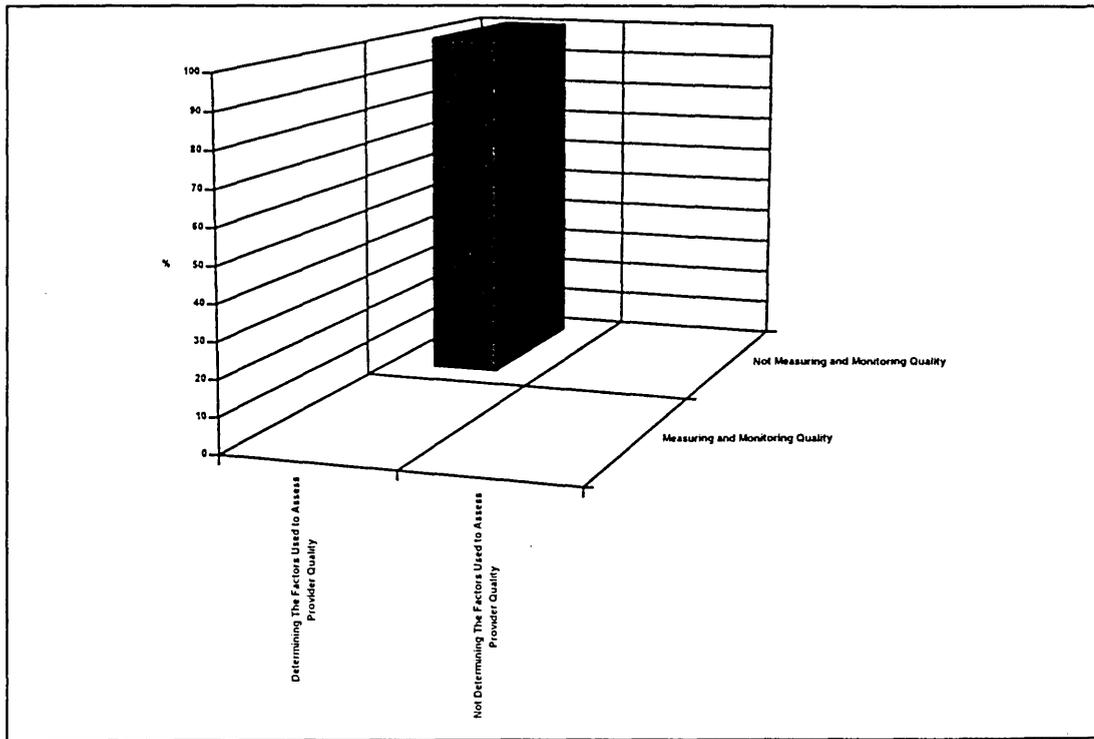


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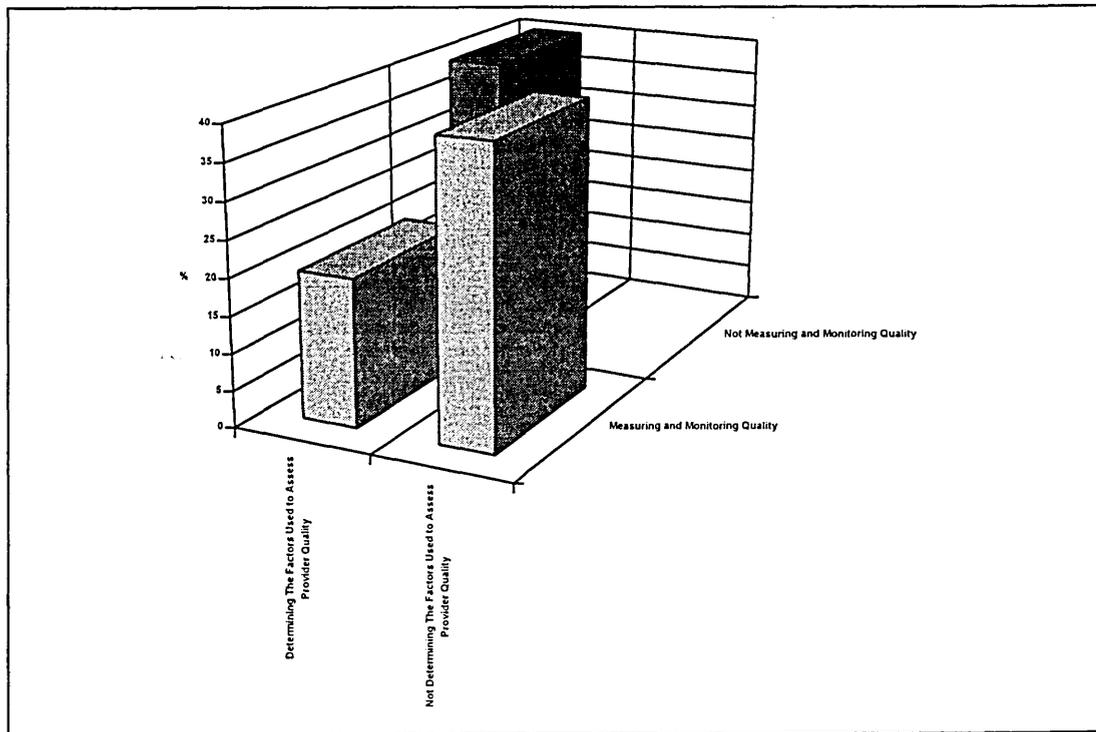


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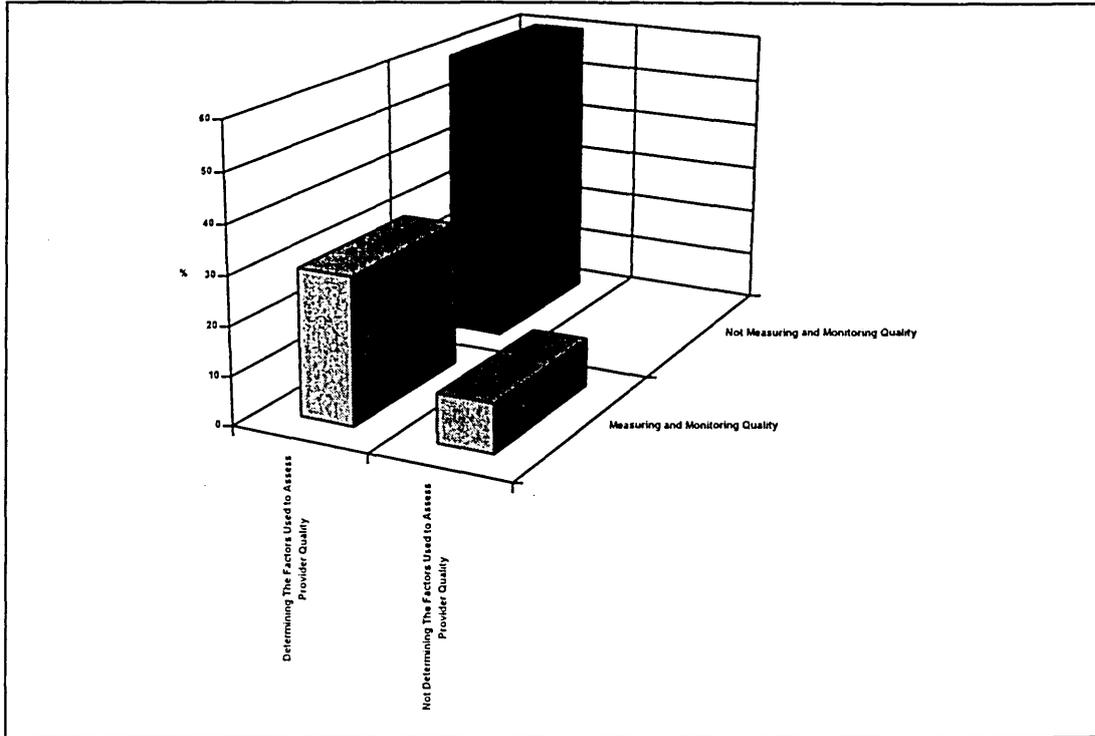
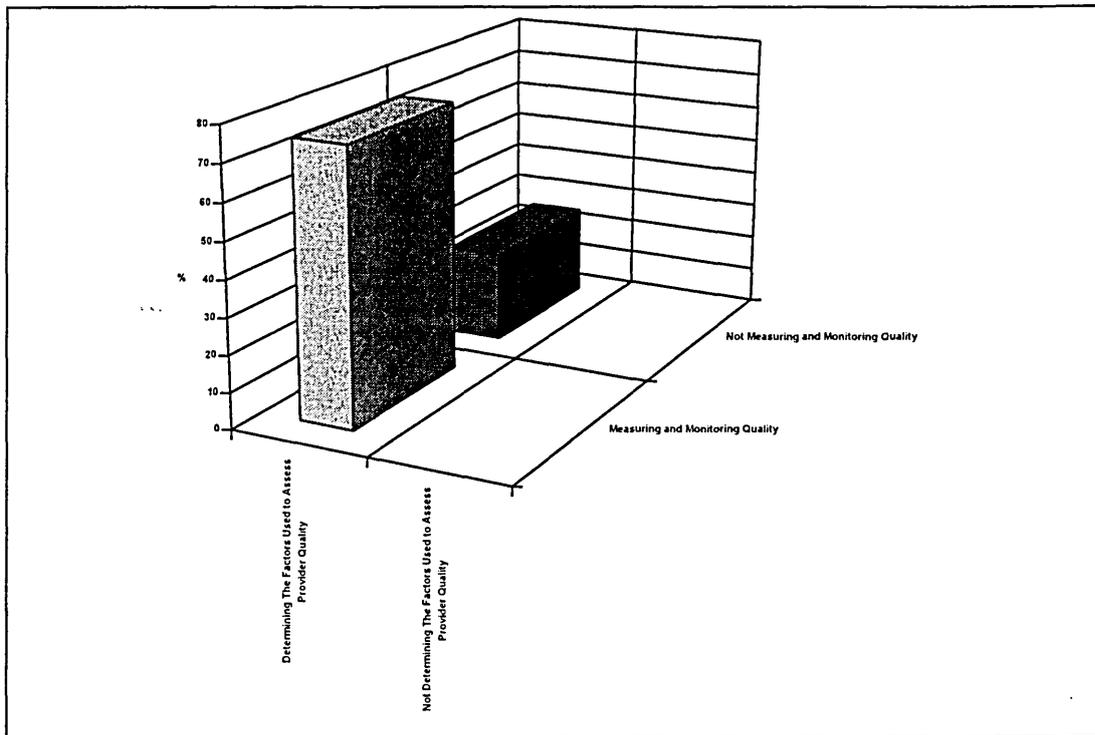


CHART 9.41 SOUTH AND WEST



DETERMINING HOW PROVIDER QUALITY IS MEASURED

CHART 9.42 WEST MIDLANDS

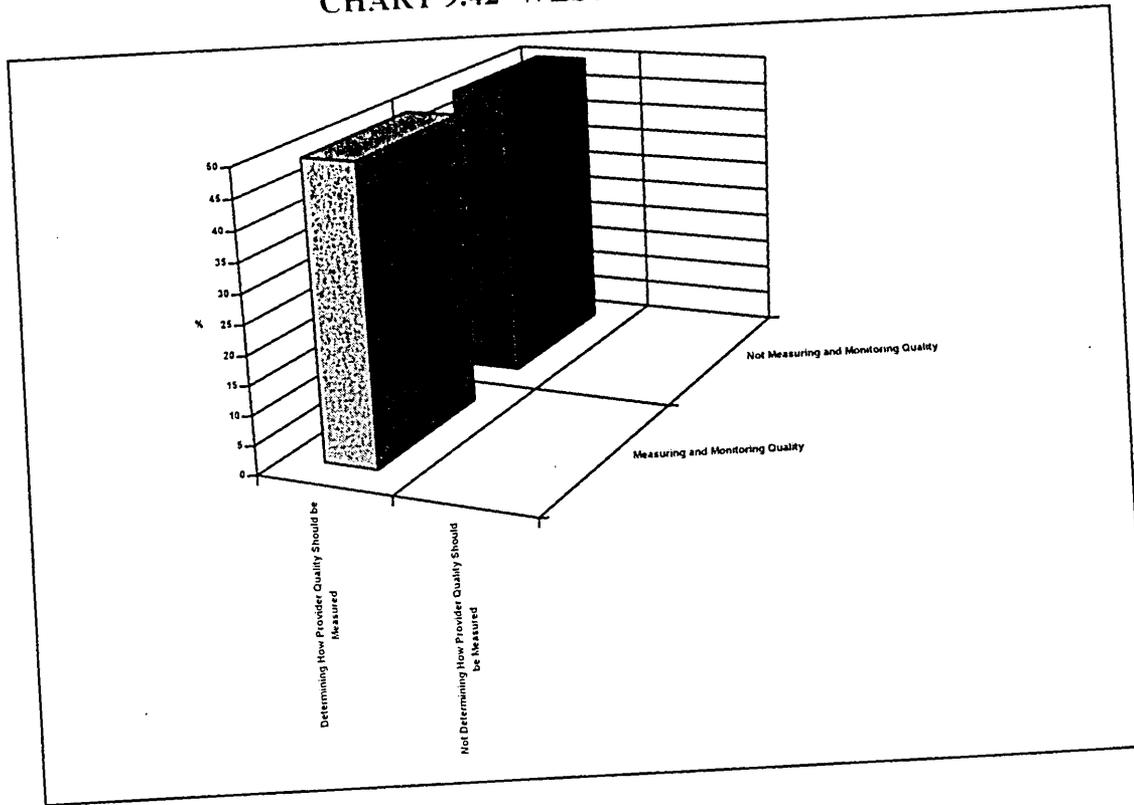


CHART 9.43 NORTHERN AND YORKSHIRE

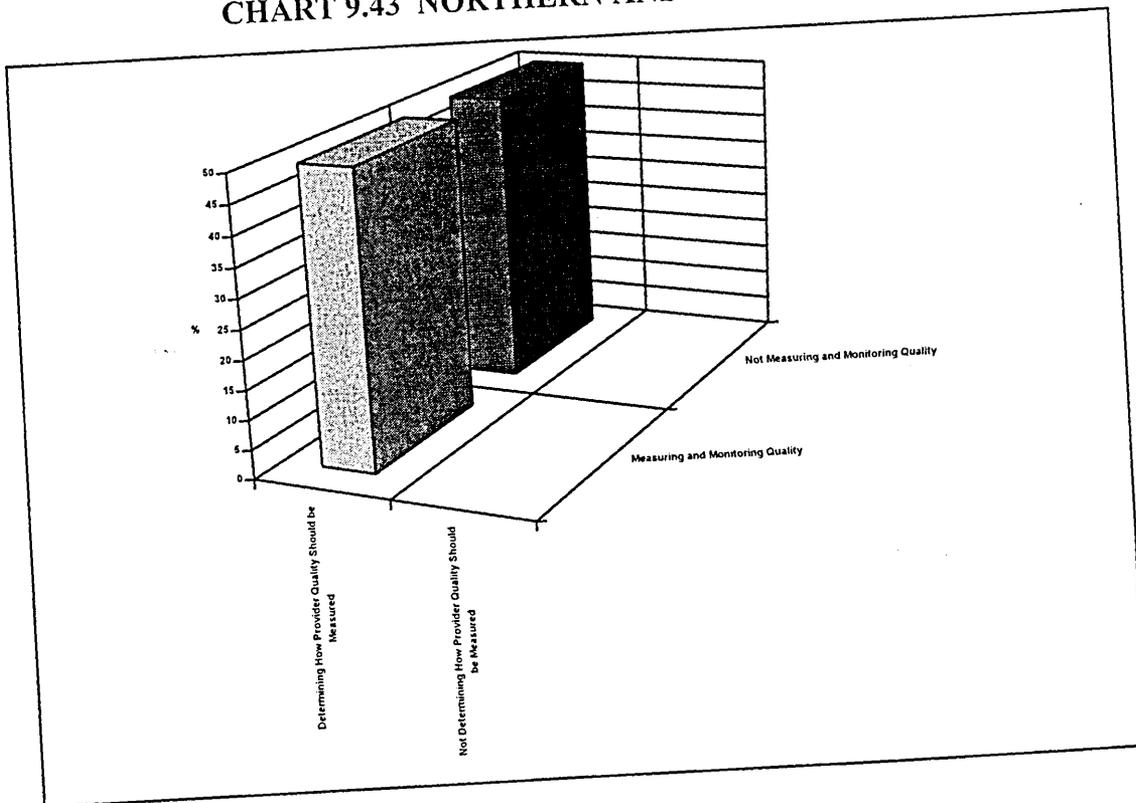


CHART 9.44 TRENT

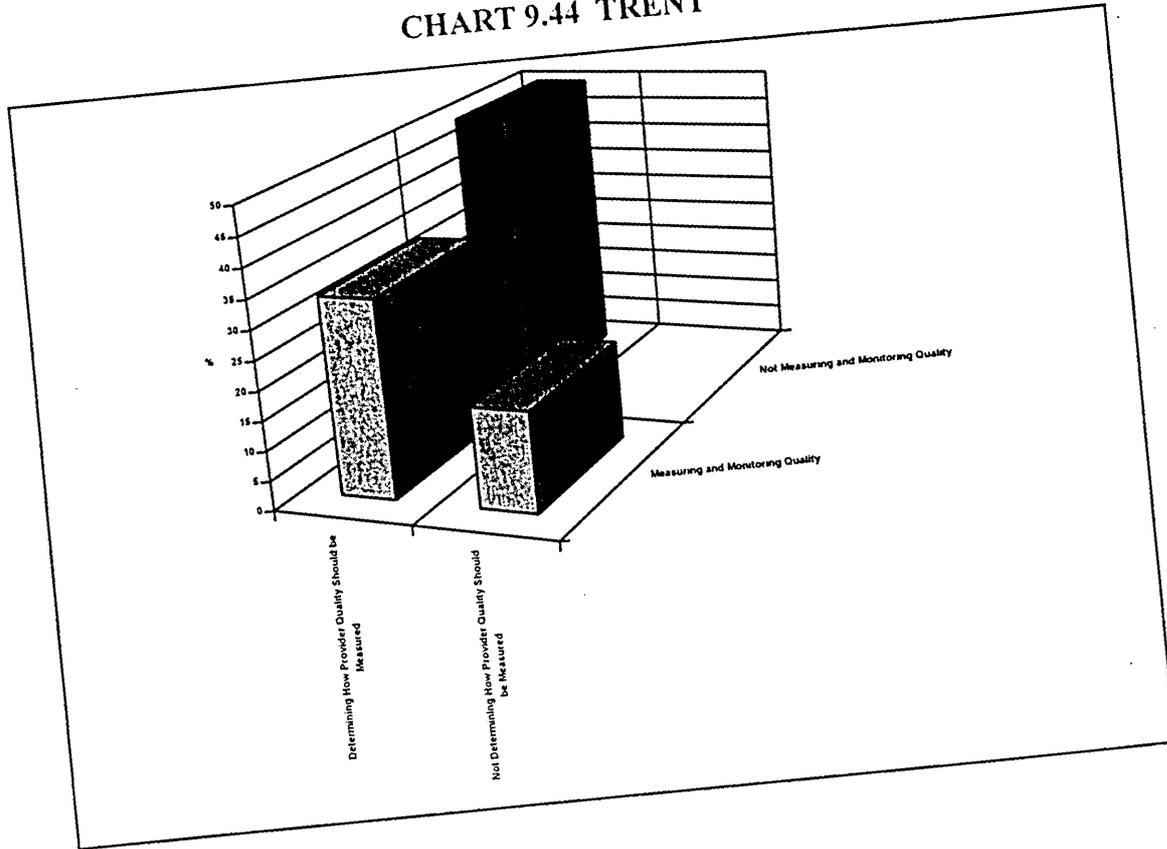


CHART 9.45 ANGLIA AND OXFORD

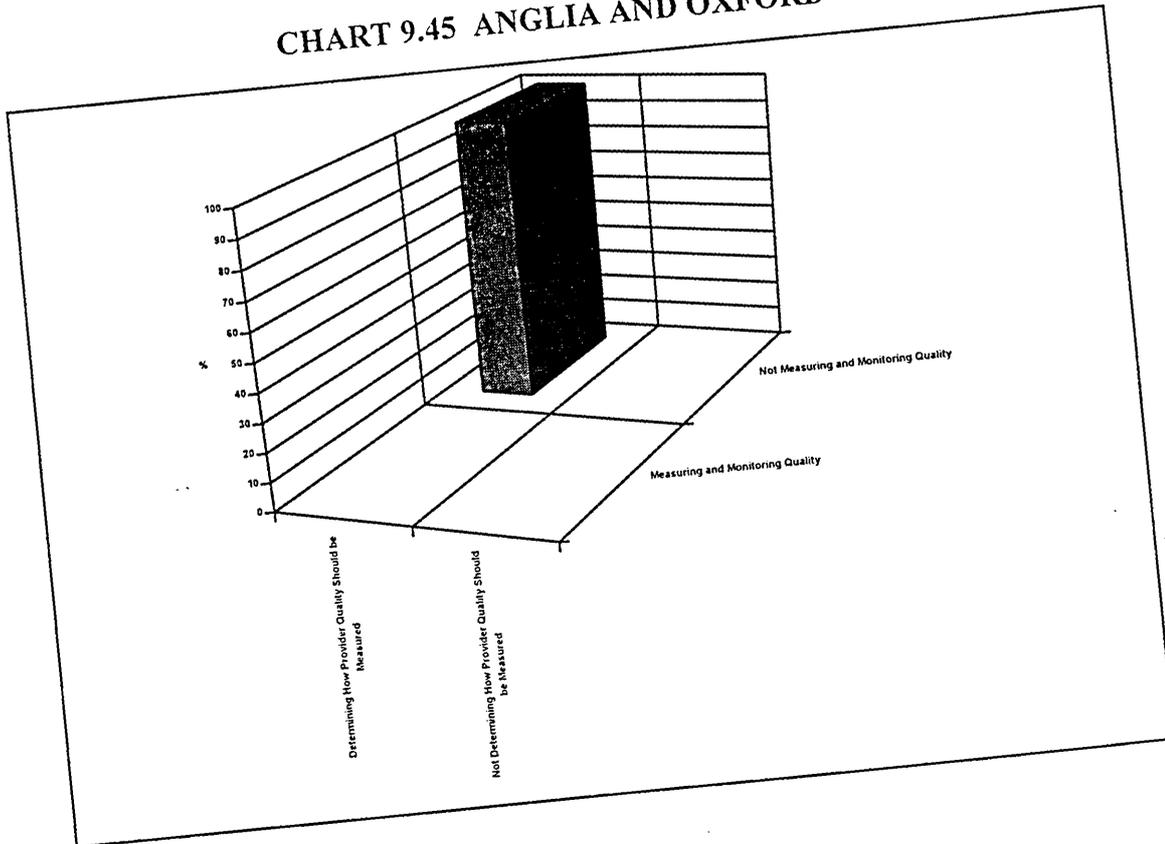


CHART 9.46 NORTH THAMES

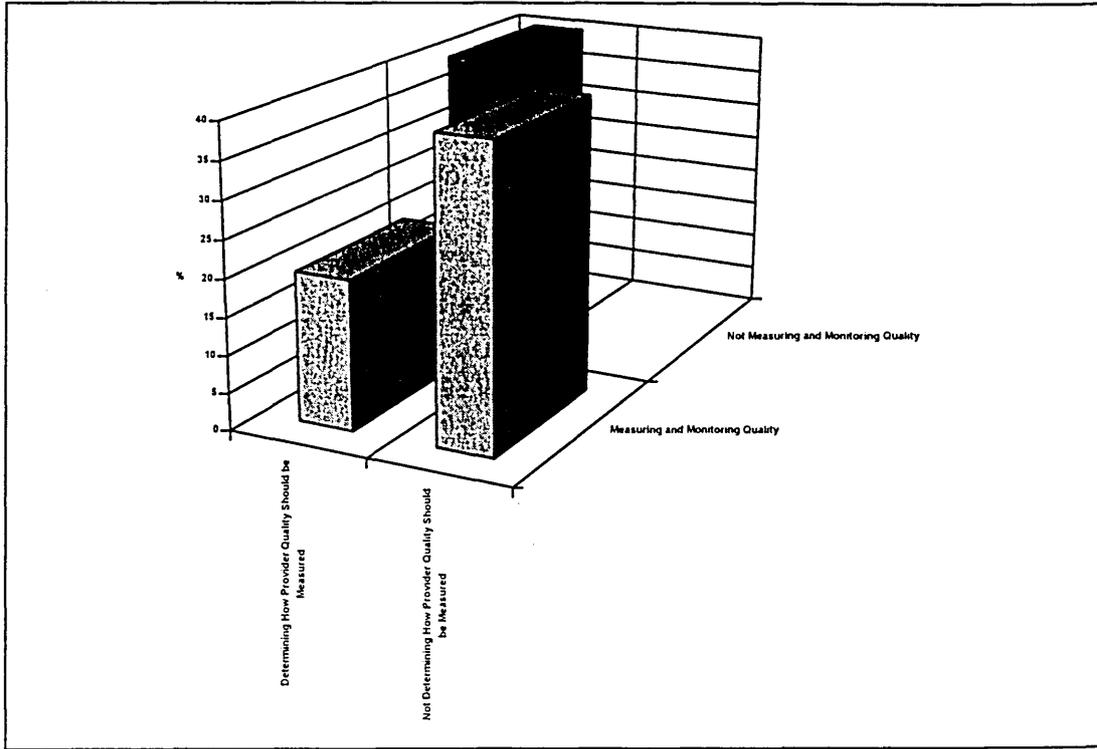


CHART 9.47 NORTH WEST

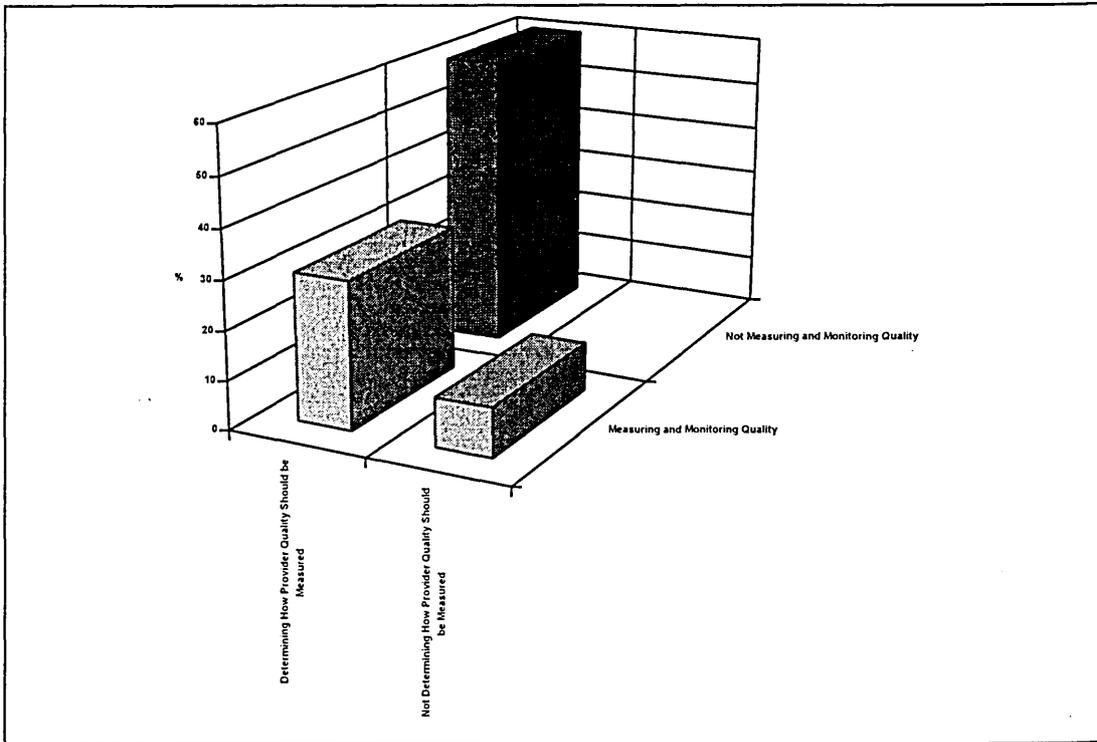
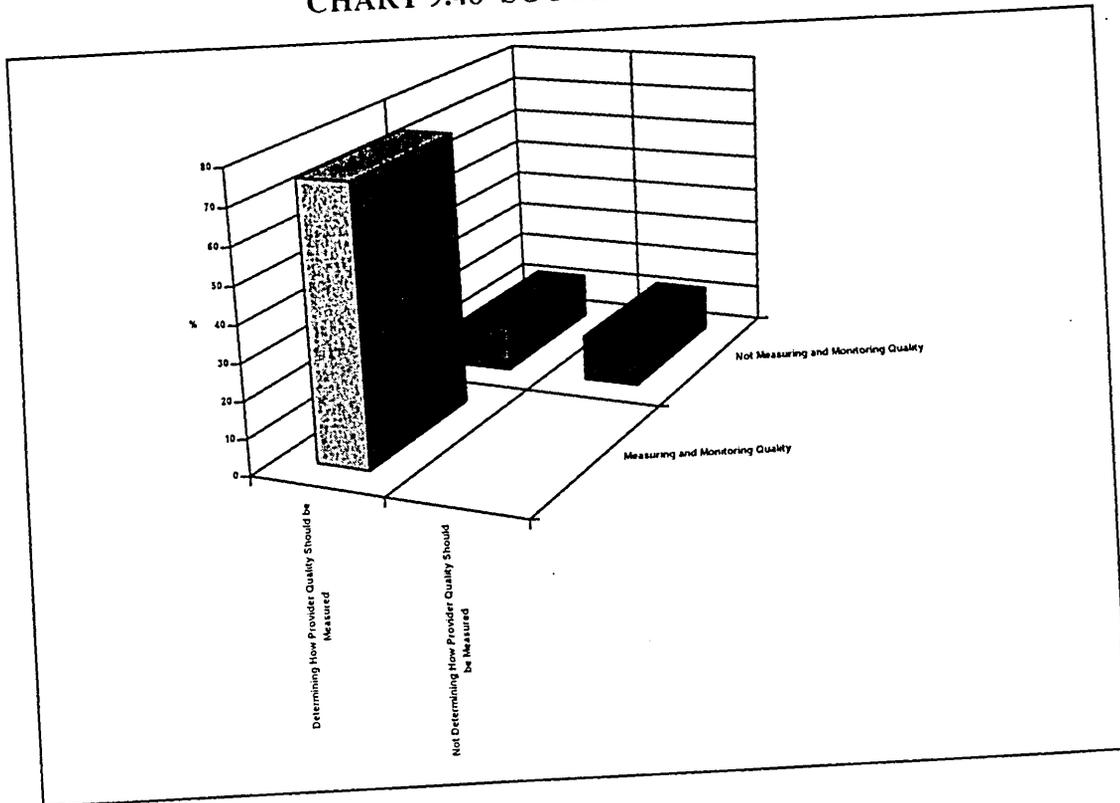


CHART 9.48 SOUTH AND WEST



MANAGING THE QUALITY OF ITS OWN ACTIVITIES

CHART 9.49 WEST MIDLANDS

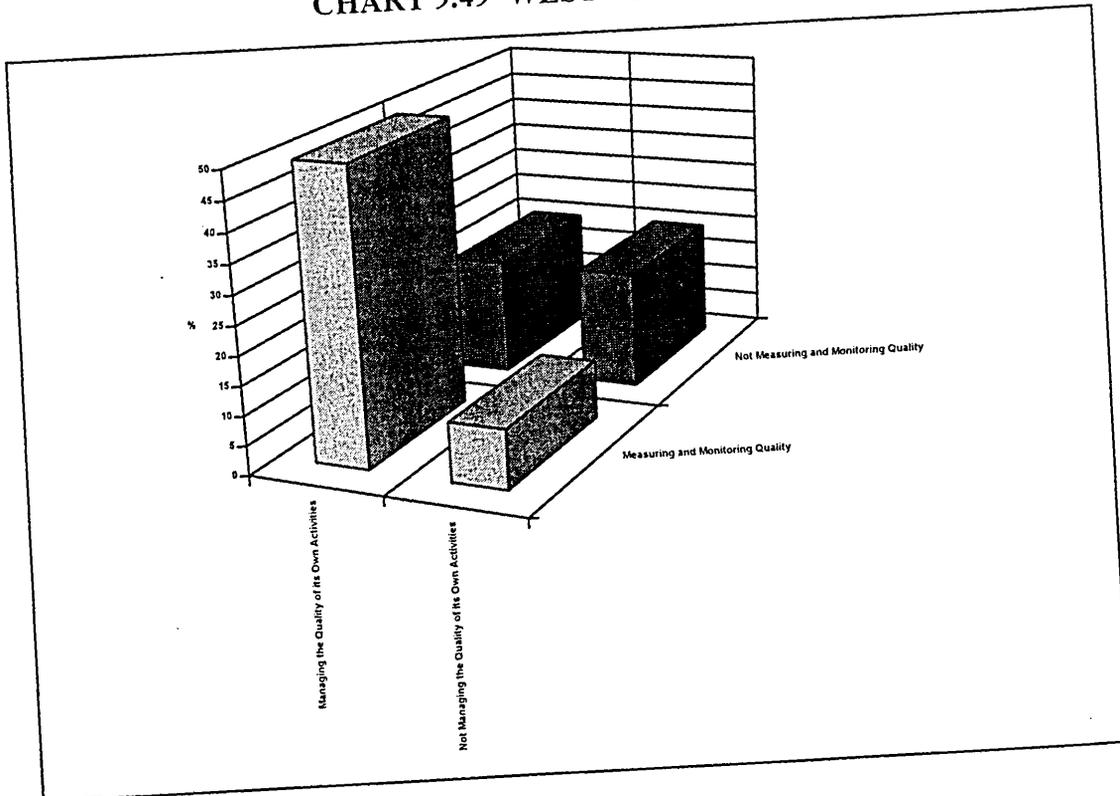


CHART 9.50 NORTHERN AND YORKSHIRE

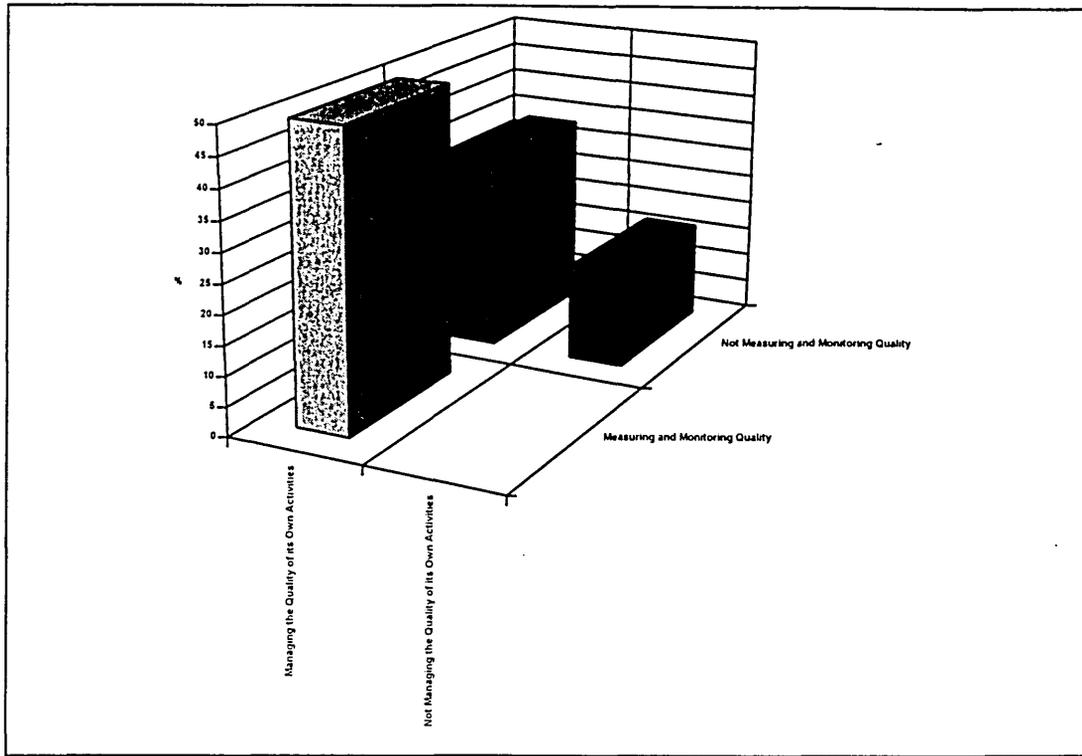


CHART 9.51 SOUTH THAMES

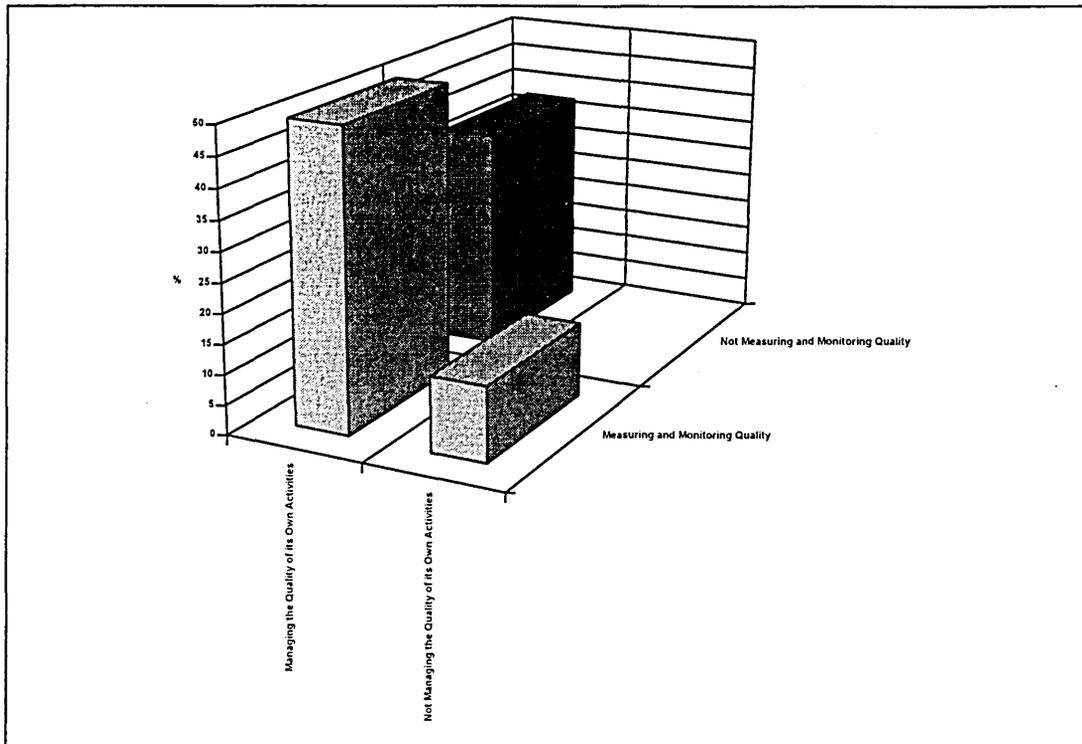


CHART 9.52 TRENT

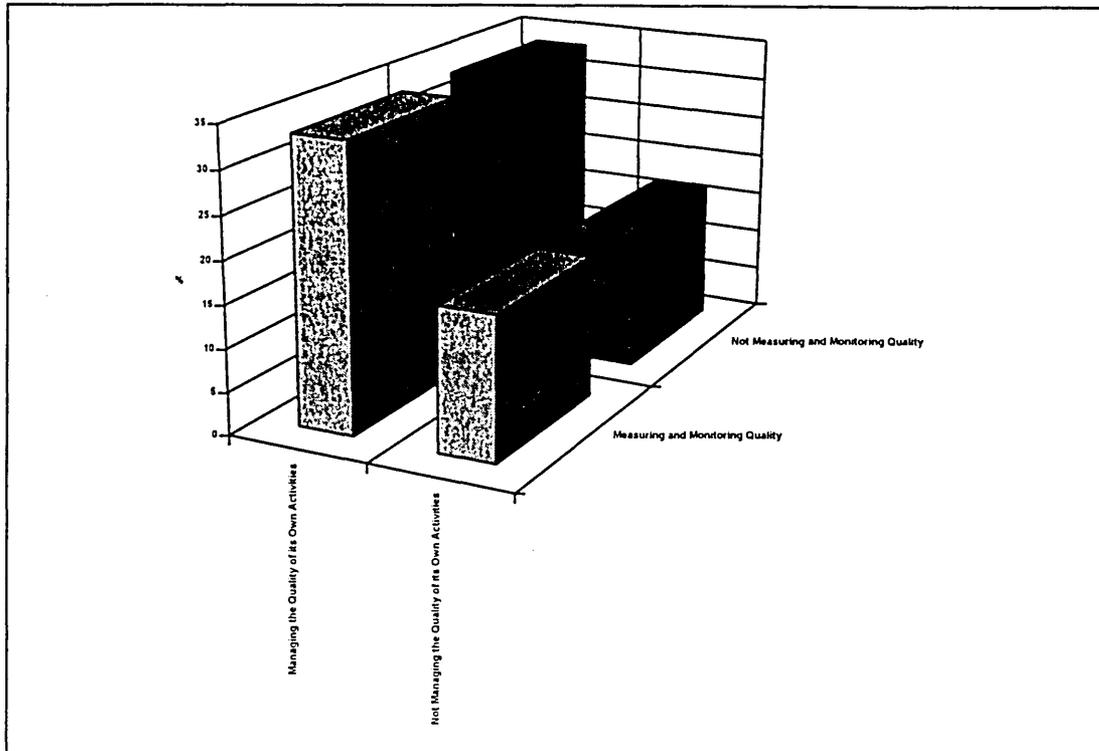


CHART 9.53 ANGLIA AND OXFORD

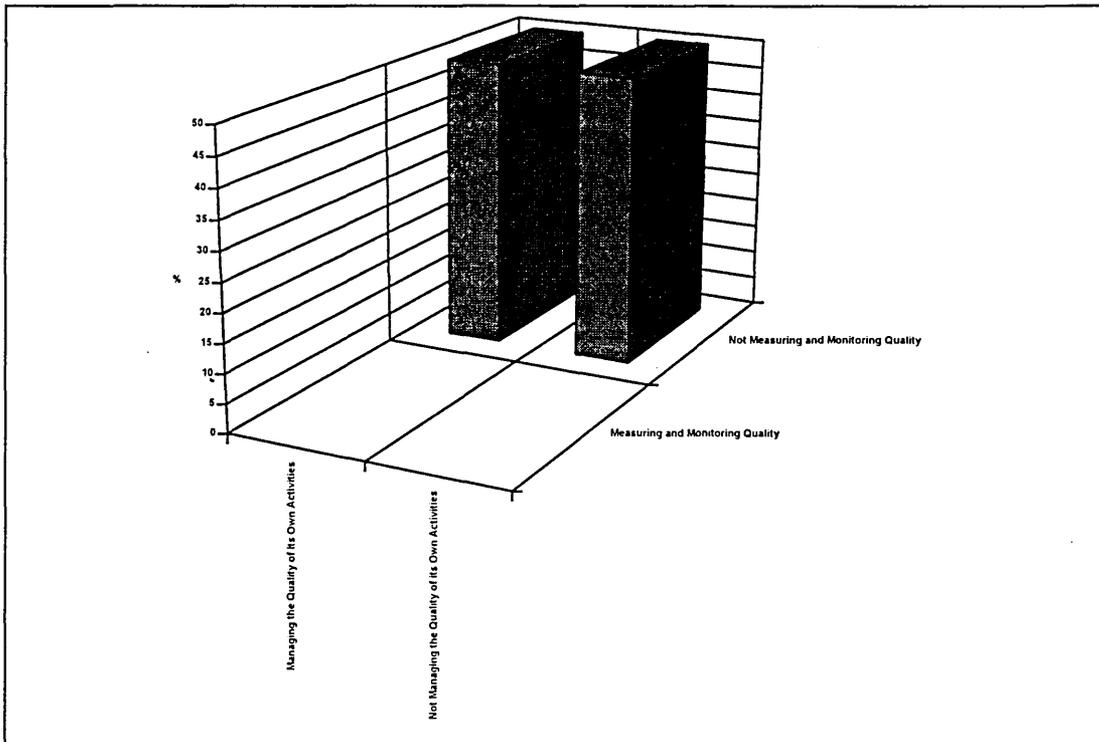


CHART 9.54 NORTH THAMES

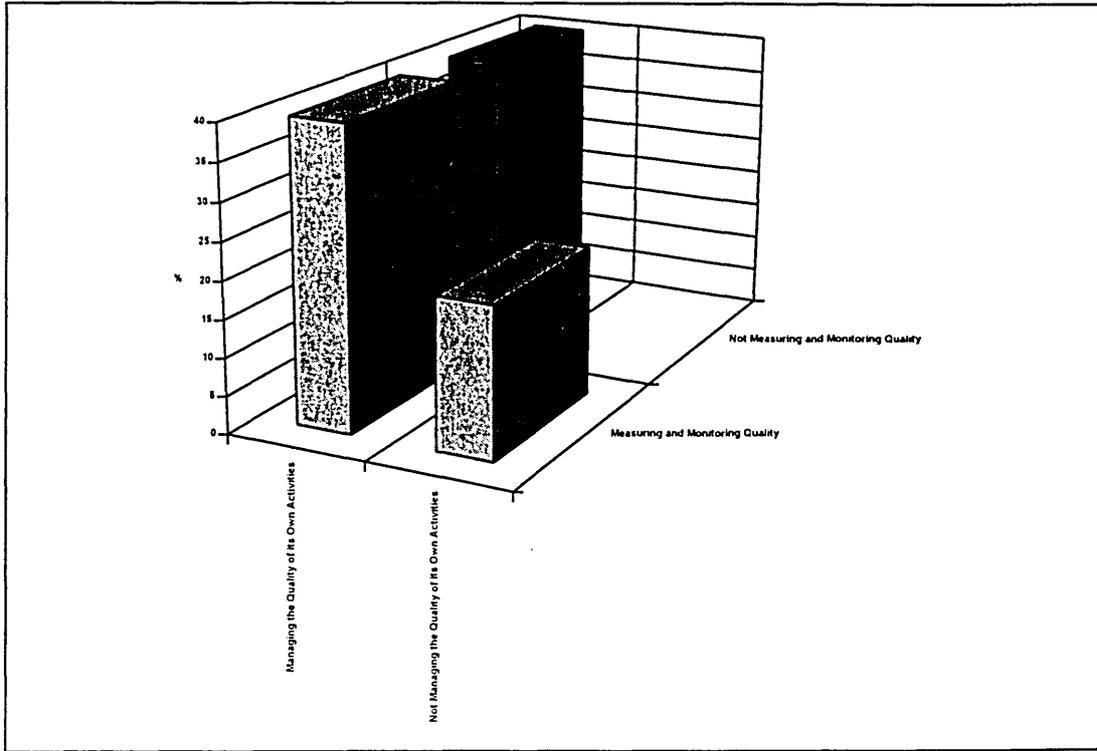


CHART 9.55 NORTH WEST

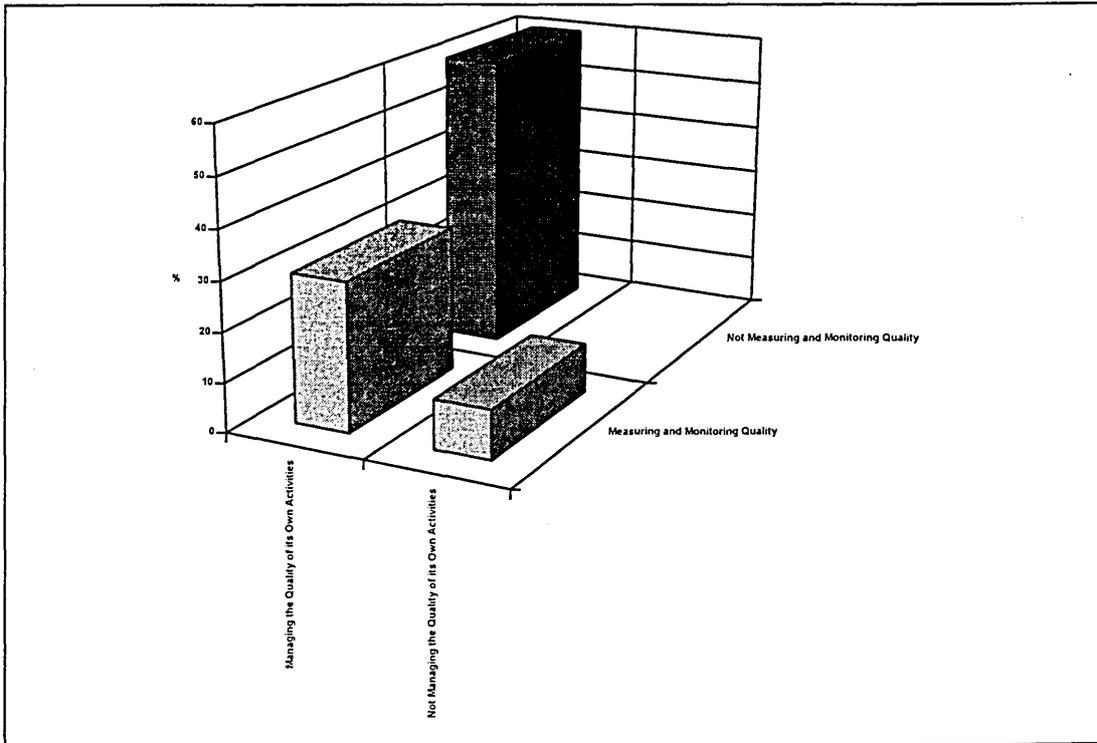
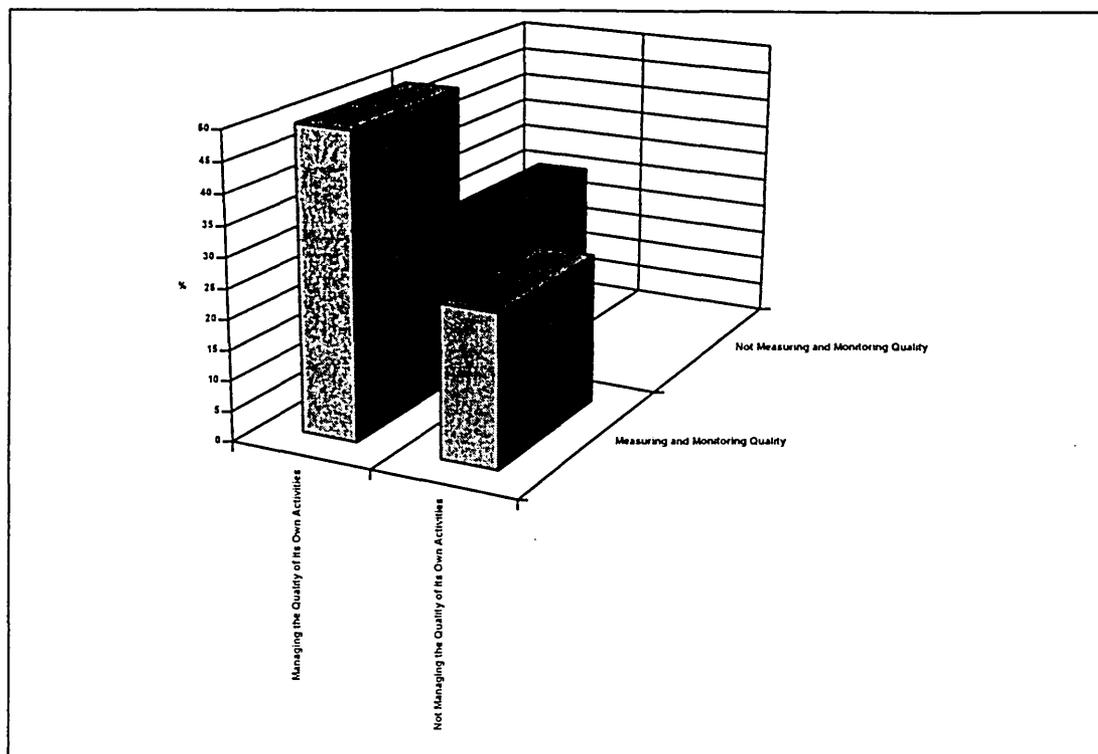


CHART 9.56 SOUTH AND WEST



CONCLUSION

The above findings highlight the fact that a large proportion of quality activities within DHAs have not been undertaken in a systematic manner and fall short of representing Total Quality Management. Despite the crucial part which measurement plays in quality improvement, few DHAs had adequate measurement processes in place. Most preferred to rely on either existing systems and/or attempted to use inappropriate systems intended for another purpose.

CHAPTER 10 ANALYSIS OF RESEARCH DATA: TOTAL QUALITY MANAGEMENT

TOTAL QUALITY MANAGEMENT

The questionnaire requested DHAs to indicate whether or not they were implementing TQM to ascertain the extent to which the concept remained an objective. DHAs were invited to provide details of their TQM initiative where it was in place and reasons for not implementing TQM where it was not. Overall, only 18.6% of DHAs claimed to be pursuing TQM. The Regional breakdown of results was as follows:

CHART 10.1 THE IMPLEMENTATION OF TQM

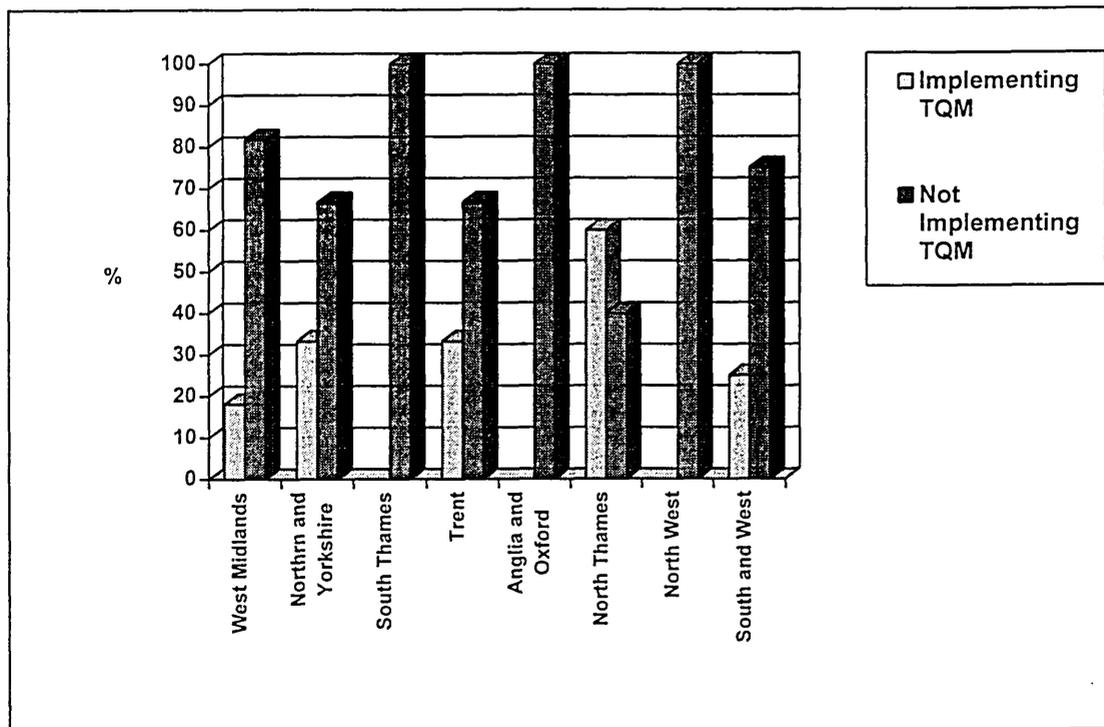


TABLE 10.1 THE IMPLEMENTATION STRATEGIES OF TQM

	How TQM is being Implemented
West Midlands	(a) Currently being implemented - first stage staff education programme (b) A consultant was commissioned to assist in training staff and the implementation of a TQM culture. Now departments have CQI groups The approach is based on Juran's definition of TQM
Northern and Yorkshire	(a) FHSA activities controlled under BS 5750: part 2/ ISO 9002. DHA activities through internal protocols but largely through the development of an organisational development strategy. (b) Currently in the process of developing a strategy based on TQM philosophy
South Thames	None
Trent	(a) Adheres to the 'principles' of a TQM style approach although not specifically referred to as such. TQM 'style' of approach has to reconcile theoretical models with practical reality. (b) TQM programme with working groups. Investors in People initiative. The DHA is committed to Investors in People with the emphasis on Individual Performance review.
Anglia and Oxford	None
North Thames	(a) Quality Management System proposed and accepted by the health authority - now on hold due to UCA (commissioning) arrangements. (b) We are only partially implementing it but the QRV programme and various other education and training initiatives for staff are addressing TQM. (c) Every department is responsible for its own work and everyone within each department.
North West	None
South and West	(a) Based on Deming model (b) Quality improvement focus being developed

TQM IN THE WEST MIDLANDS REGION

One DHA in the West Midlands Region, in the early stages of implementing TQM, provided an outline of what it believed to be the distinguishing features of a quality service.

- Professional expertise
- A consumer focus for services which are accessible and acceptable to the population served
- Total involvement of staff
- Provision for induction and training of staff
- Clarity about standards
- Regular monitoring and evaluation of performance and outcome in relation to standards
- Programmes of continuous improvement

In addition, the DHA considered a Quality Management Culture and a Quality Management structure to be the key. However, although it principally considered these to be the responsibility of Providers, "The Authority expects that Providers have a strategy for developing a Quality Management framework if one does not exist".

The features which distinguished a quality service corresponded with those identified by Donabedian (1980, 1982, 1985):

- The technical dimension: the application of science and technology to a problem
- The non-technical dimension: the social/ psychological interaction between practitioner and client
- The amenities, or setting of the service.

The key aims of the service being to secure:

- the provision of competent clinical care which takes into account the needs and expectations of the patients and their families.
- the patient's safety and well being;
- treatment/ practice appropriate to identified needs' diagnosis;
- the provision of health care delivered in a courteous manner, treating people with dignity and respect, with due regard to individuality and confidentiality and appropriate to sex, ethnic, religion or disability;
- Access to appropriate clinical services provided by other related support services;
- that standards are critically assessed in all areas , continually modified and refined;
- that resources are used in the most effective manner to the patient's best advantage;
- the provision of adequate information to patients upon which to base their choice whether or not to participate in teaching and research;
- the provision of health care by staff with appropriate qualifications, training and skills;
- a guaranteed smoke free environment for none smokers in all types of facility;
- all reasonable and practicable steps to provide a clean, well decorated and furnished, suitable heated, illuminated and ventilated environment fit for the purpose.

The DHA also detailed the means by which these aims were to be achieved:

- (a) Explicit quality standards
- (b) Adherence to Statutory requirements
- (c) Clinical audit
- (d) Human resources
 - communication
 - personnel policy
 - staff development
- (e) Specific quality standards
- (f) Monitoring of quality

The means to achieving quality, however, were once more couched in terms of the requirements which the DHA made of its Providers.

TQM IN THE NORTHERN AND YORKSHIRE REGION

A DHA in the Northern and Yorkshire Region produced a document entitled "Quality Counts: A Strategy for Action". The document outlined the DHA's approach and made it quite clear

that quality improvements included both the DHA's own services as well as the services it purchased. Ovretveit's (1992) definition of quality had been adopted: fully meeting the needs of those who need the service most at the lowest cost, within limits and directives set by authorities and Purchasers". In addition, the DHA stated its clear commitment to Total Quality Management. This was one of the few DHAs that used the term, other DHAs claimed to adhere to TQM principles whilst referring to the initiative by another name.

The DHA had identified the following principles underpinning TQM:

- putting the customers/ patients first
- meeting and exceeding customer/patient expectations
- getting the service right first time
- reducing the costs of poor quality
- reinforcing good staff performance

The DHA chose to consider the concept of the customer in the widest context that included "...patients, investors, employees, stakeholders, suppliers, the community and every interpersonal relationship!"

The implications for implementing TQM were considered to be

- management commitment to quality demonstrated through positive action
- total quality management needs to involve all activities and every single person within the organisation
- everyone needs to be responsible for total quality management
- management systems need to focus on preventing problems
- the need for continuous quality improvement needs to be recognised

In terms of the quality of services purchased, the DHA preferred Maxwell's (1984) dimensions of quality in health care over the Donabedian approach:

- accessibility: location and waiting time
- relevance of service to needs of the population
- equity: fairness of provision for different groups of people
- efficiency: economy resource use and value for money
- acceptability to the public of services available
- effectiveness of services provided

In addition, it saw three areas that were essential to delivering quality in health care:

- client quality concerned with those elements readily assessed by patients, for example, catering and decor
- managerial quality concerned with the appropriate management of health care resources
- professional quality concerned with issues of clinical effectiveness

The document differed from those of others by providing details of the DHA's own internal drive for quality and the means to introduce and sustain a quality culture. Five key areas were identified as needing to be addressed :

- developing and sharing a common meaning of quality
- investing in people management
- management commitment and involvement
- measuring performance
- recognising the need to improve processes

The document suggested that the DHA perceived no problem accommodating these requirements given that other initiatives were already in place. These being

- Investors in People
- Learning Organisation
- Internal Communications
- Local Voices
- Information Strategy
- Finance Strategy
- Research and Development Strategy
- Public Health Audit
- Project Management

There was an underlying assumption that these initiatives all neatly fitted under a TQM umbrella and mutually supported each other. Each of these initiatives had different objectives and, therefore, it could be predicted that difficulties would be encountered in attempting to reconcile the various requirements of different initiatives. Within this particular DHA, TQM was perceived by board members to be yet another initiative and were "turned off" by it.

The DHA envisaged using the European Quality Model (see page x) as a self-assessment tool and a framework to identify and address total quality issues. The self assessment exercise was considered to be the foundation of the continuous improvement process. The initiative was launched by communicating the quality strategy through open forums, team briefings,

newsletters and departmental meetings. This was followed by a period running several concurrent activities. These were establishing the self assessment process via a seminar involving the Health Executive Team, developing training material, further communication of progress using the mediums detailed above, and the establishment of three quality teams responsible for addressing:

- Contracting for Quality
- Primary Care
- Corporate Quality

Further training was to be provided to reinforce key principles and develop a shared understanding of quality. The quality teams were to report after four months with a set of action plans to be approved.

The decision to opt for this approach was made as a result of directives from the NHS Executive coupled with the realisation that the organisation had no focus for quality. Results from the self assessment exercise indicated that the organisation was weak in most areas, scoring less than 50% overall, and was very poor on perception of customer satisfaction and visible leadership but performed better on internal staff development. In terms of the contract process, the DHA's Service Quality Manager found that Providers were not always willing to work together but it had hopes that the three NHS Trusts with whom it contracted, would also adopt the European Quality Model.

Although the Chief Executive has voiced his support, the Director of Quality and Nursing was sceptical of the strength of this support and suspected that TQM would be seen as a bolt on. For example, the budget for the initiative was only £6000 and even this was not immune from cutbacks (Director of Quality and Nursing 13.6.95). It was, therefore not surprising when she stated that difficulties had been encountered in going beyond the Patient's Charter and persuading people that TQM was relevant to Purchasers.

One aspect of the strategy was to identify problem areas with a view to focusing staff training which in turn would hopefully cause awareness to trickle down through the organisation. The DHA had yet to decide whether to adopt a blanket approach or in-depth targeting.

Although there was an awareness of activities taking place elsewhere, there had been little active involvement with other DHAs. Contact had been made with one in a neighbouring Region, however, the Director of Nursing and Quality found that this DHA's focus had been more on the contracting process rather than internal quality management. There was no

support from the RHA with the emphasis on the contracting process and restricted to narrow areas. This was felt by the Director of Nursing and Quality to be at least partly due to the recent merger between the Yorkshire RHA and the Northern RHA which had left the latter's management dominating the new organisation structure.

Another DHA in the Northern and Yorkshire Region stated that it was implementing TQM using a two pronged approach. FHSAs activities were controlled under BS 5750: Part 2/ ISO 9002 and the DHA activities through some internal protocols but largely through the development of an organisational development strategy. ISO 9002 certification was achieved in March 1995.

TQM was being adopted in the midst of organisational restructuring. Thirty five job losses had already been made with a further thirty planned. According to the Internal Quality Manager, the adoption of TQM was a response by the DHA to meet its responsibilities within a rationalised structure. "Quality systems have helped to monitor performance and helped us to understand where we can make improvements". The danger with such an approach was that TQM would be associated with cut backs by members of staff. The Internal Quality Manager estimated that 40% of people within the DHA had yet to be convinced of the benefits of TQM for themselves and that managers felt themselves to be the most threatened by its adoption.

The Internal Quality Manager accepted that the process required a leader to drive through the necessary changes. The organisation culture was perceived to be changing only slowly, taking several years to be brought about. Individual recognition was not complete and the "feel good" factor was missing. Different management styles across directorates was seen as a hindrance. The mission statement and statement of values moved forward far more quickly. TQM in this DHA was undertaken for pragmatic reasons but ones which were ultimately preventing its successful implementation.

The RHA was perceived to be several steps removed from the DHA. This was seen by the Service Quality Manager to be a result of key people leaving the RHA. Broad quality measures were laid down in the corporate contract. Networking with other DHAs was not found to be particularly beneficial as it frequently turned into a point scoring exercise. Senior management needed to be involved in order for it to work. Support, through sharing information and experiences, was more informal than formal. The directives relating to the Patient's Charter were not considered useful as they were too basic, hence, the NHS Executive was not considered a big factor in the process.

The DHA had taken a “hands off “ approach in its dealings with Providers. The Service Quality Manager felt frustrated that the DHA had no control over the way in which quality was being managed by Providers.

TQM IN THE NORTH THAMES REGION

Three DHAs were implementing TQM in the North Thames Region. One DHA had made the decision to adopt a TQM philosophy in order to meet the challenge of the new business environment. It viewed TQM as a canopy beneath which assorted components, including culture change, systems, tools, training and communication, are combined to continually improve the way customer’s needs are corporately identified and met. It had subsequently based its TQM approach on the principle need to have an effective Quality Management System (QMS) in place. “The pursual of a QMS to complement the start made on introducing TQM can only be beneficial to the organisation.” Maintenance of this QMS involved documenting processes and procedures to ensure comprehensives, consistency, and the elimination of gaps and duplications, and most importantly, reviewing, updating and circulating changes. It was intended that this exercise would:

- (a) position each staff member as a “customer”
- (b) demonstrate that the involvement of each staff member as “customer” would be essential and
- (c) give rise to the birth of quality circles.

The Quality Assurance Officer (Research) saw an advantage in tailoring a model for its own purpose but particularly the use of the Deming PDCA cycle. She believed that the TQM had received an enthusiastic reception by members of the DHA although there were sceptics, the new Chief Executive and senior management team amongst them. There was no funding for the project although a limited amount of money was available at the start. She also warned that the DHA must recognise the a problem in believing that there is an endpoint.

The merger with the FHSA had proved to be a big barrier to implementation as there was uncertainty over the new structure and indeed the future of the new organisation. The other major barrier was the failure to follow up the introductory sessions. The relationship with Providers was described by the Quality Assurance Officer as being very good with the contract process being “the driving force for making quality happen.” The Patient’s Charter only went so far but it did not touch on difficult areas.

A second DHA in the North Thames Region had adopted TQM insofar that everybody was responsible for the quality of his or her own work but according to the Quality Assurance Manager this was not done in a structured way. The TQM initiative was the responsibility of the Chief Executive who had initiated it and it was heavily dependent on him, according to the Quality Assurance Manager. "if the Chief Executive was different then the whole thing could collapse."

TQM had been adopted as a way of demonstrating the quality credentials of the organisation, working with Providers to develop their own quality strategies. However, with eight or nine Providers only the ambulance service was considered to be ahead. The Quality Assurance Manager ascribed this to the relative stability of that organisation with its mechanistic activities and its freedom from upheaval.

The DHA was aware of a number of well publicised cases of quality improvement efforts within other DHAs outside the Region, but no formal links or network existed. There had been no liaison with the RHA or the NHS Executive. The RHA, however, was considering a project to undertake an EFQM self assessment exercise and had approached the DHA in order to recruit interested Chief Executives.

The Quality Assurance Manager suggested that the initiative needed a quality facilitator or champion. This role could not always fall to the Chief Executive to carry out due to time pressures. However, others perceived problems with this view as this person may appear to "own" the initiative. This debate was considered to be a potential stumbling block by the Quality Assurance Manager.

A third DHA in the Region had adopted a TQM initiative based on the Continuous Quality Improvement Programme devised by the now defunct Wessex RHA. The DHA saw the process as a partnership between Purchasers and Providers, stating that it expected Providers to demonstrate that they had a continuous quality improvement strategy.

The DHA subscribed to Maxwell's (1984) six quality dimensions (see page y) In addition it had adopted the Donabedian framework for standard setting. The "General Quality Specification for Secondary Services" supplied by the DHA indicated that it saw its role as that of an "enlightened "customer whose purchasing decisions would be based on organisational, professional and user aspects of the service.

TQM IN THE TRENT REGION

Two DHAs were pursuing TQM in Trent Region. One was implementing TQM through working groups and placed an emphasis on the Investors in People initiative driven through Individual Performance Reviews. The second was using what it described as a TQM 'style' approach, through a reconciliation of theoretical models and practical reality. For example, it had drawn upon conventional views of quality; a degree of excellence, goodness and elegance and also the ideas of Donabedian and Juran before defining quality as "that which gives complete customer satisfaction." The emphasis was placed on those aspects of health care services which purchasers should take account of when drawing up quality specifications. These were a variation of Maxwell's (1984) dimensions of quality and those of Parasuramen et al (1985). The DHA used Accessibility; Appropriateness; Acceptability; Effectiveness; Comprehensives; Efficiency; Responsiveness; Safety and Education. The DHA was a member of a local quality network consisting of three other DHAs to provide a comparable and compatible approach to purchasing health care.

TQM IN THE SOUTH AND WEST REGION

Two DHAs stated that they were implementing TQM in the South and West Region. One had been pursuing this objective for 15 months as a response to the EL 116 (93). The first item on the list of key strategy points for raising the quality profile of the organisation was implementing TQM in the Health Care Purchasing function.. The rationale for choosing TQM lay with the realisation that quality in the main was concerned with the contracting process and little attention had been focused on the operational aspects and practices of the purchasing organisation. It was felt that this needed to be rectified if the organisation was to project a credible image to both the public and to the Providers with whom the DHA contracted and whom were expected to meet strict quality standards.

The strategy outlined the need to obtain professional advice from staff within the NHS in order to improve the technical aspects of the service. It placed further emphasis on improving contract specifications that reflected key principles. Once again these principles centred once upon Maxwell's (1984) six dimensions of quality but they were also intended:

- to reflect a patient focused service
- to take account of treatment outcomes
- to take account of consumer views
- to be framed within purchasing policies based on needs a assessment.

The DHA intended to work in parallel with Providers to facilitate the implementation of TQM. It considered it important to create ownership of quality standards for clinical and associated

support services within the Providers, leaving Purchasers free to concentrate on the key areas for targeting quality. Key areas were defined as those which either continue to give cause for concern, or where standards were not met, or where there is potential for quality improvement. The overall objective was to “secure continuous quality improvement in terms of patient experience, consumer satisfaction, health improvement and health gain”

Quality Monitoring was a further key strategy point in order that the DHA could verify that the services it purchased were actually being delivered to the specifications required and to seek assurance that the Providers were setting, delivering and evaluating their own standards for clinical and support services. By putting a framework into position, the DHA considered it would be in a strong position to have a very real influence on outcomes in health care and patient experiences.

The DHA was keen to involve consumers in discussions about the delivery and development of services in order that it became more responsive to the needs, preferences and views of local people. This involved reviewing the communications strategy and reviewing the constitution of all forums that involved consumers to ensure continued appropriateness for obtaining consumer and professional views for channelling into the purchasing intelligence. In addition, the DHA sought to ensure the involvement of other key agencies, Providers and consumer’s advocates. Quality was to be co-ordinated by clearly identifying lead responsibilities and clarifying roles and responsibilities.

The second DHA implementing TQM in the South and West Region. Its understanding of quality was to be in the widest sense, encompassing the patient’s total experience of receiving a service, from the environment, courtesy and efficiency of the administrative arrangements, through the appropriateness of treatment and the skill and care which it is delivered, to the final outcome. The DHA wanted to ensure that “health care is viewed as a total system” and advocated a balanced and organisation-wide approach which gave equal balance to:

- strengthening customer focus and developing patient empowerment;
- development of, and monitoring performance against relevant and agreed key quality requirements, targets and policies;
- encouraging the development of health care organisations and the empowerment of staff

Increasing customer focus was to be achieved by improving the availability of information about health and services, acting on public opinion surveys and acting upon focus group discussions taking place within specific services such as maternity. Close adherence to the Patient’s Charter standards, actioning a Carers’ Strategy Implementation Plan and reviewing

the DHA's complaint procedure were also seen to assist in helping health services to become more customer orientated.

In addition to developing performance targets and monitoring systems, the DHA had an ambition to create an environment of organisational learning, both internally and with its Providers which it believed would foster closer relationships and diffuse awareness of best practice.

SUMMARY

The evidence collected in the research findings suggested that TQM was being interpreted in different ways by all of the DHAs. Adherence to the requirements of the Patient's Charter was to be expected. DHAs clearly saw the Patient's Charter as the pivotal element around which the TQM strategy had to be built.

DHAs also considered TQM within two contexts. There were those DHAs which focused on quality improvement within the contracting process and those which saw quality improvement as an internal organisational issue. Those DHAs which took the first perspective documented their role as inspectors of Provider services and that purchasing consistency was met through ensuring that effective reporting mechanisms were introduced by Providers. Those DHAs which adopted the second point of view saw improving the quality of purchased health services to be at least partly reliant upon the activities of the DHAs although these too stated clearly their expectations of their Providers, in terms of the quality improvement measures they expected their Providers to put into place.

Collaboration, where it had taken place, was undertaken on an informal rather than a formal basis with DHAs likely to turn to beyond their Region for assistance. Where neighbouring DHAs, had collaborated to form quality networks, these were intended to establish uniformity in purchasing rather than a forum to address the implementation of TQM.

The rationale for implementing TQM varied from one DHA to another. Some intended TQM to provide a means for the DHA to continue its current activities within a rationalised structure and fewer resources, other saw the implementation of TQM within the DHA as a means of converting Providers to follow likewise. On the other hand, at least one DHA believed it needed to adopt TQM if it was to remain credible in the eyes of Providers and the public, whilst others believed TQM was necessary to facilitate overall quality improvement in health care delivery.

The implementation of TQM was a relatively recent phenomena as none of the TQM initiatives had been in place longer than one year. There was little evidence of the influence of the TQM gurus with only one reference to the work of Deming. The EFQM quality model proved to be a popular starting point as a self assessment exercise. Many of the initiatives were therefore suffering from early stage uncertainty. The presence of a quality champion was seen as important even crucial to their survival. It was clear that the culture change needed to sustain the drive for continuous quality improvement had yet to be achieved. Furthermore, uncertainty about the future operating environment was frequently seen as a barrier to implementation with organisational restructuring cited as the main reason for slow progress. Often introductory training and awareness activities were not followed up and hence initial enthusiasm was lost as other issues took priority. In some instances, new management teams had been introduced which were not always in agreement with TQM initiatives taking place.

NON TQM DHA SITES

DHAs which were not implementing TQM were asked to provide reasons for not doing so and are tabulated below:

TABLE 10.2 THE NON IMPLEMENTATION OF TQM

	Why is TQM not being Implemented ?
West Midlands	<ul style="list-style-type: none"> • Continuous quality improvement • BS 5750 • TQM is an objective but has not been implemented yet • Time - the focus on quality has of necessity been on Providers in the last few years. This is an issue which DHAs will need to address in the future. • TQM was not considered as an approach, rather continuous quality improvement programmes
Northern and Yorkshire	<ul style="list-style-type: none"> • We see Investors in People as a catalyst for future work on TQM. We have considered BS 5750 accreditation but feel that TQM offers a more relevant approach to the organisation • TQM is one method but it is not a panacea. Elements of it are used in the organisation. Corporate objective setting linked then to individual goals and regular review of achievements - individual and corporate. • TQM principles are used but it is being implemented as a continuous improvement strategy. The framework consists of organising, using systems and techniques, measurement and feedback and changing culture. The Quality Strategy is superimposed on the organisational structure so that quality becomes one of the fundamental driving forces within the organisation.
South Thames	<ul style="list-style-type: none"> • There are alternative ways to bring about improvements • TQM is planned for next year - funding and project agreed upon • We would like TQM when resources permit • There are alternative ways to bring about improvements - we are aiming for continuous quality improvement and have not yet decided on a vehicle • Currently work up towards and TQM approach for new commissioning

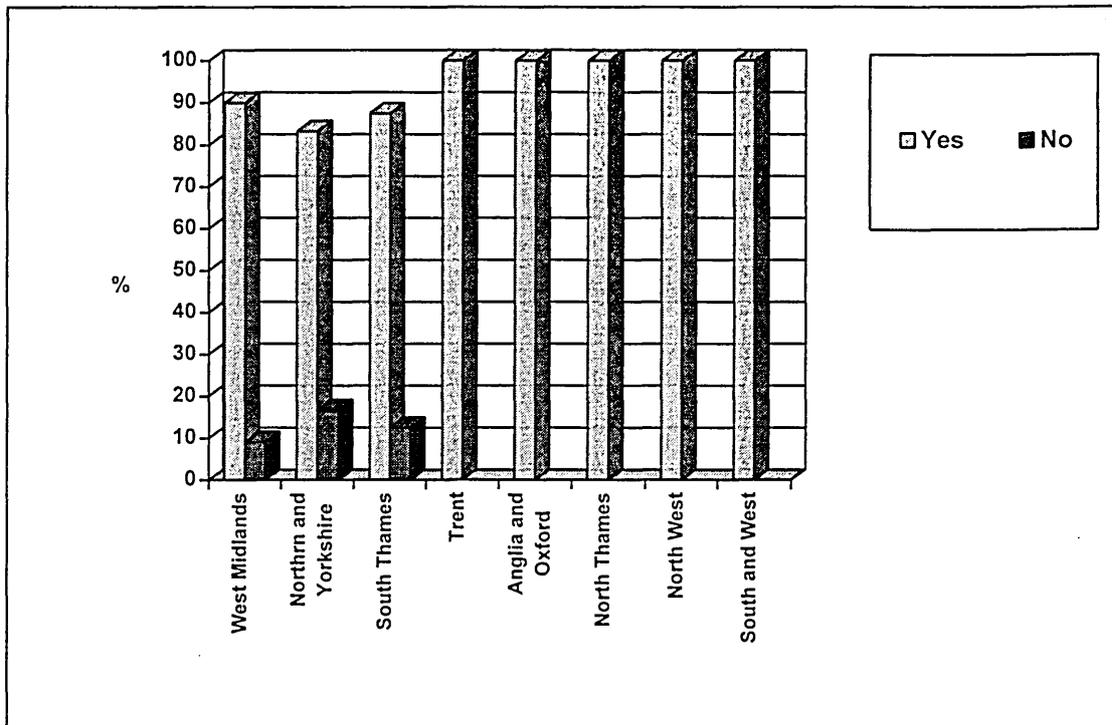
	<p>agency - need to review strategies available Initial thrust to get quality in Provider's contracts - later recognition to establish internal quality processes.</p> <ul style="list-style-type: none"> • We are a new organisation and not ready to implement TQM
Trent	<ul style="list-style-type: none"> • TQM is not a proven philosophy and is prone to failure • TQM is an objective but we have not got round to implementing it yet
Anglia and Oxford	<ul style="list-style-type: none"> • Despite a strong push from the quality staff for this no corporate agreement obtained • There are alternative ways to bring about improvements - Investors in People • No interest in looking at DHA quality by executives. Ensure Providers use a system • We are in the process of reviewing and deciding our continuous quality improvement approach . <p>The aim of the DHA is to arrange for health care of the local population to be provided to the highest standards of care. The DHA has a set of Targets and Standards developed from the following framework of quality dimensions</p> <ul style="list-style-type: none"> • Relevant - the service reflects the local pattern of disease and health care needs • Accessible - services are known and understood by the local population and are available without time, distance, social or financial barriers • Equitable - fairly shared by the local population • Effective - services achieve the intended outcome and benefit • Efficient - the optimum benefit is obtained from given resources and the least resources are used to obtain the agreed objectives • Acceptable - services are provided to meet the reasonable expectations of all those involved • Co-ordinated/ comprehensive - all relevant services are provided, ensuring a seamless continuity of care • Non-discriminatory -services should be provided in a non-judgmental way without any discrimination <p>The DHA intends to use this Directory supplemented by joint initiatives as part of the progress towards continuous quality improvement. The DHA wishes to ensure that organisations providing health care for the local population reflect a commitment to the principles set out in the Authority's philosophy statement on quality and enable the Authority to meet the conditions of its corporate objectives.</p>
North Thames	<ul style="list-style-type: none"> • TQM is an objective but we have not got round to implementing it yet • Implementation is not considered a priority
North West	<ul style="list-style-type: none"> • The organisational changes have precluded coherent work on internal quality. BS 5750 was considered but put on the back burner (or possibly back on the shelf) • There are alternative ways to bring about improvements - talking greatly with users of services • TQM is not a proven philosophy and is prone to failure and is not suitable for implementing in the NHS. There are alternative ways to bring about improvements - own systematic approach. Yet to decide tools for the DHA - Providers have established own systems - methodology is not important, outputs/ outcomes and use of service are. TQM as a recognised tools is not essential although quality management is. • TQM is an objective but we have not got round to implementing it yet. • Aspects of TQM are used but there are alternative ways to bring about improvements - Investors in People, developing project management skills, empowering staff, ownership. • There are alternatives to improving quality management. Development of a quality strategy, various policies and procedures and a quality manual for the commissioning process. Also through Individual Performance Review and a commitment to staff training.

	<ul style="list-style-type: none"> The DHA has only been in existence for one year following the merger of 3 DHAs in the area. The climate of constant change resulting from the NHS reforms has not allowed the opportunity to implement plans for our own organisation. For example a new Chief Executive was appointed and succeeded by a joint DHA/ FHSA Chief Executive 10 months later.
South and West	<ul style="list-style-type: none"> TQM was tried but has now been disbanded There are alternative ways to bring about improvements - tailored approach Recent change in Chief Executive, the old one did not like TQM. There is no stated TQM philosophy but strategic aims and values determine the way the Authority will work We are happy with the way we currently do things Integration of Quality into core business programmes rather than as a separate entity The "Quality Framework" in use lays out the DHA's position: "The main objective of the Commission is to secure and build on the established quality baselines either in Provider units or primary care services to ensure that there is continued development and progress in quality"

DHA AWARENESS OF QUALITY IMPROVEMENT ACTIVITIES TAKING PLACE ELSEWHERE

DHAs were asked whether or not they were aware of quality improvement activities taking place in other Districts or Regions of the NHS, how they became aware of these and whether they had adapted their own response as a result of this awareness. The results were as follows:

CHART 10.2 IS THE DHA AWARE OF QUALITY IMPROVEMENT ACTIVITIES TAKING PLACE ELSEWHERE ?



The results above, therefore, revealed that only three DHAs in the whole country were not aware of quality activities taking place elsewhere in the NHS. One had a Quality Assurance

Manager in place for 18 months and had carried out all the quality activities detailed in Question 1. The DHA also stated that it was measuring and monitoring the quality of its own activities. A second had an Assistant Director in place for 2 years and 6 months, and had undertaken three of the quality activities covered in Question 1. The DHA stated that it had attempted to implement TQM but this had now been abandoned because the executive board were not fully committed. The Secretary to the Authority of the third DHA had been in the post three weeks although she had worked elsewhere in the DHA for over four years. It had recently merged with the local FHSA and as a result none of the quality related activities had been addressed by the DHA.. The DHA indicated that TQM was an objective which it had yet to implement.

The evidence clearly shows that DHAs which were not aware of initiatives taking place elsewhere did not possess a quality improvement strategy in an advanced state. There might also have been an association between quality awareness and time in post and position held. One of the respondents had only been in the position three weeks, and two of the respondents held positions which did not reflect a close association with quality. The additional responsibilities of these people might well have carried greater priority, leaving little time to deal with quality.

On the whole, however, the figures indicated that there was considerable awareness of quality improvement activities taking place within the NHS. The forums used were:

TABLE 10.3 AWARENESS OF QUALITY INITIATIVES

	Awareness of Quality Initiatives in the NHS
West Midlands	<ul style="list-style-type: none"> • Conferences, Meetings, Professional Journals, colleagues in various DHAs/ RHAs • Nationally many examples. Became aware through the press/ media, conferences and networking - member of association of Health Care and citizens Charter Network • Newsletters, networks, contracting meetings, mostly within West Midlands Region • Current Literature • West Midlands RHA - sponsored "Quality Data Set Group" e.g. SIGMA initiative • Through the Kings Fund Organisational Audit Project and other networking activities. Also reading journals and NHS Executive publicity material. • West Midlands RHA and NHS Executive publications - personal networking • Requested by Host DHA in all DHAs which we contract with NHS Executive Publications. Patient's Charter information. • Within the Greater Birmingham area there has been a Quality sub-group in existence since the reforms. This meets every two months or so. There are a variety of other ways e.g. exhibitions etc.

Northern and Yorkshire	<ul style="list-style-type: none"> • Through personal contacts with other DHAs • Northern RHAs quality/ Patient's Charter monitoring processes. • Conferences, articles, publications. There is great deal of work published under the auspices of the Patient's Charter. • Regional and local circulars
South Thames	<ul style="list-style-type: none"> • Peer review • Journals and Quality Networks • Patient's Charter seminar/ Regional forum • Through the South Thames Quality Network involving all DHAs in South Thames Region • Through local networks - South Thames and London • Quality network with other Purchasers and Regional consortium • Through general literature • Regional and nationally available newsletters, publications etc.
Trent	<ul style="list-style-type: none"> • Quality networks and general awareness from contract setting • Quality support group with other local Purchasers • Networking with colleagues, Trent DHAs involved • Published Material • Conferences, journals, but mainly via external Provider's contracts using these Providers specifications cross referenced with our own • Visits, Network meetings • NHS Executive Purchaser newsletter • Through general reading on NHS and using consultants who are familiar with what is happening. • We rely on main purchaser monitoring quality and copying reports and reviews • Regional and National Communication • Networking, RHA information and journals • Networking with Regional and other DHA colleagues. National network links and journals
Anglia and Oxford	<ul style="list-style-type: none"> • We rely on main purchaser monitoring quality and copying reports and reviews • Regional and National Communication • Networking, RHA information, journals • Networking with Regional and other DHA colleagues, National network links and journals
North Thames	<ul style="list-style-type: none"> • Close working with immediate neighbouring DHA and documentation from two more local DHAs • Continuous Quality Improvement Programmes involving Wessex RHA and via NHS Executive funded study days • Networks and NHS Executive publications and other reading • North Thames RHA
North West	<ul style="list-style-type: none"> • Networking • Networking with colleagues in other DHA within the Region and also nationally • Through informal networking, publications, and Patient's Charter co-ordinators' meetings • Informal network meeting and literature search • Through various networks such as NHS Executive documents and Patient's Charter news. I think that most RHAs and Provider units are involved in quality improvement strategies. There is less evidence in DHAs • Networking • Periodicals, networking and quality co-ordinators meetings • Involvement in quality related field through RHA training and benchmarking • The "A to Z of Quality", Annual Reports and Patient's Charter Reports • Various Authorities, find out via newsletters, journals, word of mouth etc. • Newsletters, "A to Z of Quality", also informal contacts, conferences etc.
South and West	<ul style="list-style-type: none"> • South and West RHA - through Regional contacts

It was clear that the majority of reasons why DHAs were not acting related to organisational issues rather than concerns about the relevancy of information. However, two of the TQM sites stated that although they were aware of activities taking place elsewhere, the DHA was further ahead. Two non-TQM sites also raised the issue of relevancy. The comments suggested that the information is of general use but is of limited value use to those DHAs with a well established approach. The different stages at which DHAs found themselves might have made it difficult to co-ordinate information and facilitate the development of TQM.

THE IMPACT OF THE NHS REFORM PROCESS

The final part of the questionnaire sought to identify the extent of the impact of the NHS reforms. The questions were phrased to allow open ended comments. The following were the comments made by the DHAs:

TABLE 10.6 THE NATURE AND IMPACT OF NHS REFORMS ON QUALITY MANAGEMENT AT DHA SITES

Region	Reforms Which Have Had The Most Impact in Terms of Addressing Quality	Impact on the DHA
West Midlands	Patient's Charter, Value For Money Emphasis on the consumer "A-Z of Quality" Influenced by private sector ideas e.g. Baldrige Model; Performance Pyramid and NHS Executive Publications Patient's Charter, Purchaser/Provider Split Appointment of an influential Chief Executive at the RHA EL (93) 116 "Achieving an Organisational Wide Approach to Quality" Contracting SIGMA initiative, Patient's Charter Patients Charter Locality Commissioning and Consumer Involvement	More aware of the Quality of Service Provision Becoming more consumer responsive Becoming action orientated looking for real results Changes to contract documentation Raised awareness of Quality and provided explicit guidance Has forced quality onto the agenda Has reinforced the approach taken by the DHA The use of the market place to buy better quality services Has determined direction but would perhaps have developed differently, even better More sensitive to local needs

Northern and Yorkshire	<p>Restructuring as a result of the perceived pressure to become a leaner commissioning organisation Focus on customer/patient needs, Patient's Charter, Value for Money, Clinical Audit</p> <p>Patients Charter - massive impact, Trusts now widespread</p> <p>Quality specifications within contracts</p> <p>Patient's Charter, Purchaser/ Provider Split, GP</p> <p>Restructuring , 5 year health strategy, corporate contract and national approach to quality Linking to GPs, commissioning on a local basis</p>	<p>Emphasis on Value for Money, performance management, long term strategy in consultation with Providers and the public More focused on identifying customer' supplier relationships. Recognising the need to work with Providers to develop a quality strategy - less policing</p> <p>More detailed quality specifications, less direct visits to Trusts - more joint service reviews which appear more productive Inclusion of quality specification as an integral part of contracting, developing an independent monitoring approach</p> <p>No quality strategy prior to restructuring It is much more open, able to operate in projects rather than through functional streams</p>
South Thames	<p>Patient's Charter, Contract Negotiations Patient's Charter, Health of the Nation</p> <p>Purchaser / Provider split and the development of contracts, Patient's Charter Impending merger, new services has created the need to undertake extensive consumer consultation Merger of DHA with FHSA, Priorities and Planning guidance, Patient's Charter</p> <p>Patient's Charter</p> <p>Patient's Charter, Clinical Effectiveness guidelines, devolution of clinical audit</p>	<p>Pro-active, Standards are explicitly stated Creating service specific monitoring indicators with in specialities Incorporating them into contracts and in the negotiation process</p> <p>Assumptions originally made, now more open minded</p> <p>More pro-active, more awareness of quality as a means of improving service to patients</p> <p>More focused and outcomes orientated</p>
Trent	<p>The emergence of Trusts and the acknowledgement of quality as a legitimate and powerful contract issue Role of Commissions GP Fundholding, Patient's Charter, Merger with FHSA</p>	<p>Greater awareness and attention to detail</p> <p>Review of a role of organisation Alignment of goals with local GPs, much time spent on information gathering (not necessarily beneficial to patients), ability to see quality issues from a differing perspectives</p>

	<p>Patient's Charter Criteria for successful purchasing</p>	<p>More quantitative results being requested from Providers More prescriptive but within given parameters to enable Trusts to develop initiatives which we would want to purchase Examining each of the elements identify opposite</p>
Anglia and Oxford	<p>Clinically driven purchasing, GP Fundholding, Patient's Charter, Corporate Contract (givens) Purchaser/ Provider Split, Contracts, Patient's Charter</p> <p>Patient's Charter Emphasis on involving consumers</p>	<p>Priorities for attention influenced by central priorities</p> <p>More structured way of planning, developing and monitoring quality Set up consumer groups, patient focus groups, improved relationship with CHC</p>
North Thames	<p>Purchaser / Provider</p> <p>The requirement to produce a 5 year strategy and work collaboratively with FHSA ready for merger Patient's Charter, Preventative Purchasing guidance, EL 94 (79) Weighted captivation, Patient's charter/ League tables Audit Commission, Health Service Commissioner</p>	<p>Developing quantitative measures of quality to add to cost and value measures</p> <p>None</p> <p>Greater focus and vertical integration Contract specifications are amended year on year</p>
North West	<p>Merger of DHA and DHAs with FHSAs Difficult to identify specifics - probably the drive to whole culture of change Community Care Act, Care Programme Approach Not any event or reform - cultural change has had most influence Patient's Charter, Complaints review, Patient Satisfaction surveys Merger of DHA with FHSA</p> <p>Response to various reports on complaints and response to the implementation of the Patient's Charter</p> <p>Patient's Charter, Contracting</p> <p>NHS Executive guidelines/ Patient's Charter standards</p>	<p>Lack of a coherent approach</p> <p>Implemented systematic approach to monitoring and actioning the findings DHA today different from previous DHA incarnations Targeting Patient's Charter, empowering patients Improved communication - communication strategy developed, appraisal. The DHA has evolved over a period difficult to say how our strategy has been influenced</p> <p>It hasn't</p> <p>New audit tools developed to monitor new standards agreed</p>
South and West	<p>Community Care Act, Patient's Charter, Clinical effectiveness guidelines</p>	<p>Measurable targets have been set in contracts. Quality features on every contract and monitoring meeting</p>

	<p>Requirement to have a Quality Improvement strategy, national ongoing CQI project, Patient's Charter</p> <p>Devolution of clinical audit, new NHS roles and responsibilities, planning guidelines</p> <p>Importance of clinical effectiveness, GP Fundholding</p> <p>Patient's Charter</p> <p>Clinical audit and devolution of budgets, Patient's Charter - less scope to develop local standards</p> <p>Clinical effectiveness and outcomes measurement</p> <p>Patient's Charter, clinical effectiveness</p>	<p>Stronger focus on integrating and developing quality improvement as part of the total agenda</p> <p>Quality department has been integrated into the core business areas</p> <p>More medically orientated, working with GPs and clinicians</p> <p>Deciding ways of assuring "softer" standards and rights</p> <p>Become increasingly bureaucratic due to more monitoring and many more discussions with clinicians about audit outcomes</p> <p>A focus on health benefit guides our purchasing, attempts to give priority to certain areas where quality is explicit have been highlighted</p> <p>Focused more on the quality clinical care</p>
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The introduction of the internal market and the requirements of the Patient's Charter have had an enormous impact on the way DHAs operate presenting them with a whole new responsibility; that of Health Care Purchaser. However, the effect of this impact has been more difficult to ascertain. Most DHAs claimed to have become more focused in their operations, although, many have acknowledged that the greatest impact has been on Providers who have had to deliver better quality health care. Several DHAs have indicated that the reforms have had either no effect in changing the way they are managed or have had a detrimental effect.

THE INFLUENCE OF THE REGIONAL HEALTH AUTHORITIES

The fact that the role the Regional Health Authorities (RHAs) has not yet been considered within this analysis will now be rectified. RHAs are responsible for overseeing the activities of the DHAs with the relationship formalised through a corporate contract. Consequently, this contract has been an important factor in influencing the activities of DHAs. The research sought to determine how far the approach of the RHA determined the approaches taken by DHAs. Hence, in addition to the questionnaires sent to the DHAs, a modified version of the questionnaire was sent to the eight RHAs in England. A total of 5 questionnaires were returned, a response rate of 62.5%.

TABLE 10.7 QUALITY RELATED ACTIVITIES UNDERTAKEN AT RHA SITES

Activity	Participation Rates Amongst RHAs
Determining a quality strategy or mission statement for health care	100%
Determining a definition of health care	40%
Determining how a Regional quality improvement strategy should be implemented	20%
Determining the quality of DHA activities	80%
Determining the factors used to assess the quality of Providers	60%
Determining how the quality of Providers should be measured	60%
Determining how the RHA should manage the quality of its own activities	80%

Outcomes were generally being determined through a process of negotiation with the various parties involved, with the exception of one RHA which determined all the outcomes by itself except when determining which factors should be used to measure the quality of Providers and how these factors should be measured.

All the RHAs which were managing their own quality activities had taken steps to measure and monitor their own activities. These included:

TABLE 10.8 MECHANISMS FOR MEASURING AND MONITORING QUALITY EMPLOYED AT RHA SITES

Mechanisms for Measuring and Monitoring Quality Employed by RHAs
<ul style="list-style-type: none"> • Performance management arrangements with the Executive and on specific events of initiatives by "customer feedback" e.g. seminar evaluation forms • Quarterly conferences looking at the quality of RHA performance management. Internal review meetings and feedback External "Lessons Learned" conferences with Purchasers and Providers • Corporate management programme, corporate contract. Covers all activities.

None of the RHAs reported that they were implementing TQM and, therefore, it could not be said that the RHA was an influential role model. However, one RHA was in the process of piecing together a TQM information pack with the intention of it being adopted by both Purchasers and Providers.

TABLE 10.9 REASONS FOR NOT IMPLEMENTING TQM AT RHA SITES

Reasons Provided by RHAs for not Implementing TQM
<ul style="list-style-type: none"> • There are alternative ways to bring about improvement - flat structure and involvement of staff in decision making and strategy. TQM has some value but RHAs are now very small organisations, the processes and procedures of TQM - which are often a surrogate for effective communication - are less imperative • TQM is an objective but we have not got round to implementing it yet - but we will probably not go for the TQM label. • There are alternative ways to bring about improvements - TQM is one approach from which much can be learned, but the RHAs approach to quality is more incremental and eclectic • TQM is an objective - due to total reorganisation of management function this is under review • Organisation did not use formal TQM, however, quality forums were established with DHA participation.

This information provided evidence to suggest that there was no link between the implementation of TQM by RHAs and the implementation of TQM by DHAs within a particular Region. Nor was it possible to identify a relationship between the implementation of TQM by DHAs and quality related activities undertaken by RHAs. For example, Anglia and Oxford RHA have assembled a TQM “tool kit” offering useful advice concerning the implementation of TQM. This provided advice on such matters as the use of the Seven Tools of Quality and the building of quality improvement teams for health care organisations contemplating the implementation of TQM. However, none of the DHAs within this Region were implementing TQM. Possible explanations for this included:

- (a) The DHA is not aware of this material
- (b) The material was only recently produced and DHAs have not had time to act upon it
- (c) The information provided is not useful in assisting DHAs to implement TQM
- (d) The RHA has not been seen to implement TQM and this has turned DHAs against TQM
- (e) A DHA’s decision to implement TQM is made independently and irrespective of the activities undertaken by the RHA

RHAs were all aware of quality initiatives taking place elsewhere in the NHS with a mix of formal and informal means being reported. These included networking, “gossip”, and publications. Four of the five RHAs had subsequently adapted their own approach.

Of the recent events and reforms only one RHA mentioned the abolishment of RHAs as having an impact. Otherwise the Patient’s Charter and the introduction of the internal market were

reported as having the most impact in terms of the approach RHAs had taken to improve quality.

TABLE 10.10 IMPACT OF NHS REFORMS ON QUALITY MANAGEMENT AT RHA SITES

Which NHS Reforms Have Had the Most Impact in Terms of Quality	Effect on the RHA
<ul style="list-style-type: none"> • Imminent abolition of RHAs • Patient's Charter • Review of Functions and Management • Purchaser and Provider split 	<ul style="list-style-type: none"> • Total culture change - large, closed bureaucracy to a small, open clinically focused organisation • More focused on objectives and deliverable targets • Revision of purpose • Everything is subject to change and we are managing an organisation in transition

CONCLUSION

Overall, the RHAs have played a minimal role in the implementation of TQM. None of the RHA had implemented TQM themselves and there was a lack of understanding of understanding of TQM principles. Indeed, the majority of DHAs had not determined a definition of quality. One RHA claimed the TQM approach was inflexible, whilst another did not believe it was important for a small organisation. One RHA perceived the TQM label to be a potential barrier to its implementation, which suggested the concept would have to be diluted if it was to be accepted by the organisation. Consequently, informal, ad-hoc quality management initiatives had found favour within RHAs and were accompanied by informal sources of advice and information.

Measuring quality improvement was weak with no dedicated systems in place. Assessments were made against broad objectives with only vague links with quality and often carried out infrequently.

RHAs were subjected to similar pressures as DHAs, although their abolition to become outposts of the NHS Executive was an additional concern, and it was these which were imposing change on the organisation. RHAs, therefore, adapted themselves to meet the requirements of the imposed change.

CHAPTER 11 SUMMARY AND CONCLUSION

THE NOTION OF QUALITY

The thesis began by considering the essence of quality and the various approaches which have been made in the attempt to manage it. From the formation of trade guilds by craftsmen, through the rise of the inspection function in mass production systems, to the emergence of TQM via quality control and quality assurance.

It was suggested, however, that the concept of TQM is far from being straight forward. As an amalgam of ideas from several leading writers, inconsistencies and contradictions have been identified which might, in turn, have contributed to the perception that TQM was an ambiguous term. Nevertheless, a consensus could be found relating to the underpinning tenets of TQM with opinion divided concerning how should be achieved.

The work of the leading authorities or “gurus” of TQM was examined and could be categorised between those who favoured a “hard” systems approach and those who focused on the “soft” elements of culture and values. The major shortcoming of the “gurus” was identified as a failure to provide an adequate understanding of how these two facets might be integrated.

QUALITY AS A STRATEGY

The use of quality as a strategy was also scrutinised. The work of Buzzell and Gale (1987), for example, established the viability of a quality focused operating strategy. The idea that quality consisted of elements of design and conformance was presented; one which was developed by Garvin (1987) into quality attributes. These were those characteristics which customers referred to when assessing the relative quality of a product and could be traded off against each other by manufacturers. A more contentious issue concerned the trade off which existed between quality and costs. For Crosby (1979) quality was free, whilst for Juran (1988) and Hill (1983), there was an optimum level of quality

Government policy was identified as a major contributory factor to raising quality awareness and to increasing the popularity of BS 5750. A comparison of BS 5750 and TQM was made

which highlighted the differences between the two and identified TQM as the superior approach. The Malcolm Baldrige National Quality Award and the EFQM Model have provided popular TQM frameworks which allow organisations to undertake self assessment exercises.

SERVICE QUALITY

Services were afforded special consideration because of their unique nature. The work of Gronroos (1984a) and Haywood-Falmer (1988) has attempted to determine the dimensions of service quality. For Gronroos, service quality was a mix of service outcome and service delivery, whilst Haywood-Falmer recognised the difficulties associated with differentiating between outcome and delivery and preferred to conceptualise service quality in terms of contributory factors. The gap analysis model, developed by Parasuraman et al (1985), has provided one of the most widely accepted understandings of how service quality is assessed and has been applied to public sector services (Donnelly 1995).

PUBLIC SECTOR SERVICES

The issue of quality within the public sector has proved to be contentious. The adoption of quality improvement initiatives is one which stems from the overall trend towards the adoption of private sector management practices prompted by government policies such as CCT. Nevertheless, the language of quality, with its reference to customer satisfaction has not always been welcomed.

On the other hand, quality has been recognised as a means of improving the position of the service user. The real debate, therefore, has focused on whether the adoption of quality improvement initiatives within the public sector has constituted a real shift in relative power towards public service consumers, or whether in fact their power has been eroded through the apparently legitimate strive for quality improvement.

Initial attempts to invoke quality awareness within the public sector focused on aspects of customer care. Subsequently however, models of TQM have been devised which are seen as applicable to public sector services. These have fallen into two categories; generic models are perceived to have universal appeal whilst specific models attempt to address a particular range of services with distinct characteristics.

THE NATIONAL HEALTH SERVICE

The history of the NHS presented the background to the research. It established that many of the problems facing the NHS today are not new and have plagued the Service since its creation.

Principally, these problems have been the rising cost of health care provision and increasing demand.

Various attempts have been made to address these issues including two restructures. More recently, however, the NHS has embarked on a programme of radical reform. This began with the introduction of a general management function following the Griffiths Inquiry in 1983 and culminated in the establishment of the quasi internal market in 1991. During this period, the focus of attention moved towards improving the quality of care and, thus, created an interest in quality assurance and TQM.

MAIN FINDINGS

This research has clearly demonstrated that despite a great deal of rhetoric regarding the improvement of the quality of health care within the NHS, the reality as far as DHAs were concerned was to focus on meeting the requirements of centrally imposed directives, in particular, those of the Patient's Charter.

DHAs were still coming to terms with their new role as purchasers of health care and their principle responsibility was seen to be that of an enforcer of standards amongst Providers. As DHAs were previously responsible for their management, it suggested that DHAs were aware that quality management was not in an advanced state within Provider units and that policing strategies were needed. At the same time little attention had been paid to quality management within DHAs.

Where attempts had been made to implement quality management, these initiatives frequently appeared to be in a fragile state. A high proportion of DHAs had failed to define quality in health care which left them in no position to manage the process. In addition, many DHAs had also failed to put into place any systematic or planned mechanisms for measuring quality improvement. DHAs sought to rely upon existing means such as complaints handling. The absence of suitable monitoring systems resulted in problems evaluating progress.

Only 18.6% of DHAs explicitly stated that they were implementing TQM and the content of many of these initiatives were questionable. Many DHAs appeared to have been selective in the principles of TQM which they had adopted and preferred to refer to it by another name. This suggested that the concept had been watered down to make it more palatable. Indeed resistance to TQM was clearly discernible even at senior management level of those DHAs claiming to be involved in its implementation. Under these conditions TQM is doomed.

Certainly there appeared to be difficulty in achieving a blend of the “hard” and “soft” elements of TQM. Most DHAs preferred to focus on the softer aspects such as quality awareness training with claims that TQM had brought about a tangible culture change. This claim, however, must be questioned. Overall, it was true to say that there has been a greater awareness of quality issues within the NHS but this is hardly surprising with so many initiatives claiming to be in the interest of improving quality. The impact of TQM was less certain as many DHAs claimed to be experiencing difficulties as a result of their failure to follow up initial training, often due to organisational restructuring. One Service Quality Manager voiced both concern and frustration that a new Chief Executive had been appointed who was opposed to TQM. Elsewhere, TQM initiatives appeared to be rely on the continued state of present circumstances, such as the Chief Executive would continue in post or that the DHA would remain free from organisational restructuring. These conditions could never be guaranteed, and whilst implementing TQM in a climate of uncertainty was proving to be extremely difficult, it demonstrated that the culture change necessary to overcome these problems had yet to take place.

On the other hand, one DHA freely admitted that it had implemented TQM as a means of continuing its activities in the face of cutbacks. Where DHAs had decided upon a hard systems approach it was difficult to hide from the overall drive for efficiency. Although cost reduction is along term benefit of pursuing TQM, it is not its focal point.

The research highlighted the fact that there is little understanding of what constitutes TQM within DHAs. Some DHAs had attempted to use TQM as an umbrella term to cover the various initiatives being implemented although in reality it was clear that the processes involved were alien to TQM. Those DHAs who had undertaken a self assessment exercise using the EFQM model discovered that they were weak in most areas and that substantial changes needed to be made. Starting from scratch, a customer care approach would be a popular option, in addition many DHAs sought to implement initiatives offering a clearly defined approach such as Investors in People, often because of a strong push for them to do so in the belief that they contributed to improving quality. Ultimately TQM can not be achieved through adopting a series of ad hoc initiatives. On the whole, DHAs mistakenly believed it was possible to treat TQM as a bolt on activity which could be implemented alongside existing systems and procedures rather than being treated as a vehicle for change.

The research clearly pointed to directives from the NHS Executive as the motivating factor behind the interest in quality. Despite an initial push for the implementation of TQM within the NHS during the early 1990s from the Department of Health, most interest has only been shown amongst Providers. The NHS Executive had not acted upon its own directive EL 116 (93) and had failed to provide important direction and guidance. Similarly, little direction was provided by RHAs who had also failed to implement TQM although one was seen to be producing a comprehensive toolkit. Relationships between DHAs and their RHA had been formalised through the contracting process, however, DHAs who were implementing TQM stated that the RHA was not a factor in the process.

The decision to implement TQM was taken by individual Purchasers as they came to recognise the importance of becoming quality orientated in contracting with their Providers and being seen as a credible organisation. An Audit Office report into the treatment of coronary disease estimated that as much as x% of cases could have been prevented through improved purchasing arrangements.

Initiatives were often carried out on limited budgets, a typical sum being £6 000. This itself was an obstacle to its implementation being both insufficient to fund the initiative and at the same time sending out a message that TQM was not a priority. Not only had DHAs come late to realising the importance of TQM but once the decision had been made to implement it, the initiative struggled to become established. Consequently there was little expertise available within the NHS regarding TQM.

Information relating to quality in general was freely available and whilst the majority of DHAs had taken account of this when planning their own approach, most opinion was that it was only of a general nature whose use was limited to the early stages.

AREAS FOR FUTURE RESEARCH

The NHS continues to be a complex organisation, operating in an environment characterised by uncertainty and which is continually adapting in order to meet these challenges. Just as the introduction of the internal market presented the context for this thesis, so other changes will present new basis for research. Even whilst this work was being undertaken, DHAs began to merge with FHSAs to create unified health commissioning agencies, a move which was officially sanctioned in April 1996. The same date marked the abolition of RHAs being replaced as regional outposts of the NHS Executive. Over time, the impact of these moves will need to be assessed.

Le Grand (1994) has argued that the potential of a single Purchaser might create distortions and inefficiencies within an un-competitive market. A single Purchaser had fewer incentives to be respond to the user than competitive ones and there is considerable evidence of a lack of competition within the internal market. Bennett and Ferlie (1996) found that contacting in the NHS was a relational process. Rather than stimulating competition, Purchasers preferred to encourage co-operation with Providers. Appleby et al (1994) suggested that a lack of information and the ensuing uncertainty was a major area of difficulty for both Purchasers and Providers and this might have lead to a position where both parties sought to collaborate.

On the other hand, government policy has shifted the emphasis towards developing primary care with GP Fundholders expected to carry out the major purchasing function, leading to greater competition both between providers and between fundholders. The impact of the heightened role of GP Fundholders, clearly provides an opportunity for further research. A preliminary study by Whitehead (1994), for example, suggested that fundholding practices had a positive impact on quality. More work needs to be undertaken to assess the impact of the likely move from block contracts to cost-per-case contracts. The former are favoured by health authorities for their low “ex ante” transaction costs, the latter, used for referrals of individual cases, and, therefore, more likely to be used by GPs, imply higher “ex ante” costs for Providers whilst offering low “ex post” costs for GPs as they are close to the patient.¹ (see Appleby et al 1994). In particular, research could determine whether or not this would bee an incentive to implement TQM for both Purchaser and Provider alike.

The research limited itself to considering the implementation of TQM within DHAs in England. Additional research, therefore, needs to be undertaken to determine the extent of take up within the equivalent Purchasing agencies in Scotland and Wales where responsibility for NHS activities lies with the Scottish and Welsh Offices. The NHS Directorate in Wales has been an advocate of TQM and its implementation within Scottish Health Boards has been reported. (see, for example, Kelly and Swift 1991)

¹ For a discussion of transaction costs see page 105

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Total Quality Management in the NHS:

The Role of District Health Authorities / Health Commissions

Position _____ Length of time in post yrs mths

1. Which of the following areas of quality management has the DHA been involved in carrying out?

Please tick to indicate who was involved at each stage using the following key:

P Providers D Neighbouring DHAs
 R RHA N NHS ME
 N/A Activity not undertaken by any party as far as is known

Was the DHA involved? (Y/N)

	P	D	R	N	N/A
<input type="checkbox"/> Determining a quality strategy or mission statement for health care <i>(Please supply if one exists)</i>	<input type="checkbox"/>				
<input type="checkbox"/> Determining a definition of quality for health care <i>(Please supply if one exists)</i>	<input type="checkbox"/>				
<input type="checkbox"/> Determining the service quality needs of patients	<input type="checkbox"/>				
<input type="checkbox"/> Determining how a quality improvement strategy should be implemented	<input type="checkbox"/>				
<input type="checkbox"/> Determining what factors should be used to assess the quality of providers	<input type="checkbox"/>				
<input type="checkbox"/> Determining how the quality of providers should be measured	<input type="checkbox"/>				
<input type="checkbox"/> Deciding how the DHA should manage the quality of its own activities	<input type="checkbox"/>				

2. Please tick the phrase which best describes how the following activities were determined using this simple key:

- A Outcome determined for the DHA by another party
- B Outcome determined through negotiation by the various parties involved
- C Outcome determined by the DHA

	A	B	C
a) Determining a quality strategy or mission statement for health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Determining a definition of quality for health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Determining how a quality improvement strategy should be implemented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Determining what factors should be used to assess the quality of providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Determining how the quality of providers should be measured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Deciding how the DHA itself should manage the quality of its own activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Does the DHA measure and monitor the quality of its own activities? *(Please tick as appropriate)*

Yes No

If Yes, go to 4

If No, go to 5

4. How is this done and which activities are covered?

5. Are the DHA's own activities carried out under a TQM philosophy? *(Please tick as appropriate)*

Yes

No

If Yes, go to 5a

If No, go to 5b

5a. How is TQM implemented? *(Please send any relevant literature or documentation)*

5b. There are a variety of reasons why organisations may choose not to implement TQM. Please tick if any of the following statements are true in your particular case.

TQM is not a proven philosophy and is prone to failure

TQM is not suitable for implementing in the NHS

TQM is only relevant for provider units

TQM was tried but has now been disbanded
(Please explain why it has been disbanded)

There are alternative ways to bring about improvements.
(Please specify)

TQM is an objective but we have not got round to implementing it yet

Other *(Please specify)*

6. Is the DHA aware of quality improvement activities taking place in other Districts or other Regions of the NHS? *(Please tick as appropriate)*

Yes

No

If Yes, go to 7a

If No, go to 8

7a How did you find out about these and which DHAs or RHAs were involved?

7b Has the DHA adapted its own approach as a result of this awareness?
(Please tick as appropriate)

Yes

No

If Yes, go to 8

If No, go to 7c

7c Please state the reasons why not?

8. Which recent events and reforms in the NHS have had the most impact on the DHA in terms of the approach it has taken to improve quality?

9. In what way has the approach taken by the DHA changed as a result of these?

Total Quality Management in the NHS:

The Role of Regional Health Authorities

Position _____ Length of time in post years months

1. Which of the following areas of quality improvement has the RHA been involved in carrying out?

Please tick to indicate who was involved at each stage using the following key:

- P Providers
- D DHAs
- R Other RHAs
- N NHS ME
- N/A Activity not undertaken by any party as far as is known

Was the RHA involved (Y/N)

	P	D	R	N	N/A
<input type="checkbox"/> Determining a quality strategy or mission statement for health care <i>(Please supply if one exists)</i>	<input type="checkbox"/>				
<input type="checkbox"/> Determining a definition of quality for health care <i>(Please supply if one exists)</i>	<input type="checkbox"/>				
<input type="checkbox"/> Determining how a regional quality improvement strategy should be implemented	<input type="checkbox"/>				
<input type="checkbox"/> Determining the quality of DHA activities	<input type="checkbox"/>				
<input type="checkbox"/> Determining what factors should be used to assess the quality of providers	<input type="checkbox"/>				
<input type="checkbox"/> Determining how the quality of providers should be measured	<input type="checkbox"/>				
<input type="checkbox"/> Deciding how the RHA should manage the quality of its own activities	<input type="checkbox"/>				

2. Please indicate the phrase which best describes how the following activities were determined using this simple key:

- A Outcome determined for the RHA by another party
- B Outcome determined through negotiation by the various parties involved
- C Outcome determined by the RHA

	A	B	C
a) Determining a quality strategy or mission statement for health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Determining a definition of quality for health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Determining how a regional quality improvement strategy should be implemented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Determining how the quality of DHA activities should be assessed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Determining what factors should be used to assess the quality of providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Determining how the quality of providers should be measured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Deciding how the RHA itself should manage the quality of its own activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Does the RHA measure and monitor the quality of its own activities? (Please tick as appropriate)

Yes No

If Yes, go to 4

If No, go to 5

4 How is this done and which activities are covered?

5. Are the RHA's own activities carried out under a TQM philosophy? (Please tick as appropriate)

Yes

No

If Yes, go to 5a

If No, go to 5b

5a. How is TQM implemented? (*Please provide any relevant literature or documentation*)

5b. There are a variety of reasons why organisations may choose not to implement TQM. Please tick if any of the following statements are true in your particular case.

TQM is not a proven philosophy and is prone to failure

TQM is not suitable for implementing in the NHS

TQM is only relevant for provider units

TQM was tried but has now been disbanded
(*Please explain why it has been disbanded*)

There are alternative ways to bring about improvements.
(*Please specify*)

TQM is an objective but we have not got round to implementing it yet

Other (*Please specify*)

6. Is the RHA aware of quality improvement activities taking place in other Districts or other Regions of the NHS? *(Please tick as appropriate)*

Yes

No

If Yes, go to 7a

If No, go to 8

7a How did you find out about these?

7b Has the RHA subsequently adapted its own approach towards quality because of this awareness? *(Please tick as appropriate)*

Yes

No

If Yes, go to 8

If No, go to 7c

7c Are there any reasons why not?

8. Which recent events and reforms in the NHS have had the most impact on the RHA in terms of the approach it has taken to improve quality?

9. In what way has the approach taken by the RHA changed as a result of these?

{Date}

«title» «initial» «name»

«position»

«organisation»

«address»

«town»

«postcode»

Dear «title» «name»,

Quality Management in the National Health Service

I am a PhD student at Sheffield Business School currently undertaking a study of quality management in the NHS. An important part of the research is determining the role played by Regional and District Health Authorities/ Health Commissions. In order to gather basic information, the enclosed questionnaire is being sent to all Regional and District Health Authorities/ Health Commissions in the country.

I realise that there are constraints on your time and I apologise for imposing on you in this manner but I would be very grateful if you could help in this research, either by completing the questionnaire yourself or by passing it on to an appropriate colleague. A reply paid envelope is supplied in order to return the completed form to me.

All information received will of course be treated as highly confidential and individual health authorities will not be named without prior consent. If you have any queries regarding the questionnaire then please do not hesitate to contact me.

Thanking you in anticipation of your co-operation.

Yours sincerely

Joe Watkinson

Enc.

POSITION OF RESPONDENTS

West Midlands	Frequency	Percentage
Service Quality Manager	4	36.4
Assistant Director of Nursing	3	27.3
Nursing/ Quality Advisor	1	9.1
Quality Advisor	2	18.2
Executive Director of Nursing and Consumer Relations	1	9.1

Northern & Yorkshire	Frequency	Percentage
Director of Nursing and Quality Development	1	16.7
Head of Quality Assurance	1	16.7
Assistant Director Nursing	1	16.7
Nursing Advisor/ Quality Manager	2	33.3

South Thames	Frequency	Percentage
Director Acute Commissioning	1	12.5
Quality Co-ordinator	1	12.5
Quality Advisor	1	12.5
Director	1	12.5
Quality Assurance Manager	1	12.5
Head of Acute Purchasing	1	12.5
Contracts Manager (Quality)	1	12.5
Assistant Director: Quality Development	1	12.5

Trent	Frequency	Percentage
Personnel Manager	1	16.7
Director Professional Standards	1	16.7
Quality Manager	3	50.1
Nurse Advisor/ Assistant Director of Commissioning and Quality	1	16.7

Anglia and Oxford	Frequency	Percentage
Director	1	25
Quality Development Officer/ Nursing Advisor	2	50
Director of Quality	1	25

North Thames	Frequency	Percentage
Quality Assurance Manager	2	40
Director of Commissioning	1	20
Director	1	20
Executive Director of Quality and Community Relations	1	20

North West	Frequency	Percentage
Standards & Quality Assurance Manager/ Nursing Advisor	3	27.3
Quality Lead	1	9.1
Senior Manager (Performance Management)	1	9.1
Quality Assurance Officer	1	9.1
Director Service Development and Planning	1	9.1
Nurse/ Quality Advisor	1	9.1
Acting Director Quality and Nursing	1	9.1
Commissioning Manager	1	9.1
Quality Manager	1	9.1

South and West	Frequency	Percentage
Assistant Director of Quality	1	12.5
Director of Quality	1	12.5
Quality Development	1	12.5
Head of Quality and Clinical Effectiveness	1	12.5
Director of Quality	1	12.5
Manager: Quality and Community Relations	1	12.5
Assistant Director (Corporate Strategy)	1	12.5

DETERMINING A QUALITY STRATEGY OR MISSION STATEMENT FOR QUALITY CARE

West Midlands	f	%	P	D	P+D	N/A
Yes	9	81.8	2	1	2	4
No	-	-	-	-	-	-
Missing	2	18.2	-	-	-	1

Northern & Yorkshire	f	%	P	N/A
Yes	5	83.3	2	4
No	1	16.7	-	1
Missing	-	-	-	-

South Thames	f	%	P+D	P+R	N/A
Yes	6	75	-	1	5
No	1	12.5	-	-	1
Missing	1	12.5	1	-	-

Anglia & Oxford	f	%	P	N/A
Yes	4	100	2	2
No	-	-	-	-
Missing	-	-	-	-

Trent	f	%	P	P+D	P+D+R	N/A
Yes	5	83.3	3	1	1	-
No	-	-	-	-	-	-
Missing	1	16.7	1	-	-	-

North Thames	f	%	P	P+D	P+R	N/A
Yes	4	80	1	2	1	-
No	-	-	-	-	-	-
Missing	1	20	-	-	-	1

North West	f	%	P	D	P+D+R	N/A
Yes	8	72.7	2	2	1	3
No	2	18.1	2	-	-	-
Missing	1	9.1	-	-	-	1

South and West	f	%	P	R	P+D	P+R	N/A
Yes	8	100	2	1	1	1	3
No	-	-	-	-	-	-	-
Missing	-	-	-	-	-	-	-

DETERMINING A DEFINITION OF QUALITY

West Midlands	f	%	P	P+D	N/A
Yes	6	54.5	2	2	2
No	2	18.1	-	-	2
Missing	3	27.4	-	-	3

Northern & Yorkshire	f	%	P	N/A
Yes	3	50	1	2
No	3	50	-	3
Missing	-	-	-	-

South Thames	f	%	P+R+N	N/A
Yes	3		1	2
No	2		-	2
Missing	3		-	-

Anglia & Oxford	f	%	P	N/A
Yes	3	75	2	1
No	1	25	-	1
Missing	-	-	-	-

Trent	f	%	P	D	N/A
Yes	3	50	2	1	-
No	1	16	-	-	1
Missing	2	34	1	-	1

North Thames	f	%	P	P+D	P+D+R+N	N/A
Yes	3	60	1	1	1	-
No	-	-	-	-	-	-
Missing	2	40	-	-	-	2

North West	f	%	P	D	P+R	N	N/A
Yes	7	63.6	2	1	1	1	2
No	2	18.2	-	-	-	-	2
Missing	2	18.2	-	-	-	-	2

South and West	f	%	P	R	P+D	R+N	N/A
Yes	8	100	3	1	1	1	2
No	-	-	-	-	-	-	-
Missing	-	-	-	-	-	-	-

DETERMINING THE SERVICE QUALITY NEEDS OF PATIENTS

West Midlands	f	%	P	P+D	R	P+R+N	N/A
Yes	9	81.8	6	-	1	2	-
No	-	-	-	-	-	-	-
Missing	2	18.2	-	1	-	-	1

Northern & Yorkshire	f	%	P	P+D
Yes	6	100	5	1
No	-	-	-	-
Missing	-	-	-	-

South Thames	f	%	P	P+D	P+R	P+R+N	N/A
Yes	7	87.5	2	3	1	1	-
No	-	-	-	-	-	-	-
Missing	1	12.5	-	-	-	-	1

Anglia & Oxford	f	%	P	P+D	P+D+R
Yes	4	100	2	1	1
No	-	-	-	-	-
Missing	-	-	-	-	-

Trent	f	%	P	P+D	P+D+R
Yes	5	83.3	4	1	1
No	-	-	-	-	-
Missing	1	16.7	-	-	-

North Thames	f	%	P	P+D
Yes	4	80	1	3
No	-	-	-	-
Missing	1	20	-	1

North West	f	%	P	D	P+D	P+R	P+R+N	N/A
Yes	10	90.9	4	1	2	1	2	1
No	-	-	-	-	-	-	-	-
Missing	1	9.1	-	-	1	-	-	-

South and West	f	%	P	P+D	P+R+N	P+D+R+N
Yes	8	100	5	1	1	1
No	-	-	-	-	-	-
Missing	-	-	-	1	-	-

DETERMINING HOW A QUALITY STRATEGY SHOULD BE IMPLEMENTED

West Midlands	f	%	P	P+D	R	P+R+N	N/A
Yes	8	72.7	4	1	1	1	-
No	-	-	-	-	-	-	-
Missing	3	27.3	1	1	-	-	1

Northern & Yorkshire	f	%	P	NA
Yes	4	66.7	3	1
No	2	33.3	-	2
Missing	-	-	-	-

South Thames	f	%	P	P+D	P+D+R+N	N/A
Yes	7	87.5	4	1	1	-
No	-	-	-	-	-	-
Missing	1	12.5	1	-	-	1

Anglia & Oxford	f	%	P	P+D	P+D+R
Yes	4	100	2	1	1
No	-	-	-	-	-
Missing	-	-	-	-	-

Trent	f	%	P	P+D+R	NA
Yes	4	66.6	3	-	-
No	1	16.7	-	-	1
Missing	1	16.7	-	1	-

North Thames	f	%	P	P+D
Yes	4	80	2	2
No	-	-	-	-
Missing	1	20	1	-

North West	f	%	P	D	P+D	P+R	P+R+N	N/A
Yes	7	63.6	3	-	1	1	1	1
No	3	27.3	2	-	-	-	-	1
Missing	1	9.1	-	1	-	-	-	-

South and West	f	%	P	P+D	P+R	P+N	NA
Yes	6	75	2	1	1	1	1
No	1	12.5	-	-	-	-	-
Missing	1	12.5	1	-	-	-	1

DETERMINING THOSE FACTORS WHICH SHOULD BE USED TO ASSESS THE QUALITY OF PROVIDERS

West Midlands	f	%	P	P+D	P+D+R	P+R+N	N/A
Yes	9	81.8	3	1	2	1	1
No	-	-	-	-	-	-	-
Missing	2	18.2	-	1	-	-	1

Northern & Yorkshire	f	%	P
Yes	6	100	6
No	-	-	-
Missing	-	-	-

South Thames	f	%	P	P+D	P+R	P+D+R+N	N/A
Yes	7	87.5	1	2	2	1	1
No	-	-	-	-	-	-	-
Missing	1	12.5	1	-	-	-	-

Anglia & Oxford	f	%	P	P+D
Yes	4	100	2	2
No	-	-	-	-
Missing	-	-	-	-

Trent	f	%	P	P+D+R	P+R+N	NA
Yes	5	83.3	3	1	-	1
No	-	-	-	-	-	-
Missing	1	16.7	-	-	1	-

North Thames	f	%	P	P+D	P+D	P+D+R+N
Yes	3	60	-	1	1	1
No	-	-	-	-	-	-
Missing	2	40	1	-	-	-

North West	f	%	P	D	P+D	P+R	P+R+N	N/A
Yes	10	90.9	5	1	2	1	2	1
No	-	-	-	-	-	-	-	-
Missing	1	9.1	-	-	1	-	-	-

South and West	f	%	R	P+D	P+R	P+D+R	P+R+N
Yes	8	100	1	2	1	1	3
No	-	-	-	-	-	-	-
Missing	-	-	-	-	-	-	-

DETERMINING HOW THE QUALITY OF PROVIDERS SHOULD BE MEASURED

West Midlands	f	%	P	P+D	P+R	P+D+R	P+R+N	N/A
Yes	9	81.8	4	1	1	1	1	1
No	-	-	-	-	-	-	-	-
Missing	2	18.2	-	1	-	-	-	1

Northern & Yorkshire	f	%	P
Yes	6	100	6
No	-	-	-
Missing	-	-	-

South Thames	f	%	P	P+D	P+R	P+D+R+N	N/A
Yes	7	87.5	1	2	2	1	1
No	-	-	-	-	-	-	-
Missing	1	12.5	1	-	-	-	-

Anglia & Oxford	f	%	P	P+D+R
Yes	4	100	3	1
No	-	-	-	-
Missing	-	-	-	-

Trent	f	%	P	P+D	P+D+R	P+R+N
Yes	5	83.3	3	1	1	-
No	-	-	-	-	-	-
Missing	1	16.7	-	-	-	1

North Thames	f	%	P	P+D	P+D+R+N	NA
Yes	3	60	-	2	1	-
No	-	-	-	-	-	-
Missing	2	40	1	-	-	1

North West	f	%	P	D	P+D	D+R+N	R+N
Yes	10	90.9	4	1	1	1	1
No	-	-	-	-	-	-	-
Missing	1	9.1	-	1	-	-	-

South and West	f	%	P	P+D	P+R	P+R+N	NA
Yes	7	87.5	3	2	1	1	-
No	-	-	-	-	-	-	-
Missing	1	12.5	-	-	-	-	1

DETERMINING HOW THE DHA SHOULD MANAGE THE QUALITY OF ITS OWN ACTIVITIES

West Midlands	f	%	P+D	N/A
Yes	7	63.6	-	7
No	-	-	-	-
Missing	4	36.4	1	3

Northern & Yorkshire	f	%	P	NA
Yes	5	83.3	1	4
No	1	-	-	1
Missing	-	16.7	-	-

South Thames	f	%	P	P+D	R	R+N	N/A
Yes	7	87.5	-	2	1	1	5
No	-	-	-	-	-	-	-
Missing	1	12.5	1	-	-	-	-

Anglia & Oxford	f	%	D+R	NA
Yes	2	50	1	1
No	1	25	-	1
Missing	1	25	-	1

Trent	f	%	R	N	NA
Yes	4	83.3	1	1	2
No	1	-	-	-	1
Missing	1	16.7	1	-	-

North Thames	f	%	D+R	NA
Yes	4	60	1	1
No	-	-	-	1
Missing	1	40	-	1

North West	f	%	P	R	R+N	NA
Yes	9	90	2	1	2	4
No	1	5	-	-	-	1
Missing	1	5	-	-	-	1

South and West	f	%	P	R+N	NA
Yes	6	75	1	1	4
No	1	15.5	-	-	1
Missing	1	12.5	-	-	1

HOW THE OUTCOME FOR EACH ACTIVITY WAS DETERMINED

Determining A Quality Strategy Or Mission Statement For Health Care

	A f	A %	B f	B %	C f	C %	M• f	M• %
West Midlands	-	-	2	18.2	8	72.7	1	9.1
Northern & Yorkshire	-	-	3	50	2	33.3	1	16.7
South Thames	-	-	3	37.5	4	50	1	12.5
Trent	1	16.7	3	50	2	33.3	-	-
Anglia and Oxford	-	-	2	50	1	25	1	25
North Thames	-	-	3	60	2	40	-	-
North West	1	9.1	4	36.3	6	54.5	-	-
South and West	-	-	3	37.5	5	62.5	-	-

M• Missing Cases

Determining A Definition Of Quality For Health Care

	A f	A %	B f	B %	C f	C %	M f	M %
West Midlands	-	-	2	18.2	5	45.4	4	36.4
Northern & Yorkshire	1	16.7	1	16.7	2	33.3	2	33.3
South Thames	-	-	6	75	2	25	-	-
Trent	2	33.3	2	33.3	1	16.7	1	16.7
Anglia and Oxford	-	-	2	50	1	25	1	25
North Thames	-	-	4	80	1	20	-	-
North West	-	-	4	36.4	5	45.6	2	18.2
South and West	-	-	5	62.5	3	37.5	-	-

Determining How A Quality Strategy Should Be Implemented

	A f	A %	B f	B %	C f	C %	M f	M %
West Midlands	-	-	2	18.2	7	63.6	2	18.2
Northern & Yorkshire	1	16.7	3	50	1	16.7	1	16.7
South Thames	-	-	6	75	2	25	-	-
Trent	-	-	5	83.3	-	-	1	16.7
Anglia and Oxford	-	-	3	75	1	25	-	-
North Thames	-	-	4	80	1	20	-	-
North West	1	9.1	5	45.4	3	27.3	2	18.2
South and West	1	12.5	4	50	2	25	1	12.5

Determining Which Factors Should Be Used To Assess The Quality Of Providers

	A f	A %	B f	B %	C f	C %	M f	M %
West Midlands	-	-	9		-	-	2	
Northern & Yorkshire	-	-	4		2		-	-
South Thames	-	-	5		3		-	-
Trent	-	-	6		-	-	-	-
Anglia and Oxford	-	-	3		1		-	-
North Thames	-	-	4		-	-	1	
North West	-	-	7		4		-	-
South and West	-	-	7		1		-	-

Determining How The Quality Of Providers Should Be Measured

	A f	A %	B f	B %	C f	C %	M f	M %
West Midlands	-	-	4	36.4	6	54.5	1	9.1
Northern & Yorkshire	-	-	5	83.3	1	16.7	-	-
South Thames	-	-	5	62.5	3	37.5	-	-
Trent	-	-	5	100	-	-	-	-
Anglia and Oxford	-	-	3	75	1	25	-	-
North Thames	-	-	5	100	-	-	-	-
North West	-	-	7	63.6	4	36.3	-	-
South and West	-	-	5	62.5	2	25	1	12.5

Determining How The DHA Itself Should Manage The Quality Of Its Own Activities

	A f	A %	B f	B %	C f	C %	M f	M %
West Midlands	-	-	1	9.1	6	54.5	4	36.4
Northern & Yorkshire	-	-	1	16.7	4	66.7	1	16.7
South Thames	1	12.5	2	25	5	62.5	-	-
Trent	-	-	1	20	4	80	-	-
Anglia and Oxford	-	-	2	50	2	50	-	-
North Thames	-	-	1	20	4	80	-	-
North West	2	18.2	1	9.1	7	63.6	1	9.1
South and West	-	-	1	12.5	5	62.5	2	25

DOES THE DHA MEASURE AND MONITOR THE QUALITY OF ITS OWN ACTIVITIES?

	Yes %	No %
West Midlands	54.5	45.5
Northern & Yorkshire	50	50
South Thames	62.5	37.5
Trent	40	60
Anglia and Oxford	0	100
North Thames	40	60
North West	36.3	63.7
South and West	75	25

DOES THE DHA CARRY OUT ITS ACTIVITIES UNDER A TQM PHILOSOPHY?

	Yes %	No %
West Midlands	18.2	81.8
Northern & Yorkshire	16.7	83.3
South Thames	0	100
Trent	40	60
Anglia and Oxford	0	100
North Thames	60	40
North West	0	100
South and West	25	75

IS THE DHA AWARE OF QUALITY IMPROVEMENT ACTIVITIES TAKING PLACE IN OTHER DISTRICTS AND REGIONS OF THE NHS?

	Yes %	No %
West Midlands	90.9	9.1
Northern & Yorkshire	83.3	16.7
South Thames	97.5	12.5
Trent	100	0
Anglia and Oxford	100	0
North Thames	100	0
North West	100	0
South and West	100	0

HAS THE DHA ADAPTED ITS OWN APPROACH AS A RESULT OF THIS AWARENESS?

	Yes %	No %
West Midlands	63.7	36.3
Northern & Yorkshire	50	50
South Thames	75	25
Trent	93.3	16.7
Anglia and Oxford	50	50
North Thames	60	40
North West	54.5	45.5
South and West	100	0