

**An Analysis of the Feasibility of Developing
a Generic Model for the Implementation of
Total Quality Management
within the National Health Service**

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CONTENTS

	<u>PAGE</u>
ACKNOWLEDGEMENTS	(iv)
ABSTRACT	(vi)
DECLARATION	(ix)
CHAPTER ONE:	1
INTRODUCTION	1
RATIONALE	3
SCOPE OF RESEARCH	6
AIMS AND OBJECTIVES OF THE STUDY	9
OVERVIEW OF THE THESIS	10
BACKGROUND TO THE RESEARCH	13
CRITICISM	15
BACKGROUND TO RESEARCH METHODOLOGY	17
DATA COLLECTION	20
QUALITATIVE/QUANTITATIVE ARGUMENT	28
OVERVIEW OF FIELD WORK	29
SAMPLING	31
HOSPITALS	33
DATA ANALYSIS	33
HOW THE QUESTIONNAIRES WOULD BE ANALYSED	36
RELIABILITY AND VALIDITY	39
EXTERNAL VALIDITY	39
REFERENCES	40
CHAPTER TWO:	47
CREATING THE NATIONAL HEALTH SERVICE	47
POLICIES TOWARD THE NHS AND THE YEARS OF CONSENSUS POLITICS	50
THE NHS SINCE 1979: THE CONSERVATIVES AND THE ENDING OF CONSENSUS	55
THE NHS SINCE 1990: THE INTRODUCTION OF TOTAL QUALITY MANAGEMENT	61
REFERENCES	65

CHAPTER THREE:	67
HISTORICAL DEVELOPMENT OF QUALITY	67
WHAT IS QUALITY?	72
QUALITY IN HEALTHCARE	81
WHAT IS TOTAL QUALITY MANAGEMENT?	99
QUALITY MANAGEMENT PHILOSOPHIES	125
THE DEMING PHILOSOPHY	125
JOSEPH M. JURAN	128
THE PHILIP CROSBY PHILOSOPHY	131
OTHER QUALITY PHILOSOPHERS	134
PRINCIPLES OF TOTAL QUALITY MANAGEMENT	136
REFERENCES	139
 CHAPTER FOUR:	 155
IMPLEMENTATION OF TQM	155
TRADITIONAL TQM; A CULTURE CHANGE PERSPECTIVE	187
THE GURUS ON IMPLEMENTATION	189
THE STRATEGIC APPLICATION OF TQM	196
TRADITIONAL TQM MODELS; A HEALTHCARE PERSPECTIVE	200
EMPIRICAL FINDINGS	208
ANALYSIS	211
REFERENCES	220
 CHAPTER FIVE:	 228
PITFALLS OF TQM	228
PITFALLS OF TQM; A PUBLIC SECTOR PERSPECTIVE	252
PITFALLS OF TQM; A HEALTHCARE PERSPECTIVE	256
PITFALLS OF TQM; NHS PERSPECTIVE	261
EMPIRICAL FINDINGS	279
REFERENCES	303
 CHAPTER SIX:	 313
BACKGROUND TO THE CASE STUDIES	313
ANALYSIS	315
CASE STUDY ONE: SOUTHFORKE HOSPITAL	316
CASE STUDY TWO: DESMOND HOSPITAL	336
CASE STUDY THREE: BROOKESIDE HOSPITAL	355
REFERENCES	384

CHAPTER SEVEN:	387
EMBARKING ON TQM	387
EMBARKING ON TQM IMPLEMENTATION	399
IMPLEMENTATION: INFRASTRUCTURAL MANAGEMENT	402
HOW IT WORKS: PRE-SET-UP PHASE	406
SET-UP PHASE	409
EDUCATION AND TRAINING	414
GET-UP PHASE	419
THE 'HOW-TO-DO' APPROACH TO TQM IMPLEMENTATION	421
SUCCEEDING WITH THE 'HOW-TO-DO' APPROACH TO TQM	424
USING THE MODEL; IMPLEMENTATION	425
STAY-UP PHASE	436
MOVE-UP PHASE	437
COMPARISON BETWEEN THE HOW-TO-DO APPROACH AND THE MIXED MODEL	439
ADVANTAGES OF THE HOW-TO-DO MODEL	446
REFERENCES	448
 CHAPTER EIGHT:	 451
CONCLUSION	451
RESEARCH FINDINGS	452
RECOMMENDATIONS FOR FUTURE RESEARCH	458
REFERENCES	460
 BIBLIOGRAPHY	 461
 APPENDICES	 471

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Sir Isaac Newton.

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ABSTRACT

**Analysis of the Feasibility of Developing
a Generic Model for the Implementation of
TQM in the National Health Service**

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This is an exploratory case study evaluating the process of TQM implementation in the 23 TQM demonstration sites in the NHS. These sites were set up in 1989 by the Department of Health as centres of excellence for the implementation of TQM. An earlier study¹ evaluating TQM in the NHS failed to adequately contextualise the reasons for the argument that orthodox TQM has failed in the NHS. Against this background, it became necessary to carry out an extensive reassessment of TQM initiatives in the NHS. The central thrust of the study involves the identification of:

- the differing modes of implementation of TQM across the sites;
- the difficulties managers were encountering in the implementation of TQM - barriers to the implementation of TQM;
- the critical key success factors for the successful implementation of TQM in the NHS; and
- based on empirical evidence seeks to determine whether a specific model of TQM is required in the NHS.

As Francis Bacon noted, 'if anyone wants to understand nature, he has to study nature rather than base their understanding on Aristotle's postulations of nature. This is because Aristotle did not understand nature, his ideas about nature were not empirically determined'² Hence, to gain a conceptual understanding of TQM, it is necessary to understand 'implementation' and not base understanding on the outmoded ideas of the Gurus, whose philosophies are not grounded in empirical data. Thus, the TQM literature is inundated with TQM models that are based on anecdotal evidence and the personal prescriptions of TQM writers³. This situation has led to a call by a number of writers⁴ for an empirically determined implementation model for TQM; particularly in the healthcare setting. To determine whether such a model is required in the NHS, this exploratory study used a unique combination of qualitative and quantitative data to sample 23 Quality Managers at the 23 TQM sites in order to provide an accurate rendition of the TQM process in the NHS. The study makes a valid contribution to the quality literature, by contending that TQM has not failed in the NHS as earlier suggested by one study⁵, but is yet to be tried. Allegations of failure arise from improper implementation, which is itself symptomatic of the lack of a context-specific model for the implementation of TQM in the NHS. The conclusion was reached from a number of perspectives:

- (1) the critique of current TQM literature which is based on the personal ideas of quality management proponents (Chapter Three).
- (2) a reconceptualisation of the implementation of TQM. The study suggests that the traditional paradigms of TQM lack adequate contextualisation. They only provide answers for the "what" of TQM in the form of step-by-step approaches, or of TQM as a vehicle for culture change, without providing the practising manager with the 'how' of the implementation process. This apparent limitation, the author suggests, makes TQM orthodoxy inappropriate to deal with the complexities of the NHS (Chapter Four).

- (3) the study also found that the suggestions in the literature that the barriers to the implementation of TQM have generic applicability across organisations is a misnomer. In most of the hospitals the difficulties that quality managers were facing were specific to the organisational context (Chapter Five).
- (4) seventeen critical success factors were identified as valid and specific to the NHS. These factors, unlike the 'Ten Critical Success Factors' identified by Black⁶ are of equal importance for the implementation of TQM and are not categorised on a scale of importance (Chapter Seven).

In the final analysis, the study, as a major contribution to knowledge in the quality management field, provides the first empirically determined context specific model for the implementation of TQM in the NHS. The model represents the first problem specific model validated by the experiences of fifteen quality managers in the NHS. It provides an empirical understanding of the 'nature' of the implementation of TQM within the confines of the British National Health Service. In addition, a measurement framework to monitor the progress of TQM at various stages of the implementation process is offered (Chapter Seven).

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DECLARATION

Whilst the author acknowledges the referenced materials used in this study, no portion of the work in this thesis has been submitted in support of an application for another degree or qualification at any other University.

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CHAPTER ONE

INTRODUCTION:

A growing number of hospitals within the National Health Service are promoting and adopting the practices of Total Quality Management (TQM) or Quality Improvement¹. Under this approach, patients should be viewed as active partners in the provision of healthcare. However, efforts in both provider and purchaser settings to implement this radical understanding of the new role and function of the patient have yet to come to fruition². The experience of a number of health service provider units will be explored.

Consistent with the principles of Total Quality Management, the Department of Health, through its reforms for change, actively promotes patient involvement in quality improvement. For example, the Department of Health working paper, "The Patient Charter", The King's Fund "Organisational Audit", both encourage accountability, innovative leadership, feedback from internal and external users of services, and total organisational commitment to continuous improvement in the provision of healthcare. In addition, an organisational culture that involves patients, and all who use the services, is advocated. This means that hospitals should seek "ongoing feedback on the quality of care from patients, their families, General Practitioners (GPs), GP fundholders, etc.". This patient inclusive approach to Total Quality Management, when compared with the traditional notion of "we know what's best for our patients", is one of the greatest challenges presented by the TQM initiative³.

However, models are needed to guide providers in meeting this challenge. For example, the Department of Health's guidelines on the Patient Charter still reflect the traditional provider-centred approach to quality improvement. Patient participation, even though echoed by health practitioners, is not evident in the development of professional standards - a troubling fact, given the central role that meeting patient needs play in quality improvement initiatives. Other Agenda for Change in the NHS presents the patient as only one voice among many others in the total quality management feedback loop.

This inaptness is noteworthy, given that the roots of Total Quality Management lie in the industrial sector⁴ where the meaning of quality is that ascribed by interested, involved parties in any given transaction or set of transactions. In TQM, the customer plays a critical role in defining quality.

"The customer is the most important part of the production and service line. Quality should be aimed at the needs of the consumer, present and future"⁵.

Quality is defined as

"fitness for use, which means product features that meet customer needs and freedom from deficiency"⁶.

Fitness for use clearly has the customer as its central thrust. This could be stated as:

"Quality is a customer determination, not an engineers determination, not a marketing determination. It is based upon the customers actual experience with the product or service, measured against his or her requirements - stated or unstated, conscious or merely sensed, technically operational or entirely subjective and always representing a moving target in a competitive market. The purpose of quality measurement is to determine and evaluate the degree or level to which the product or service meets the expectation of the customer"⁷.

The differences between the industrial and health service approaches to defining quality is forcible. In industry, the customer together with the manufacturer and/or service provider defines quality; in the health service the provider unit defines quality. Yet Total Quality Management cannot be fully implemented in the health service, without accepting that the nature and direction of change must be driven by the needs and preferences of the patient, not the values of the provider⁸.

To implement TQM in the NHS requires a fundamental shift in organisational culture. The existing attitude within the NHS of "if it ain't broke, it don't need fixing" must

be replaced by the attitude of "when it ain't broke is maybe the only time you can fix it"⁹. From an organisational prospective, to do a better job must entail expanding the focus of quality improvement and managerial activities to include both processes that are "broken" and processes that are not yet at a crisis stage. Total Quality Management provides such a mechanism for the prevention of organisational defects.

The NHS faces many challenges to successful implementation and integration of TQM. Recognising these challenges and their associated pitfalls and the development of a comprehensive generic model for implementation are essential for making progress towards continuous quality improvement and a more responsive and efficient system of patient care. This study analyses the implementation process of TQM in the NHS by exploring the difficulties encountered from its origins through to fruition.

A growing number of academics, practitioners and experts have taken up the issue of the implementation of TQM in healthcare¹⁰⁻¹⁴. But none have addressed the issue of the difficulties healthcare organisations face in implementing TQM. This thesis will attempt to address this gap by providing a comprehensive analysis of "pitfalls" with the aim of generating a solution leading to their eradication.

RATIONALE:

The TQM literature is inundated with articles extolling the virtues of TQM; success stories of how organisations have used the quality strategy to rescue their fledgling businesses. Notable success stories include Rank Xerox, Motorola and Miliken. But on closer examination, research^{15,16} shows that about 70 per cent of TQM initiatives fail in the U.S.A.¹⁷, and a British Broadcasting Corporation (BBC) business report in 1993 noted that 10 out of 15 quality initiatives fail in Britain¹⁸. Smit et al¹⁹, have noted that most quality programmes fail after the initial 18-24 months honeymoon period is over due to partial implementation. This view is supported by the author's consultancy experience in helping a number of healthcare organisations in the U.S.A. implement TQM. The result was that many of the programmes were abandoned within 24 months without identifiable cause. Nonetheless, few systematic studies have been carried out to establish the factors inhibiting the implementation of TQM. Kogan et al²⁰ have advanced the claim, fully supported by the author, that 'there is yet to be a good study

on the failures or pitfalls of TQM'. Despite the attention given to TQM in the real-world organisations, relatively little academic research has addressed the topic of the difficulties managers face in the implementation of TQM²¹.

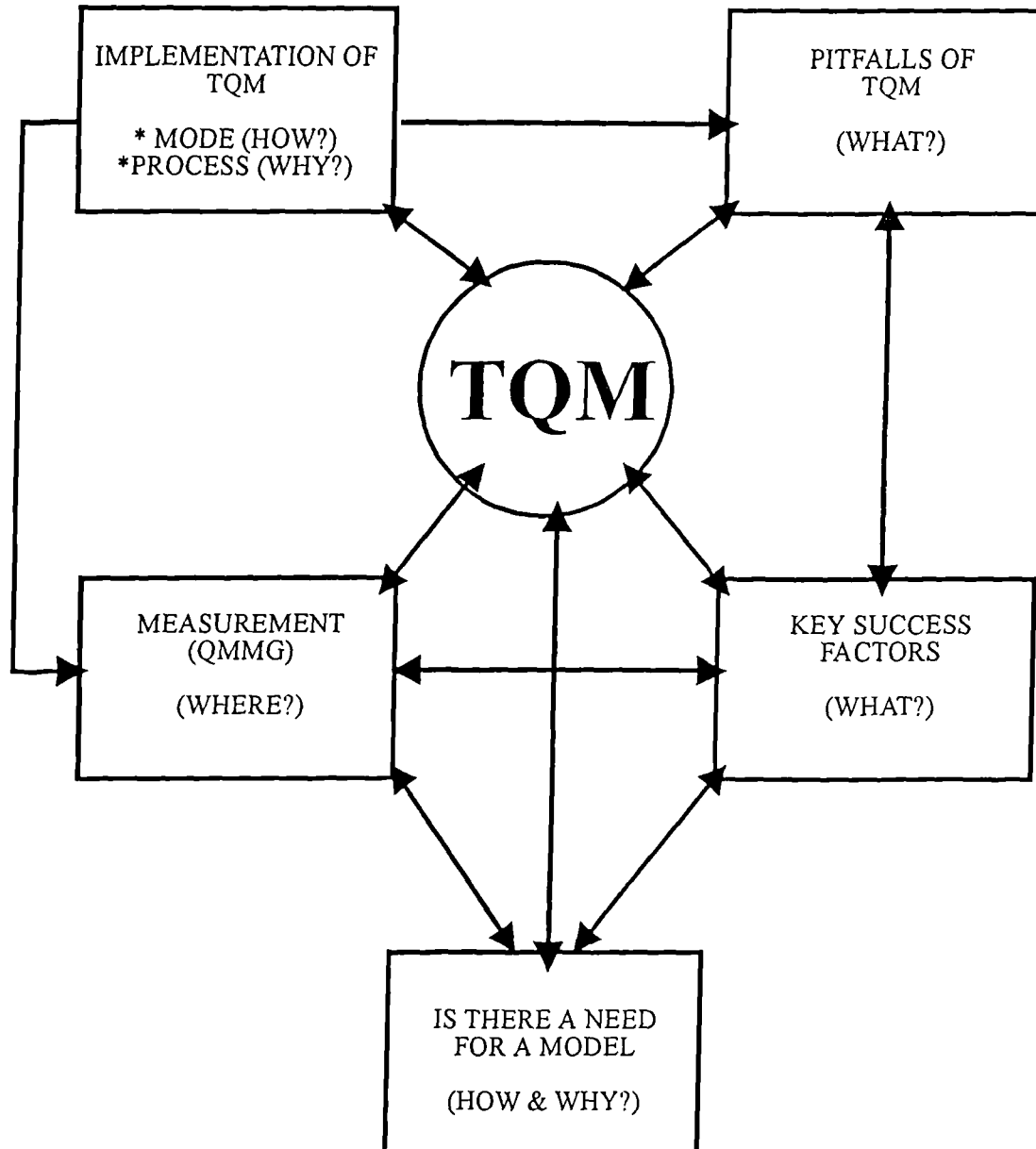
Given the lack of systematic research in this area, the author decided to embark on a Doctoral research to unravel the difficulties Quality Managers, or whoever is responsible for the introduction and implementation of TQM, were facing in the process of implementing TQM in the NHS. However, it must be noted that, it would be impossible to determine the exact difficulties of TQM without an indepth study of its implementational process. Hence, the remit of this study is the exploration of the TQM process in the NHS. In the main, the complementary attributes which are concomitant to the successful implementation of TQM will be examined. These characteristics include:

- Mode of implementation
- Difficulties of implementation
- Critical success factors for implementation

On this basis, it is possible to make an informed judgement as to whether TQM has failed in the NHS as has been claimed in an earlier study²². A graphical representation of the dimensions of the study is presented in Figure 1.

FIGURE 1

THE CONCEPTUAL FRAMEWORK OF THE STUDY



Source: Designed by the Author (1993)

The author embarked on this research for two main reasons:

1. to find answers, which he failed to identify as a consultant, as to 'why' TQM programmes often fail.

2. whilst the number of quality programmes seem to increase in the NHS, the scholarly published material on healthcare quality programmes is rather limited. This can be explained by the fact that some writers have argued that quality is rather a vague phenomenon²³. Thus, it seems appropriate to provide a systematic overview of quality programmes as they appear in the twenty-three government selected sites. The purpose being to determine precisely where the NHS stands in relationship to quality. The importance of this determination is an assessment measure upon which quality improvement interventions can then be based.

The National Health Service (NHS) was chosen as the setting for the research because:

1. the author has a consultancy interest in quality provision in the healthcare sector, but lacks experience in what is required for the effective implementation of TQM in public sector health organisations.
2. despite the attempt by two earlier studies^{24,25} to evaluate TQM initiatives in the NHS, those studies failed to fully address the issue of the 'pitfalls' managers were facing in adopting this initially, industrially based quality paradigm.

In addition, the National Health Service plays a huge role in supporting the British economy. The NHS is the largest single employer of labour in Britain employing 1.25 million personnel, provides healthcare for a population of about 60 million with a budget of about £36 billion per annum²⁶. So it becomes interesting to study how such an 'elephant' sought to implement the tenets of Total Quality Management.

SCOPE OF RESEARCH:

At the initial stages a number of research questions were raised with particular reference to the appropriate method that would elucidate a meaningful outcome. Techniques such as experiments and surveys were evaluated but were found inappropriate because experiments are particularly suited for focused studies which fail to take into account behavioural events²⁷, whilst surveys have the disadvantage of addressing issues pertaining to who, what, where, how much²⁸, etc.

Case studies have the advantage over the other two considered approaches because they present the reader with a richer and holistic view of how three NHS hospitals have implemented TQM by giving an accurate rendition of actual events²⁹. The case study is unique in its ability to deal with a full variety of evidence: documents, artifacts, interviews and observations³⁰. Whereas surveys can try to deal with phenomenon and context, their ability to investigate the context is extremely limited³¹. The survey designer, for instance, constantly struggles to limit the number of variables to be analysed, hence limiting the number of questions that can be asked³², whilst an experiment has the disadvantage of divorcing the phenomenon from its context in order to focus on a few variables³³.

This study represents an exploration to identify the 'how' and 'why' of TQM in the NHS. The 'how' in this instance, represents 'how' the NHS has approached the implementation of TQM. The why deals with the question 'why' a certain approach was chosen against other competing or complementary models. Yin³⁴ notes, that the case study:

"is an empirical inquiry that:

- investigates a contemporary phenomenon within its real-life context; when
- the boundaries between phenomenon and context are not clearly evident; and on which
- multiple sources of evidence are used."³⁵

To investigate the contemporary phenomenon of 'TQM' in the NHS, it is essential to explore the process of implementation in the last six years (1989-1995). The objective being to find answers to the 'how' and 'why' questions and to assess any changes or modifications to the chosen or preferred method of implementation.

To effectively conduct the investigation and substantiate the 'how' and 'why' questions, it was decided that the best person to provide answers to these key questions would be the people charged with the responsibility of implementing TQM as it is their responsibility to decide on the approach to TQM and how to go about implementing it.

Furthermore, those people have experienced at first hand the problems of implementing TQM in an alien setting. They are in a vantage position to recount the nuances of the organisation's TQM initiative. Hence, it was decided that the contact person in the TQM demonstration sites would be the Quality Managers who have as their functional remit the introduction and implementation of TQM.

In the NHS, as in most traditional organisations, one person is chosen and charged with the responsibility to "get on" with quality. Thus, in such a situation only that person would have an insight into the factors which have helped or hindered the progress of TQM. At the time of writing there were 292 Trust hospitals in the United Kingdom³⁵. However, only 23 were considered to have a fully developed TQM programme³⁶. Since the research was not a comparative study between TQM and non-TQM hospitals, the study concentrates its investigation on the 23 TQM hospitals established in 1989 by the Department of Health (DOH) to serve as centres of excellence for the implementation of TQM. When this study started, the 23 hospitals were already four years into TQM which made them appropriate for research because they had established TQM programmes.

Nevertheless, due to limited research funding, it was impossible to visit all 23 hospitals to conduct interviews, hence, the decision was taken to undertake a more in-depth study of only 3 of the 23 hospitals, whilst the remaining 20 would be investigated through postal questionnaire surveys. The decision to use a multi-method approach (triangulation) was influenced by the fact that some critics of the case study method have suggested that the case study has the disadvantage that the data produced are not readily generalisable³⁷. Nevertheless, in this study the use of multiple cases and questionnaire surveys would justify the validity and reliability of the data. The research is based on two perspectives: micro and macro.

At a micro level, the research will explore, in-depth and extensively, the implementation process in 3 Trust hospitals. Whilst at the macro level, through the use of questionnaires, it will further explore the process of TQM, its difficulties and key success factors in 20 hospitals. In the author's opinion, the multiple approach affords ample opportunity for generalisation from the discrete empirical data. Hence, both quantitative and qualitative data would be collected. The 3 TQM sites were chosen because they agreed in writing when the author made his first initial contact with the Quality Managers of the 23 TQM sites to serve as industrial collaborators to the research. Nonetheless, the three Trust hospitals represent a wide geographical spread and are amongst the first wave of Trust hospitals which had, as a policy requirement, a need to introduce an on-going TQM programme. These hospitals present perhaps the best vantage point from which to explore the process of the implementation of TQM in the NHS.

AIMS AND OBJECTIVES OF THE STUDY:

The aims include:

- (1) a critical assessment of the characteristics and tenets of TQM as posited by leading writers and practitioners. Among the works that will be considered will be those of Deming, Juran, Crosby, Feigenbaum and Conway.
- (2) a critical assessment of the orthodox model of TQM to determine its suitability for application within the NHS.
- (3) an analysis focusing on the identification of 'pitfalls' of TQM which have impeded the TQM process.
- (4) the identification of the process of TQM implementation in the NHS - modes of implementation and whether there is a resemblance to orthodox models of TQM.
- (5) an exploration to confirm whether TQM has failed in the NHS as an earlier study suggested.

- (6) on the basis of empirical findings, a determination of whether a generic model is required for the implementation of TQM in the NHS.

OVERVIEW OF THE THESIS:

The thesis is structured into eight distinct but interrelated Chapters. Each is a "standalone" chapter which makes a discrete contribution to knowledge. The aim was to make certain that each chapter could constitute an academic publication. However, each of the chapters represents an essential element for the successful implementation of TQM. These elements include: the approach to implementation, pitfalls of TQM, implementation and the key success factors of TQM specific to the NHS. The aim in the chapters is to first undertake an in-depth review of the literature relating to each element before testing the relevance of theory to practice. The author is of the opinion that TQM is a practical subject and, as such, theory should be grounded in empirical evidence. Thus, what will be found throughout the chapters, is an attempt to marry theory to practise but overall the study represents a thorough analysis of the TQM process in the NHS unlike earlier studies which represent anecdotal accounts. The chapters include:

- Chapter Two:** provides a historical account of the different changes the NHS have undergone (1979-1990), and includes the reasons why the NHS embarked on TQM by setting up 23 TQM sites in 1989.
- Chapter Three:** provides an assessment of the meaning of quality and total quality management. A literature review is undertaken to establish whether a generic definition of quality exists. An insight is offered as to what quality means in the context of the NHS. Furthermore, a historical account of the evolution of TQM is offered. The chapter concludes by delineating the principal elements of TQM.
- Chapter Four:** provides a critical assessment of the implementation of TQM. An extensive review of the literature is undertaken of orthodox TQM models. Arguments are posited to the effect that orthodox

TQM models represent, in the main, piecemeal approaches to TQM. This leads to a reconceptualisation of TQM implementation. A contribution is made to knowledge in the form of delineating, from the literature, a set of common implementational characteristics amongst the leading proponents of TQM. The model, which the author terms a "TQM infrastructural framework" made up of five different but interrelated stages designated as Pre-Set-up, Set-up, Get-up, Stay-up and Move-up, is defined. The model represents the first contextualised infrastructural framework in the field of quality. A further contribution is made to the field of TQM by the offering of a holistic model of TQM. The chapter concludes by arguing that orthodox models of TQM are inappropriate for the NHS because they are not problem-specific, that is they are not grounded in empirical data and cannot, therefore, deal with the complexities of the NHS. A call for a specific model for the implementation of TQM is made. Furthermore, a summarised tabulation of the TQM process in 12 Trust hospitals is offered.

Chapter Five:

provides an extensive review of the pitfalls encountered in the implementation of TQM as posited in the literature. The pitfalls are categorised under four stages: Set-up, Get-up, Stay-up and Move-up. On the basis of the analysis, a questionnaire is designed based on 40 generic pitfalls from which conclusions can be drawn as to whether the pitfalls are 'generic' and thus have applicability in the NHS. A further questionnaire, based on the Parasuraman gap analysis framework, is administered to further identify the 'pitfalls' to TQM in the NHS. The extensive survey reveals the factors inhibiting TQM but, most importantly, identifies the 'real cause' of the difficulties of implementing TQM in the NHS. In this chapter a contribution is made to the effect that the term 'generic' is an in-appropriate word to use because analysis indicates that whilst some barriers to TQM were assumed to be generic in the literature, they were indeed

not applicable within the confines of the NHS. Detail on the 'pitfalls' to TQM in the NHS is offered.

Chapter Six: contains the case studies. A detailed account is offered as to how three Trust hospitals implemented TQM. In addition, a cross-case analysis of the three cases is presented to determine elements of commonality between the cases. Furthermore, a questionnaire survey based on the Crosby Quality Management Maturity Grid (QMMG) is undertaken. This represents the first time the QMMG has been applied and utilised in the context of the NHS. A contribution to knowledge is made to the effect that the results of the survey repudiates the conclusion of the Brunel University Report, Evaluating TQM Initiatives in the NHS, which erroneously concluded that TQM has failed in the NHS. The chapter concludes by reiterating the earlier call for a model for TQM and advocates a context specific model for the implementation of TQM in the NHS.

Chapter Seven: provides an examination of the critical success factors for the implementation of TQM in the NHS. Using Porter and Parkers' framework of critical success factors, an examination of the applicability of this approach to the NHS is undertaken through the use of a questionnaire. The analysis of the data confirmed that Porter and Parkers' critical success factors have applicability to the NHS but, that that applicability is not exhaustive. There are other critical success factors specific to the NHS which the prescription failed to take into account. Thus, a contribution is made by extending the Porter and Parkers' framework to include other essential critical success factors for the implementation of TQM within the NHS. A further contribution to knowledge is offered in the chapter in the form of the development of a context specific model for the implementation of TQM in the NHS. Additionally, the model is compared to the Mixed Model developed by the Brunel University Team of Researchers who

undertook an evaluation of TQM in the NHS in May 1994. The context specific model represents the first TQM model to encompass both an infrastructural and measurement framework.

Chapter Eight: is the conclusion of the study. The key points of each chapter are offered and conclusions drawn to the effect that TQM has not failed in the NHS. It has yet to be tried. The problem of TQM in the NHS is highlighted as improper implementation due to the lack of a context specific model for implementation. In addition, recommendations for future research is offered.

BACKGROUND TO THE RESEARCH

A CRITIQUE OF THE BRUNEL UNIVERSITY REPORT:

EVALUATION OF TQM INITIATIVES IN THE NHS, JOSS ET AL

The Brunel Report by Joss et al³⁸, 'Evaluation of TQM Initiatives in the NHS (1991-1994)' formed the main background to this study. That Report was sponsored by the Department of Health and the remit of the research was an 'evaluation of the usefulness and feasibility of installing orthodox TQM'. The research evaluated TQM projects in eight TQM sites. It included an assessment of the aims and objectives of each project and considered alternative approaches to the development of TQM. It monitored the progress of the project at different stages of installation and completion, through a process sequence. It made comparisons with NHS sites not involved with TQM. It noted the contribution of different processes in introducing and achieving TQM, paying particular attention to the use of special initiatives as against the ordinary or organic models of introduction and installation³⁹. The project coordinated sites and evaluated the outcome of the projects on a wide range of criteria and involved all of those with a stake in TQM.

The Brunel Report⁴⁰:

- (1) found a number of quality assurance initiatives. These were broadly categorised as

1. Technical - those concerned with the employment of specialist knowledge and expertise;
2. Generic - those concerned with generally agreed standards of conduct; and
3. Systemic - making sure that the whole organisation works in a coherent and well planned way.

Furthermore, the Report identified critical success factors underpinning each of the quality assurance mode:

- Senior Management commitment
- Funding
- Training
- Recognition and reward

It also identified the following as problems inhibiting TQM:

- Lack of infrastructural management
- Lack of funding
- Lack of adequate conceptualisation of TQM before implementation
- Unempowered Quality Officers.

The Report concluded that only two TQM sites have made significant progress in systematic quality. Most of the sites have failed to make any significant progress in implementing an ideal - typical model of TQM. In addition, TQM has failed in the NHS for two reasons:

- (1) TQM implementation in the NHS was underpinned by commercial models of TQM.
- (2) the Department of Health created a paradox in setting out to use an orthodox style of TQM.

CRITICISM

It is the author's opinion, on reading the Report by Joss et al, that they failed to adequately establish the reasons for the failure of TQM in the NHS. The premise on which their study was based lacks validity because a study that evaluated the usefulness and feasibility of installing TQM should have centred the collection of data on the central actor whose responsibility it was to introduce and implement TQM - the Quality Managers. However, the study chose to interview the Chief Executives and frontline staff about TQM. As the author has argued elsewhere, in most hospitals only five percent of staff are involved in the TQM process⁴¹. In other words, most CEOs and the frontline staff in most cases are ignorant or unaware of the level of importance of TQM. This is not an ideal situation but, it is reality in the NHS. In addition, the study failed to make use of any systematic or evaluative criteria on which to base its conclusion as to the failure of TQM in the NHS. The author is of the view that to come to the conclusion that TQM has failed, a study needs to first establish whether or not the models adopted in the NHS are indeed orthodox models of TQM, to examine the difficulties of implementation and to systematically measure the organisation's relationship to quality using either the Crosby Quality Maturity Grid (QMMG) or the European Foundation for Quality Management Assessment Model (EFQM); these are established evaluative tools to use in measuring an organisation's exact position to quality; but Joss et al did none of these. Instead, their evaluatory criteria were based on an INPUT → PROCESS → OUTPUT measure which does not necessarily mean high quality. In some healthcare organisations to constantly achieve high quality output may be considered successful TQM, whilst, in other organisations, having highly optimised processes may be construed to produce a state of high quality. Thus, using INPUT - PROCESS - OUTPUT as a measuring criteria is fundamentally flawed. The INPUT - PROCESS - OUTPUT measure is better used in TQM training sessions as a means of explaining the 'holism' of TQM rather than as an evaluative tool. Furthermore, one of the conclusions of the study was that only two TQM sites had made significant progress in TQM. However, the study failed to show 'how' this conclusion was reached and what was meant by the term 'significant'. Hence, the claims, made in the Report cannot be substantiated.

The Report also stated that the reason why TQM has failed in the NHS is because of the adoption of commercial based TQM models. In fact, no attempt was made by the researchers to establish whether there were other fundamental reasons for failure. Their reason for the failure of TQM smacks of the obvious. What could have been expected from the study, given that it was sponsored by the Department of Health, was a more thorough insight into the reasons for failure and a more convincing argument to justify the use of orthodox models of TQM in the NHS. The researchers should have given examples of which hospitals in the NHS have actually adopted an orthodox model of TQM. The use of a case study would have illuminated this; instead what the study provided was an anecdotal account of TQM in the NHS.

The Brunel Study also gave insights into the existence of three differing types of quality assurance initiatives in the NHS. In contrast, on closer examination of TQM initiatives, what is prevalent in the NHS is professional quality rather than technical, generic, or systemic quality. There seems to be a tendency amongst the staff of the NHS to regard standard setting and monitoring as quality. The NHS has, in essence, adopted an essentially medically-driven, or medically determined, approach to TQM.

In the final analysis, the Brunel Report suggested a quality assurance mixed model for the implementation of TQM in the NHS. The author considers the mixed model to be the fundamental failure of the study. Quality assurance represents a retrogressive approach to TQM. It emphasises professional quality rather than systemic quality. It stands in direct contrast to the ethos of TQM because it encourages a blind adherence to professionally set standards without recourse to the needs and expectations of customers. Furthermore, the mixed model fails to address the issues of improving work processes in the NHS which Ovretveit⁴² has identified as the most ignored element of the TQM process in the NHS. In addition, the Brunel Report failed to justify 'why' it advocated a quality assurance mixed model rather than a holistic TQM approach. This raises the question as to whether the study would have been better justified as an evaluation of quality assurance initiatives in the NHS rather than an investigation of the introduction of TQM; which was their immediate remit. Thus, the lack of a systematic and rigorous assessment of TQM in the NHS, as depicted by this critique of Joss et al's study, informed the decision to reappraise the TQM process

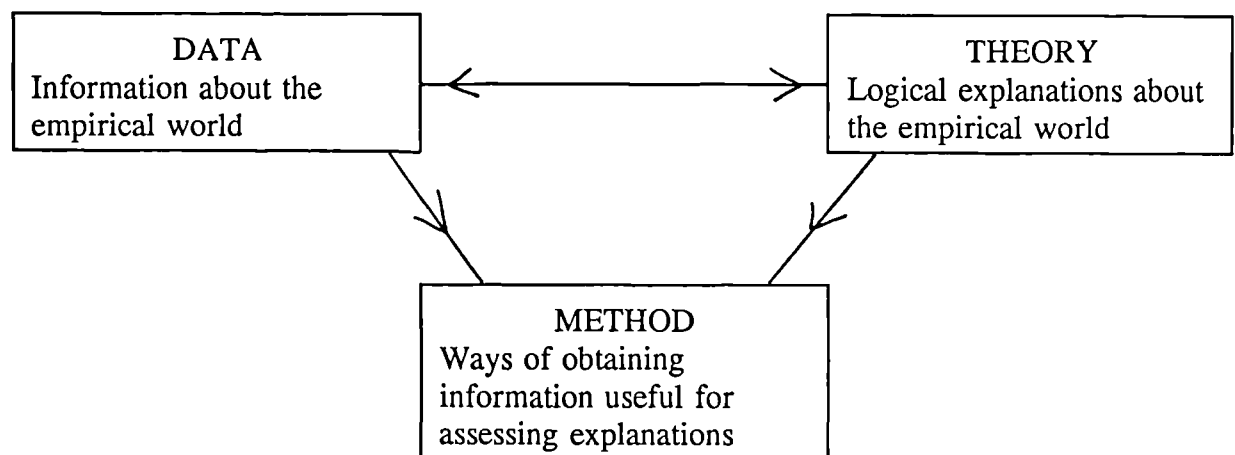
in the 23 TQM sites, in order to present a systematic accurate account of TQM initiatives in the NHS.

BACKGROUND TO RESEARCH METHODOLOGY:

The author would argue that, research is generally structured along three lines: courses in subject matter, in theory, and in research methods. Some researchers foster the unfortunate idea that subject matter, theory, and methods are either independent of one another or that they can be integrated only at the highest level of abstraction. However, theory, method and substance are inseparable. Miles⁴³ observed that each social scientist must be a theorist and a methodologist. Therefore, it can be argued that the pursuit of research information necessitates an integrated approach encompassing quantitative and qualitative data; as evidenced by this research.

Whilst it is true that theory and method can themselves be objects of study, it is also true that 'research' cannot proceed profitably unless it is encompassed with a fundamental theoretical and methodological framework. Furthermore, the relationships between data, theory and method are important as a continual process of interaction in research methodology:

FIGURE 2
RELATIONSHIPS OF THEORY, METHOD AND SUBSTANCE



Source: Eckhardt and Ermann; Social Research Methods Perspective, Theory and Analysis (1977)

Nevertheless, there are various forms of research depending on the expertise of the researcher. For example, sociological research, which like all scientific enquiry is fundamentally promoted by simple human curiosity; i.e. investigations of why people commit suicide⁴⁴. Some research aims only to describe, in detail, a situation or set of circumstances. It aims to answer questions like 'how many?' and 'who?' and 'what is happening?'⁴⁵. Whilst other research seeks to explain a social phenomenon; it asks "why?" and tries to find the answer to a problem. This may be a social problem or a sociological problem⁴⁶. However, the purpose of this study is to examine how the NHS have approached the implementation of TQM over a six year (1989-1995) period.

The approach which affords the researcher the opportunity of presenting a rich account of the exact situation regarding implementation of TQM in the NHS is the case study approach. The case study affords the researcher enormous flexibility in that the design process can be altered, changed or developed as the researcher becomes more acquainted with the phenomenon being investigated⁴⁷; whereas the experiment and survey techniques require that the design format be established at the beginning and then put into practice⁴⁸; with any deviation from the initial design being considered a disaster of such magnitude as to necessitate starting all over again⁴⁹. The study of TQM implementation in the NHS requires advancing with an open mind to explore findings, and allowing theory to be grounded in data. This is because the NHS is a complex organisation with more complexities than might be discerned by an outsider. For example, anecdotal evidence suggests that the NHS is not uniquely different from any other organisation and, thus, that any model that has worked in the commercial sector is bound to work in the NHS. However, on closer examination, the NHS is indeed uniquely different on three major counts:

- (1) its close linkage to politics
- (2) its complex organisational structure (Directorates)
- (3) the fact that its objective is continually shifting - the NHS environment is under siege from concurrent governmental changes.

Carrying out a research investigation into the NHS with a strictly determined research design format, particularly an investigation on the implementation of TQM, would be inappropriate because what the researcher would find would be an aberration to the pre-structured design, thus jeopardising the reliability of the data. At the time this study was embarked upon there were only two previous studies^{50,51} which had attempted to evaluate TQM initiatives in the NHS. The first study⁵² did not specifically address TQM in the NHS but focused upon what its authors called quality initiatives in hospitals in the whole of England and Wales. The research methodology was based on questionnaire surveys; the validity and reliability of which are open to question⁵³. From the author's experience, NHS employees are wary of completing questionnaires that would portray them as being too negative of their organisation. In fact, staff are required to clear with their superiors before the completion of questionnaires that ask intimate questions about the organisation. On the basis of this finding, research into the NHS which is strictly based on a questionnaire survey could be open to enforced managerial bias.

Furthermore, the postal questionnaire survey as the only research tool has the disadvantage of not being exhaustive. The researcher is always struggling to limit the number of questions to be asked⁵⁴. The second study, the Brunel Report was not based on any of the familiar research strategies as identified by Yin; experiment, survey, archival, analysis, history or case study⁵⁵. The Report merely recorded findings based on the semi-structured interviews held with NHS staff in eight district hospitals. It failed to provide a format from which an informed judgement of TQM initiatives in the NHS could be derived. Against this background, the author was influenced to adopt the case study method which would give an accurate profile of the process of TQM in the NHS. As Robson⁵⁶ noted, 'the case study allows the researcher to study real world situations as they unfold, non-manipulative, openness to whatever emerges, and lack of predetermined constraints on outcomes'. This allows the reader to form his own judgements⁵⁷.

DATA COLLECTION

(A) INTERVIEWS

A commonly made distinction between types of interview is based on the degree to which the interview is structured⁵⁸. This highlights a dimension of difference, where at one extreme resides the fully structured interview, with predetermined set questions asked and the responses recorded on a standardised schedule, through to semi-structured interview, where the interviewer has worked out a set of questions in advance, but is free to modify their order based upon his perception of what seems most appropriate in the context of the conversation⁵⁹. Powney and Watts prefer a different typology, making the basic distinction between respondent interviews and informant interviews⁶⁰. In respondent interviews, the interviewer remains in control throughout the whole process, whilst in informant interviews, the prime concern is for the interviewee's perceptions within a particular situation or context⁶¹. Against this background, the semi-structured face-to-face interview format was chosen to be held with three quality managers in the chosen three TQM sites. The face-to-face interview offers the possibility of modifying a line of enquiry, of following up interesting responses and of investigating underlying motives in a way that postal and other self-administered questionnaires preclude⁶². The 'interview' was the main data collection strategy used in this study. In addition, before the first set of interviews was started, a set of 24 questions were worked out (See Table 1) but, the author felt obliged to modify their order based upon the perception of what seemed most appropriate in the context of the conversation. The first set of interviews started on 26th April, 1993 at one of the sites. Each interview with each of the three Quality Managers lasted approximately two hours. During the interviews, the aim was to secure a broad range of the Quality Manager's views on the 24 pre-determined questions and the last half an hour of the first interviews concentrated on the implementation of TQM within the hospitals. The three hospitals were each visited six times every four months over a two year period (1993 to 1995). A total of 36 hours of in-depth face-to-face interviews was held with the Quality Managers. It must be noted that the semi-structured schedule allowed for supplementary questions to be asked where it was deemed necessary. It allowed the Quality Managers to talk at length in their own terms, not inhibited by any structured format. The aim was to facilitate the open and forthright

expressions of 'how' the TQM programme was first introduced and implemented, their perception of the 'difficulties' they were experiencing and 'what', in their experience, were the key success factors of TQM in the NHS.

The 'open-ended' approach enabled the Quality Managers to talk frankly about what they considered to be the barriers to the implementation of TQM within their respective organisational settings. Sometimes their frankness surprised the author. They all gave detailed accounts of their TQM programme. One factor not recognised in the methodological literature and which helped the author in facilitating the collation of the real facts as seen by the Quality Managers was the author's practical background derived from his consultancy experience in the implementation of TQM. Hence, the author spoke relatively the same language as the Quality Managers. The author also distanced himself from academia by telling the Quality Managers during the first contact that the research would be practically based devoid of all academic jargons. This helped relax the respondents as they saw the author as one of themselves. Thus, they were able to "open up", giving, at times, detailed and confidential information concerning the TQM programme. For example, the Quality Managers allowed the author to tape the two hour long interviews; a practice almost unheard of in the NHS. In addition, because of the close link forged with these managers, the author was at liberty to telephone them during the writing-up phase of the research to confirm or reconfirm statements. This rare closeness to the interviewees helped rule out the question of ambiguous responses which is often the criticism of interviews.

Throughout the two hour sessions, notes were also taken which were immediately written-up along with the transcribed tapes and stored away in files which bore the names of the respective hospitals. The two hour interview sessions repudiated the widely held view in the literature that interviews should last no more than one hour⁶³. The two hour sessions were very informative and sometimes stretched beyond two hours. Given the opportunity afforded by the assurance that their statements would be held in utmost confidentiality, NHS staff were willing to talk endlessly about quality and other issues; particularly the organisational complexities of the NHS.

Each hospital was visited on a quarterly basis over the period of the study; the aim being to monitor any major changes which had, or were, taking place. For example,

on one of the sites, the author, on phoning in to arrange for the third quarterly interview with the Quality Manager, found he had been made redundant and replaced by a junior member of staff who had the enormous responsibility of coordinating the TQM programme in a hospital with 4,000 employees. Nonetheless, the interview was held with the new Quality Manager. The major advantage of the use of the interview as the primary data collection vehicle was that it afforded the author the opportunity to note all the underlying organisational changes in the NHS which other tools of data collection would have failed to gather. The environment in which the NHS operates is prone to continual changes because of its link to politics; only the 'interview' method could provide the format to gain an accurate account of the real perceptions of the agents of change - the Quality Managers.

TABLE 1**THE RESEARCH QUESTIONS**

1.	How did it all start? Whose idea was it?
2.	Why Total Quality? Was TQM chosen because the organisation suffered any particular crisis?
3.	What initial steps or methods were taken for the introduction?
4.	How is TQM defined within the organisation?
5.	Describe the organisation's implementation process.
6.	What problems were encountered at: (a) the start (b) during implementation.
7.	How has the organisation tackled the problems?
8.	What does TQM mean to top management
9.	Have you fashioned your TQM Programme after any of the Gurus' philosophy? If yes, why? and if not, why not?
10.	In what ways would you ensure the Programme does not fizzle out?
11.	What problems do you anticipate in the future?
12.	Is the TQM Programme a Department of Health initiative or that of the hospital?
13.	In what ways have you tried to win the cooperation and involvement of consultants and the other professional staff?
14.	What misgivings do you have about TQM? Does management totally believe in it?
15.	What systems have you got in place to support the tenets of TQM?
16.	Do you have any reward and recognition system in place? How do you intend to maintain a sustained staff commitment to TQ?
17.	Do you consider standard setting as the core of the TQ Programme in healthcare?
18.	What is the total budget for the Programme?
19.	What training do staff get? How regular it is? Are there any external consultants involved?
20.	Is TQM a good idea for healthcare; why from your organisation's perspective?
21.	What are the organisation's key TQM objectives? To what extent are the objectives being met?
22.	To what extent have services improved since TQM? Could you state the benefits so far?
23.	In what ways do you measure quality improvement? What techniques are used for collecting data on customer satisfaction? How do you identify customer needs/requirements?
24.	What constitutes quality service in your organisation?

(B) POSTAL QUESTIONNAIRES

The postal questionnaire was used in order to facilitate a wider coverage of the 23 TQM sites. Since three of the sites were chosen for visits, because of their geographical spread and ease of access, the other twenty had to be covered by means of a questionnaire. In total, the study used five different but interrelated postal questionnaires to aid the internal validity of the research.

- (1) The first questionnaire dealt with the preparation of the TQM programme. Respondents (Quality Managers) in twenty hospitals were asked to provide information regarding their TQM programme in four sections. The first section asked about the initial preparation for TQM. The second section asked the question of what followed on from the initial preparation. The third section asked for information about the process of implementation whilst the fourth asked for comments about the programme. This questionnaire aided the coverage of the TQM sites that the author was unable to visit for interviews due to their refusal of access and disinclination to serve as industrial collaborators to the research.
- (2) The second questionnaire was based on the Crosby Quality Maturity Grid (QMMG)⁶⁴ in order to determine systematically where the 23 TQM sites were in relationship to quality. As Schmele and Foss noted, 'the QMMG represents an evaluative tool to determine where an organisation lies in relation to quality'⁶⁵. In line with this argument, it is anticipated that the QMMG would aid the provision of where exactly the NHS is in relation to quality. This would enable answers to be provided as to whether TQM had failed in the NHS. The Grid would also formally enable the Quality Managers to be aware of where their organisation stood in relation to TQM. Furthermore, it would serve to inform the reader how far the NHS had progressed along the TQM route.
- (3) The third questionnaire was based on 40 generic factors identified by the author after an extensive review of the literature (Appendix 3) on the 'barriers' to the implementation of TQM. The aim of the questionnaire was to:

1. determine whether the generic factors are applicable within the context of the NHS
2. provide the practising Quality managers with a tabulation of the factors that inhibit TQM in the NHS.

It is important that Quality Managers are aware of the potential difficulties of TQM prior to and during implementation, so that they can learn how to avoid them. As Hammer and Champy⁶⁶ note in the implementation of re-engineering, 'the first logical step in re-engineering is for managers to know what the mistakes are and avoid them'. Business writers often claim that the pitfalls of TQM are generic, but is that really true? Thus, the analysis of this third questionnaire would provide the answer to that question but, of more importance, is the identification of the 'pitfalls' to the implementation of TQM in the NHS. This would enable managers to build upon, and improve upon, the existing organisational weaknesses. Thus, on a five point scale; Most Significant, Significant, Least Significant, Not Significant and Does Not Apply, the Quality Managers were asked to rate each of the forty factors as it applies to the context of their organisation.

- (4) The fourth questionnaire was based on the Parasuraman et al⁶⁷ Gap Analysis Model. This was used in order to further elucidate the difficulties of TQM. As Parasuraman et al noted, 'the existence of the gaps in any organisation implies the provision of poor quality service to the customer'⁶⁸. This questionnaire asked the Quality Managers to rate their organisation against each gap (see Appendix 4). The aim being to determine whether the NHS was providing a quality service.
- (5) The fifth questionnaire was based on Parker and Porter's eight critical success factors for TQM⁶⁹ (Appendix 5). The aim was to establish its applicability to the NHS; although the respondents were asked to add to the eight success factors any other additional factors which, in their experience they considered critical in managing the TQM programme in their respective hospitals.

The fifth questionnaire would provide the Quality Managers, and also the researcher, with the critical success factors of TQM in the NHS. Thus, a tabulation of the critical success factors would be provided at the end of the analysis so that Quality Managers in the NHS would be aware of the factors that should be present in their TQM programme in order to facilitate success. Often managers are not aware of the essential requirements of TQM which would enable its 'holistic' implementation. It is hoped that, through the analysis of the returned data, managers can benchmark the characteristics of their approach against the essential requirements; thus, building upon the potential strengths of those factors. The decision to base the fifth questionnaire on Parker and Porters' Eight Critical Success Factors was informed by one writer's⁷⁰ suggestion that Parker and Porters' Eight Critical Success Factors represented the most elaborate collection of the success factors for TQM. The suggestion goes further to note that the critical factors were compiled after an extensive review of the literature by the authors.

Secondly, a recent PhD⁷¹ on the critical success factors of TQM in the manufacturing industry was based on the adaptation of Parker and Porters' model.

Thirdly, a comparison of Parker and Porters' Eight Critical Success factors to the eight success factors identified by Saraph et al⁷², showed little, if any, difference between them. Against this background the Parker and Porter model was chosen as the evaluatory tool by which to measure and determine success factors specific to the NHS.

Questionnaires 1, 2, 3 and 4 were clipped together as one and sent out to 20 TQM sites. In total, 12 out of the 20 questionnaires sent out were returned. The 20 questionnaires were first sent out in June 1994 and respondents were given 8 weeks to complete and return them. Remarkably, the 12 questionnaires were returned within four weeks. A follow-up of the same questionnaires was sent to the eight hospitals which had failed to return their questionnaires in October 1994, but they still declined to cooperate. Thus, the analysis of questionnaires 1-4 is based on:

- (a) 12 returned postal questionnaires
- (b) 3 self-administered

In total 15 out of the 23 TQM sites participated, representing a response rate of approximately 65 per cent.

The extensive use of questionnaires in combination with the in-depth interviews was mainly utilized for two reasons:

- (1) to provide a wider coverage of the 23 TQM sites since it was impossible on the basis of finance and access to visit all 23 hospitals.
- (2) to facilitate the notion that no research technique is without bias, although as Atkinson has noted, 'Methods of research rely on different assumptions... thus we should not assume, therefore that contrasting methods can be combined in a simple additive way'⁷³. However, the author is of the opinion that a triangulation method as used in this study would be useful in validating the information and data provided.

For example, for questionnaires 3, 4 and 5, but, in particular, questionnaires 3 and 5, which contained the 40 generic factors inhibiting TQM and the eight critical success factors respectively, the author supplemented these by asking the three Quality Managers in the face-to-face interview sessions to identify other inhibiting, as well as success factors, within their specific environment that have aided or inhibited TQM but which had not been identified in the questionnaires. This approach served to substantiate the reliability of the responses.

(c) DOCUMENTARY SOURCES

Documentary sources were mainly from the three TQM sites visited by the author. They were in the form of policy documents relating to the overall TQM programme. The Quality Managers allowed the author to take away, for reference purposes, their hospital profile documents. The profile document contains the Aims, Objectives, Mission Statements, Quality Strategy and the organisation's Short and Medium Term Goals/Plan. However, the documents were not detailed on the actual implementation process adopted within each of the hospitals, neither did they contain the difficulties

and the critical success factors of TQM. Thus, overall, the documentary evidence was not very useful in addressing the research questions of 'how' the organisation implemented TQM and 'why' a particular approach was chosen. The semi structured interview, however, provided that data.

QUALITATIVE/QUANTITATIVE ARGUMENT

The author, in line with Bryman⁷⁴, argues that it would be methodologically naive to argue that quantitative research methods are more appropriate to business research than qualitative methods but that the distinctions between the two approaches are merely technical. Thus, there exist both qualitative and quantitative data which have to be dealt with in rather different ways and from a variety of approaches rather than from a quantitative or qualitative perspective⁷⁵.

There is no rule in research that says that only one method must be used in an investigation⁷⁶. Using more than one method in an investigation can have substantial advantages. One important benefit of multiple methods lies in the reduction of inappropriate certainty⁷⁷. Using a single method and finding a clear-cut result may delude investigators into believing that they have found the 'right' answer. Using other, additional methods, may point to differing answers which remove specious certainty⁷⁸.

Research employing both quantitative and qualitative data can be used to address different but complementary questions within a study - 'the complementary purposes model'. This focuses on the use of different methods for alternative tasks. It deals with what happens when initial exploratory work is done by means of unstructured interviews, and subsequent, descriptive and explanatory work employs a sample survey⁷⁹. For example, to explore the process of TQM in three of the 23 TQM sites, the semi structured interviews were used. Whilst the postal questionnaires were employed in the explanatory aspect of the study which involved:

- the TQM programme in the other 20 TQM sites
- the identification of the 'pitfalls' of TQM

- measurement of where the NHS is, in relation to TQM
- identification of key success factors

The intention was to use the quantitative and the qualitative methods in a complementary fashion to enhance the 'interpretability' of the data collected. As Robson notes, 'researchers need not be prisoners of a particular model or technique when carrying out an enquiry'⁸⁰.

OVERVIEW OF FIELD WORK

The data collection period started in April 1993. The intention was to visit each of the sites periodically over two years. Since the NHS operates in an environment where the goal posts are constantly shifting it was important not to be away from the scene for too long. At the beginning, the author thought that returning to a hospital every four months was too short a time for any remarkable changes to take place, however, the visit each quarter saw more remarkable, and at times ridiculous, changes; particularly in the mobility and redundancy of staff. On some occasions, due to concurrent government interventions, the TQM programme was stalled whilst Quality Managers turned their attention to ensuring that the hospital met with both Patient Charter and Purchaser specifications. At other times, the Quality Managers were measuring this or that service element to meet with the King's Fund organisational audit. In short, each visit was filled with different quality perspectives that made the fieldwork an intriguing experience.

The interview schedule with the three Quality Managers of the three TQM sites are summarised in Table 2:

TABLE 2

INTERVIEW SCHEDULE AT 3 NHS HOSPITALS
APRIL 1993 - FEBRUARY 1995

HOSPITALS	DATES OF VISITS	DATA COLLECTION TECHNIQUE	TIME HRS.	RESPONDENT
Southforke Case Study 1	26 April 1993	Semi structured	2	Quality Coordinator
	26 August 1993	Semi structured	2	
	5 January 1994	Semi structured	2	
	23 May 1994	Semi structured	2	
	26 September 1994	Semi structured interview	2	
	2 February 1995	Semi-structured interview	2	New Quality Coordinator
Desmond Hospital Case Study 2	29 April 1993	Semi-structured interview	2	Asst. Quality Director made redundant then:
	12 August 1993		2	
	6 December 1993		2	
	7 January 1994 (due to change of personnel to establish why)	Semi-structured interview	2	Senior Quality Officer
	18 July 1994 (went on Maternity leave)	Semi-structured interview	2	Senior Quality Officer
Brookeside Hospital Case Study 3	6 February 1995	Semi-structured interview	2	Senior Quality Officer
	10 January 1993	Semi-structured interview	2	Quality Development Manager
	13 September 1993		2	
	28 January 1994		2	
	17 May 1994		2	
	18 October 1994		2	
	3 February 1995		2	

June 1994	Postal questionnaire: 1, 2, 3, 4 sent out to 20 TQM sites
17 January 1995	Postal questionnaire 5, sent out to 19 TQM sites

Source: Compiled by the author

During the fieldwork, telephone interviews were periodically held with the Quality Managers to double check comments that seemed confusing to the author. The Quality Managers gave very detailed accounts, and offered lengthy insights into the problems

of TQM within the healthcare setting; particularly the difficulties of getting both top management and the professional staff on board the TQM programme. Of interest was their scepticism of academic postulations and of traditional models for the implementation of TQM. They argued that academics theorise about issues in the NHS but lack the practical tools to bring change about. The biggest indictment to come out of the fieldwork was the failure of the traditional TQM paradigm to have any meaningful influence on the approaches adopted by the managers.

SAMPLING

Since the central thrust of the research was to focus on the implementation of TQM in the NHS, it would only be possible to investigate this phenomena in hospitals that have an up-and-running TQM programme. At the conceptual stage of the study, there were 23 recognised TQM sites of the 292 Trust hospitals, and 175 self managing units⁸¹. The 23 sites, as earlier stated, were established in 1989 by the Department of Health to serve as demonstration sites for the implementation of TQM after the Griffiths Enquiry severely criticised the NHS for poor provision of quality care⁸². Armed with the list of the 23 sites, the author spent a week collecting the telephone numbers of each of the hospitals. Having collected the numbers, the hospitals were telephoned to collect the names of the person(s) in charge of quality. The author also double checked with the receptionist, or whoever the telephone call was transferred to, that the hospital had a TQM programme. On getting the names and appropriate titles, the author wrote in late February 1993 to 23 TQM managers asking for their collaboration with the research. Of the 23 letters sent out only three replied expressing their willingness to serve as collaborators to the study. A follow-up letter to the none replying organisations yielded no further response. Thus, the decision was made to use the three responding hospitals as the cases for the research. However, the identity of the three hospitals would be anonymous because of the promise of confidentiality made at the very beginning of the study. The author did not have the luxury of choosing which hospital to investigate and had to "make-do" with the hospitals which were willing to collaborate. Nevertheless, the three hospitals were noted by the NHS Management Executive and the Department of Health to be centres of excellence for TQM⁸³. The hospitals were further noted by the NHSME to be furtherest down the TQM route than the remaining 20⁸⁴.

Furthermore, the three samples met the objectives suggested by Schatzman and Strauss⁸⁵:

- (a) suitability: the three hospitals had been operating an on-going TQM programme since 1989; as part of the TQM demonstration project.
- (b) feasibility: the hospitals were accessible, allowing for regular visits. In addition, the respective quality managers were receptive to the author throughout the entire period of fieldwork.
- (c) tactics: the Quality Managers are evangelists of the quality movement. They strongly believe that TQM is the way forward for the NHS; thus enabling a common ground for discussion. This aided the frank and in-depth answers they gave to questions posed by the author.

Prior to the acceptance of collaboration by these hospitals, the author had already determined;

Who	:	which person would be interviewed?
Where	:	setting for data collection
When	:	at what times?
What	:	which events, processes were to be explored?

The "who" in most organisations, be they in the private or service organisation, is the one person appointed to oversee, introduce and implement TQM organisation wide. It becomes the responsibility of this person to identify the what, how and why of TQM within the organisation's context. Thus, a study into TQM in such an organisation demands that the person spoken to is in the position to offer the researcher a full insight into the organisation's TQM activities and is also the person designated as having responsibility for implementing TQM. In the NHS such a person is either designated a Quality Manager or Assistant Director of Quality or the Director of Nursing and Quality. This person undertakes to move a hospital through the various stages of the TQM process to the state of continuous quality improvement.

In the author's opinion, for TQM to succeed entails four essential characteristics:

- (1) the mode or approach to implementation must be 'holistic'.
- (2) the manager or the organisation needs to be aware of the 'pitfalls' or the common mistakes of TQM and learn to avoid them, and improve upon them.
- (3) the organisation should build on its key success factors critical to its survival.
- (4) there must be constant measurement of the progress made.

Thus, in investigating the progress of TQM in the NHS, it was imperative to carry out an in-depth analysis of these four key components of any TQM initiative. This was the main failure of the Joss et al study. It failed to critically evaluate the TQM initiatives from these key interrelated sequential parts of TQM.

HOSPITALS

The three hospitals which represent the Case Studies will be called Southforke (Case 1), Desmond Hospital (Case 2) and Brookside Hospital (Case 3) respectively to preserve their anonymity. However, the background to the hospitals is provided in Chapter Six.

DATA ANALYSIS

Qualitative data has been described as an 'attractive nuisance'⁸⁶. Its collection is often straightforward. It has a quality of 'undeniability' which lends verisimilitude to reports⁸⁷. There is no clear and accepted set of conventions for the analysis of qualitative data. The central requirement in qualitative analysis is clear thinking on the part of the analyst. As Fetherman notes, 'in the context of an ethnographic stance, the analysis is as much a test of the enquirer as it is a test of the data'⁸⁸. First and foremost analysis is a test of the ... ability to think, - to process information in a

meaningful and useful manner⁸⁹. Bromley⁹⁰ in his argument for the quasi-judicial approach for analysis of case studies, suggests that throughout the process, four important questions should be kept in mind:

- (1) what is at issue?
- (2) what other relevant evidence might there be?
- (3) how else might one make sense of the data? and
- (4) how was the data obtained?

The quasi-judicial approach is concerned with evidence and argument. Miles and Huberman⁹¹, Lofland and Lofland⁹², Tesch⁹³, and Robson⁹⁴, suggest basic rules for dealing with qualitative data:

TABLE 3

BASIC RULES FOR DEALING WITH QUALITATIVE DATA

1. Analysis of some form should start as soon as data is collected. Don't allow data to accumulate without preliminary analysis.
2. Make sure you keep tabs on what you have collected (literally - get it indexed).
3. Generate themes, categories, codes, etc. as you go along. Start by including rather than excluding; you can combine and modify as you go on.
4. Dealing with the data should not be a routine or mechanical task; think, reflect! Use analytical notes (memos) to help to get from the data to a conceptual level.
5. Use some form of filing system to sort your data. Be prepared to re-sort. Play with the data.
6. There is no one 'right' way of analysing this kind of data - which places even more emphasis on your being systematic, organised and persevering.
7. You are seeking to take apart your data in various ways and then trying to put them together again to form some consolidated picture. Your main tool is comparison.

However, in this study, due to the sample size of 23, the author is of the opinion that descriptive statistics were most appropriate for the analysis of the data. As Goulding⁹⁵ noted, 'the methods most... useful in analysing information gained from investigations

of a limited sample are those of descriptive statistics; whether the information arises from questionnaires which respondents themselves complete, or whether it arises from a structured interview or both, makes no difference to the way the data can be handled'. Descriptive statistical methods provide 'pictures' of the group under investigation; these 'pictures' maybe in the form of Charts, Tables, Percentages, or Averages⁹⁶. In line with Goulding's argument, the analysis of the data gathered from the questionnaires would adhere to the use of descriptive statistics in which tables would be used for questionnaires 1-5 to show percentages and the patterns of responses. However, from each table, the prime aim would be to draw implications from the data. Whilst the analysis of the semi-structured interviews held with the three Quality Managers, that is the case studies, would be analysed in the context of Yin's 'explanation building' theory⁹⁷ because it fits this research best. In a multiple case study, as is the case with this study, the aim of explanation building is to develop a general explanation that fits each of the individual cases, even though the cases vary in their detail⁹⁸. The cases consist of an accurate account and rendition of the facts and conclusions are drawn based on the simple 'explanation' that appears most congruent with the facts⁹⁹. The research process used in this study is akin to detective work where the detective's purpose is to establish an explanation of the crime. He is shown the scene of the crime, its description, eye-witness report and must judge the relevance of the data in devising his explanation. The requisite explanation becomes a credible depiction of a motive, and method which fully accounts for the facts than do alternative explanations¹⁰⁰. Thus, in moving from one case to other cases, from within case to cross case, the detective may be able to use the first explanation to establish that both crimes were committed by the same person¹⁰¹. In this study, an accurate rendition of the cases will be undertaken, a critical appraisal of the individual cases to judge the relevance of the 'mode of implementation' to the holistic nature of TQM will be offered, followed by the major goal of the research; a cross-case analysis to depict elements of 'commonality' between the cases. This will be compared to the brief summary of twelve other individual cases (see Chapter Four) established through the wider survey. The aim being to find a common 'explanation' on the 'mode' of TQM implementation in the NHS.

This will ensure the presentation of an in-depth and systematic study of TQM in the NHS. Furthermore, the complementarity of both methods, qualitative and quantitative,

will provide results from which deductions can then be made. This will ensure that the theoretical postulation to be offered in this study is 'grounded' in data.

HOW THE QUESTIONNAIRES WOULD BE ANALYSED

QUESTIONNAIRE 1:

A tabulation representing a brief summary of the implementation process of the 12 hospitals that replied to the survey. As Yin¹⁰² suggests... 'there is no need for any simple case report but a brief summary of individual cases'. The aim of the tabulation is to support the 'explanation' that the NHS has adopted individualised approaches to TQM rather than the orthodox TQM models.

QUESTIONNAIRE 2:

The Crosby Quality Maturity Grid¹⁰³ will be analysed using Crosby's suggested scoring format. Each stage of the grid has a score corresponding to the stage number. Example: Stage 1, Score = 1; Stage 3, Score = 3. Each stage has five categories, hence a maximum score of 30 is achievable.

QUESTIONNAIRE 3:

Stoner and Freeman¹⁰⁴ identified four interrelated activities expected of any managerial process; **planning, organising, controlling and leading**. Similarly, in extending Stoner and Freemans' work, the author has identified four key elements of any managerial process, essential for the successful implementation of TQM. These include:

- (1) **management systems and processes**
- (2) **workforce**
- (3) **senior management**
- (4) **management practices and work methods**

The 40 generic factors were broadly categorised to fit each of the four elements. Thus, questionnaire 3 will be analysed from the four complementary perspectives which are essential and which must work in unison for TQM to work. Furthermore, a table with percentages will be provided to show the pattern of responses. The percentages represent highest scoring statements of which 40 per cent is seen as least score. Scores between 40-100 are taken as significant. The computation of the percentages will be done using the Statistical Package for Social Science (SPSS). Thus, Table 18 in Chapter Five will show hospitals by obstacles, observation rate and row percentages. This is in contrast with the widely held view that qualitative research is incapable of statistical analysis.

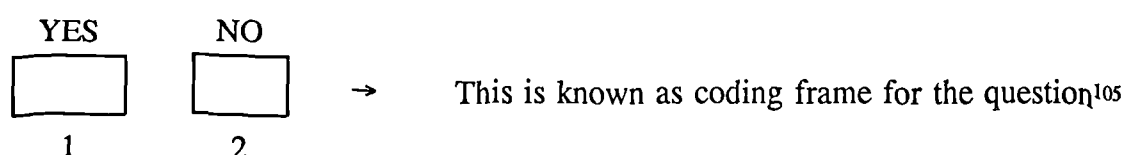
QUESTIONNAIRE 4:

The analysis of questionnaire four would be based on the presentation of a table which shows the pattern of responses for each of the seven gaps in percentages for the individual hospitals.

QUESTIONNAIRE 5:

Because questionnaire 5 asked the respondents to answer Yes or No to each of Parker and Porters' eight critical success factors, for the purpose of coding, before the questionnaires were sent out, two numbers were attached to each question. For example, question number one in the questionnaire reads:

'Necessary Management Behaviour: Clear leadership, commitment and vision is required for senior management'. Is this significant in the NHS in your experience?



The numbering is known as nominal scales¹⁰⁶. For instance, the analysis of the nominal data collected in the 23 TQM sites would be the totalling of the 'yes' responses (coded 1) and the 'no' responses (coded 2). For example, if out of the 20 returned data, eleven have responded yes, the percentages would be represented in a table of the total number, i.e.

For the yes responses, it would read:

$$\frac{11}{20} \times 100 = 55\%$$

Thus, the table for each of the questionnaires 2-5 will show percentage scores. Nevertheless, the aim is to draw implications from the data in order to build theory.

Qualitative and quantitative research, as earlier noted, differ in that qualitative research is often developed when little information is available on a topic¹⁰⁷. The researcher plans to look for and describe attributes, themes, and underlying dimensions of a particular unit in order to discover what distinguishes the characteristics or attributes of the unit. The quantitative research aims to measure the magnitude, size, or extent of the units¹⁰⁸. Although polar types of qualitative and quantitative research may be developed, this research contains features of both.

Features of qualitative research include the case study method which is usually inductive and deductive. The methods for data collection, included in-depth face-to-face semi structured interviews. This enabled the collation of the opinions of experts; that is the Quality Managers. Features of quantitative research include the use of postal questionnaires which were mainly deductive i.e. to identify modes of TQM, difficulties, measurement and critical success factors of TQM in the NHS.

Lastly, the author will argue that in considering the choice of techniques for research, irrespective of whether the methodology chosen is quantitative or qualitative, three features are important:

- (1) how well does the technique illuminate the views or experiences of the respondents?
- (2) representativeness; to which other groups in the population or the organisation does the information elicited relate?
- (3) resources; what expertise, people, time, cash, would be required by the technique?

RELIABILITY AND VALIDITY

To ensure that the data collected is reliable and valid, on writing up the three cases, the author sent it to the respective Quality Managers for their review and input, in order to ensure that the rendition of the cases are accurate from the information they gave during interviews.

EXTERNAL VALIDITY

The findings in the study were compared to earlier studies in the field which had previously evaluated TQM initiatives in the NHS. This was done in order to establish:

- (a) consistency of results
- (b) provision of new evidence

In the final analysis, it would suffice to note that the theories and TQM models generated in this study, in the words of Glaser and Strauss, 'is grounded in empirical data'¹⁰⁹.

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CHAPTER TWO

CREATING THE NATIONAL HEALTH SERVICE

"All developed countries have some system for ensuring that their citizens have access to health care. The U.K. has a health care system in which the state both finances health care for citizens and manages its provision".¹

That the U.K. has such a system of health care is not the result of chance nor can it be said to be the outcome of comprehensive, rational planning. On the contrary, the health care system which has emerged within the U.K. has been the result of an incremental process emanating from the political decision making process.

Over the last one hundred and fifty years the battle against ill-health has been waged on four main fronts and in three overlapping phases. Initially, during the second half of the nineteenth century, emphasis was upon preventive measures and was more specifically focused on environmental improvements, e.g. housing and sanitation. Toward the end of the century a new trend can be discerned in favour of a more personal approach to health with particular attention being addressed to the protection and improvement in the health of children. The early years of the twentieth century saw improvements in medical science which led to an increasing curative approach to the plight of the sick through the ever-growing use of drugs and the application of technological advances, e.g. X-rays. The final phase can be said to date from the introduction of the National Insurance Act (1911)² which provided increased access to health services. For many writers it was this piece of legislation more than any other which paved the way for the enactment of the National Health Services Act, 1946.³

The first four decades of the twentieth century were ones of progress but progress of a limited kind. Despite the virtual eradication of the diseases such as cholera and typhus, access to health still depended upon the availability of the services and the ability of the individual to meet the fees charged. As Anthony Forder has noted:

"In the inter-war years the personal health services were the subject of scrutiny and planning...."⁴

Scrutiny was evidenced from the 1920s onwards in the form of numerous reports and studies which took as their subject the inadequacies of the medical care available to the public and the requirement that such care should be placed on a more orderly basis. Planning may be viewed as a response to the growing threat of war which became more apparent after 1933⁵ and the realisation of the need to make provision for the many civilian and military casualties it was feared twentieth century war, especially aerial warfare, would produce.

Collectively these investigations revealed that there existed serious deficiencies and anomalies in Britain's health service provision. Such shortcomings are worthy of comment because of the influence that they were later to exert upon the foundation of the National Health Service after 1945. In particular, it was revealed that: more than half of the population was not covered by National Health Insurance; local variations existed in the provision of additional benefits; the distribution of medical specialists and general practitioners was uneven throughout the country; variations existed in the adequacy and efficiency of local authority health provision and hospital services were also unevenly distributed⁶. All of these findings strengthened the case of those demanding the creation of a national health service.

Both the scrutiny and planning investigations generated a consensus among informed opinion as to the health needs of the nation. This consensus developed around the belief that medical care should be available to all and should not depend upon the ability of an individual to pay for treatment. There also developed a majority view among health professionals that the services then provided by local authorities, general practitioners and hospitals must be integrated with hospital services being organised on a regional basis to ensure efficiency of provision. There was also agreement to recognise both the preventative and curative elements of health provision⁷.

The consensus which emerged by the outbreak of the Second World War among medical experts was limited. Important questions remained unanswered or were the subject of disagreement. Among these were questions of finance, payment of service personnel and the form of service administration. Should the service be financed from contributions made from local authority rates, direct taxation or some form of insurance scheme? Should staff be paid by salary, capitation fees or by items of

service? What contribution should the individual citizen make to the service and for treatment? By what means and by whom should the service be administered? It was these questions which ensured that when a national health service was created by the National Health Service Act, 1946, that it would be born in a climate of heated political controversy. Significantly, these same questions have re-emerged as elements of contention in the debate about the NHS in the years since 1979.

Throughout the years leading up to the Second World War, the idea of a fully fledged state health service was increasingly gaining favour in both medical and political circles. As early as 1920, the Dawson Report had noted the fragmented nature of the existing arrangements and their inadequate distribution and had recommended a more unified approach based on a series of health authorities and health centres distributed to reflect local community needs and available to all⁸. Support for comprehensive health provision came from the Royal Commission on National Insurance which advocated an extension to the current National Insurance coverage as a first step toward the separation of health from insurance and the funding of a health service from national taxation⁹.

By the 1930s a fully fledged health service was being advocated by the Labour Party, the Fabian Society and a group of radical medical practitioners who had formed themselves into the Socialist Medical Association (SMA)¹⁰. It was to be this latter group which conducted an active, national campaign through the media and lobbied MPs to raise the issue in Parliament. In particular, the SMA wanted: medical services to be free of charge; doctors to be employed on a full-time basis by the state; and the introduction of health centres and large district hospitals with administration to be under the control of enlarged local authorities¹¹.

Before any decisive action could be taken on these proposals, the Second World War intervened and it was not until 1942 that the issue of a national health service again became the subject of debate when planning for the post-war years was commenced. The first statement of policy was contained in the Beveridge Report on Social Security and Allied Services. Available to Beveridge was the report of the Medical Planning Committee¹² which had recommended that medical administration should be separated from social security and that medical care of an individual should not depend on

insurance contributions. Both of these recommendations were accepted by Beveridge and his proposals advocated a comprehensive health and rehabilitation service for the prevention and cure of disease and restoration of the capacity to work available to all members of the community.

Following the Beveridge Report, the Minister of Health published a draft plan for a unified health service and two years later a revised plan, in the form of a White Paper, proposed that: free health services would be available to all; administrative areas would be based on joint local authorities; these area health authorities would incorporate voluntary hospitals with local authority hospitals and would also run health services in health centres; and general practitioner services were to remain independent but GPs would work under contract for the state health service and receive payments on a capitation basis.

Extensive discussions took place on the White Paper as advocates and opponents voiced their preferences. It was to be the method of payment to medical personnel, which was again to prove contentious with the British Medical Association (BMA) arguing that GPs were concerned at the prospect of a salaried service and that medical specialists were afraid that a state medical service could threaten their private practice upon which they depended to permit them to give free services in many of the public wards of hospitals. In general the BMA favoured extending National Insurance cover both in terms of persons and benefits although supportive of the coordination of hospitals on a regional basis¹³.

POLICIES TOWARD THE NHS AND THE YEARS OF CONSENSUS POLITICS

The General Election of 1945 which brought into office the first majority Labour Government, under the premiership of Clement Atlee, with Aneurin Bevan as Minister of Health, published the National Health Service Bill in March 1946; a Bill much in accordance with the tenets of equality and social justice to be found in socialist ideology.

After much parliamentary scrutiny, the Bill became the National Health Service Act, 1946. Its main provisions were that: hospitals were taken over and administered by the Government through agencies called Regional Hospital Boards and Hospital Management Committees; consultants and hospital doctors were to be salaried but could still undertake some private work; family practitioner services were provided under contract by individual practitioners working together in local authority health centres; local authorities became responsible for health centres and ambulances as well as retaining responsibilities for public health, immunisation, school health and maternity services; all health services were free of charge; freedom of choice was retained in that doctors could choose or refuse patients, and vice versa, and private practice was permitted so that not all patients or doctors had to use or join the NHS.

Further debate, often acrimonious and always vociferous, took place before a National Health Service, born out of compromise, came into existence in 1948. Certain principles were behind its foundation and certain objectives were set for it.

The principles and objectives which were stated in the National Health Services Act (1946) were the following:-

- (i) The provision of optimum standards of service. The social security legislation of the time had made provision for a basic minimum level of service provision but the newly created health services were "to secure improvement in the physical and mental health of the people and the prevention, diagnosis and treatment of illness". The breadth of approach was also to be seen in that the Service was designed "to meet health needs wherever and whenever they arise".
- (ii) Services were to be comprehensive in scope and universal in population coverage.
- (iii) To ensure this last point, services were to be free of charge.
- (iv) Expenditure was to be financed mainly from general taxation.

- (v) Services, especially hospitals, were to be integrated and more effectively planned and distributed.

and,

- (vi) All of these points were to be underpinned by the notion of freedom. No one was to be compelled to join and whilst patients could change their doctor or dentist, the medical practitioners could also undertake private work.

Following the legislation which marked the advent of the Welfare State in Britain, many writers noted that a broad political consensus had emerged as to the role that the state was to play in the life of society. For some, this consensus emerged in the late 1940s and lasted through to the late 1970s whilst others felt that there was evidence of its decline by the mid-1960s. If there was doubt as to the longevity of the consensus there was also doubt as to its depth and scope. For some, it marked the end of ideology¹⁴ and represented that stage in societal development where there was agreement about the collective ends which society was seeking. For others, the consensus was shallower and concealed the fact that profound differences still existed at both practical and ideological levels as to the means that should be used to attain societal goals. For some, the consensus encompassed not merely the institutional framework within which policy making took place, but also the processes by which policy was formulated, enacted and implemented and the objectives which policy was designed to produce. For others, the consensus was narrower and did not extend beyond the basic tenets necessary for the effective functioning of a democratic polity.

Despite the differing parameters which were used to characterise the consensus, there can be little doubt that those who proclaimed its existence and those who questioned its extent arrived at their respective positions after consideration of a common factor, namely, the size, scope and operation of the public sector which lay at the heart of the debate about the success of governments in managing the mixed economy and in creating a society free of the tensions which are generated by large and visibly manifested disparities in the health, wealth and general well-being of its members.

The fact remains, however, that the idea of a consensus existing in British political, economic and social life is probably a relative one which has perhaps been accentuated with the passage of time and now appears more real than it did during the years when it was felt to be at its height. Its origins can be traced to a characterisation of the relationship between the two major political parties in the post-war years on matters of policy and style of government which, it was held, exhibited marked areas of cross-party accord on many of the fundamental aspects of British political life. It would be an overstatement to maintain that it encompassed the absence of political opposition and inter-party conflict and more realistic to contend that it was denoted by broad agreement on the limits of public policy and the most appropriate role for government to play in economic and social life.

According to Savage and Robins there are three features which are most commonly cited as the framework of public policy underpinning the consensus¹⁵:

- (i) **The Role of the State in Economic Affairs:** during the majority of the post-war years, it is contended that both of the major political parties in the British political system, Conservative and Labour, were of the opinion that central government had a crucial role to play in the management of the economy and that the economy was perceived to be characterised as a "mixed economy"; incorporating elements which included both public and private sector organisations. Over time, this perception entailed the acceptance of a number of different forms of amalgamation of those two types of enterprise. This partnership role entails the public sector not seeking to do that which the private sector already does but lies in the ability of government to supplement the role of the private sector by undertaking those necessary functions which, because of commercial and other considerations, the private sector does not seek to perform.
- (ii) **The Role of the State in Welfare Provision:** the views of the two major political parties coincided on the question of state involvement in social and welfare provision. Both were in favour of such provision being made and agreed that government should play an active role in that provision. They were not in accord over the extent of the provision that the government should itself

make although they did agree that such provision should be in excess of a "safety net" for the most unfortunate members of society. The most noticeable result of this consensus resulted in the acceptance of the NHS. Yet even here the role of the state was not that of exclusivity for other bodies coexisted with, and offered services not incompatible with but parallel to, state provision e.g. private beds in NHS hospitals. Voluntary organisations also played a part in the totality of provision. It was the degree of contribution made by the state and the private sector respectively which afforded the scope for inter-party contention with Labour traditionally favouring more of the former whilst the Conservatives favoured a larger role for the latter. The debate was never about whether or not it was proper and appropriate for the state to perform and fulfil a welfare function in relation to societal needs for this was accepted by both of the major political parties.

- (iii) **Corporatism:** a third strand in the consensus and characterised the way in which the government approached decision making on policy issues. Post-war governments had come to utilise an approach which led to the development of a consultative climate over a broad spectrum of policy areas. This meant that on any particular policy question the government sought the views and opinions of interest groups which possessed specialist knowledge of the area and, not infrequently, sought the active involvement of those groups in the implementation of policy. The rationale here was the belief that efficiency and effectiveness could best be achieved through policies which enjoyed the widest possible support from those most closely involved in a particularly policy area. This approach demanded that all involved make genuine attempts to reach compromises to which they felt committed. Yet such compromises could often only be achieved at a price, namely, the adoption of policies which fell short of the full attainment of the 3 Es; efficiency, effectiveness and economy. Such a price was one that was considered to be worth paying as it eradicated the worst effects arising from confrontation¹⁶.

The NHS fitted comfortably into these elements of the post-war consensus in that it was a key partner in the provision of health services which the private sector could not, or would not, provide. Also the NHS reflected the commitment of successive

governments of differing political persuasions to the attainment and provision of a comprehensive health care system in accord with the principles which had underpinned its creation. Lastly, health policies were the outcomes of consultation between all of the interested actors in the area of health provision.

THE NHS SINCE 1979: THE CONSERVATIVES AND THE ENDING OF CONSENSUS

Although the NHS fitted comfortably within the political framework of the consensus years it was not without its critics. In particular criticism was advanced of the fact that the achievements of the NHS had been modest and that the rate of improvement in the nation's health had not been greater than that which had been achieved in the 1930s. Factors other than the presence of the NHS were cited as having led to improvements in health; higher standards of living and housing, and scientific advances and changes in working patterns. Claims were made that significant deficiencies existed in the NHS such as the number and distribution of doctors, hospitals and health centres. It was contended that the nation could not meet the ever-escalating costs of the NHS. That as a near monopoly provider of health services the NHS had become impersonal, inflexible and lacking in financial discipline. Furthermore, the structure of the NHS was seen as having resulted in a fragmented and uncoordinated system not dissimilar to that which had existed prior to its creation. Lastly its more vociferous critics charged that the NHS had disabled and demoralised people by causing them to rely on cure rather than prevention and to abuse a free service¹⁷.

These criticisms seem to be inter-related and by the late 1960s it was widely accepted both in governmental and medical circles that they could best be addressed through a restructuring of the NHS for only in that way could there be an end to wasteful duplication of service and administrative structures; a closer coordination between the administrative and medical arms of the service; the effective exploitation of technological developments in medical science and improved patient care through the more economic use of resources.

In 1968 a Green Paper on the structure of the NHS proposed a virtual single tier system of 40-50 area health boards. Another Green Paper in 1970 expanded the

proposed number of boards to 90 and added the idea of advisory regional health councils to provide coordination and suggested the creation of some 200 district committees to monitor the services of area boards. 1971 saw the publication of a Consultative Document by the Conservative government which was quickly followed by a White Paper (1972) and the National Health Service Act (1973) which provided the basis of the structure which came into effect in 1974¹⁸. This Act brought into being a structure which unified the three parts of the Service, hospital services, family practitioner services and local health authority services, but had three operating levels; region, area and district.

The new structure fell some way short of overcoming all of the divisions of the former structure and, in the eyes of its critics, failed to deliver the promised unity and coordination. Three significant charges were levelled against it:

- (i) **Lack of Unity:** this element had several aspects among which were the observations that occupational and environmental health services were excluded from the NHS: family practitioner services were not fully integrated with hospital and community health schemes; District and Area Health Authority boundaries were based on local government boundaries and were not appropriate for medical needs; and that health was separated from housing, education and personal social services.
- (ii) **Administration and Management:** again several elements emerged and charges were levelled that the system was too bureaucratic resulting in slow decision making and ineffective use of resources because of the multi-tiered structure; the form of management was inappropriate and out of date because it reflected a mechanistic, hierarchical "top down" approach rather than an organic, participative "bottom up" approach and power was left in the hands of the medical professionals who formed a "medical technocracy" with its views dominating what are often social rather than medical needs.
- (iii) **Response to the Public:** it was contended that the reorganisation was deliberately aimed to secure effective management with the representative

function going to Community Health Councils which meant that the voice of the public was limited¹⁹.

Such criticisms resulted in the creation of a Royal Commission on the NHS in 1975 to "consider in the interest both of the patients and those who work in the NHS the best use and management of the financial and manpower resources of the NHS". The Royal Commission reported in 1979 and within twelve months was followed by the Black Report, "Inequalities in Health Care"²⁰. Both investigations confirmed disparities between differing medical services, between different geographical regions and between different social classes. They both agreed that despite the fact that the cost of the NHS had risen from £500 million in 1951 to £7,000 million in 1974, social justice and the effective use of resources could only be achieved through more open access to health provision and a reallocation of resources. The government's response was to issue a consultative paper, "Patients First", to rectify the "well founded" criticisms of the existing arrangements which were seen to have produced too many tiers of administration, too many administrators and too much money wasted²¹.

For these defects to be corrected four courses of action were seen to be necessary:-

- (i) better use of existing resources since under the new structure too many man hours were being wasted especially when doctors and nurses were having to attend numerous consensus management committees and too many administrators were being maintained. In addition, poor financial control systems and treatment regardless of cost were seen to be unnecessarily consuming resources.
- (ii) the possibility of more rationally determining priorities between the different arms of the Service had to be considered.
- (iii) cost reduction through prevention via health boards had to be investigated.
- (iv) consideration had to be given to the possibility of expanding the private sector²².

In 1979 these four possible courses of action marked a departure from the ideas and values which had hitherto underpinned the NHS but they fitted well alongside the philosophy being espoused by the incoming Conservative government under the leadership of Mrs. Thatcher which showed a marked ideological preference for what was termed neo-liberalism. In place of the three key elements of the consensus years, the new Conservative government had a belief in:

- (1) **The Superiority of the Market:** successive Conservative governments have been committed to the neo-liberal view that the market is the best mechanism for producing and distributing resources and is preferable to state run or state regulated processes. The market is seen as being more efficient, more responsive to people's needs and ultimately more productive than any state system. This in turn has led to the Government's strategy of "rolling back the frontiers of the state" and has fostered policies of privatisation, liberalisation and deregulation and the encouragement of competitive tendering and contracting out in the NHS and elsewhere in the public sector.
- (2) **Individualism:** is closely linked to a belief in the superiority of the market in that the individual is seen as self-reliant and responsible for his/her own actions. Too much state provision is viewed as reducing individual self-reliance and individual responsibility and credited with the creation of a "dependency culture". The post-war Welfare State was seen to have damaged individual self responsibility and "to roll back the welfare state" was held to be the way to rekindle the individualist ethos through the offer of greater choice. In terms of the NHS this meant the choice to choose between health care provided by either the state or private sector.
- (3) **A Belief in Strong Government:** the notion of firm or resolute government which would sweep away the corporatist ethos of the consensus years and create in its place a framework for the attainment of the 3Es through leaving the running of enterprises, both public and private, to their respective managements who were held to be best placed to determine and meet customer demands. In the NHS this was to mean the ending of consensus management, the strengthening of the right of managers to manage through the introduction of

private sector managerialism and assisted by a reduction in trade union influence²³.

It was these tenets of neo-liberalism which were to serve as the underpinning rationale of the policy of successive Conservative governments to the NHS in the decade ahead.

This new orientation was evidenced in the early days of the first government under Mrs. Thatcher when the government issued a consultative paper, "Patients First" which sought to rectify the "well founded" criticisms of the existing arrangements in the NHS which were seen to have produced too many tiers of administration, too many administrators and too much money wasted²⁴.

The "area" tier of organisation was abolished in 1982 and the proportion of the budget spent on administration was reduced. Annual reviews of the performance of Regional Health Authorities (RHA) by Ministers and the Department of Health and Social Security began in 1982 and have been extended to RHA reviews of District Health Authorities (DHA) and DHA reviews of unit managers. From 1983, performance indicators have informed these reviews which have themselves reinforced the importance of Ministerial and RHA views on policies and priorities and enhanced upward accountability. The NHS Management Inquiry, which reported in 1983, led to the introduction of the concept of "general management" in place of corporate, consensus decision making²⁵. The intention here being that this change would increase effectiveness and ensure that expenditure reached its intended target and that management of the health service was geared primarily to the interests of patients.

Value for money initiatives have featured in the NHS since 1979²⁶. The Annual Report for the Health Service in England (1985) contended that "Getting the best out of resources in terms of maximising the services to patients is... a fundamental challenge... for the Government" and was to be achieved through improvements in the structure and management of the Service, improved accountability of health authorities, better utilization of manpower and the execution of substantial and sustained cost-improvement programmes. This latter initiative embraced the policy of competitive tendering which involves contracting with the private sector for the provision of services²⁷. It was advocated by the then Minister for Health, Dr. Gerald Vaughan, in

both 1980 and 1981, was the subject of a draft circular in 1983 and appeared in the Conservative manifesto for the 1983 general election before definitive guidance followed later that year²⁸. Efficiency was the underlying rationale of competitive tendering which was itself seen as a way of securing cost reductions.

By the mid-1980s, the above changes brought about in the daily operating of the NHS were the subject of much political debate and controversy. At the general election of June 1987, the NHS was a major issue as the Service seemed to be plagued by a financial crisis of unprecedented proportions. Ward closures and delays in treatment captured media attention as patients sought legal protection for their rights to treatment. The Presidents of the three Royal Colleges publicly proclaimed that the Service was underfunded. At the Conservative Party conference in September 1987, the newly appointed Secretary of State, John Moore, attacked the welfare state as breeding a dependency culture whilst the Prime Minister felt it prudent to assure both supporters and critics of her government's health policy that "The National Health Service is safe in our hands". Nonetheless, the controversy surrounding the nature and degree of change brought about in the NHS by successive governmental initiatives failed to go away and reached a new peak in early 1988 when a junior health minister, Edwina Currie, suggested that those waiting for operations under the NHS should buy them rather than take a second holiday. Under increasing pressure both within and without Parliament, Mrs. Thatcher announced a review of the NHS.

The NHS Review was seen by the Opposition both as a muddled response to a crisis in the Service and as a cynical strategy by which the NHS was to be allowed to run into a crisis: thus making the radical alternative of private medical care more attractive. Irrespective of motive, the thrust of the Review was toward efficiency improvements in the Service rather than toward increased funding of it²⁹.

The NHS Review worked in secret and the identity of the members of the team was not made public. The findings of the Review were revealed in January 1989 and contained a mixture of radical and consensus measures. The most radical proposals were to enable hospitals to manage their own affairs independently of the health authorities of which they were a part and to give general practitioners budgets which they could spend on purchasing care for their patients. Both of these proposals entail

a distinction being made between financing and provision and seek to move hospitals away from global budgets toward income which is related to the services performed. The intention was to create an "internal market" in the NHS with health authorities being transformed into purchasers rather than providers of care as had been the traditional pattern. Consensus proposals were contained in the recommendation that care should continue to be free at the point of delivery and should still be funded from general taxation³⁰.

Opposition has taken two forms. On the one hand it has come from those who although sympathetic to the general thrust of governmental policy have been concerned about the scale and rate of change. They advocate caution and the need for experimentation before radical changes are made to the way in which the Service is financially managed. Others offered more fundamental criticisms. In this latter category is the British Medical Association and its resistance to the introduction of budgets for GP practices. Until now GP services have not been cash limited and the BMA sees the advent of budgets as the first step along a downward slope which will leave GPs as tightly controlled financially as the hospital sector³¹.

Despite a vociferous public campaign and extensive use of advertising in the media and particularly in the press, the BMA has lost its battle with the Minister. In 1989, the then Secretary of State, Kenneth Clarke, told the Social Services Select Committee that he was determined to proceed with the creation of an internal market within the NHS.

THE NHS SINCE 1990: THE INTRODUCTION OF TOTAL QUALITY MANAGEMENT

The recommendations of the NHS Review with an emphasis on the provision of better health care and improved services to patients were enshrined in the Health and Community Care Act of 1990 which came into affect in April 1991. Within the changes, NHS services will still be available to all; paid for mainly out of taxation and mostly free at the point of delivery. To ensure these objectives, some major changes have been made to the organisation of the NHS with effect from April 1991. In particular, health authorities and some GPs became purchasers of the health services their residents need and local hospitals became providers of those services. District

Health Authorities were streamlined to enable them to focus on their major role of assessing the health needs of their population. All hospitals are now required to provide efficient and effective health services to meet the needs identified by health authorities and earn their income from contracts for services and some hospitals have already chosen to become NHS Trusts; responsible for managing their own affairs without the intervention from District or Regional Management.

All of these changes can be seen to be in accord with the professed aim of successive Conservative Governments since 1979 to introduce the tenets of their ideology into the NHS. They stand in marked contrast to the broadly based cross-party agreement on the NHS which informed health policy during the consensus years and reflect the market orientation and emphasis upon individualism which has come to replace the former emphasis upon the mixed economy and a commitment to the welfare state as it was for so long envisaged. More specifically, the NHS has been transformed to accord with the Conservative view that the introduction of private sector managerialism is the best method by which the organisations of the public sector can be made to exhibit the features of efficiency, effectiveness and economy which have been previously seen as being the exclusive preserve of the private sector. In essence, the health policy of Conservative Governments over the past 13 years has focused upon the attainment of the 3 Es through legislation which has removed, or at least lessened, the administrative culture which typified the NHS from its foundation until 1979 and replaced it with a managerial culture more in keeping with the thinking of the New Right. this movement from administration to management was characterised as long ago as 1972 by Keeling but typifies more recent changes in the NHS³² (see Table 4).

TABLE 4

	Administration	Management
Goals	<ul style="list-style-type: none"> • In general terms: Infrequently reviewed or changed 	<ul style="list-style-type: none"> • Broad strategic aim supported by more detailed short-term goals and targets, reviewed frequently
Attainment Criteria	<ul style="list-style-type: none"> • Mistake avoiding 	<ul style="list-style-type: none"> • Success seeking
Resource Use	<ul style="list-style-type: none"> • Secondary task 	<ul style="list-style-type: none"> • Primary task
Organisational Structure	<ul style="list-style-type: none"> • Roles defined in terms of areas of responsibility • Long hierarchies: limited delegation 	<ul style="list-style-type: none"> • Roles defined in terms of tasks • Shorter hierarchies: maximum delegation
Management Role	<ul style="list-style-type: none"> • Arbitrator 	<ul style="list-style-type: none"> • Protagonist
Perception	<ul style="list-style-type: none"> • Passive: workload determined outside system; best people used to solve problems • Time insensitive • Risk avoiding • Emphasis on procedure • Conformity: national standards 	<ul style="list-style-type: none"> • Active: seeking to influence environment, best people used to find out and exploit opportunities • Time sensitive • Risk accepting, but minimising • Emphasis on results • Local experiments: need for conformity to be proved
Skills	<ul style="list-style-type: none"> • Legal or quasi-legal • Literacy 	<ul style="list-style-type: none"> • Economic or socio-economic Numeracy •

Source: Haigh and Morris: Social Studies Review, Vol. 6, No. 2, November 1990.

Furthermore, the interest in TQM in the NHS, emanated from the enquiry chaired by Sir Roy Griffiths into the management of the NHS³³. The Report submitted was highly critical of the NHS on two counts, principally:

- The failure of the NHS management to adequately take responsibility for continuous assessment of performance against such measures as level of service quality, budgetary control, productivity, motivation and rewarding staff.
- The lack of a clearly defined general management function throughout the NHS. 'General Management' in the Report alluded to the responsibility drawn together in one person at different levels of the organisation for planning, implementing and control of performance³⁴.

The Report advocated the installation of general management at various levels throughout the NHS and made it clear that 'Quality Assurance was of primary and vital importance as part of management task', thus giving a high profile to the need for a more customer focused service and the monitoring of the delivery of care. 'Working for Patients'³⁵, also drew the attention of the NHS management to the need for a more business-like approach. Providers of healthcare were required to place a greater emphasis on improving 'quality of care'. The Griffiths Report and 'Working for Patients', laid the foundation for a quality revolution within the NHS.

As a consequence, in 1989, the Department of Health, set up 23 TQM schemes. The 23 hospitals were to serve as demonstration centres for the introduction and implementation of quality management in line with the underlining principles of TQM. Thus, developing effective implementation approaches to TQM ranked high on managerial agendas in the NHS³⁶. However, it does appear that the current state of play in the NHS shows a considerable variation as to how managers in the 23 TQM sites are proceeding towards achieving continuous improvement. It has been argued that some hospitals have placed emphasis on professional quality, others on client quality, while others have stressed management quality, but most have placed great emphasis on generally imposed standards of conduct based on the setting and monitoring of clinical standards³⁷.

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CHAPTER THREE

HISTORICAL DEVELOPMENT OF QUALITY

In its broad form, quality means any action or differing form of activity directed toward providing consumers with products (goods and services) of appropriate quality¹. Quality has been an important aspect of production operations throughout history. In Egypt, around 1450 BC, the Egyptian wall paintings showed evidence of quality inspection and measurement activity. Stones used to build the pyramids were cut so precisely that it was impossible to put a knife blade between the blocks². The success of the Egyptian pyramids was due to uniform methods, procedures, and precise measuring devices. The Egyptians also entertained the idea of interchangeable bows and arrows, but fully interchangeable parts were not introduced until the late 1700s, when it was then considered possible to produce parts to exact dimensions, however, difficulties were encountered in actually doing so. Gauges, which fixed upper and lower tolerance limits on each fitting part, were introduced about 1870, when the belief that physical laws were exact began to give way to the idea that such laws were statistical, and that what is assumed to be constant is really a certain statistical distribution. However, the concept of interchangeable parts eventually led to the industrial revolution, and made quality a critical component of the production process³. With the industrial revolution came the factory system; quality was controlled through the supervised skills of craftsmen. Later, written specifications, measurements and standardisation were introduced. This encouraged the development of methods for improving production efficiency in factories.

Immediately prior to the First World War, the work of Frederick W. Taylor, regarded as the Father of Scientific Management was very influential. Taylor recommended the decomposing of jobs into individual work tasks with engineering specialists planning the work so that workers and foremen need only execute it. For the first time this led to inspection tasks being separated from production tasks, which resulted in the creation of a separate quality department in manufacturing organisations⁵.

During the First World War, manufacturing systems became more complex and quality began to be verified by full time inspectors rather than by the workers themselves. Thus quality control by inspection was born; this involved post production inspection

to separate good production from bad and reached its zenith with the creation of large quality inspectorate departments totally independent of the production process⁶. Bell Telephone was the pioneer leader in the early modern history of quality control⁷. An inspection department was established in the Western Electric Company to support the Bell organisation's operating companies. The duties of this group involved the development of new theories and methods of inspection for quality improvement and maintainability. An early leader of the quality control movement, Walter Shewart, was part of this group. Walter Shewart introduced the idea that controlling quality meant distinguishing between two types of variation: those arising from special causes, and those arising from common or assignable causes⁸. Shewart argued that by removing the variation due to special causes a process could be made to function predictably. Shewart developed the control chart for monitoring such process variation and for deciding when to interfere with a process⁹. About the same time, Harold Dodge and George Edwards designed acceptance sampling techniques which involved identifying the risks involved in sampling individual production and the use of economic analysis techniques for quality problem solving; thus laying the foundation for modern quality assurance¹⁰. However, organising production around inspection was the dominant approach for twenty years after the First World War¹¹. This reliance upon post-production defects detection may now seem out-dated and uncompetitive, but it was then the norm. American products were generally well received and the number of quality specialists armed with the new tools and techniques grew, but their influence was limited by prevailing organisational structures and a limited appreciation of the quality function¹².

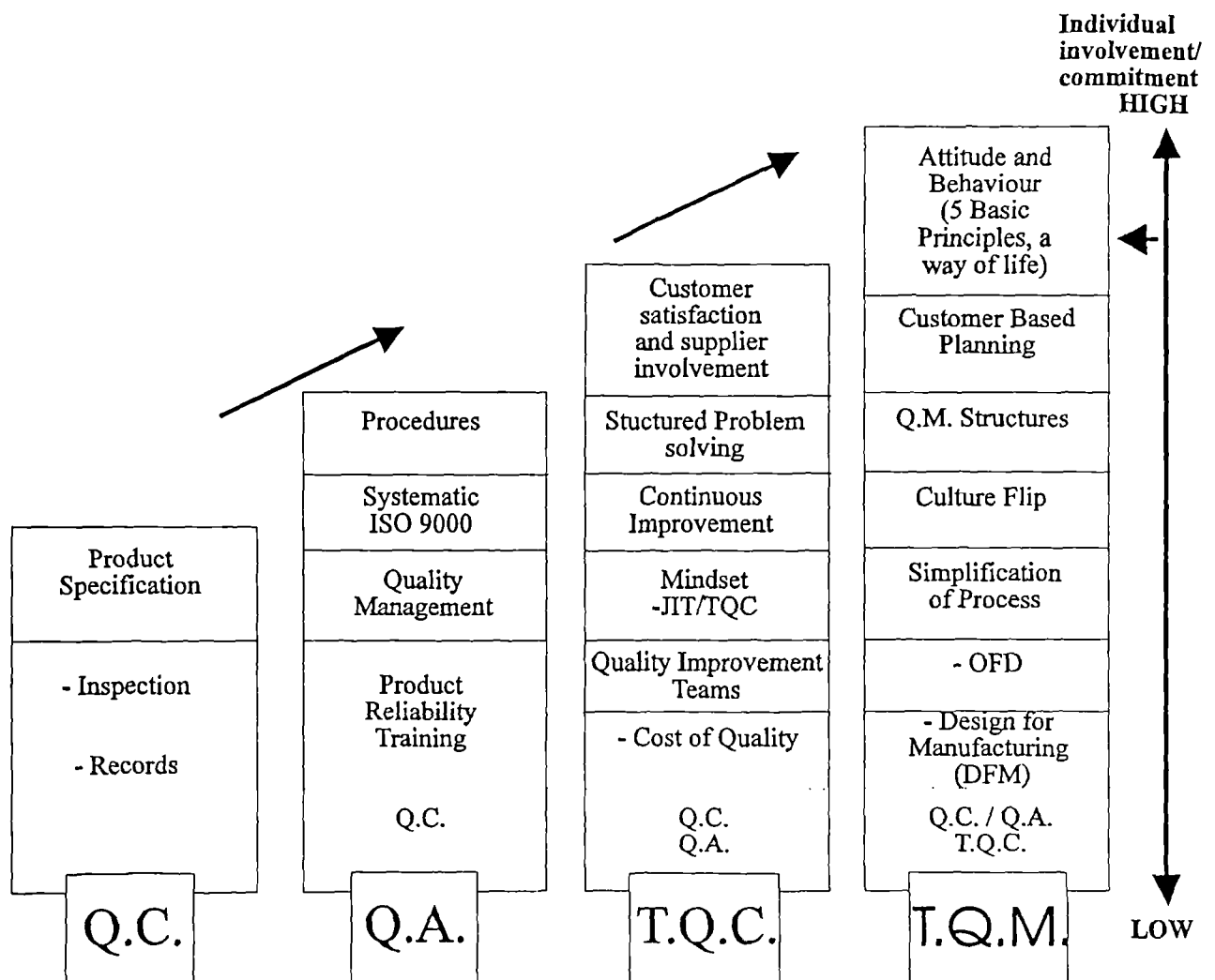
During the Second World War, the American industrial strategy was to shift emphasis from consumer goods to war materials. The U.S. military began using statistical sampling procedures and imposing strict standards on suppliers. Thus, statistical quality control became widely known¹³. In 1942, the USA War Production Board began sponsoring training courses in statistical process control (SPC), for both military goods suppliers and government procurement staff¹⁴. This encouraged the adoption of SPC by other industries. During this period sampling labels such as "MIL-STD" for 'military standard' were developed and are still extensively used¹⁵. Juran¹⁶ maintains that, despite the advent of statistical quality control, the basic system of assuring quality by post-production inspection has remained unchanged.

After the Second World War, the United States and Canada was the only industrial entity to emerge with its industrial capacities intact¹⁷. Pent up consumer demand for goods was suddenly realised. American companies found themselves in a sellers market, free of competition and the attitude was more geared towards meeting delivery dates rather than to delivering quality; hence, the period of mass-production was born. In this period, the management class of most organisations remained detached from the process of managing for quality and the central quality function became marginalized; organisations were aligned to meet pressing needs for goods rather than to lay emphasis on product quality¹⁸.

Amidst this confusion, Juran¹⁹, who had worked in the inspection engineering department at Western Electric, launched a private consultancy and undertook to write the first edition of his book the 'Quality Control Handbook'; which became the professions bible for Quality Control. Due to the publication of Juran's Quality Control Handbook, quality control became a recognised discipline in the late 1940s but its influence was limited to the factory floor. Juran espoused the idea that organisations should invest in quality improvement as long as the costs of poor quality remained high²⁰. In 1956, Feigenbaum, in a classic article in the Harvard Business Review, coined the term "Total Quality Control"; recommending that 'high quality products were unlikely to be produced if the manufacturing department was working in isolation with the rest of the organisation'²¹. The underlying principle of total quality control (TQC), as put forward by Feigenbaum, is that "to provide genuine effectiveness, control must start with 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 of TQC is to recognize that quality is everybody's job²². Feigenbaum argued that as all new products moved from design to market the same activities were involved and these could be grouped into three categories: 1. New design control, 2. Incoming material control, and 3. Product or shop floor control. To be successful, these activities required the cooperation of every department²³. However, most delivery focused organisations ignored these recommendations because it was at the time a sellers' market. According to Gabor²⁴, quality control was relegated to the background in America's booming postwar economy because demand for products outstripped supply. Thus, companies were more inclined to meeting market demands no matter how inferior were the products produced. In 1961, the zero defects movement was

born. Its chief proponent was the Martin Company, a company which specialised in building Pershing missiles²⁵. Another authoritative personality in the advocacy of zero defects was Philip B. Crosby. His 14-step quality methodology was published by ITT in 1967 as quality improvement through defect prevention²⁶. This programme was introduced to ITT companies worldwide. The zero-defects movement, however, failed to endure; possibly because many people had difficulty conceptualising zero defects²⁷. Zero-defects was the last major movement in the quality assurance era²⁸.

FIGURE 3
HISTORICAL EVOLUTION OF QUALITY



Reactive → Stability → Incremental Improvement → Revolutionary

Market Service → Market Presence → Market Leadership

Source: Foxboro, A Side Company

Note: The five basic principles: 'a way of life' involves:

1. Customer satisfaction
2. Respect for people
3. Structured problem solving
4. Management by Fact
5. Continuous improvement

The decade of the 1980s, saw a remarkable change and awareness of quality by consumers, industry and government²⁹. Consumers began to notice a difference in quality between Japanese and Western-made products. A report in 1980 by Hewlett-Packard, after testing 300,000 16K RAM chips from three U.S. and three Japanese manufacturers, found that the Japanese chips had an incoming failure rate of zero compared to rates of 11 and 19 failures per 1,000 for the U.S. chips³⁰. In 30 years, 1950-80, the Japanese had penetrated a major market that had been dominated by American Companies³¹. However, Britain's share of World trade is declining and the dramatic effect that this is having on the standard of living is amply demonstrated by rising unemployment and bankruptcies³². Demand for British goods no longer happens automatically, it has to be created, but the declining share of home market held by domestic producers shows, all too clearly, that the average Briton prefers foreign products³³. The disastrous effect that this foreign penetration is having on the British domestic market and living standards is underlined by a 1986 OECD Report, showing that living standards in the U.K. ranked only 10th among the 15 top industrial nations³⁴.

These are dangerous developments. The overall pattern of world trade is changing. The "Northern Industrialised" countries no longer need the vast quantities of consumer goods for which demand was so great in the 1950s and 1960s. Consumers worldwide are akin to buying 'quality' irrespective of products' country of manufacture. The consumer boom is over as is the heavy expenditure on infrastructure and central services that accompanied it³⁵. The way the world works is being transformed by new technologies and an intense global competition demands improved quality and productivity. Clearly, a country's economic performance and its reputation for quality is made up of the performance and reputations of its individual companies and products

and the effective use of its human resources³⁶. Although a number of British companies have a good reputation for their product quality and perform well, the overall reputation and the lack of demand for British goods shows that there are more companies that do not provide the standard of quality that meets customer requirements³⁷. This is due to British companies' reliance on the BS 5750 Certification which supposedly guarantees that a firm's quality procedures are properly organised³⁸. However, the cost of the process and the amount of paper work involved has been harshly criticised. It now emerges that in some cases the award may be worthless, because having a BS 5750 Certification does not necessarily guarantee a quality company. Voss and Blackman³⁹ have argued that BS 5750 is not a sufficient condition for success in quality management. BS 5750 does not link with customer satisfaction, it is essentially concerned with monitoring the procedures by which the attainment of standards is assured rather than by improving product or service quality⁴⁰. Despite being designed to improve British industrial competitiveness, the standard has become a nightmare for many small and medium-sized enterprises. Critics say it is expensive, bureaucratic, and difficult to set-up and maintain. Some argue that, while BS 5750 was designed for manufacturers, the standard lacks relevance for many smaller companies which are providers of services⁴¹. Thus, it could be argued that to improve the competitiveness of British companies, in particular, Public Service organisations a new approach is required. An approach which would reduce post production inspection, sorting, rectification and warranty costs. That approach in the author's opinion, is Total Quality Management.

WHAT IS QUALITY?

Dotchin and Oakland⁴² state that 'scholars face many problems when defining quality as an economic as opposed to a transcendent concept'. These difficulties apply equally to goods and services. Edwards⁴³ defined quality as being "the ability of a commodity or service to satisfy human wants". This suggests that for many products, customer judgements are made over their useful life, based on reliability, durability, price, and ease of maintenance⁴⁴.

Similarly, Shewart⁴⁵ drew attention to the particular difficulty of knowing and measuring what consumers will consider to be acceptable quality in the future. The implication being that customer needs are not static. Townsend and Gebhart separated 'quality of perception', as seen subjectively by the customer, from 'quality of fact' or performance to the standard which has been set. They state that both perspectives need to be acknowledged and recognised in any TQM initiative⁴⁶. For Juran⁴⁷, quality is 'fitness for purpose'. Quality, he notes, is judged by the user, not by the manufacturer or merchants. A different, but equally important definition, was given by Crosby⁴⁸, who defined quality as conformance to requirement not elegance. Whilst for Garvin, quality can be seen from five approaches⁴⁹:

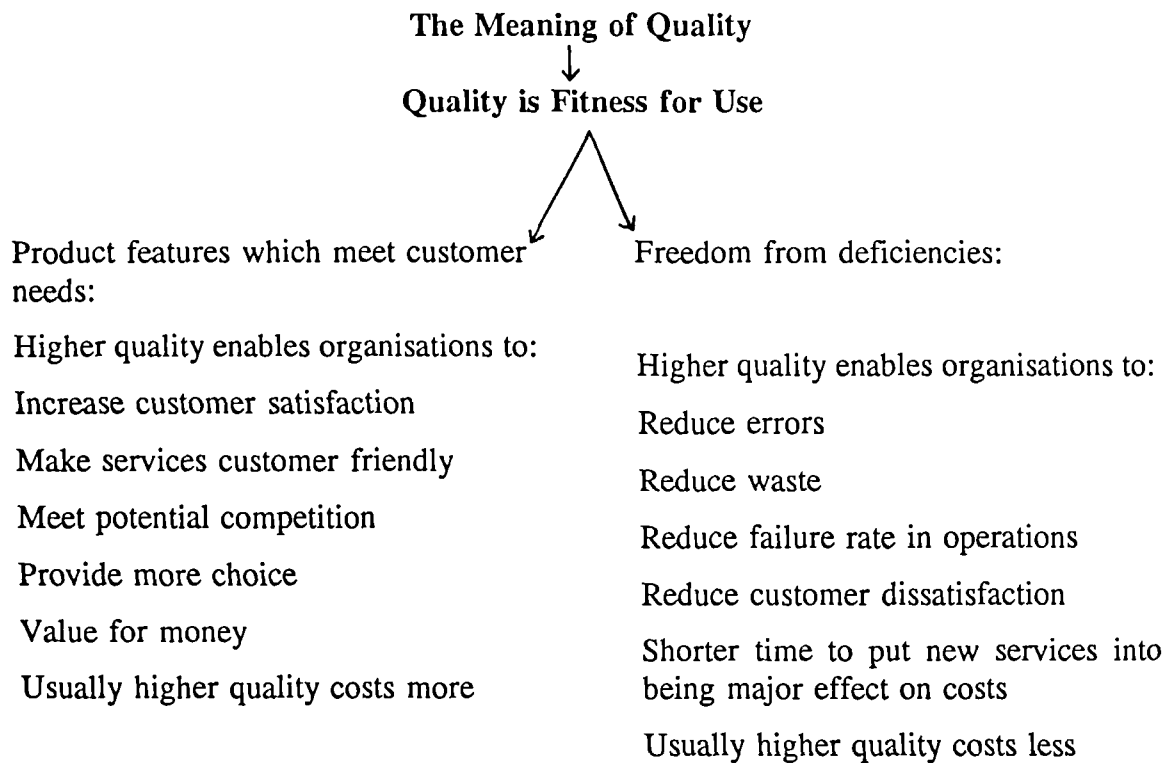
1. transcendent or innate excellence
2. product-based or the amount of a desirable attribute which is present
3. user-based in the context of fitness for use
4. manufacturing-based on conformance to specification
5. value-based or satisfaction relative to price.

Garvin is of the view that these meanings can co-exist within an organisation. He goes on to suggest that it may become necessary to give quality different meanings in different industries, and also probably change the approach taken towards quality from user-based to product based, as products move through market research to design; and then from product-based to manufacturing based, as they go from design into manufacture⁵⁰. However, the user based definition is more appropriate in a service organisation because it denotes that those services which meet customer preferences and expectations are the central thrust of high quality⁵¹. In addition, the author is of the opinion, that the management of the relationship with the customer is also crucial. This is consistent with the view of Kogan et al⁵², who argue that 'given that the client is both a consumer and a producer, the management of the company-client interface becomes extremely important and a delicate task for any service organisation'.

Collard notes that "quality is about attitudes, culture and commitment within an organisation; it applies in all organisations, be it manufacturing, service or the public sector". He further states, "in organisations of every kind, quality can be regarded as a means to an end - customer satisfaction in all aspects of the product or service"⁵³.

Quality, Collard contends, should be all-pervasive, covering not only the design, performance and reliability of a product or service but the constant improvement of what is on offer⁵⁴. However, the British Standard (BS 4778) offers an alternative systemic definition of quality; "the totality of features and characteristics of a product or service that bear on its ability to satisfy a given need"⁵⁵. On the basis of this definition, it is possible to evaluate quality firstly on the criteria of "fitness of purpose", and secondly on the ability to satisfy a given need, which may include availability, maintainability, reliability and design⁵⁶. The 'Fitness for Purpose' definition, advocated by Juran can be diagrammatically represented as follows:

FIGURE 4



Source: (Morris & Haigh, 1993) Quality and Productivity in Health Service through the implementation of TQM

Tom Peters⁵⁷ prefers a different typology, and suggests, "perception is all there is". "Quality is not a technique, it is about care, people, passion, consistency, eyeball contact and gut reaction". He suggests that quality comes from people who care and are committed; quality comes from the belief that anything can be made better, that beauty is universally achievable; in the collection of garbage, in services, in the

raising of chicken, in the design of a retail store, etc. Peters argues that quality involves living the message of the possibility of perfection and infinite improvement, living it day in day out, decade by decade⁵⁸. Peters further contends that, quality is a function of commitment - from all hands on the loading dock, at the receptionist desk, in the design space, without that commitment only human beings can give it you will not get top quality. Thus, quality is primarily a function of human commitment exemplifying passion and pride⁵⁹.

The Organisation Development Institute (ODI) has identified two elements in the definition of quality⁶⁰:

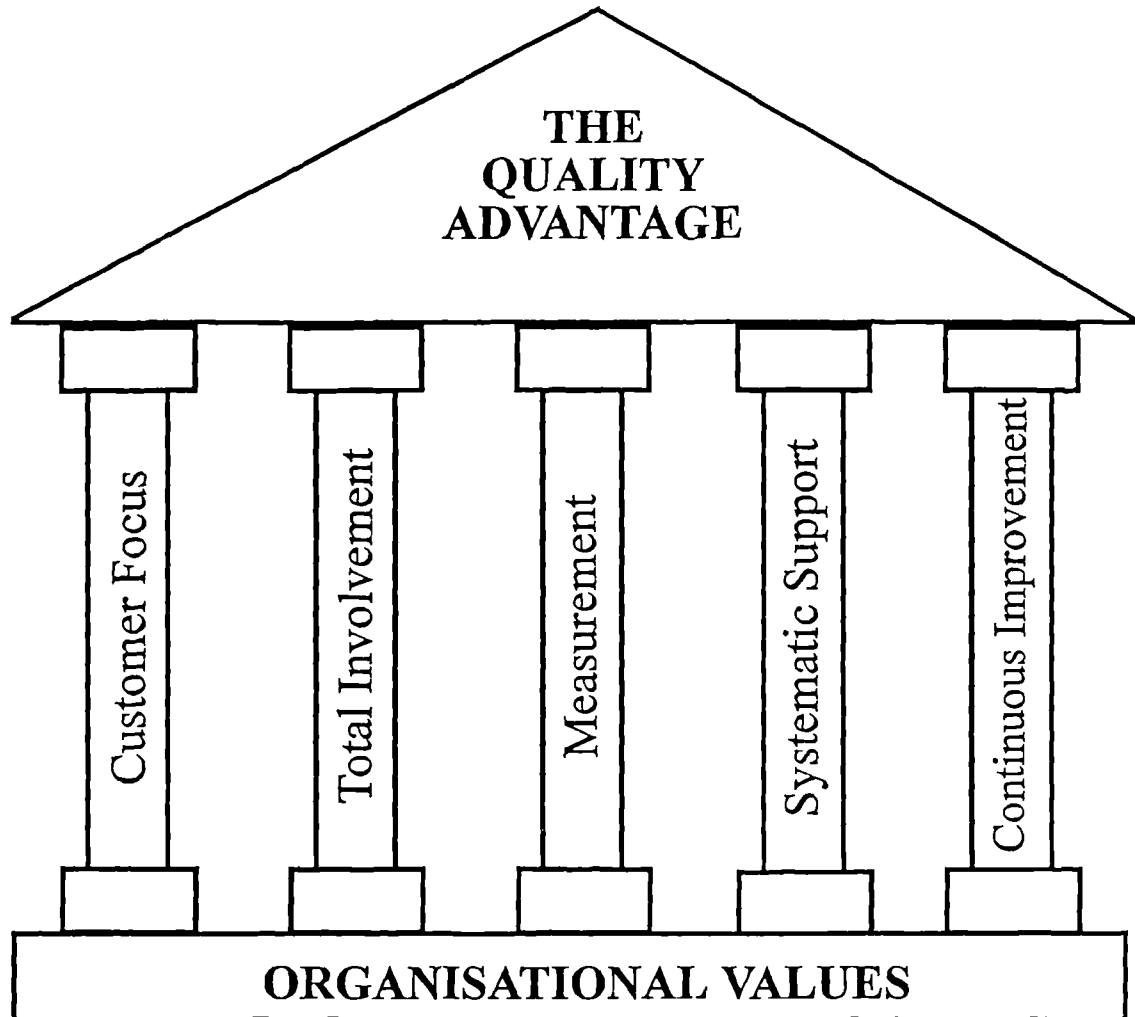
1. **Alignment**, which is ‘**doing right things**’ and, 2. **Execution**, which is ‘**doing things right**’. To do things right means, by implication, identifying customers needs, converting those needs into agreed requirements, then aligning work process to be capable of meeting those requirements. In order to do things right, an organisation must execute its work processes in a way that meets those requirements. Quality, the ODI states, has several other dimensions; including the relationship with the customer, the integrity with which products and services are supported, the timeliness of delivery, and the cost to the customer of acquiring the product or service. The ODI suggests five pillars of Quality⁶¹:

- (a) Customer Focus
- (b) Total Involvement
- (c) Measurement
- (d) Systematic Support
- (e) Continuous Improvement

To support quality, these pillars must be built on a foundation of organisational values that employees can believe in:

FIGURE 5

THE FIVE PILLARS OF QUALITY



Source: ODI Publication, (1989)

However, Black notes⁶² that most TQM writers have failed to provide an adequate definition of quality that can be easily related to the philosophy of TQM. He suggests that the differing definitions of quality only link with aspects of TQM and not with its totality. For example, Deming⁶³ defines quality as control of variation, Juran⁶⁴ sees quality from internal customer perspectives, whilst for Crosby⁶⁵, quality is meeting requirements. None of these definitions Black notes, address the management of quality which encompasses the optimisation of processes that occur both within the

organisation and beyond. According to Black, the meaning of quality should be as relevant to a typing process as it is to manufacturing, order processing, or the performance of a service⁶⁶. In support of Black's contention, the author is of the opinion that, not only have the definitions of quality omitted its management aspect but, that whatever definition an organisation adopts, it should reflect the organisational system as a whole. Thus, quality should be seen more as meeting both the needs emanating from the internal and external environments of the firm; in particular the external environment, because it is external customers who pay the bills which keeps the organisation profitable.

From a marketing perspective, Parasuraman et al⁶⁷ derived a purified set of five quality dimensions which they argue are important to consumers of service businesses:

1. Tangibles - physical facilities, equipment, and appearance of personnel.
2. Reliability - ability to perform the promised service dependably and accurately.
3. Responsiveness - willingness to help customers and provide prompt service.
4. Assurance - knowledge and courtesy of employees and their ability to convey trust and confidence.
5. Empathy - caring, individualised attention the firm provides to its customers.

These dimensions the authors contend, a quality company, particularly a service organisation, should exhibit.

Similarly Peters⁶⁸ holds the view that quality is what the customer says he needs, not what our producer/processor indicate is satisfactory. In his definition of quality, the man who first coined the words Total Quality Control, Feigenbaum states: "Quality

is a customer determination, not an engineer's determination, not a marketing determination or a general management determination, it is based upon the customer's actual experience with the product or service measured against his or her requirements - stated or unstated, conscious or merely sensed⁶⁹". Thus, product and service quality can be defined as: "The total composite product and service characteristics of marketing, engineering, manufacture and maintenance through which the product and service in use will meet the expectations of the customer"⁷⁰.

For Lesley and Mauro Faure⁷¹, quality is defined by the customer. They suggest that an organisation needs to first of all agree what the customer wants (the customer requirements) then produce exactly what is wanted within the agreed time frame at minimum cost. This view of quality is probably the best way of assuring customer loyalty, the best defence against foreign competition and the only way to secure continuous growth and profits in difficult market conditions. In continuing with the notion of the superordinate customer, Morris⁷² notes that quality is possibly one of the most commonly misunderstood words in manufacturing. She defines quality as "the degree of fitness for purpose or function" indicating that quality is a measure of the satisfaction of customer needs. Thus, the quality of a motor car or a garment or medical care is the extent to which it meets the requirements of the customer. She contends that before any discussion on quality can take place, it is necessary to be clear about the purpose of the product or service - "the needs of the customer". Whether the customer is internal or external, meeting his/her satisfaction is of prime importance⁷³.

This is consistent with Gronroos' work, where it is stated that a consumer's experience of a service influences his post-consumption evaluation of the service quality which he has experienced, i.e. the perceived quality of the service. Hence, the quality of a service is dependent on two variables: expected service and perceived service⁷⁴. Consequently, for an organisation to claim to be delivering quality, it should make sure that the services or products provided meets or exceeds the customers expectation. From the foregoing discussion it is possible to discern four differing types of definition to quality:

1. **Product based definition** - quality is defined as precise and measurable variable, the differences in quality reflect differences in quantity of some product attributes.
2. **User based definition** - Quality is determined by what a customer wants and what he or she is willing to pay for. Individuals have different wants and needs and, hence, different quality standards. This is exemplified by the "fitness-for-use definition.
3. **Manufacturing based definition** - quality is an outcome of engineering and manufacturing practice, or conformance to specifications. Specifications are targets and tolerances determined by designers of products and services⁷⁵.
4. **Value based definition** - Quality is defined in terms of costs and prices, a quality product is one that provides performance at an acceptable price rather than a name brand, since it provides the same performance at a lower cost. For example, although the mini automobile was introduced with great hype by the Rover group it failed to corner the small car market because the quality of conformance to customer expectation was not good despite its low production cost⁷⁶. Thus, for a product to be called a quality product, it should provide quality in finite terms and be of value to the customer.

As an illustration of how the four different views to quality can apply to a single product, consider the services provided by a hospital. The value definition of quality is characterised by an image of excellence as perceived by the competency of the medical staff, the availability of treatments for rare or complicated disorders and also the availability of advanced medical technology⁷⁷, whilst the auditing of hospital efficiency, the measurement of treatment consistency and resource utilisation are viewed along the product based dimension. However, the patients' (external customers') perception of care is focused on the user-based definition. Thus increasing the pressure on hospitals to provide services to meet these expectations. As the demand for a flawless service increases, the medical staff and ancillary services

(internal customers) must turn their attention to quality improvement rather than concentrating on providing a professionally focused service. Therefore, it could be argued that the user-based definition in the context of 'fitness-for-use', has received the greatest attention in recent times because of the on-going restructuring of the National Health Service⁷⁸. However, it is the author's contention that, quality in the NHS should be viewed from several different perspectives in order to meet the differing needs of individual patients.

The need for different definitions of quality is fundamental⁷⁹. This is because customer perspectives change at different points in an organisation. Hence, the reliance on a single definition is frequently a source of problems. There needs to be in the author's opinion, a change in the perception of quality as the patient moves through the hospital process. Thus, the four differing views of quality are necessary and must be embodied in an overall company philosophy in order to result in a quality service⁸⁰. The diversity of these definitions can also be explained by Garvin's eight principal quality dimensions⁸¹:

1. Performance: "A products primary operating characteristics".
2. Features: "The 'bells and whistles' of a product".
3. Reliability: The probability of a product's surviving over a specified period of time under stated conditions of use.
4. Conformance: "The degree to which physical and performance characteristics of a product match pre-established standards.
5. Durability: The Amount of use one gets from a product before it physically deteriorates or until replacement is preferable.
6. Serviceability: "The speed, courtesy and competence of repair".
7. Aesthetics: How a product looks, feels, sounds, tastes, or smells.
8. Perceived Quality: Subjective assessment resulting from image, advertising or brand names.

According to Dotchin and Oakland, the most applicable definitions of quality are: fitness for use (the user perspective) and conformance to specifications (the manufacturing perspective)⁸². "Both are necessary for customer satisfaction". They further argue that these definitions are not mutually exclusive, as they may at first appear, but apply in different contexts. What the two definitions have in common is; (1) Powerful simplification of the concept of TQM and, (2) They are memorable⁸³.

Crosby notes that both definitions have passed into general use and have even stimulated argument and disagreement among various commentators; but that popular acceptance of them is based on their implicit as well as on their explicit meanings⁸⁴.

However, in whatever form an organisation decides to define quality, one 'fact' cannot be compromised and that is an organisation needs a clear and consistent understanding of what quality means and how to deliver it⁸⁵. This is because if an organisation cannot consistently define quality, that organisation must look to the customers they serve. The customers' perceptions of the value they are receiving must become the common yardstick from which to discern a companywide definition of quality. In the author's opinion, to overcome the difficulties organisations face in defining quality, the underlying meaning of quality is best seen from two primary perspectives as: (1) Fitness for use⁸⁷, (2) Conformance to requirements⁸⁸. This is because the two definitions convey a simplistic message - the customer is king.

QUALITY IN HEALTHCARE

NHS employees, along with other professionals, have for sometime prided themselves on the service they provide, often stating that the service is one of quality. This has largely been driven by individual professional interest groups, rather than by patients or customers. Patients are now set to take their rightful place at the forefront of healthcare provision. Gone are the days of the quiet and compliant patient who dared not speak, much less challenge the care providers. Today's better informed patient can and is willing to make judgements and to discriminate about quality of care.

Sir Roy Griffiths made it clear in the Management Inquiry Report published in 1983⁸⁹ that "Quality assurance was of primary and vital importance as part of the management task". 'Working for Patients' emphasised that a more business-like approach was needed. Hence, providers of healthcare need to place a greater emphasis on quality because of competition.

Thus, provider units were required to produce data on the quality of services provided. This was to be achieved through a range of monitoring activities, ranging from asking patients questions relating to their experiences, to the use of formal questionnaires, surveys, and clinical audits⁹⁰, implying that the concept of quality in any environment can vary depending on who defines the term. Traditionally within the healthcare system, the definition of 'quality of care' was the prerogative of the clinical staff; occasionally with some ideas adapted from hospital administrators. In the NHS, the definers are Quality Managers, Quality Officers or whoever has responsibility for implementing this approach across the whole organisation. However, if the notion of quality improvement and continuous quality improvement is to make any sense in healthcare, the definition of 'care' must reflect the representative view of other participants involved in the provision of the service⁹¹. Donabedian identifies the difference between art and the science of medicine; he is of the view that in order to observe the difference it is necessary to have an in-depth knowledge about clinical issues⁹². In line with Donabedian's argument, it may be inferred that the consultant is in the best possible position to perform the evaluation of the consultant/patient encounter because he or she possesses the clinical expertise. In contrast, Ferreira argues that, "we should base the evaluation of quality of care from different and differing sources i.e. customers, service users, patients, providers of care (clinical/non-clinical staff), hospital administrators, government"⁹³. He advocates the integration of these various view points in order to avoid a conflict of interest. Hence, "quality of care becomes that kind of care which is expected to maximise an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts"⁹⁴. Furthermore, it has been argued that, healthcare organisations' quality programmes generally have three major focii: assessing or measuring performance, determining whether performance conforms to standards, and improving performance when standards are not met⁹⁵. However, this traditional approach to quality has several limitations. To begin with, the classical

definition of quality of care seems too narrow to meet the needs of modern healthcare providers. For example, Donabedian's formulation emphasises, quite appropriately, the extent to which healthcare providers improve the physical and psychological health of individual patients but, fails to highlight that the needs of patients and other stakeholders should always be paramount⁹⁶. This is because the Health Service is increasingly called on to meet the needs of other individuals and groups such as patients' families, referring GPs, GP fundholders, and the general public. Furthermore, it is difficult to ascertain the difference in the definition of quality of care from its operationalisation. There seems to be a congruence between researchers in this field, namely, that to agree a universal definition of 'quality of care' it is important to enumerate the elements which belong to it⁹⁷. In the literature two elements can be identified:

1. **The technical aspect of care;** "Curing", which relates to how clinical issues in general are applied in a particular personal situation, taking into account currently available medical knowledge and technology⁹⁸. The technical aspect of the quality of care implies judgements about the competence of providers (effectiveness of cure, thoroughness, and clinical outcomes). The second element is the **Interpersonal aspect of care or "caring"**, which represents the humane aspects of care and the socio-psychological relationships between the patient and the care providers. This involves explanations of illness and treatment, the availability of information, courtesy, and the warmth received: that is the way care providers interact personally with patients. Both technical and interpersonal aspects are considered part of science and part of art, though it is not always possible to distinguish between these two aspects of care⁹⁹. However, there is sufficient evidence that the caring process, i.e. the non-clinical (interpersonal) aspect, is usually appreciated by patients and considered as one of the most important aspects they take into account when they evaluate the quality of medical care¹⁰⁰. Ware et al¹⁰¹ describe three features used by patients to evaluate the quality of care; accessibility, availability and the continuity of care. Accessibility and convenience are factors involved in the receipt of care, such as time spent to get a first appointment, waiting times, transportation, or the possibility of receiving care at home. Part of accessibility of care includes easy access to emergency care i.e. calling out doctors, ambulances. The other aspect is the availability of care resources which

involves the number of staff (doctors, nurses and paramedics) and also the completeness of hospital facilities¹⁰². The continuity of care (seeing the same nurse, doctor, or consultant) is another dimension important to patients. However, 'being treated as an individual' is by a considerable margin more important to patient satisfaction than 'getting better', and having timely, adequate information about their condition is more desirable than the newness of facilities or the flexibility of hospital rules¹⁰³. Berwick defines quality in healthcare as that quality of care which has the capability to meet the needs of those who depend on the care¹⁰⁴. In other industries he contends, this means 'meeting the needs of the customer' but the word 'customer' he opines offends some people in healthcare. In healthcare, quality can be defined by listing the results and attributes of the healthcare system that are wanted by people who depend on that system; such as restoring function, relieving pain, prolonging useful life, answering questions and respecting dignity. Similarly, the American Medical Association (AMA) definition of quality is 'care which consistently contributes to improvement of, or maintenance of, the quality and/or duration of life'¹⁰⁵. Whilst for the U.S. Joint Commission on Accreditation of Healthcare Organisations quality is 'the degree of adherence to generally recognised contemporary standards of good practice and the achievement of anticipated outcomes for a particular service, procedure, diagnosis or clinical problem'¹⁰⁶. Brooks defines quality as continually meeting people's defined healthcare requirements¹⁰⁷. The key word in the definition is 'defined', which describes the process of negotiation and agreement which must take place between the provider and customer to achieve a deliverable level of service. Yet, the concept of quality has two basic elements, focusing respectively on the product and the relationship of user and product¹⁰⁸. By focusing on the service, quality is seen as the degree to which a particular service conforms to its specifications. This is a view of quality that is based upon identifiable faults which can be discovered by inspection. Thus, services which have faults can be identified and remedied. However, a more dynamic view of quality emphasizes the extent to which the service is fit for the purpose for which it is intended¹⁰⁹. Something might conform perfectly to its specification without being of any use for the circumstances in which it is used¹¹⁰. Thus, organisations should look outward as the key determinant of success, change from the control of internal service systems to the relationship with the customer. For Calman, quality "is a concept which describes in both quantitative and qualitative terms the level of care or services provided"¹¹¹. Quality he states has two components. The

first is **Quantitative** and measurable, the second is **Qualitative**, and although assessable, is associated with value judgements. Calman argues that, quality is a relative not an absolute concept, suggesting that in describing the quality of a service it must always be compared with something else - either a similar activity or the same activity measured at another time. This implies measuring consistency over time. Therefore, the quality of medical care may be seen to comprise¹¹²:

- knowledge - technical skill and competence
- professional standards - ethical issues
- attitudes and behaviour, including communication skills
- managerial functions, including the ability to work within resources
- teaching, audit and research

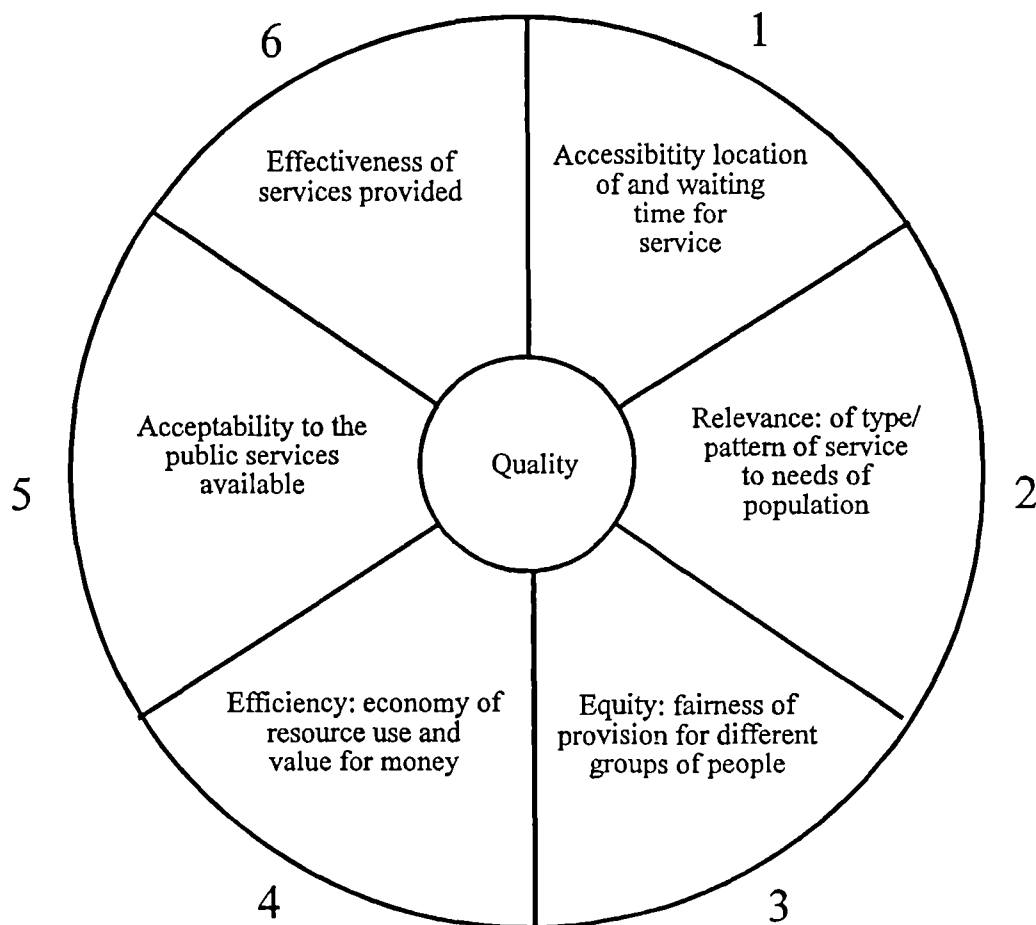
However, in the author's opinion, Calman does not point out how all these elements are connected and aggregated to constitute quality medical care. Thus, the integration of the elements within a holistic framework of quality of care would be difficult.

Reinhardt¹¹³ viewed quality from a micro and macro context. At a micro level quality is that element of service rendered to the individual patients, whereas at the macro level, the term quality embraces the ethical quality of the healthcare system as a whole; that is the percentage of the population enjoying unfettered, dignified access to a minimally adequate level of service. Whilst for Brook and Lohr, quality is that "component of the difference between efficacy and effectiveness that can be attributed to care providers, taking account of the environment in which they work"¹¹⁴. The author disagrees, because today's patients want to be more actively involved in the decision-making process concerning their care and treatment. The era of the patient as the ultimate customer has arrived. Healthcare consumers can easily discriminate between quality of care and the quality of caring they receive; between the way they are treated medically and treated personally. As patients, they feel competent to evaluate the quality of the caring they receive and justified in making treatment choices on that basis. Moreover, it is imperative that healthcare organisations, particularly hospitals within the NHS, concentrate on improving the quality of caring; that is the way patients are treated and the interpersonal relationships between staff and patients.

Koch notes that healthcare quality means continually meeting customer (purchaser/patient) requirements¹¹⁵. Koch has identified six main components in any quality service:

FIGURE 6

SIX COMPONENTS OF QUALITY IN PUBLIC SERVICES



Source: Hugh Koch - Quality Health care and TQM (1991)

Koch's six components for a quality service are a valuable contribution to the understanding of quality however, a seventh essential component is omitted, namely, the assessment of patient goals and values. For the author, the real kudos for

providing quality healthcare, is the way the patient is treated as a person; which entails meeting his/her goals and values.

As part of the National Health Service reforms guidance was given by the Department of Health (DOH) suggesting that contracting for quality should involve¹¹⁶:

- Appropriate treatment and care
- Achievement of optimal clinical outcome
- All clinically recognised procedures to minimise complications and other preventable events
- Attitudes which treat patients with dignity as individuals
- An environment conducive to patient safety, reassurance and contentment
- Speed of response and minimal inconvenience
- Involvement of patients in their own care.

These initiatives suggested by the DOH, the 'key to quality of care', are intended to ensure the 'understanding of the patients expectations, the identification of who the customers are and their views of the technical care and non-clinical service they receive'. However, the DOH failed to reveal the interrelatedness of these elements. Yet it is important to demonstrate how the elements combine to constitute a concise representation of quality of care, i.e. the quality of care required to turn hospitals into places where patients will be treated as people and not as case files and through-puts. Quality health care requires some common understanding of the term quality; comparisons of health facilities in terms of good quality demand agreement on the concept and its measurement¹¹⁷. Whilst quality of healthcare has been an issue since Florence Nightingale, a major problem remains in deciding whether quality should be based on patients' values or those of the service providers¹¹⁸. Conflict over

standards may arise between the service providers and the patients. Overall satisfaction with treatment is the way in which patients may determine the quality of care. However, health practitioners determine quality in terms of accuracy of diagnosis and efficiency of treatment even when patient satisfaction is low¹¹⁹. This conforms to the ethos of the traditional medical quality assurance paradigm which represents a static approach to quality. In the NHS, the practice of appraising quality of care has focused mainly on the providers side; i.e. the professional perspective rather than patients satisfaction, forgetting that quality must be based on the needs of the customer not the values of the provider no more no less¹²⁰. Furthermore, it is the patients satisfaction approach which helps to ensure that the services provided are responsive to the views and needs of the community¹²¹.

Donabedian and Maxwell have informed a good deal of operational and academic research in the area of healthcare quality assurance since they draw a distinction between the patient perspective and that of the provider of care¹²². In Donabedian's model, quality of care is evaluated in terms of the structure of health facilities, the process of care, and the outcome of care. He states that what is actually done in giving and receiving care, including both practitioners and patients contributions, changes in the health status of patients as well as improvements in their understanding and their satisfaction, are all essential elements of quality healthcare¹²³. It could be argued from Donebedian's perspective, that to define quality of care, emphasis should focus on the 'structure-process-outcome' relationship between the provider and the patient, whilst the six dimensions of Maxwell's methodology illustrate the differing concerns of patients and providers¹²⁴. In contrast, Bruce has provided a framework for evaluating quality that is heavily weighted towards the patient's perspective¹²⁵. In this framework, customer expectations are viewed as desires or wants of consumers i.e. what they feel a service provider 'should offer' rather than 'would offer'. Although a profession consisting of doctors, consultants, and nurses will tend to stress that a patient should be given 'not what he wants but what he needs'. What is important in the author's opinion, is to get the balance right, the balance between professional excellence and customer satisfaction.

Whilst many NHS hospitals are increasingly professionally focused, patient satisfaction is of more significance in healthcare. Therefore, those hospitals that cannot

demonstrate successful achievement of service quality standards to potential patients, will find themselves in deep trouble, as the concept of the internal market develops and competition between provider units tightens. The difference might centre on how patient needs are met.

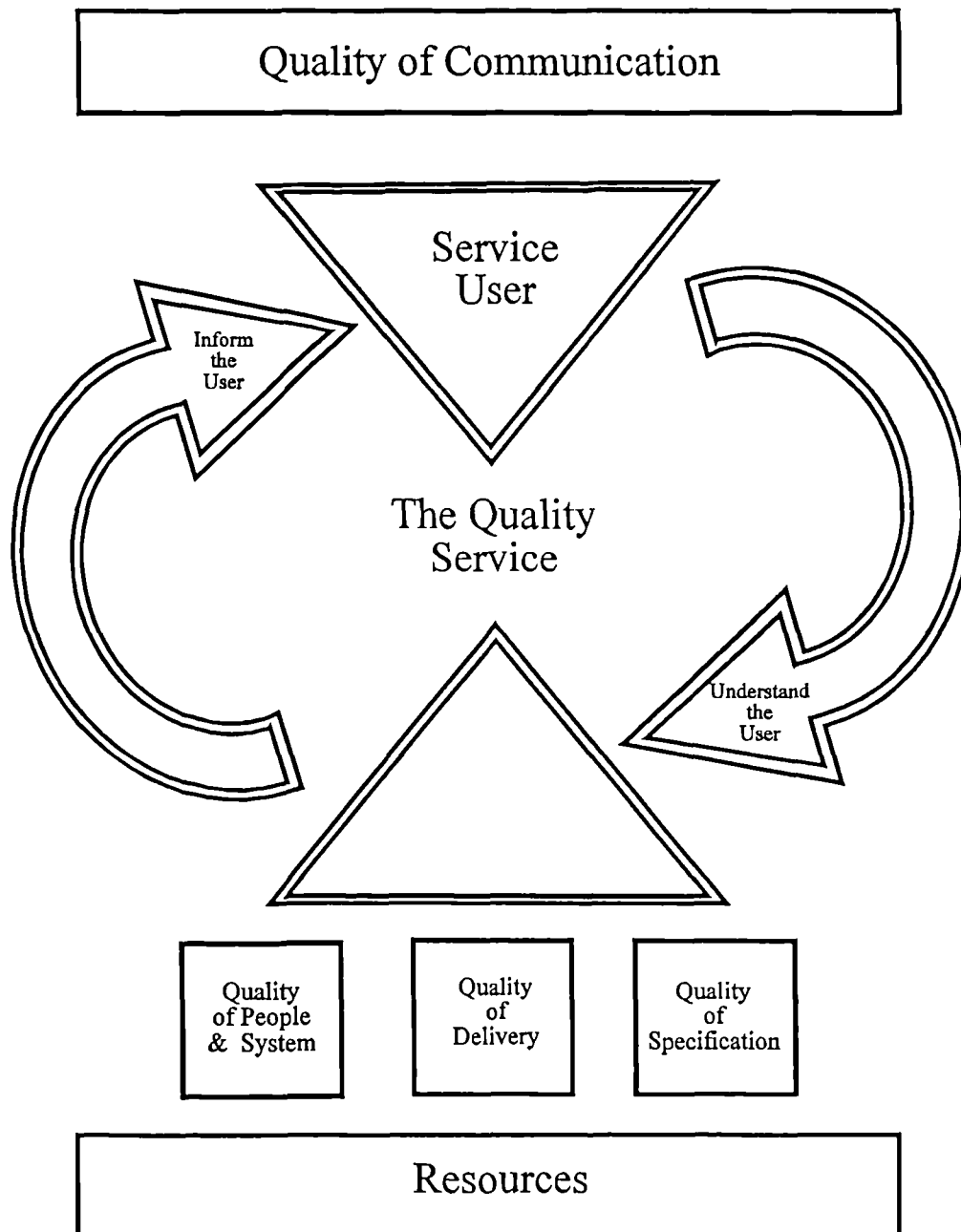
For any kind of quality definition, whether or not aiming for zero defects, the question is, the quality of what? Quality can only be judged in relation to explicit objectives and targets. Thus, the Audit Commission has identified four areas of quality which it argued contribute to a quality service¹²⁶:

- Quality of Communication: communicate with, listen to and understand users.
- Quality of Specification: users' needs converted into clear standards for service delivery.
- Quality of Delivery: are the standards actually delivered, and is remedial action taken when failure occurs.
- Quality of People and Systems: are staff motivated, trained, well managed and supported by good management, process and systems.

The Commission further argued that a quality service should have a foundation of adequate resources, be user effective and without waste to deliver the service¹²⁷.

FIGURE 7

*The Quality Map is made up of four key elements of quality: communication, specification delivery and people



Source:
Audit Commission Occasional Papers
Measuring and Appraising Quality in Public Services, March 1993

The Audit Commission suggests that applying the definitions and processes of quality used in the private sector to the public sector can be dangerous. In the private sector,

satisfying stated or implied needs will lead to increased sales and profits. This is not necessarily true in the public sector. In the health service, for example, increased quality leading to increased demand may lead to increased expenditure against limited budgets. This problem does not invalidate the need to consider users' needs in service delivery, rather it emphasises the importance of informing users about what can be done, understanding users' expectations and incorporating this understanding into policies and targets¹²⁸. Hence, high quality service involves adherence to customer expectations, not a compromise between what the customer wants and what the organisation is comfortable in providing¹²⁹.

Pollitt¹³⁰ notes two definitions relating to the health field. He sees problems with the first, the 1984 King's Fund definition of quality assurance, now widely used by Health Authorities. The key words are effectiveness, acceptability (to consumers and providers), equity (of access and distribution) and economy. He is concerned that one aspect may be traded off against another (a recurring problem, surely, with the whole value-for-money concept of three E's - Efficiency, Effectiveness and Economy) and that the definition is broad as to be not very useful. Pollitt also quotes a definition by Robert Brook and Kathleen Lohr, where "quality is seen as the difference produced by doctors and other care providers in their treatment of patients between efficacy - performance in ideal conditions - and effectiveness - performance in the actual environment¹³¹. This he notes is interesting but, it only adds to the difficulty of finding a working, operational and measurable definition of quality". However, it may be argued that the aspects of quality in the private and health sectors have quite a lot in common¹³²:

TABLE 5

SOME DEFINITIONS OF QUALITY

PRIVATE SECTOR	HEALTH CARE
Better than what's provided elsewhere	Comprehensive
As cheap as possible	Economic
Value for money	Effective
Fitness for purpose Conformance to requirements	Accurate
Up-to-date	Reliable
Reliable (free from errors, consistent)	Acceptable to consumers and providers
Satisfies the customer	Speedy
Delivered on time	Equitable (access and distribution 'Efficacy minus Effectiveness')

Source: Gaster, L. (1991) "Quality at the Frontline", p. 22.

Donabedian's classification of quality into three main aspects (Technical, Non-technical and Environment) is not altogether consistent with regard to their relative importance, but he tends to stress the first two as being totally interdependent. This makes immediate sense and is easily transferable to the NHS. Donabedian's three groupings are¹³³:

- Technical
 - the application of science and technology to a problem
- Non-technical
 - the social and psychological interface/interaction in relation to the problem

- Amenities/environment
- different attributes of quality: what makes a particular service good or bad in the eye of the beholder

Donabedian suggests that the practitioner, consumer, manager and citizen can be located in these groupings, followed by an assessment, depending on the perspective and the nature of the service, of the relative importance of the technical aspects compared with the interpersonal, (and) of the impact of the environment on either or both.

Donabedian suggests that further quality improvement can be gained by applying these concepts to the structure of the service - its characteristics in terms of the care givers, the tools, resources and organisational setting - and to the process and the outcome. Most of Donabedian's attention was focused on the processes that doctors perform. For outcomes, he felt that it is often not easy to distinguish the effect of medical intervention compared with other factors¹³⁴.

Whilst Donabedian acknowledges that a qualitative or value judgement of some kind is inherent in most decisions, for example, about the quantity of care to provide, he has reservations about broadening the working definition of quality too much:

"There is a danger of enlarging the definition of quality so much that it loses distinctiveness and analytic utility, becoming almost a slogan which means nearly anything anyone chooses it to mean"¹³⁵.

Therefore, he seems inclined to see accessibility, for example, as a service attribute separable from quality and points out that in some cases increased accessibility can mean a decrease in quality; a point also made by Lipsky¹³⁶, who suggests continuity and coordination of care as possible facilitators of quality, but not as attributes of quality itself. However, it is the author's opinion that this view is certainly debatable. In a hospital setting, good coordination is an essential element in the service encountered between the provider of service and the patient. Furthermore, in respect to Donabedian, he failed to contextualise 'how' hospitals can focus on treating patients as real people and not as 'hemorrhoid' in ward 5 nor as the cancer patient in ward 7.

Thus, it is important for hospitals to have a broad definition of quality. This is because patients have differing needs and expectations of the quality of medical care.

Stewart and Walsh set at variance the concept of quality from the three E's by using a framework of "elements" to describe quality¹³⁷:

- fitness for purpose and freedom from faults: does the core service do what it is supposed to do?
- service surroundings
- service inter-relationships

Stewart and Walsh note that the relative importance of each factor will vary from service to service and according to whether the service is "generalistic" (it does not matter who provides it) or "particularistic" (it does matter). They further identified 9 quality dimensions¹³⁸:

- speed
- reliability
- accuracy
- responsiveness
- sensitivity
- possibility of choice
- access
- welcoming, understanding, credible, trustworthy, knowledgeable service
- secure from threats

The author disagrees with Stewart and Walsh because the 9 dimensions are not plausibly interconnected. The interconnectedness of the aforementioned elements is essential, if they are to be realistically implemented within an organisational setting.

The Management Executive of the NHS (NHSME), in its publication, "The Quality Journey - A Guide to TQM in the NHS", defines quality as¹³⁹:

1. "Meeting customer requirements. Under this definition, it is the customer of a product or service who defines the quality of what is delivered. The customer knows what he or she wants and only the customer can decide whether or not it is up to scratch".
2. "Meeting people's healthcare requirements. These requirements will be negotiated and agreed with the user - the patient"¹³⁹. Furthermore, the two definitions by NHSME are congruent with the work of Dotchin and Oakland¹⁴⁰, who noted that the most widely used definitions of quality today are:
 1. "Fitness for use"
 2. "Meeting customer requirements"

However, from the literature, a third definition can be discerned, the traditional view of quality. This represents quality of care as defined by healthcare professionals. But, this definition fails to take into account economic factors, such as the tax payer and the importance of accountability, and patients' expectations¹⁴¹. Laffel and Blumenthal note that the traditional approach to quality healthcare implicitly assumes that some rate of poor outcomes is acceptable and that little information can be obtained from the analysis of cases in which prevailing standards are met¹⁴². Furthermore, the traditional approach tends to focus on physician performance and to underemphasise the contributions of non physicians and organisational processes generally¹⁴³. Nonetheless, quality improvement in modern healthcare will require complex, simultaneous changes involving employees and professionals in many departments to bring about a change in the status quo. Thus, to achieve quality healthcare three distinct factors will play a role in the patient's judgement¹⁴¹:

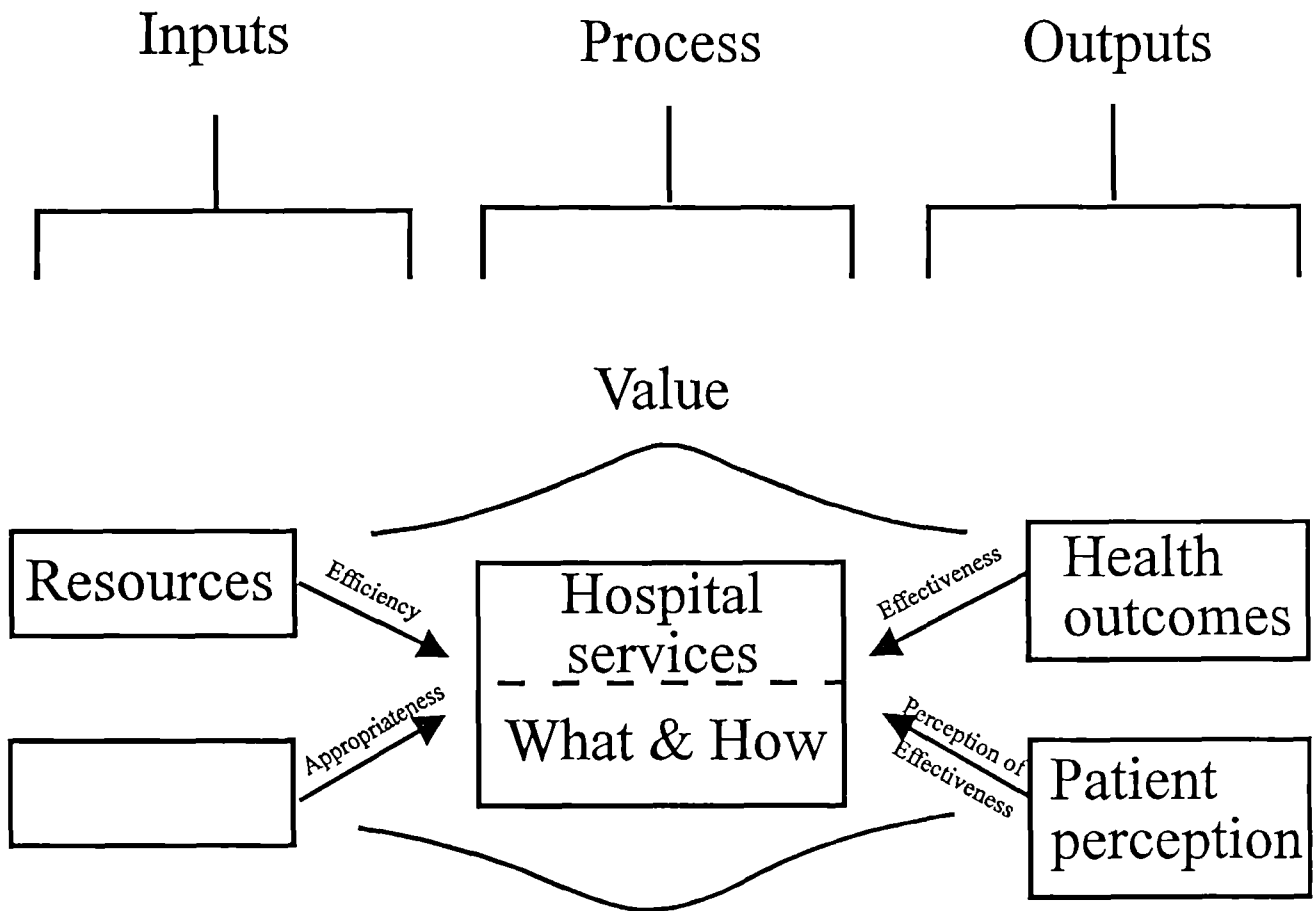
- The patient's standard or nominal expectation
- What the patient has experienced in the past that has detracted from the quality of care

- What the patient has experienced in the past that has enhanced the patient-medics relationship.

Each of these three factors tends to be a discrete item in the patient's mind and, by listening to the patient, hospitals can compile a valuable map of what constitutes quality 'care' from the patient's perspective. However, some researchers infer that, as healthcare professionals are the 'experts', they should be the ones whose voices are listened to most closely¹⁴⁵. But, the trouble in listening only to clinicians, in the author's opinion, is the obvious fact that professional judgement is not always correct. In recent times, there have been cases of wrong clinical diagnosis in a number of NHS Trust hospitals. This is consistent with Nelson et al's definition of quality of care based on the fact that one of the primary functions of healthcare is to ensure patient's welfare¹⁴⁶. This perspective requires that important decisions about medical benefits and risks be shared with the patients and that practitioners be considered as working on behalf of the patients. Thus, the patient should no longer be considered as the 'disappointed observer of care', or as 'the final victim of poor health', but as the focus for quality care¹⁴⁷. Both of these perspectives belong to a wider model of providing healthcare; the 'systems model' - patient is the one who receives an output of a process which is itself any set of actions that transform an input from a supplier into an output evaluated and used by the consumer¹⁴⁸. The benefit of this output being always judged by the consumer and never by the persons involved in the process¹⁴⁹. In healthcare, the concept of 'the consumer' includes not only the patients but also the consultants, the nurses and paramedics, who interact with the patients in reducing their pain or improving their health status. Every service provided within a hospital setting can be seen as a string of processes involving relations between suppliers and consumers of care¹⁵⁰.

FIGURE 8

A SYSTEMS VIEW OF THE HEALTH SERVICE



Source: The New Healthcare Market by P. Boland (1988) Cited in Lanning (1990)

However, as identified by the author, there are different definitions as to the meaning of quality in the NHS. This has inhibited a 'systems view to the services provided. In one particular hospital visited by the author, there were four different definitions of quality in use:

1. To the medical staff, quality is about whether 'the patient lives or dies'.
2. To the receptionists, 'quality is about how we present things'.

3. To the Chief Executive, 'quality is low cost'.
4. To the Quality Manager, 'meeting every patients' needs is ridiculous, the hospital cannot afford that, we can only try to provide the patient with what is medically advisable'. This means what the patient actually needs.

In one other hospital an employee defined quality as 'Auditing'. This means 'checking me to see whether I do my job well'. Another employee in this particular hospital asked the Quality Manager, 'When is this quality thing going to finish?'. What was evident in this latter hospital was that whilst TQM was in full swing, most employees felt that this "quality thing" was unnecessary after all, 'we do our job well'; confirming the fact that in a professional setting, once an employee feels he or she is carrying out a job within the confines of professional requirements he is providing a quality service, it does not matter whether the patient is satisfied. Whereas in the private sector, employees provide services in order to ensure repeat customers. Thus, in most cases with private sector, the needs of the customer are met.

These findings are congruent with the study by Kogan et al¹⁵¹, who noted a "lack of a common definition of quality in the NHS, due to the diverse professional groupings". Whilst Dalley and McIver¹⁵², also identified a parallel mixture of definitions of quality. They noted a mixture of both Donabedian and Maxwells' definitions in the NHS. However, the author disagrees with the assertion of Dalley and McIver because, in the NHS, many managers are not familiar with the quality literature to know about Donabedian's or Maxwell's definitions. Whilst their actions might portray these definitions, the Quality Managers with whom the author spoke all defined quality from a basic premise of "meeting customer needs"; rarely did they mention a definition offered by any particular writer. Although it could be suggested that Crosby's definition of quality, 'meeting customer requirements', is more widespread than any other definition of quality. But, if the members of a typical Trust Hospital's Board were to be asked for their definition of quality, the question would generate answers revealing different and varying aspects of the definition of quality, whereas in a commercial organisation, say Miliken Europe, the Board would have one consensual definition which depicts togetherness. The lack of consensus amongst NHS employees

as to what quality means is as a result of the failure of Quality Managers to adopt an organisation-wide definition of quality.

One Quality Manager noted that the definition of quality is implicit, "everyone knows that quality is about meeting customer needs. Hence, it is not important to adopt an organisation-wide definition of quality". In the author's opinion, the failure of most NHS hospitals to adopt a specific definition of quality has contributed to the lack of a systematic approach to the implementation of TQM. A commonly held definition by all employees is a good starting point for TQM because it provides the organisation with the ultimate 'focus' for TQM. For example, Juran's definition of quality, 'Fitness for Use', as an organisation wide definition informs the workforce explicitly that the services we provide should be 'fit for purpose' of our customers. Thus, providing the opportunity for every employee to adopt the new philosophy. An organisation-wide definition of quality is a must for the successful implementation of TQM.

WHAT IS TOTAL QUALITY MANAGEMENT?

One of the difficulties in the discussion of Total Quality Management is the apparent lack of consensus as to what it means¹⁵³. There seems to be confusion as to what different commentators mean when they discuss TQM, although certain buzzwords are common in the literature, for example, 'Zero defects', 'Right first time', 'Plan-do-check-act' and 'Fitness for use'¹⁵⁴. However, Oakland, tries to ease this confusion by arguing that while the so-called quality 'gurus' (Deming, Juran, and Crosby) seem to present "different solutions to the problems of quality management and control, their solutions only reflect differences in dialect rather than language"¹⁵⁵. The British Quality Association (BQA) have put forward three definitions of TQM¹⁵⁶. The first focuses on the 'soft' qualitative characteristics; customer orientation, culture of excellence, removal of performance barriers, teamwork, training, employee participation and competitive edge. From this perspective, TQM is seen as consistent with open management styles, delegated responsibility and the empowerment of staff¹⁵⁷. The second definition places emphasis on the **production** aspects, such as systematic measurement and control of work, setting standards of performance, using statistical procedures to assess quality; this is the 'hard' production/operations management view. The third definition is a mixture of 'hard and soft', comprising three features:

an obsession with quality, the need for a scientific approach and the view that all employees are part of one team¹⁵⁸. However, these definitions are rather arbitrary and it is unlikely that the practising manager would have much time for the 'soft' side of TQM given their emphasis on tools, measurement and bottom-line performance¹⁵⁹.

For Oakland, "TQM is a 'way of managing to improve the effectiveness, flexibility and competitiveness of the business as a whole', meeting customer requirements both external and internal to the organisation"¹⁶⁰. TQM is conceptualised in the form of a triangle - with the three points representing; 'management commitment', 'statistical process control' and 'teamworking' - and a chain, indicating the interdependence of customer - supplier links throughout the organisation. The concept of a quality chain is central to Oakland's view of TQM. His concern is that the chain can be broken at any point by one person or piece of equipment not meeting the requirements of the internal or external customer, and that this failure usually finds its way to the interface with external customers. By focusing on internal customer expectations all along the supply chain to the final customer in the market place, the intention is to build up an internal customer environment¹⁶¹. But, Oakland does not tell us explicitly how this internal customer environment will be built. He also tends to forget about the external customer environment and throughput process of the organisational environment. For Collard, quality management represents "a systematic way of guaranteeing that all activities within an organisation happen the way they have been planned. It is a management discipline concerned with preventing problems from occurring by creating the attitude and controls that make prevention possible"¹⁶². Furthermore, Collard draws attention to the fact that everything that is done within a company depends on people and it is essential to motivate everyone within the organisation with the commitment to quality¹⁶³. However, Collard forgets that no matter how motivated 'people' are to the TQM process within an organisation, it is only the top management that can effect changes. Thus, it is imperative that top management is the first to be motivated and to exhibit commitment, in order for TQM to work; because it is the responsibility of top management to effect 98 percent of the changes required in the system whilst employees are only able to make 2 percent change which is inadequate in creating an environment of continuous quality improvement.

Dale and Plunkett suggest that for the implementation of TQM, "it is necessary to change behaviour and attitudes throughout the organisation"¹⁶⁴. They suggest that, the key features of TQM are: "employee involvement and development and a teamwork approach to dealing with improvement activities". Although Dale and Plunkett accord a recognition to the role which must be played by employees in making TQM operate effectively, the principal focus of their work remains on the statistical and operational characteristics of the system¹⁶⁵. However, the author would add that TQM is based on an understanding of a combination of organisational values, customer expectations and the granting to employees of the opportunity to deliver good service to the customer. This implies that a TQM programme centred around statistical control of processes would encounter difficulties because of the limited knowledge of statistical tools amongst many employees. This view is consistent with the work of Schaffer and Thompson who note that many organisations have failed to adapt Deming's philosophy because of its emphasis on statistical control of processes¹⁶⁶.

Furthermore, involving employees and undertaking a teamwork approach does not necessarily guarantee quality. In the author's opinion, what makes quality work, irrespective of teamwork, is an optimised organisational 'system'. A system designed to meet both external and internal environmental needs and expectations. Thus, without an optimised system which works under a hundred percent statistical control, any TQM initiative will falter.

For Crosby quality has no qualifiers. He defines quality management as a systematic way of guaranteeing that organised activities happen the way they are planned. 'It is a management discipline concerned with preventing problems from occurring by creating the attitudes and controls that make prevention possible'¹⁶⁷. TQM advocates zero defects in the products and services produced by an organisation. It is about driving quality into all aspects of a company's operation and perhaps, even more importantly, it is about doing things 'right first time'; an approach which adds nothing to the cost of a company's product or services¹⁶⁸. The author questions Crosby's idea of zero defects, arguing whether it is possible to achieve zero defects when human and environmental factors are involved. Furthermore, Haigh and Morris identified three complementary views of TQM¹⁶⁹:

TOTAL - Organisation-wide process involving everyone from post room to the board room.

QUALITY - Establishing quality goals for each and every element in the process of product or service delivery so as 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.

They go further to suggest that TQM is a process which embraces the conscious striving for zero defects in all aspects of an organisation's activities or management with workforce co-operating in the processes developing, producing and marketing quality goods and services which satisfy customers' needs and expectations first time and every subsequent time¹⁷⁰.

Whilst for Macdonald and Piggot¹⁷¹ quality management is not a fixed body of truths but a process that is evolving and which will take different forms to meet the needs of individual companies. Whereas Atkinson¹⁷², taking a proactive stance, sees TQM as a preventative strategy replacing rework, fire-fighting and crisis management by planning, coordination and control. TQM, he suggests, is the umbrella under which a great number of quality initiatives can be managed. However, Sinclair notes that such definitions as put forward by MacDonald and Piggot and Atkinson are limited because of the failure to recognise the role and place of the workers within organisations. It is this failure which has been responsible for the failure of many programmes of TQM¹⁷³.

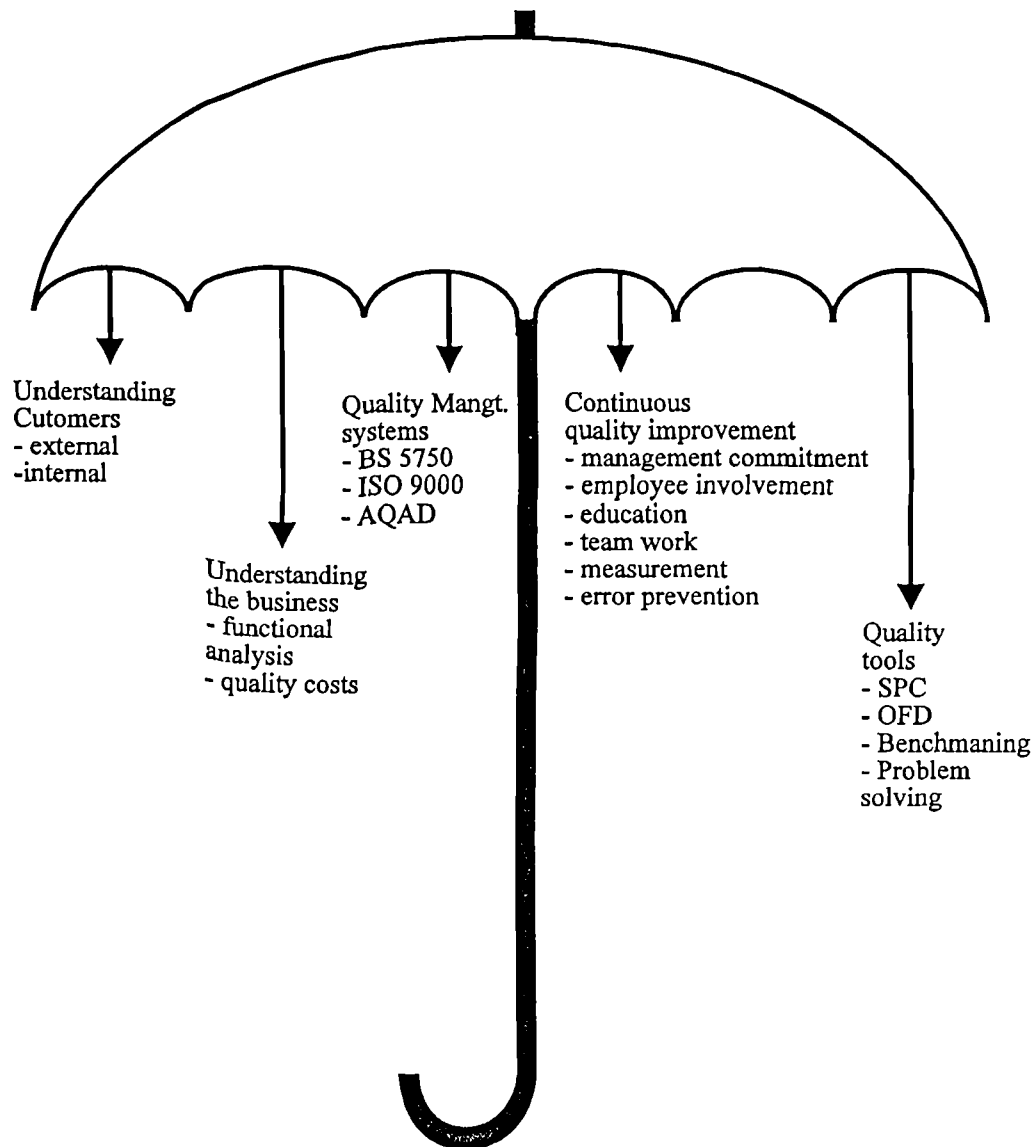
Lesley and Malcolm Munro-Faure define TQM as 'a proven, systematic approach to the planning and management of activities'¹⁷⁴. They state that the objective of TQM is to satisfy customer requirements as efficiently and profitably as possible. In a total quality environment all employees must strive to:

- (i) **do the right things** - only the activities that satisfy the requirements of customers should be encouraged, all other activities are to be analysed or discontinued if they are considered unnecessary
- (ii) **do things right** - all organisational activities should be performed correctly to ensure that output meets customer requirements
- (iii) **do things right first time, everytime** - if this is possible, then money should not be wasted on checking, and scrapping output or correcting errors.

They go further to suggest that TQM can be successfully applied to any type of organisation provided it integrates certain components¹⁷⁵:

FIGURE 9

TQM: COMPONENTS OF TQM MEETING CUSTOMER REQUIREMENTS AT MINIMUM COST



Source: Lesley & M.M. Faure. Implementity TQM. 1992

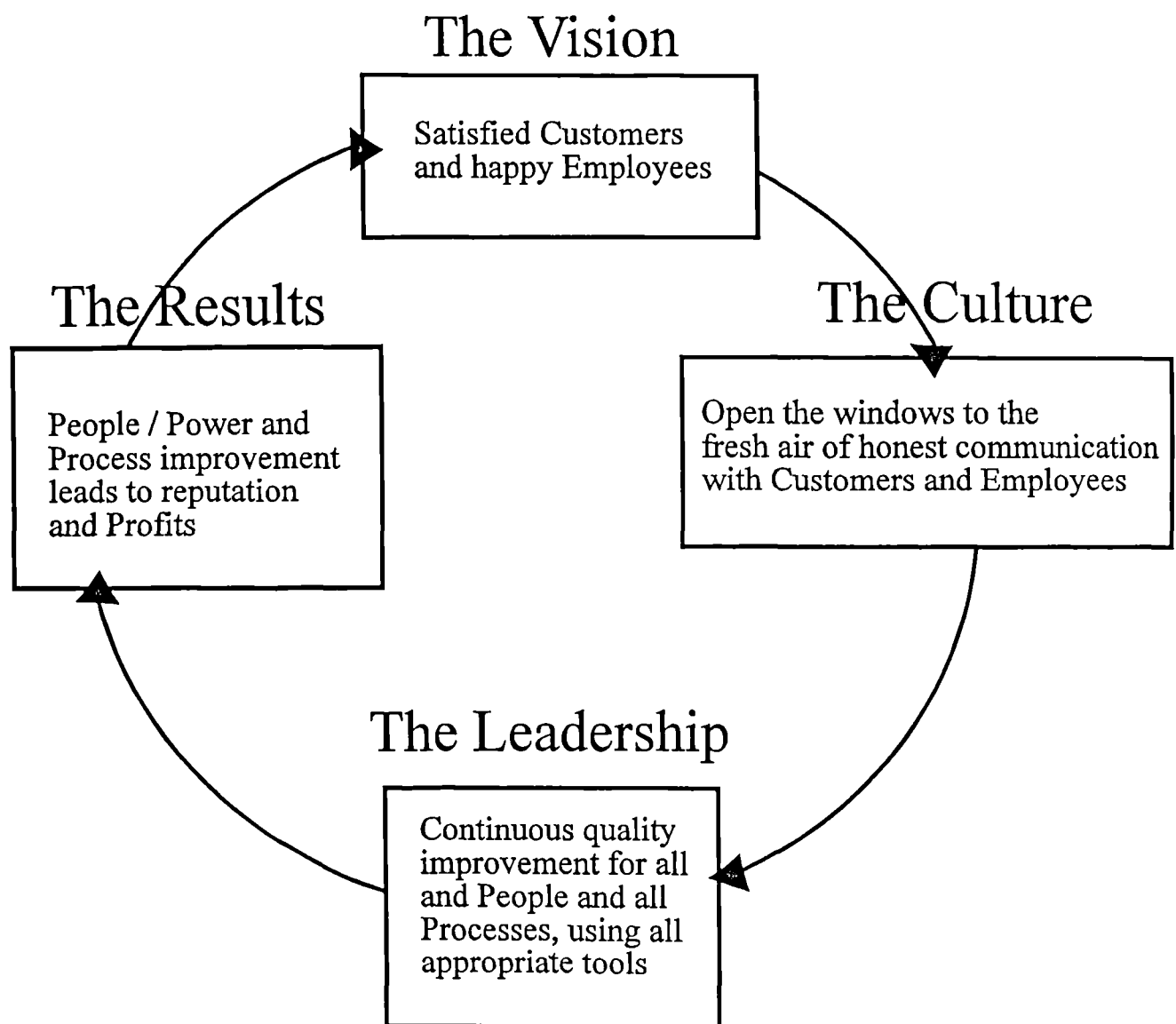
The author agrees with the components of TQM as advocated by Lesley and Malcolm Faure but would suggest that any model of TQM should establish clear, customer-oriented performance standards and the meticulous measurement of performance against those standards. A commitment to TQM without a commitment to standards and

measurement would be a dedication to lip service, not customer service. Only with customer-focused standards and customer-based satisfaction measurements is it possible to create and maintain a quality focused organisation.

Hagan notes that the underlying theme of most discussions on TQM is two fold¹⁷⁶: the need for sufficient cultural changes in industry to support the concept of continuous quality improvement, and the need to carry this concept beyond traditional quality assurance applications into work processes, ultimately including management:

FIGURE 10

A CLOSED-LOOP NOTION OF TWO UNDERLYING THEMES OF TQM



Source: Hagan, J., Management of Quality, 1993²¹³

Hagan further notes that TQM's basic strategy is 'to integrate primary management techniques, existing improvement efforts, and technical tools into a disciplined approach focusing on how to improve the way work gets done'. This directly addresses customer satisfaction, the elimination of chronic waste, and the reduction of excess variability in performance. TQM involves the management of four basic pillars of business:

1. Customer - "management must become customer-driven, for both the external and the internal customer. This means anticipating and meeting or exceeding the customers' needs and desires.
2. Quality - with quality being as defined by the customer, it must become the number one priority of the enterprise, taking precedence over all other considerations, specifically over cost and schedule.
3. Continuous process improvement - lasting improvement can only be obtained by focusing on the process.
4. People - these are the important part of any process. They should be treated more as a resource rather than as capital¹⁷⁷.

However, as the author has argued elsewhere, there are five rather than four basic pillars of TQM¹⁷⁸:

1. Continuous improvement
2. Quality measurement
3. Customer is king
4. Everyone participates
5. Aligned corporate systems

The argument being that the five principal elements must work in unison for a quality transformation to take place.

Bergman, in his definition of TQM, takes a three dimensional perspective. Firstly, he defines 'Total' as meaning that it is not only external customers that count. To achieve high external quality it is necessary also to satisfy the internal customers. Every process in the company has customers. All of these have to be satisfied in order to be able to do a good job. Secondly, he notes that TQM is about leadership and employee participation. It involves cultural change towards an organisation which is strongly customer focused and strongly committed to continuous improvement in all of its processes. The central part of today's quality he ascribes to the customer's orientation. Thirdly, he proceeds to state that the quality strategy of an organisation has to be revered by everyone in the organisation. Everyone is responsible for a process. Everyone should make improvements based on facts interpreted in the light of process knowledge. Everyone has to be involved. Thirdly, he advocates the importance of top management commitment in achieving TQM. 'Top management has to create respect for quality and the quality strategy of the organisation'¹⁷⁹. To Bergman's list the author will add the need for demonstrated and committed leadership from top management, particularly the Chief Executive Officer, who must be seen to be overtly involved in the TQM programme.

Foster and Smith¹⁸⁰ view quality management as a generic term that includes all of the activities, whether clinical or non-clinical, that are being employed to improve the quality of service to patients and customers, but more specifically, they further defined QM as a strategy for ensuring a process of planned organisational change which aims to anticipate and meet internal and external customer/patient requirement as efficiently and effectively as possible¹⁸¹. However, the major premise of TQM is the definition of quality by Juran as "fitness for use" which may be seen to be the key to business success in the 1990's; it is this, rather than price or delivery, that holds the key to competitive advantage¹⁸². The aim is to have quality built-in rather than inspected-in, with quality being the responsibility of all employees, rather than the exclusive presence of a specialist department. This will lead to costs falling because of a decline in failure rates, warranty costs, returned goods, and a reduction in the costs of detection¹⁸³. TQM involves a primary focus on the requirements of the customer, whether external or internal to the organisation. This involves not only conventional market research, it also requires sales market research and demands requires sales staff, managers and designers to develop an awareness of the requirements of the

external customer. In addition, those employees who do not have direct contact with external customers are encouraged to view their colleagues as internal customers¹⁸⁴.

Wilkinson et al, quoting Smith, state that every organisation member has a customer for his work; the department which receives the data, the next operator in the process line, the users of the service, the boss and the secretary, who is the customer depends on the transaction. Yet each transaction must have an identified customer. Without a customer response it is impossible to discern whether value has been added¹⁸⁵. Thus, Wilkinson et al suggest that all employees should be seen as part of a chain, from supplier through to external customer; a chain which includes both line and support functions. In this way, TQM attempts to emphasise that all employees are ultimately involved in serving the final customer, with that quality mattering at all stages and with teamwork and co-operation being deemed to be essential¹⁸⁶. Wilkinson et al, suggest that there are mainly two aspects to TQM; 'hard and soft'. The former involves a range of production techniques, including statistical process control, changes in the layout of design, processes and procedures of the organisation, just-in-time inventory control and, most importantly, the seven basic TQM tools used to interpret data: process flow charting, tally charts, pareto analysis, scatter diagrams, histograms, control charts, and cause and effect analysis¹⁸⁷.

The 'soft' side of Total Quality Management is largely concerned with creating customer awareness within an organisation and as such could represent a form of internal marketing¹⁸⁸. Thus, in manufacturing companies, programmes may be run to show the workforce the end product, i.e. outcome measures, while in service organisations there is a major emphasis on customer-care programmes; thus highlighting the importance of the soft side of TQM. In highlighting the soft side of TQM, Oakland¹⁸⁹ states that "TQM is concerned with moving the focus of control from outside the individual to within, the objective being to make everyone accountable for their own performance, and to get them committed to attaining quality in a highly motivated fashion". The assumptions a director or manager must make in order to move in this direction is that people, employees do not need to be coerced to perform well, but that employees want to achieve, accomplish and influence activity and challenge their abilities¹⁹⁰.

Within such a context there are clear implications for the workforce in the message that "quality is everyone's business. Firms are urged to move away from supervisory approaches to quality control towards a situation where employees themselves take responsibility¹⁹¹. Therefore, the soft side of TQM puts emphasis on the management of human resources in the organisation¹⁹². Nonetheless, at the initial stages of TQM (one to two years) quality should be the responsibility and ownership of top management. This would ensure its understanding of TQM and thus, win its commitment and leadership to the process as a precursor to the involvement of first level operatives.

Foster et al¹⁹³, echoing the soft aspect of TQM, see TQM as an effective approach to improving managerial and organisational performance both in the short and long term. They infer that total quality management aims to continuously improve the quality of service by:

- setting standards to meet and then surpass service requirements
- measuring the standards of service provided
- creating organisational policies, procedures and practices focused on service standards
- eliminating wasted time, effort and resources by achieving those standards first time
- establishing relevant service monitoring and review procedures¹⁹⁴.

However, their definition seems to imply that, in TQM, performance is defined as the quality of service delivered to customers by meeting previously specified standards. This may not necessarily be so, because some organisations set standards based on what they think the customer wants, rather than upon the customers' own personal input. In addition, no reference is made by Foster et al to the issue of performance management. They tend to forget that unless TQM delivers on results, organisations will remain sceptical of TQM as a transformational strategy. Moreover, meeting

specified standards does not necessarily guarantee a quality service or product. High quality service involves adherence to customer expectations, not a compromise between what the customer wants and what the organisation is comfortable with providing.

Macdonald and Piggot, quoting Ishikawa, state that: "quality management is a revolutionary management philosophy characterized by the following strategic goals"¹⁹⁵:

- seek quality before profits
- develop employees' infinite potential through education, delegation and positive support
- build a long-term consumer orientation, both outside and inside the organisation
- communicate throughout the organisation with facts and statistical data and use management as motivation
- develop a company-wide system focusing all employees on the quality related implications of every decision and action at all stages of development of the product or service, from design to sales

Ishikawa notes that in all types of organisations it is necessary to know about customers' likes, tastes, and applications¹⁹⁶. In addition, organisational functions should recognize the internal supplier-customer relationships, with the next process being the customer. However, there are many in the quality movement who argue against the idea of an internal customer, because it takes away the 'focus' on the end customer¹⁹⁷. This is evidenced by Motorola, widely regarded as one of the quality success stories, firmly rejects the "internal customer" approach arguing that there is only one customer; the 'person' who pays the bills¹⁹⁸.

Kanji notes that the modern concept of quality is defined as conformance to requirements, and requirements are defined as the task to be accomplished in meeting customer needs. In general he notes that TQM is defined as follows¹⁹⁹:

Quality - Is to satisfy customer's requirements continually.

Total Quality - Is to achieve quality at low cost.

TQM - Is to obtain total quality by involving everyone's daily commitment.

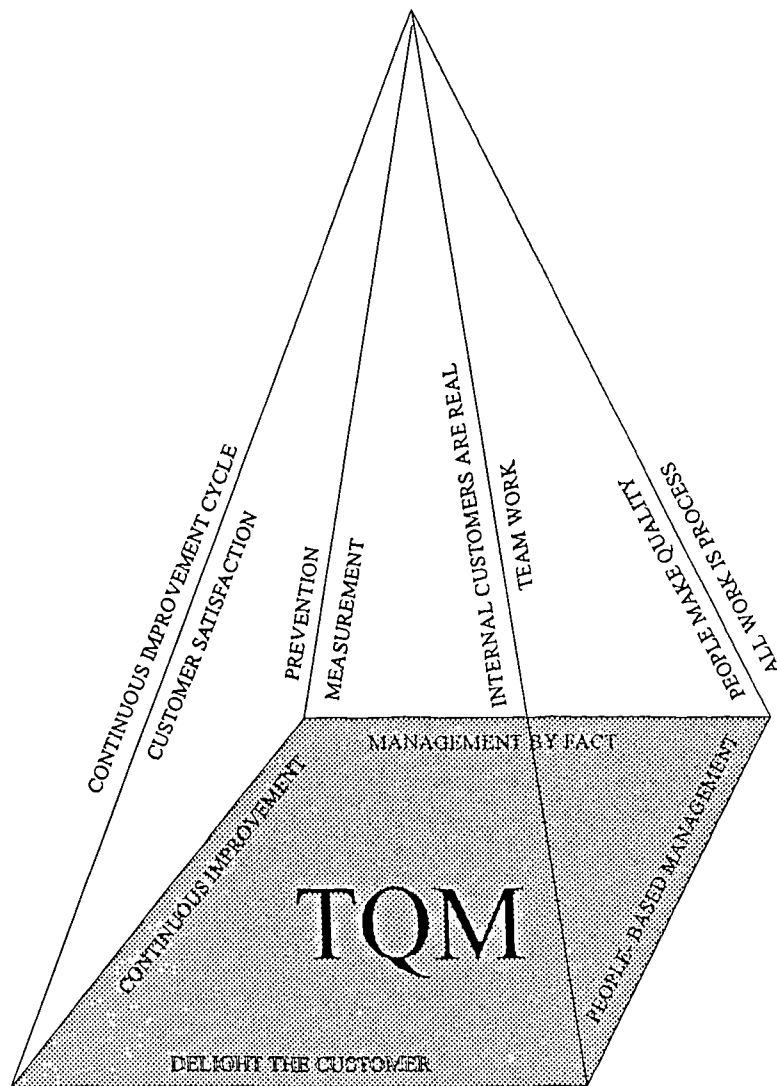
Kanji further suggests that TQM is about continuous performance improvement; of individuals, of groups, and of organisations. What differentiates TQM from other management processes, he notes, is the emphasis on continuous improvement. TQM, he argues, is not a quick fix; but is about changing the way things are done - for ever²⁰⁰. In order to improve performance, Kanji suggests that, organisations need to know 'what to do' and 'how to do it', 'have the right tools to do it', be able to measure performances, and to receive feedback on current levels of achievement. TQM provides this by adhering to a set of general principles. These are discerned as being²⁰¹:

- (1) delight the customer
- (2) management by fact
- (3) people-based management
- (4) continuous improvement

Furthermore, Kanji advocates a four-sided pyramid principles together with core concepts which he argues need to be present in any TQM environment:

FIGURE 11

PYRAMID PRINCIPLES OF TQM



Source: Kanji and Asher (1993) 'TQM Process: A Systematic Approach', Cartax Publishing

However, a number of studies^{202,203} seem to challenge the pro-TQM stance taken by Kanji. They argue that TQM has historical roots in Taylorism and Fordism in ways which lead to dysfunctional results. Thus, in practice TQM is an extension of the deregulation mentality into the workplace; 'Get rid of non-management-imposed

restrictions, government agency restrictions, union work rules, removal of employee rights, and institute the idea of letting management manage', without any recourse to improving the employees' welfare²⁰⁴. Therefore, TQM is not about changing the ways things get done but a repackaged Taylorist agenda that would exist as a conspiracy to de-humanise the worker using self pretentious principles such as teamworking, empowerment and motivation²⁰⁵.

Cuylenberg sees TQM as part of the corporate culture; "TQM must be accepted as a natural way of working by every employee. In such a culture every employee cannot help but be involved..., this would involve an awareness of the hundreds of business processes which combine to make any company work"²⁰⁶.

Similarly, to Shirley²⁰⁷, TQM is a cultural based approach. He notes, that for TQM to succeed management must operate an open and participative management style. Management must communicate with employees and, more importantly, must trust and respect them. All too often in the U.K., managers treat members of the workforce as if they were incapable of anything except exercising a limited range of mechanical skills. Thus, in this kind of environment to ensure the cultural change takes place there must be a fundamental review of the:

- approach to quality determination and improvement
- scope of the quality programme
- philosophy of quality assurance
- standards of work
- review mechanisms

Shirley argues that an adherence to these key elements, will ensure a change from retrospective quality control to the 'right first time' philosophy²⁰⁸.

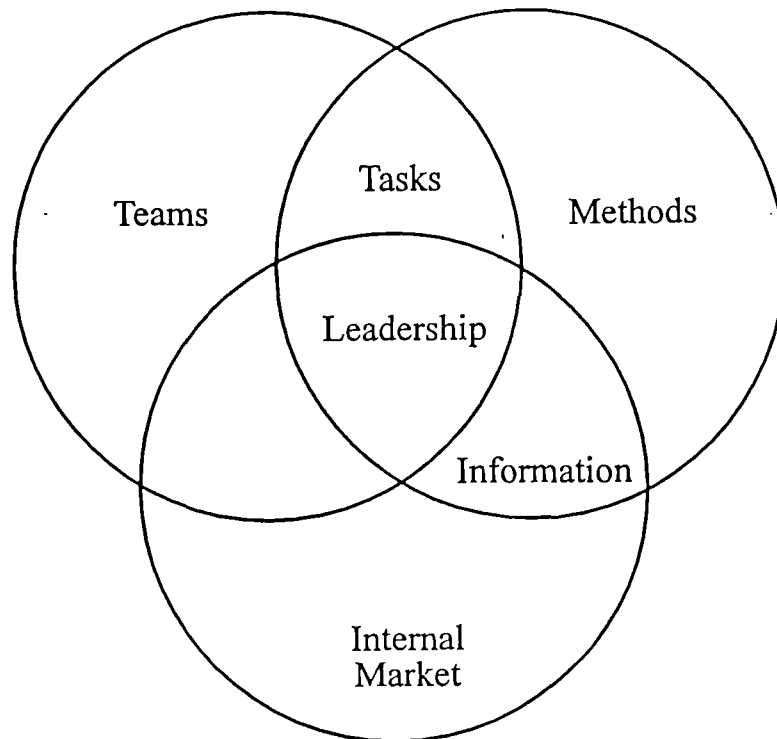
For Dalley and Carr-Hill, quality is a cultural change initiative involving six key characteristics²⁰⁹:

- it requires full commitment from all levels of the organisation

- there must be clear communication in each direction
- it requires continuing leadership from management throughout the process
- all disciplines, all levels and therefore, all staff must be involved
- quality activities must be consumer focused
- it requires a good quality system which allows a coherent and co-ordinated strategy to be put into action.

However, Dumaine²¹⁰ argues that for culture change to happen, it must come from the bottom, and the CEO must guide it. Organisations have to start with the premise that people at all levels want to contribute and make the business a success. This means that the CEO must live the new culture and become the walking embodiment of it²¹¹. He must also spot and celebrate managers and employees who exemplify the values he wants to inculcate²¹². This would ensure that quality becomes a way of life that permeates every part and all aspects of organisational activities. The essence of TQM lies in its ability to bring together, under a single integrated approach, four areas of organisational life of equal importance²¹³:

FIGURE 12



Source: Adrian Wilkinson and Barry Witcher-
Management Decision 1991, pages 46/51

However, recent events at Milliken's European division at Wigan, seem to suggest that at the present time TQM is still an aspiration rather than an ideal for most companies²¹⁴. The Managing Director of Milliken, Mr. Jeans, was quoted as saying, 'Some companies have been working at quality for 30 years... To think we could catch up in a decade would be lunacy. Like every company embarking on the quality voyage, Milliken finds that the further it advances, the longer the road seems. Cresting the top of one problem reveals the foothills of the next'²¹⁵. Similarly, within the National Health Service, which started experimenting with TQM since 1989, it is possible to visualise the confusion, the patchy traces of quality within departments while, for the meantime, TQM constitutes a mere 'aspiration'.

Berwick describes four general 'theses' upon which TQM rests: Firstly, an organisation's success depends fundamentally on meeting the needs of those it serves (its customers). Secondly, quality, defined as the ability to meet the needs of customers, is an effect caused by the processes of production in which the causal

systems are complex but, with effort, understandable. Thirdly, most people are motivated to work hard and do well. Fourthly, simple statistical methods can determine the faults in the production systems and will produce information to enable the continuous improvement of those processes to be undertaken²¹⁶. Thus, TQM represents an application of quality assurance to every company activity, so that zero defects are achieved through continuously improving customer satisfaction by quality-led-companywide management²¹⁷.

Atkinson defines TQM as a strategic approach to producing the best product and service possible through constant innovation²¹⁸. This is a recognition that concentrating not only upon the production side but also on the service side of a business is tantamount to success. TQM, he suggests, is an organisation-wide commitment 'to getting things right'. However, Burr²¹⁹ sees TQM as a concept rather than a single programme or method. The concept of TQM, he argues, is based on two precepts:

- (1) Planning - Any organisation will function most effectively if the efforts of all of its people are directed at a common objective, goal or vision. Given this common objective, each individual's efforts must be directed to specific actions that will, collectively, accomplish the overall objective.
- (2) Communication - Every individual in an organization must contribute to its success. Through 'continuous and effective communication'. He goes further to suggest, what he calls, 'six common manifestations' of TQM²²⁰:

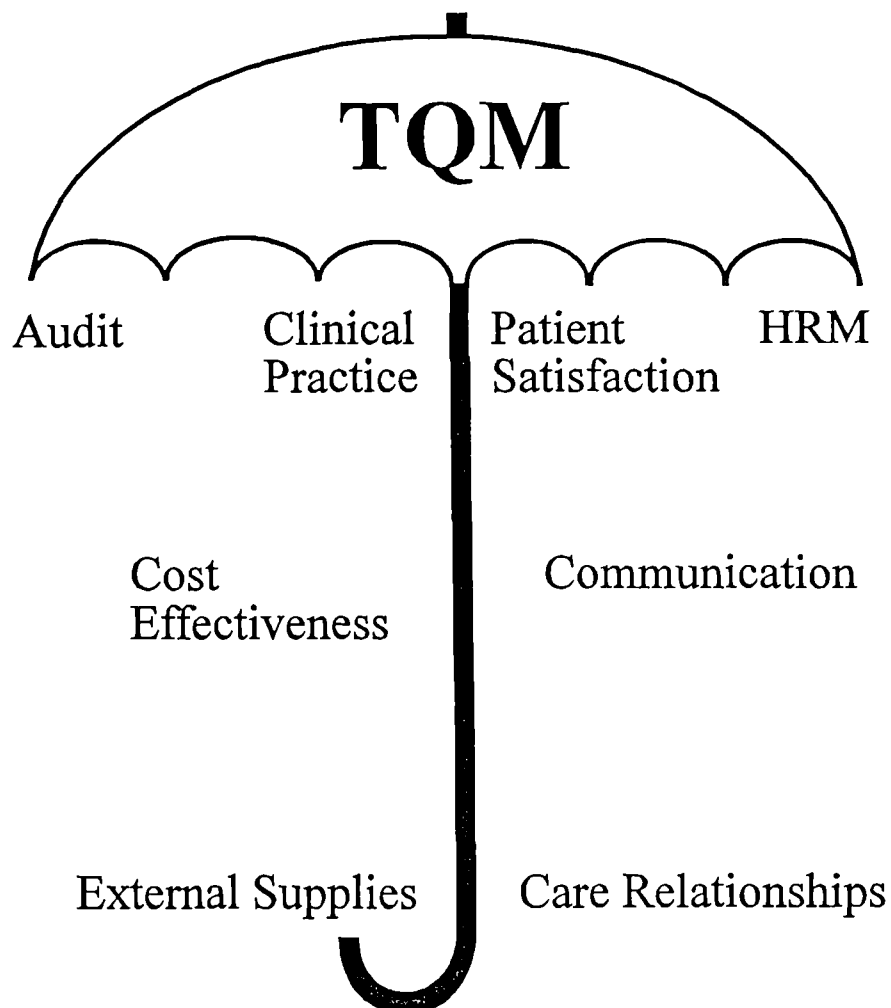
- (1) TQM starts at the top
- (2) TQM requires total involvement
- (3) TQM focuses on the customer
- (4) TQM uses teams
- (5) TQM requires training for everybody
- (6) TQM uses tools to measure and follow progress.

For Lemmermeyr²²¹ people are the key to TQM. If their actions, and reactions are quality oriented then expensive failures and the accumulation of hidden costs maybe reduced to an acceptable minimum or even prevented altogether. Quality should be in the mind, influencing all activities rather than starting and ending at a prescribed point. Only by recognising quality as a philosophy, a philosophy of good human relationships and thoughtful activities, can cumulative errors be prevented and subsequent costly repairs avoided.

Lemmermeyr suggests that TQM is a holistic concept that requires the motivation of all the people within an organisation towards a common goal²²². Gabor holds a similar view that TQM is holistic in that it can only be conceived if it includes all the functions in the organisation, all the people who work there, and all the other organisations and individuals supplying and receiving goods and services from it²²³. However, there is no one single organisational pattern for quality. To expect the establishment of a favourite organisational structure to produce the required results is naively optimistic, disregarding the imperfections of human nature²²⁴. To achieve TQM, the necessary links must be built-up between real living people; employees are not only the organisation's greatest and most expensive asset, but they alone are the creators of quality²²⁵.

For Woollas, TQM is the 'strategic approach to developing the best service possible'. It needs the full medical practices commitment to getting things right. She suggests that TQM is the umbrella for all the activities of medical practice²²⁶:

FIGURE 13



Source: Tricia Woollas 1993 Total Quality-Management within the Practice Seminar- Brochure (2) second edition

Woollas states the principles of TQM as being:

- TQM needs to be driven from the top by doctors and practice managers together
- TQM is not a short term expedient, it goes on forever, through continuous improvement and does not end with a certificate on the wall

- TQM involves everyone in the practice and everyone needs to take personal responsibility for quality.

The TQM drive, she contends, must be tailored to meet the specific needs of each department²²⁷. However, Woollas' principles of TQM failed to integrate the fact that organisations are not mere apparati. Thus, they should not only manage what is done for the customer, but the way they do it is also fundamental; the totality of the input - process - outcome relationship is the basis for TQM.

As Berwick noted, a sound total quality management approach should consist of²²⁸:

- Strategic elements (e.g. lining up organizational agendas with customer needs, and carefully planning changes within the organisation)
- Technical elements (including the tools of quality planning, quality control, and quality improvement)
- Cultural elements, which will include leadership behaviours, compensation systems, training methods, and teamwork.

Furthermore, for an organization to succeed in TQM it must also ensure that four elements for effective quality control are in place, namely²²⁹:

- a clear definition of quality: What is this process intended to accomplish?
- clear targets for performance: At what level is this process expected to perform?
- a way to evaluate actual performance to targets: Are results consistent with expectations?
- a way to take action on the difference between actual and expected performance: Who can do what, when results differ from expectations?

However, it is difficult to translate these general elements into images specific enough to enable them to be managed. To Berwick's list, the author will suggest a fifth element, the need to realign all corporate systems; because if the 'system' is not appropriately optimised to meet the needs and expectations of the customer, TQM will be meaningless.

The Department of Health (DOH) defined TQM as;

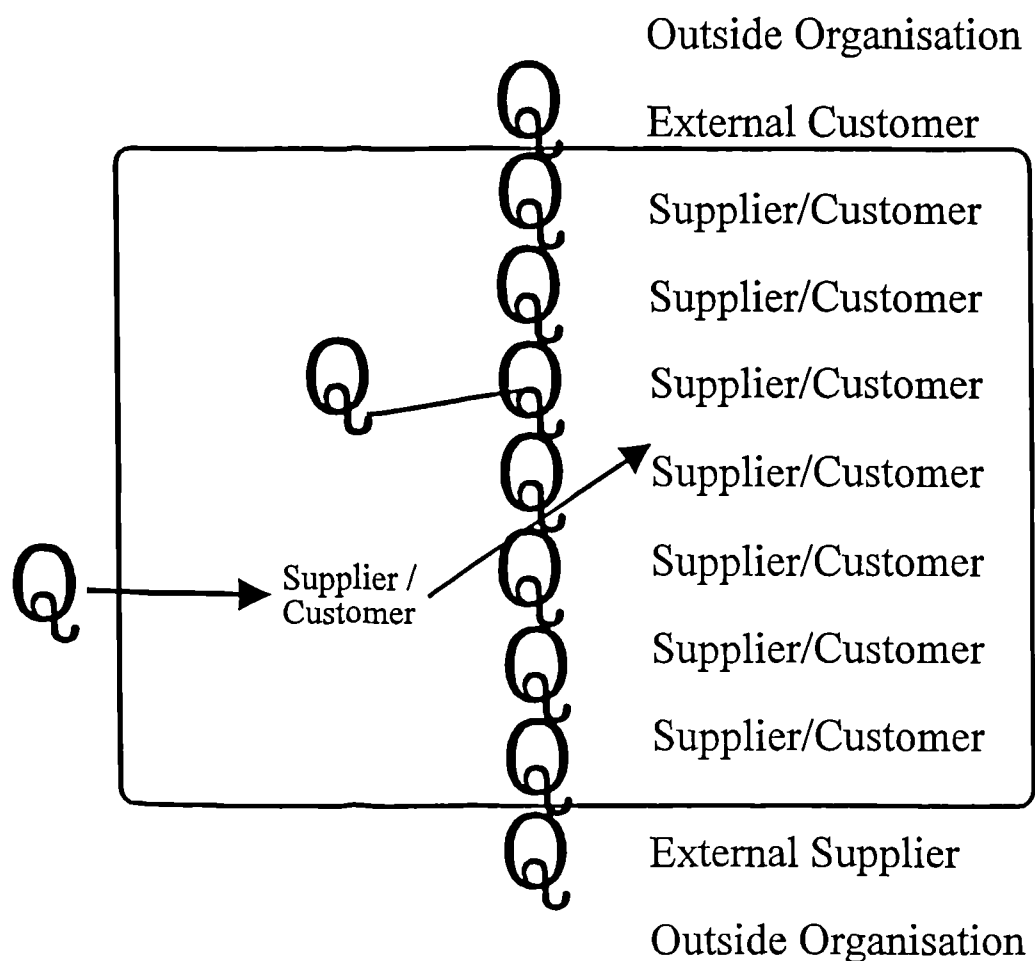
"Total Quality Management is a corporate management approach which recognises that the customer needs, and business goals are inseparable"²³⁰. Whilst, the NHS Management Executive (NHSME) defined TQM as a strategy to get an organisation working to its maximum effectiveness and efficiency. This could be achieved by challenging traditional ways of working and encouraging organizations to adopt innovative practices. In a mature TQM environment, they perceive²³¹:

- Everything is driven by the customer needs
- A highly trained and motivated workforce continually seeking better ways of working
- Change is based on measured fact and monitored in a continuous cycle of improvement
- Errors are relentlessly traced and eliminated
- A hands-on management drives the search for quality.

These elements emphasise the point that organisations need to focus on the needs of customers and to adopt an organisation wide management strategy. Oakland develops this further by suggesting that 'the concept of TQM is basically very simple. Each part of an organisation has customers, whether within or without, and the need to identify what the customer requirements are and then get about meeting them forms the core of a total quality approach'²³². This definition encourages organisations to see customers not only as those people who receive the end product but also that each

service and department also has customers, the internal customer²³³. Applied to the NHS, the internal customers would be consultants, ward sisters, theatre managers, suppliers, finance departments etc.²³⁴ At the various points along the customer-supplier chains there must be a genuine desire to understand the needs of customers and to negotiate the extent to which these needs can be met; this also takes into account the extent to which staff are considered as the customers of managers²³⁵:

FIGURE 14
THE QUALITY CHAIN



Source: Oakland, J. (1989) 'TQM, The Route to Improving Performance, Heineman

For Koch²³⁶, TQM is an attempt to develop a positive culture which encourages all staff to produce quality improvements in their own particular services and involves:

- Standard Setting
- Monitoring and Review
- Quality Information Production
- Customer feedback strategies and action
- Training for Quality
- Communication
- Resource Management and integration of quality criteria into contracts.

Koch further suggests that any service wishing to implement quality improvement should ensure the presence of the following features;

- the existence of a robust management structure involving medical and nursing staff at a senior level, with the organisation of quality improvement expertise clearly stated and understood.
- a thorough and rigorous approach to clarifying and specifying the main processes of healthcare and service, plus ways to control variability in those many processes through monitoring of standard, clinical and service outcome, audit and failure-cost reduction.
- a responsiveness towards the several 'customers' of healthcare in terms of provision of information, eliciting of feedback and subsequent corrective action to improve services.
- an organisation which values its staff provides a 'culture' which empowers staff to innovate and take decisions near the level of patient care, and ensures that staff are fully informed. TQM he argues further requires the integration of these four elements at all levels of the provider unit so that all staff live and breathe quality improvement²³⁷.

However, Koch fails to provide a contextualised framework that would enable managers to discern the relationship and interconnectedness of the various elements of his prescription. Thus, at the outset of the implementation of TQM, Koch's list of quality features would seem daunting and confusing. Invariably, the first question that readily comes to mind is "where do I start?" and "how do I proceed?". The consequence is a journey that was never started.

Mr. Bray, Total Quality Management Co-ordinator at Dupont-Howson in Leeds, contends that TQM begins with a definition of quality which to his company is 'satisfying customer requirements profitably'. This means no failures, consistency, continuity of supply and value for money²³⁸. Therefore, the essence of TQM lies in building a system of continuous improvement in everything an organisation does and in ensuring that everyone is responsible, not just quality controllers²³⁹. Teamwork is also critical to the success of TQM. Seeing how others work and how your contribution affects them is vital and, by working together in teams, the result is greater than the sum contribution of the individuals²⁴⁰. However, Boje and Winsor, argue that the success of TQM is highly dependent on a social organisation where workers are made to feel a sense of obligation to their co-workers and thus the whole enterprise, this peer pressure means that surveillance and influence are excelled by fellow "team members" rather than by a supervisory or hierarchical control mechanism. Thus, defeating the whole ethos of teamwork²⁴¹.

Fulop and Rosier state that TQM encapsulates at least nine concepts²⁴²:

- (1) top management leadership of the quality programme;
- (2) transformation of the organisational culture;
- (3) education and training of all personnel to create a common language and understanding;
- (4) institutionalizing continuous improvement or incremental change; focusing on internal and external customers;

- (5) concentrating on systems and processes;
- (6) using measurement and controlled experiments to identify areas for improvement;
- (7) fostering teamwork;
- (8) improved communication and information sharing; and
- (9) adopting a holistic and integrated strategy for quality management.

Fulop and Rosier define TQM as a management process that prepares the manufacturer for world class competitiveness through a system of management that has customer satisfaction as its primary business objective²⁴³. Whilst, Stuart and Mueller argue, the customer is anyone within the supply chain who receives materials from a previous step in the supply process; such a person can be both internal and external to the organisation²⁴⁴. They suggest that a TQM system begins with top management commitment and leadership. Management determines the total quality vision and plans for the organisation and must review and encourage its progress towards total quality. They note the important features of TQM to include: quality concepts which need to be clearly articulated and thoroughly integrated throughout all activities of the company and involving all business functions; an employee commitment to continuous quality improvement; management systems must be based on a continuous and systematic approach of gathering, evaluating and acting on facts and data as they relate to customer satisfaction and suppliers should be made full partners in the quality management process, involving close working relationships between suppliers and producers²⁴⁵.

Having identified the various definitions of TQM in the literature, the author is of the opinion that they offer generic prescriptions which rely heavily on the hard aspects of quality (tools and techniques) without any reference to organisational design and human issues. Such definitions show the current thinking of most quality writers that TQM can be superimposed on existing organisational structures with minimum attention paid to wider issues of organisational structure, worker dignity, process improvement,

communication, culture and organisational politics. Such perceptions are the cause of many implementational problems. The dominant belief that TQM can be designed and bolted-on has misled the management of most organisations to view change of this sort as being unproblematic and amenable to programmes that are applied universally across a company²⁴⁶. Therefore, most quality programmes across most industries start with intensive training for staff on the tools and techniques of TQM. Staff are exhorted to give commitment and participate and above all to recognise their customers (both external and internal) while getting their job right first time. This is an over-simplistic way to implement TQM²⁴⁷. Practising managers cannot be blamed, but TQM proponents who advocate these methods can be held culpable. What is required is not prescriptive qualifications of what constitutes TQM but a more informed and realistic definition of TQM and its implications for companies seeking to become quality organisations²⁴⁸.

QUALITY MANAGEMENT PHILOSOPHIES

Three individuals, the late W. Edwards Deming, Joseph Juran, and Philip Crosby, have emerged as the major international "philosophers" in the quality field. They have developed distinctive philosophies on how to manage and improve quality. Two other individuals, Armand V. Feigenbaum and Bill Conway, have also had a significant impact on the development of quality management.

THE DEMING PHILOSOPHY

The late W. Edwards Deming was originally trained as a statistician, and much of his philosophy can be traced to these roots. He worked for Western Electric during its pioneering era of statistical quality control development in the 1920's and 1930's. During World War II he taught quality control courses as part of the national defence effort. Deming began teaching statistical quality control in Japan after World War II and is credited with having been an important contributor to the Japanese quality improvement programmes. The highest award for quality improvement in Japan is called the Deming Prize. While Japan embraced his methods for 30 years, he was virtually unknown in the United States until 1980²⁴⁹.

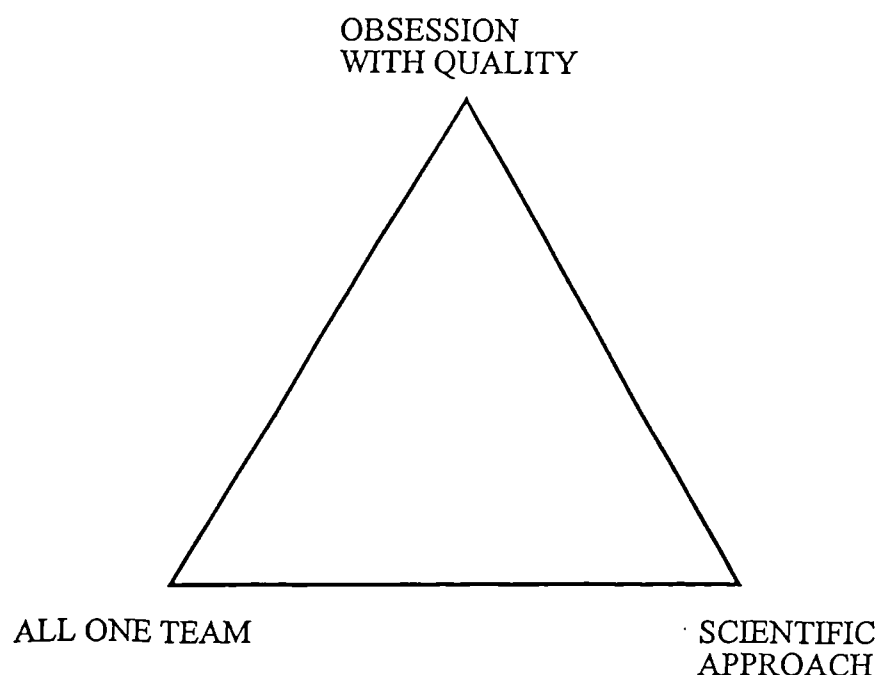
Unlike some other quality gurus, Deming was not content to try and make do with the traditional management milieu, he knew that that in itself constituted an impenetrable barrier to the improvements which would otherwise be possible²⁵⁰.

Deming was of the view that organisations need to stay ahead of their customers. "The customer does not know what he will need one, three, or five years from now. If you, as one of his potential suppliers wait until then to find out, you will hardly be ready to serve him"²⁵¹.

Deming's management philosophy was based on an all-embracing concept of quality and the understanding of the theory of variation, i.e. the statistical control of processes. Deming's work can be briefly expressed as management by positive co-operation as opposed to the traditional norm of management by conflict²⁵². Deming's teachings also embodied a win-win solution within the organisation as opposed to an 'I win, you lose' situation.

The embodiment of Deming's teachings can be explained by the use of the Joiner Triangle:

FIGURE 15: DEMING PHILOSOPHY - THE JOINER TRIANGLE



Source: Neave, H. (1990)

Deming argues that to achieve total organisationwide quality there has to be total teamwork and the use of the 'scientific approach'²⁵³. The scientific approach requires deep understanding of the nature of variation, particularly controlled and uncontrolled variation due, respectively, to common and special causes. In order to help people understand and implement his way of thinking, Deming produced a list of 14 points for management²⁵⁴:

- (1) Create constancy of purpose
- (2) Adopt the new philosophy
- (3) Cease dependence on mass inspection
- (4) End lowest tender contracts
- (5) Constantly improve the system
- (6) Institute training on the job
- (7) Institute leadership
- (8) Drive out fear
- (9) Break down barriers
- (10) Eliminate exhortations
- (11) Eliminate arbitrary numerical targets
- (12) Permit pride of workmanship
- (13) Encourage education
- (14) Top management commitment

However, Flood²⁵⁵ has identified three main weaknesses in Deming's philosophy:

1. The Action Plan and Methodological Principles are too vague; implying that there is no clear Deming method. The author agrees, because Deming failed to actually contextualise in explicit format the implementation process of TQM.
2. Deming failed to show how leadership and motivation could drive and sustain the TQM programme. He failed to draw on the wider literature available on leadership and motivation.

3. The Deming philosophy is silent about interventions in environments that are political and coercive, such as that found in the NHS.

In addition, the author is of the opinion that the Deming philosophy has no place in the implementation of TQM. What Deming offered are 14 points which represent necessary conditions that will enhance an organisation's chances of success but something which falls short of being an implementation model for TQM. Furthermore, Deming failed to show the interrelatedness of the 14 points and 'how' to operationalise his concepts within an organisational context. In short, Deming's ideas represent too much task without an action plan.

JOSEPH M. JURAN

Joseph Juran joined Western Electric in the 1920's, during its pioneering days in the development of statistical methods for quality, and spent much of his time as a corporate industrial engineer. In 1951, the Quality Control Handbook was written. Juran taught quality principles to the Japanese in the 1950's, just after Deming and was a principal force in their quality re-organization. Like Deming, he concludes that the West is facing a major crisis in quality due to the loss of sales to foreign competition and the huge costs arising from the presence of poor quality. To solve this crisis, he offers new thinking about quality which advocates the inclusion of all levels of the managerial hierarchy. Upper management, in particular, requires training and experience in managing for quality²⁵⁶.

As opposed to Deming, however, Juran does not propose a major cultural change in the organisation, but rather he seeks to improve quality by working within the system. Thus, his programmes are designed to fit into a company's current strategic business planning with minimal risk of rejection²⁵⁷. Juran contends that employees at different levels of an organisation speak in different 'languages'. Top management speaks in the language of dollars, workers speak in the language of things, and middle management must be able to speak both languages and translate between dollars and things. Thus, to get top management's attention, quality issues must be cast in the language it understands - dollars²⁵⁸. Hence, Juran advocates the use of quality cost accounting and pareto analysis to focus attention on quality problems. At the

operational level, Juran's focus is on increasing conformance to specifications through the elimination of defects, extensively supported by statistical, analytical tools²⁵⁹.

Juran defines quality as "fitness for use". This is broken down into four categories: quality of design, quality of conformance, availability, and field service. Quality of design focuses on market research, the product concept, and design specifications. Quality of conformance includes technology, manpower, and management. Availability focuses on reliability, maintainability, and logical support. Field service quality comprises promptness, competence, and integrity²⁶⁰.

The pursuit of quality is viewed by Juran on two levels: (1) the mission of the firm as a whole is to achieve high product quality and (2) the mission of each individual department in the firm is to achieve high production quality. Like Deming, Juran advocates a never-ending spiral of activities that includes market research, product development, design, planning for manufacture, purchasing, production process control, inspection and testing, and sales followed by customer feedback.

Juran's prescriptions focus on three major quality processes, the Juran trilogy:

quality planning - the process for preparing to meet goals,

quality control - the process for meeting quality goals during operations

quality improvement - the process for breaking through to unprecedented levels of performance²⁶¹.

In common with other writers on quality management, Juran provides organisations with a step-by-step approach to implementation comprising 10 steps to quality improvement²⁶²:

1. Build awareness of the need for improvement
2. Set goals for improvement

3. Establish quality improvement teams and other infrastructure needed to support progress
4. Provide training
5. Perform quality improvement projects
6. Report progress
7. Give recognition
8. Communicate
9. Record success
10. Integrate into annual company systems and cycles

However, Flood notes three key weaknesses to the Juran trilogy²⁶³;

1. The emphasis on management's responsibility for quality fails to get to grips with the extensive literature on motivation, leadership and culture change.
2. Juran undervalues the contribution a liberated worker can make, thus rejecting, in principle, bottom-up initiatives.
3. Juran's methods are mainly traditional and old-fashioned, failing to deal adequately with the human dimension of organisational life particularly cultural and political issues.

Similarly, the author will add that Juran's suggestion that organisations need not change their culture enroute to TQM is shortsighted. To succeed with TQM, organisations

need to make a conscious effort to realign their culture to adhere to the ethos of TQM. Bolting-on TQM to an existing Taylorist culture is a recipe for disaster.

THE PHILIP CROSBY PHILOSOPHY

The essence of Crosby's view of quality is embodied in what he calls the 'Four Absolutes of Quality Management'. Crosby purports that a successful organisation must know and practise the 'Four Absolutes of Quality Management'²⁶⁴:

- (1) **Quality Means Conformance to Requirements.** ALL the actions necessary to run the company and dealing with the customer must be met as agreed. If managers employ people to 'do it right the first time'; they have to tell everyone clearly what 'it' is.
- (2) **Quality Comes from Prevention.** Organisations have to prevent rather than inspect-out defects.
- (3) **Quality Performance Standard is zero defects (or defect free).** No amount of error is statistically significant.
- (4) **Quality Measurement is the price of nonconformance.** Crosby notes that manufacturing companies spend at least 25% of sales doing things wrong, whilst service companies spend almost 40% of their operating costs on the same wasteful actions²⁶⁵.

In addition to the four absolutes, Crosby provides 14 steps for implementing TQM:

- (1) Management commitment
- (2) Quality improvement team
- (3) Quality measurement
- (4) Cost of quality evaluation
- (5) Quality awareness
- (6) Corrective action
- (7) Establish an ad hoc committee for the zero defects programme

- (8) Supervisor training
- (9) Zero defects day
- (10) Goal setting
- (11) Error cause removal
- (12) Recognition
- (13) Quality councils
- (14) Do it over again

Unlike Juran and Deming, Crosby's programme is primarily behavioural. He places more emphasis on management and organizational processes for changing corporate culture and attitudes than on the use of statistical techniques. Like Juran and unlike Deming, his approach fits well within existing organizational structures²⁶⁶. However, in the NHS, it has been noted that the Crosby approach is good in detail but lacking in substance²⁶⁷. Crosby's model is an overlong and complicated process designed to achieve relatively simple ends. NHS managers were more positively drawn to an informal approach introduced through people who were concerned with improvements²⁶⁸.

In addition, Crosby's approach, provides relatively few details about how firms should address the finer points of quality management²⁶⁹. The focus is on managerial thinking rather than on organizational systems. By allowing managers to determine the best methods to apply in their own firm's situation, his approach tends to avoid some of the implementation problems experienced by firms that have adopted the Deming philosophy, which is basically the realistic application of statistical methods in industry where most employees are empowered not to think or use their brains. In fact, from the managerial hierarchy down to the shop floor, only very few understand the language of statistics²⁷⁰.

Crosby's philosophy has not earned the respect of his rivals. David Garvin of the Harvard Business School in an article by Jaclyn Fierman, is quoted as saying, 'As a programme for changing attitudes (Crosby's) course makes good sense ... as a basis for specific action, it's seriously lacking'²⁷¹. As for Juran, 'I do not regard Crosby as an expert in the field of quality ... he is an expert in public relations. He is a

combination of P. T. Barnum and The Pied Piper', but Juran gives Crosby credit for being an entertaining speaker and a great motivator²⁷².

Additionally, Flood notes five weaknesses to Crosby's philosophy²⁷³:

1. The philosophy implies that workers are to blame for quality problems.
2. The ideas are based on slogans and platitudes, raising insufficient awareness of genuine difficulties that will be encountered enroute to TQM.
3. The 14 steps are strongly management and goal orientated.
4. A misconception about zero defects on the part of the workforce.
5. An assumption based on a conciliatory workforce. Would not be effective in political or coercive context.

Whilst Deming, Juran and Crosby have a contradictory, and different approaches to implementation, each philosophy, emphasises the fact that quality requires total commitment from everyone within the organisation. Implying that all organizational activities should be viewed from three different but interrelated perspectives²⁷⁴:

1. **Function:** a task or group of tasks to be performed that contribute to the mission or purpose of an organisation.
2. **Process:** a set of steps, procedures, or policies that define how a function is to be performed and what results are expected.
3. **Ideology:** a set of values or beliefs that guide an organisation in the establishment of its mission, processes, and function.

This is consistent with the work of Evans and Lindsay who note that, 'quality is a philosophy that must pervade the organisation: everyone must believe in it and support it'²⁷⁵. In contrast, NHS managers view quality from vast and differing perspectives. One manager in an interview with the author pointed to the fact that "if quality is meeting all customer needs; then the definition is ridiculous, because the NHS cannot feasibly meet all customer needs". She supported this view by stating that the NHS is starved of cash to finance every patient's needs. Her definition of quality was meeting the professionally determined needs of the patient. In another hospital, the Quality Manager defined quality as meeting the needs via specifications of the purchasers of the service because they pay the bills; but with the implicit assumption that the sick patient will be treated. This statement that the broadest viewpoint of quality is that everyone must believe in it and support it, might not necessarily be true. It is, for instance, possible to believe in an ideology but not necessarily to support it by actions; alternatively, situational analysis might warrant the support of a concept or strategy not believed in but supported by actions because of the adverse personal consequences which could follow were it not to be so supported.

OTHER QUALITY PHILOSOPHERS

A. V. FEIGENBAUM

Feigenbaum is known for three primary contributions to quality: his international promotion of the quality ethic, his development of the concept of total quality control and his development of the quality cost classification.

Feigenbaum says that quality of products and services is directly influenced by nine basic factors, or what he calls the 'Nine M's'²⁷⁶.

The Nine M's are:

- markets
- money
- management
- men

- motivation
- materials
- machines and mechanisation
- modern information methods
- mounting product requirements

BILL CONWAY

Conway does not have a specific definition of quality, but incorporates it into his brief description of quality management, "Developments in manufacture, administration and distribution of consistent low-cost products and services that consumers want and/or need". He believes also that it means constant improvement in all areas of operations, including supplies and distributors to eliminate waste material, capital and time²⁷⁷. He claims that wasting of time is the biggest waste that occurs in most organisations. Another category of waste is excess inventory which, says Conway, occupies space; 60% of which is not really required but which must be paid for and maintained²⁷⁸.

Conway shares the view that often top management is lacking in conviction that quality increases productivity and lowers costs. This leads to the conclusion that "The bottle neck is located at the top of the bottle". Conway talks about a new system of management, the primary task of which is continuous improvement in all areas. He believes that this is the most important change required for it means changing all the company rules and giving people positive reinforcement.

Conway advocates a strong use of statistical methods to achieve waste reductions on the grounds that attempts to improve quality and productivity by generalists always fail. The simple tools are flow charts, fishbone charts, histograms, bar-charts, run charts, correlation charts, surveys of customers which, according to Conway, can be used to solve 85 % of a company's problems. The more sophisticated statistical process control (SPC) methods are needed only for the remaining 15 %.

Conway identifies six tools for quality improvement²⁷⁹:

1. Human Relations Skill: The responsibility of management to create at every level among all employees the motivation and training to make necessary improvements in the organisation.
2. Statistical Surveys: The gathering of data about customers, internal as well as external, employees, technology and equipment to be used as a measure for the future progress and identification of what needs to be done.
3. Simple Statistical Techniques: Clear charts and diagrams that help identify problems, track work flow, gauge progress and indicate solutions.
4. Statistical Process Control: The statistical charting of a process, whether manufacturing or non-manufacturing, to help identify and reduce variation.
5. Imagineering: A key concept in problem solving, involving the visualization of a process, procedure or operation with all waste eliminated.
6. Industrial Engineering: Common techniques of pacing, work simplification, method analysis, plant layout and material handling to achieve improvement.

From the analysis, it could be argued that, whilst the quality experts differ as to the meaning of TQM there seems to be a general consensus as to what constitutes the essential principles which underpins the philosophy of TQM:

PRINCIPLES OF TOTAL QUALITY MANAGEMENT

- **The Theme:** TQM is geared to the continuous improvement of quality in an organization. However, the literature is devoid of suggestions as to how to sustain this never-ending journey. The author is of the view that for TQM to actually constitute a never-ending process, it must deliver on performance.

Therefore, TQM must be result-oriented in order for employees/management to believe it actually delivers as a transformational strategy.

- **The Focus:** TQM is based on customer expectations and on meeting customer needs. However, in the health service, the identification of the customer is a relatively new concept. The patient is not traditionally viewed as the ultimate 'external' customer. The idea of the patient and the existence of other external customers such as the government, taxpayers, and purchasers has only recently been acknowledged. In addition, in an environment characterized by professional dominance, the identification of the customer and the anticipation of their needs is rather alien²⁸⁰.
- **The Control:** TQM requires an organisation's long-term commitment. But, However, the literature further fails to show 'how' an organisation would win and sustain a long term commitment, in circumstances where TQM fails to yield results.
- **The Approach:** TQM is management driven. Applied to the hospital setting, with its dual line of authority, this means that both administrators and the consultants will have to take the lead and move beyond 'advanced lip-service' in applying the TQM principles and tools to their work setting²⁸¹. However, this is easier said than done. It has been reported that in the NHS the polarized relationship between administrators and consultants have hindered the progress of TQM²⁸².
- **The Scale:** TQM involves all employees and the empowerment of staff. However, the author will argue that empowerment within TQM remains an illusion. Many senior managers are still not prepared for an empowered subordinate.
- **The Scope:** TQM's focal point is collaborative teamwork. Nevertheless, the TQM literature remains vague on how to achieve collaborative teamwork, particularly in a healthcare setting, where consultants see themselves as better trained and more qualified than the rest of the staff.

In the final analysis, it is the author's opinion that the fundamental failure of the traditional principles of TQM is the failure to include or recognise the politics of

culture change as an important, if not the most important, principle of TQM. This failure to recognise the importance of a change in organisational politics is seen by practising managers to mean that TQM can be implemented without a fundamental overhaul of the existing culture. A change in attitude, as recognised by the literature, cannot affect a change in culture. However, a change in behaviour would, as a consequence, necessitate a change in people's attitude. Thus, no matter how committed the top management of a firm is to TQM, without a corresponding change in behaviour, and the eradication of internal politics, any TQM initiative would definitely fail.

Furthermore, the author is of the opinion that the approach to TQM demands systems management. But, this is not highlighted in the literature as a key principle of TQM. This obvious omission has led to a situation where organisations are implementing only parts of the TQM process rather than concentrating on the 'whole'. The attitude being that you can get what you want by getting rid of what you don't want. However, getting rid of what we don't want is like walking into the future facing the past. The whole trick of organisational improvement is to know where we want to go. To determine organisationally where we want to go requires the principle of systems management that takes into account the interactions of the system, and not just the separate performances of the various parts. Most failures of TQM are caused by a lack of systems orientation²⁸³. Thus, to facilitate the success of TQM, top management must ensure that the TQM process is directed at what the organisation wants, and not what you don't want.

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CHAPTER FOUR

IMPLEMENTATION OF TQM

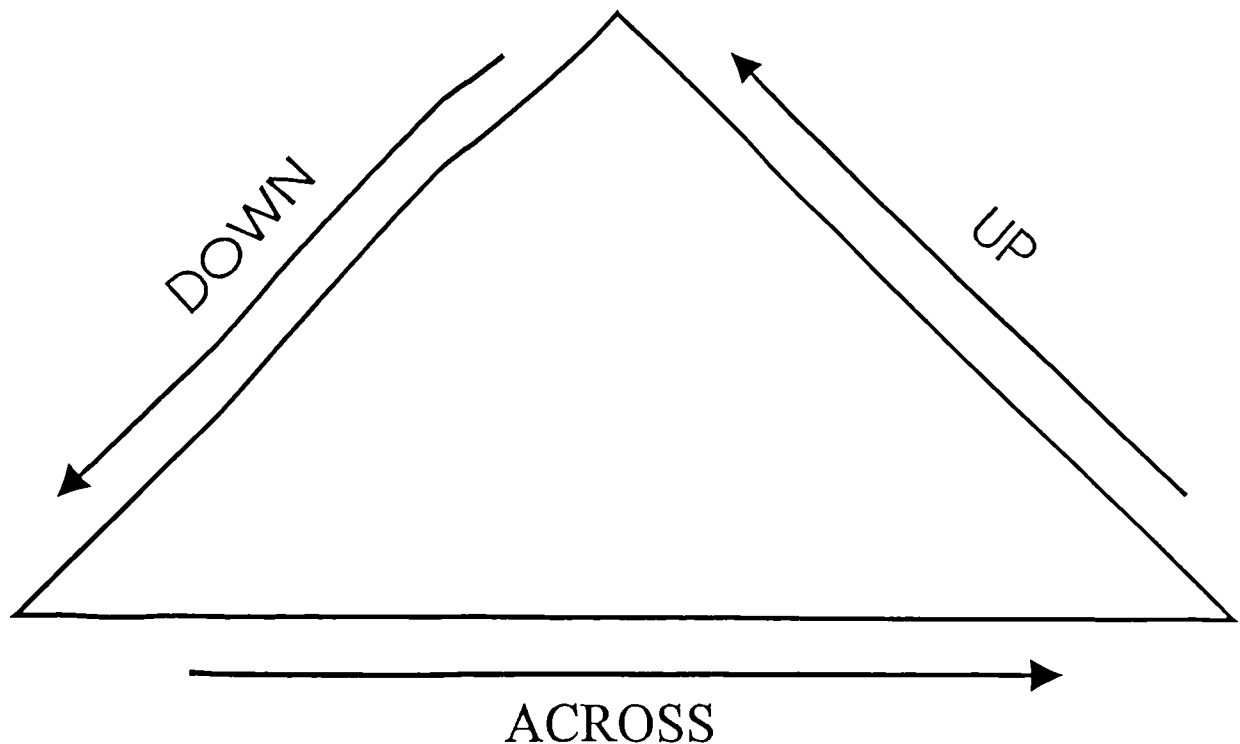
The quality revolution sweeping through corporate America is being emulated by the NHS. Hence, Trust hospitals and directly managed units have adopted TQM principles based on their subjective understanding of TQM. The TQM literature seems inundated with a variety of approaches/models to the implementation of TQM which have been shaped over the past decades by a variety of 'Gurus' (Deming, Crosby and Juran). The models are usually presented as 'steps' to quality or 'phases' of quality improvement¹. The purpose of this Chapter is to assess the suitability of these 'models' within the context of the NHS.

Claus² argues that what organisations should keep in mind when implementing TQM is that TQM is itself a model for organisational change, requiring that a number of necessary conditions will need to be present for change to occur. He further argues that if a hospital's continuous improvement process is to be reflected in the attitude and behaviour of its employees, the hospital environment will need to acquire the attributes of a learning organisation. According to Claus, the 'Change' step model to TQM in healthcare involves:

- Organizing for change
- Preparing the environment
- Empowering employees
- Focusing the environment
- Engaging the environment

The continuous improvement strategy of any hospital needs to be carefully developed, implemented and time-phased in a manner that can be effectively managed for short- and long-term results³. However, an organisation needs to be aware of existing barriers and obstacles which can jeopardize the implementation of the quality improvement process. As Hillman⁴ notes, the most crucial element to the successful implementation of TQM is 'effective' communication. To be effective, he argues, the communication framework must work well in three directions:

FIGURE 16



Source: Hillman, P (1991) TQM Magazine, Oct.

If communication is affected as the diagram illustrates this would ensure that everyone in the organisation knows and understands;

- | | |
|--|--------------------------------|
| - "Where the organisation wants to be" | - mission |
| - "What we need to do differently" | - planned improvement |
| - "What we have achieved" | - feedback and success stories |
| - "What still needs to be done" | - next steps |
| - "What are our customer requirements" | |

It is important that organisations, in communicating the need for change, should use a non-threatening and motivating language⁵. Whatever is being communicated must be reinforced by action because people are more influenced by what they experience rather than by what they see or hear⁶. However, it has been reported that, within the NHS, communication is flawed in the sense that patients move horizontally across hospital functions whilst communication within hospitals is vertical⁷. Thus, Hillman's three dimensional communication model is not being addressed in the NHS. Fried⁸

suggests that for TQM to succeed in healthcare, a quality management effort must have an agreed meaning of quality. However, a commonly held definition of quality has been elusive in healthcare⁹. A central problem for TQM in healthcare is whether the system should provide patients/customers with what they want or with what they need? Bramwell¹⁰ purports her hospital favours the latter. It is believed by many that patients fare better if their care is co-ordinated by one provider with whom they have a long-term relationship¹¹. Thus, Fried argues that to succeed, the language of TQM might need modification; words like 'customer' create problems for health professionals. Thus, substituting 'Total Patient Care' for "meeting customer requirements" is a small but significant change¹². Brookes¹³ suggests that an NHS-style TQM approach should be built on the following principles:

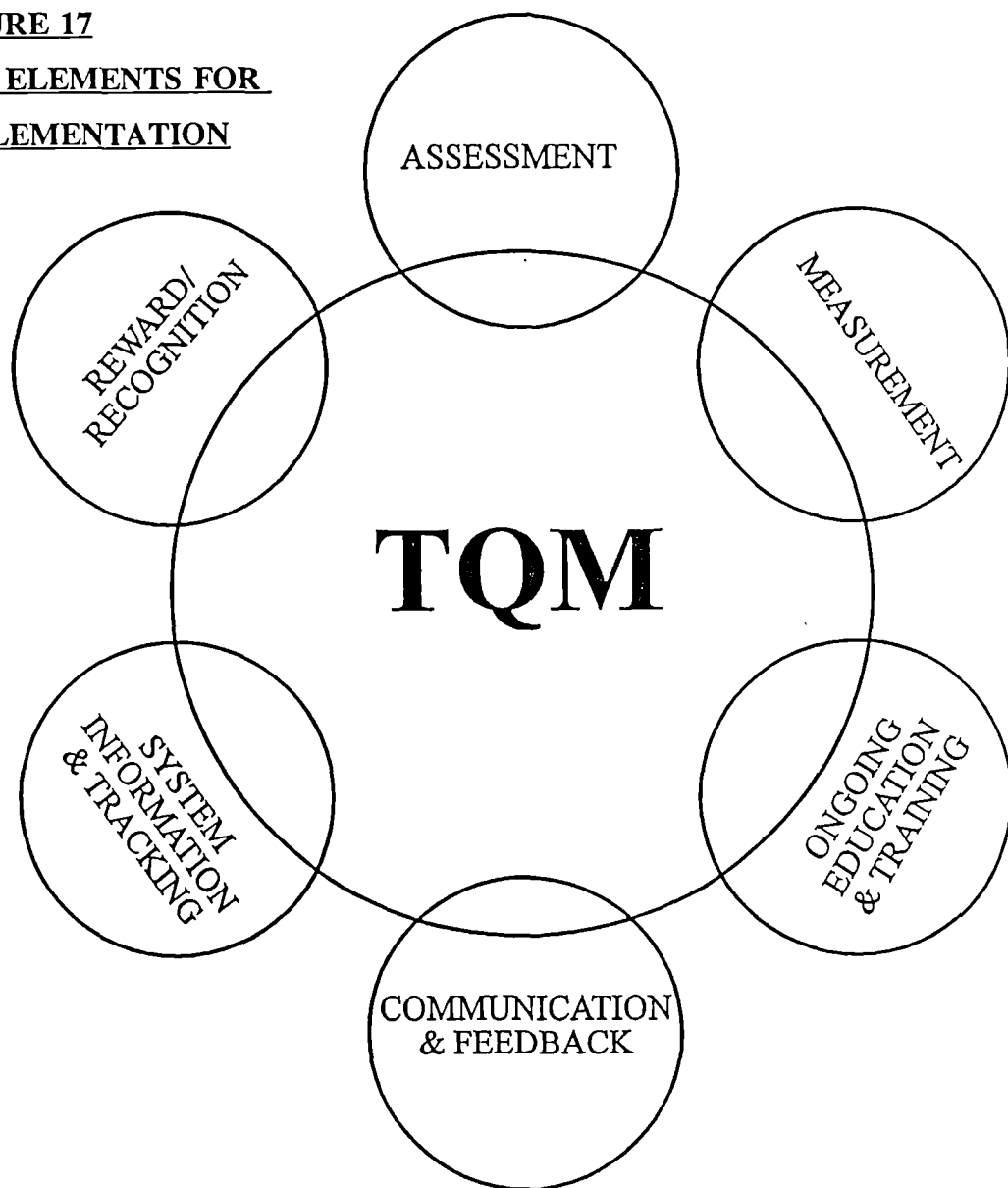
- Clear purpose, and shared values
- Led from the top
- Patient and client focused
- Investment in staff
- Continuous
- Fact-driven action
- Organisation-wide commitment (everyone's business)
- Built-in not inspected out

Furthermore, she proposes that patience and commitment is required to make TQM happen in the NHS. However, Fried¹⁴ argues that 'prescriptions', such as those outlined by Brookes, need to be redesigned prior to adoption into a healthcare setting; suggesting that what is required is simple, easily implemented tools which may be used on a just-in-time basis; because busy people, such as consultants, will not tolerate canned lectures or groupings designed for assembly-line workers¹⁵. Similarly, Claus¹⁶ notes that no perfect TQM design can be plugged into a healthcare organisation and at the same time meet all of the organisation's strictures. However, some basic steps can be discerned:

- Phase 1: Executive Education (Commitment)
- Phase 2: Middle Management/Supervisory Education and Action
- Phase 3: All Employee Education and Action

In order to be successful, a continuous improvement process has to be management driven, driven through a number of key elements. Although there is no perfect implementation model, the author believes that for TQM to succeed a sustaining and supportive infrastructure is required. This will ensure that the TQM programme is adequately managed. What Claus fails to contextualise in his prescriptions is the 'requirements' at the initial stages prior to the introduction of a TQM initiative. Some activities are essential for the sustainability of the programme; (1) strengths and weaknesses of the firm; (2) values and beliefs which have to be realigned to meet the principles of TQM.

FIGURE 17
KEY ELEMENTS FOR
IMPLEMENTATION



Source: Claus, L. M. (1991) TQM A Healthcare Application, Total Quality Management, Vol. 2, No. 2.

Voss and O'Brien¹⁷ have no doubt but that successful quality management requires not just good procedure and documentation, but excellent equipment and a good skill base; it also depends on the integration of quality concepts and practices into all business processes. Quality management requires a new set of interrelationships which must affect all parts of an organisation, including quality communication, sustained commitment and broad based staff involvement. The demands of quality management require a constancy and tenacity of purpose¹⁸. If the quality vision is to be cascaded through the organisation from the top down, it requires the co-operation of lower level staff¹⁹. Interestingly not many organisations implementing TQM bother to win the co-operation of lower level staff²⁰. Cases in the NHS²¹ show that, where management has led strongly, and has not yet secured the beliefs and commitment of those at the operational levels, the TQM initiative remains at the level of training and the raising of consciousness. In order for TQM to work, it is first essential to develop a strategy that aims to emphasize quality as an integral part of every individual's task, to encourage the commitment of all members of staff to create an organisational structure focused on all aspects of clinical service and to promote customer orientation²². Most importantly, management understanding, conviction, commitment and involvement are essential. Those in management will have to be seen to practice what they preach and to 'work-the-job'²³. Thus, the implementation of TQM will require the creation of an accompanying management structure and of an action plan which defines the objectives, policies and principles of the hospital unit. Also important, is the formation of a total quality strategy committee composed of staff drawn from multiple disciplines, responsibility of which is to oversee the TQM process²⁴. Measurement of quality is another important ingredient for the success of TQM. 'What cannot be measured, cannot be managed' argue Haigh and Morris²⁵. Roy²⁶ suggests that for 'quality' to succeed in the NHS, quality standards will need to be identified throughout directorates and units and that the associated standards should be monitored and evaluated continuously. This will lead to an improvement in the efficiency and effectiveness of services provided. Additionally, the nature of the NHS as a service provider, and the limited human/financial resources available, make it imperative that an incremental approach to the implementation of TQM should be adopted; initially to ensure success, thereby offering quick-investment-for-effect and reinforcement of the quality message. This view is compatible with Nwabueze et al²⁷ who noted that what is required in the

NHS is 'sustainable quick-fixes' through a process-led strategy. This will ensure that the NHS builds on any early returns to motivate people.

Nevertheless, it has been identified that the nature of healthcare organisations works against implementing TQM²⁸. There is a hierarchical structure with conventional reporting relationships and the workforce is multidisciplinary; thus, it cannot be managed like most employees within the commercial sector. Moreover, consultants make decisions which dominate every aspect of a hospital's activity, hence, any impetus for change should always come from clinicians. Similarly, Melum and Sinioris²⁹ contend that if TQM is to be successful in a hospital setting, consultants must play a central role. But they note that achieving substantial consultant involvement in TQM is one of the most difficult and paradoxical challenges facing healthcare executives. Traditional TQM paradigms ask consultants to support a strategy to ensure the survival of an organisation. However, the primary identification of such consultants is to their profession. Healthcare organisations can maximise their chances of successfully appealing to consultants by ensuring that their strategy meets at least four criteria;

- Management commitment to TQM and action
- Identification of a 'Champion' amongst the consultant hierarchy
- Effective differentiation of TQM and quality assurance
- Development of improvement projects that address consultants top-priority problems

Furthermore, hospitals should address the three roles consultants play: customer, processor, and supplier; emphasising improvement in clinical outcomes and a reduction in patient waiting time.

Melum and Sinioris further suggest three implementational strategies which are imperative in building consultant support for TQM:

- (1) We're in this together - make consultants full partners in the organisation's TQM effort from the beginning

- (2) Prove it first: prove the validity of TQM to consultants through demonstration projects before asking them to participate
- (3) Help consultants help themselves - implement TQM in the consultants' office practice; clinical areas

These strategies are consistent with the view of Fried³⁰, who notes that 'attempting to impose changes (TQM) in medical practice from the administrative side without clinical support is a recipe for disaster'.

However, the issue of consultant superiority as implied by Fried, has been established as one of the reasons for the failure of TQM in the NHS. Pollitt³¹ argues that the government's approach to TQM in the NHS is firmly based on the principle that the quality of medical work can only be reviewed by a doctor's peers; hence, Medical Audit. In consequence, the 23 TQM pilot schemes now have a programme of total quality minus medical quality; representing a 'hollow-centred' rather than a 'totality' approach to TQM. The question then arises: 'Is quality for the customer or for the provider?'. The author is of the view that, the customer is the central thrust of any quality improvement programme. Supporting the view for a totality approach to quality, Batalden et al³², outlined what the healthcare leadership must learn in order to implement TQM successfully with the appropriate focus:

- Management must learn the meaning of quality, including an understanding of the importance of the customer.
- Top management must sponsor and encourage the continuous improvement of quality, including the wise use of teams that can work effectively to improve systems and other processes.
- Management must understand the use of statistical thinking.

However, in healthcare, professionals view quality as a process of evaluating and regulating themselves, to gain and protect their professional domains and autonomy but TQM does not respect existing professional standards, it is continually demanding new

ones. The reality is that for TQM to work in healthcare, both the models of TQM and professional bureaucracy must be accommodated³³:

TABLE 6

Professional		TQM
Individual responsibilities Professional leadership Autonomy Administrative authority Professional authority Goal expectations Rigid planning Response to complaints Retrospective performance appraisal Quality assurance	←Versus→	Collective responsibilities Managerial leadership Accountability Participation Performance/Process expectations Flexible planning Benchmarking Concurrent performance appraisal Continuous improvement

Source: McLaughlin and Kaluzny, 1992

McLaughlin and Kaluzny³⁴ suggest 11 actions which they believe must be undertaken for management to function well in a TQM environment:

- (1) Redefine the role of the professional
- (2) Redefine the corporate culture
- (3) Redefine the role of management
- (4) Empower the staff to analyze and solve problems
- (5) Change organisational objectives
- (6) Develop mentoring capacity
- (7) Drive the benchmarking process from the top
- (8) Modify the reward system
- (9) Go outside the health industry for model
- (10) Set realistic time expectations
- (11) Make TQM programme a model for continuous improvement

However, McLaughlin and Kaluzny's 11 actions represent a lot of theory without back-up by tools. There is a big difference between suggesting actions necessary for TQM and showing someone 'how to do it?'. It is important that organisations learn to

purpose-build in the implementation of TQM rather than doggedly following prescriptive packages.

According to Collard (1989)³⁵, a successful TQM programme should be based on the following principles:

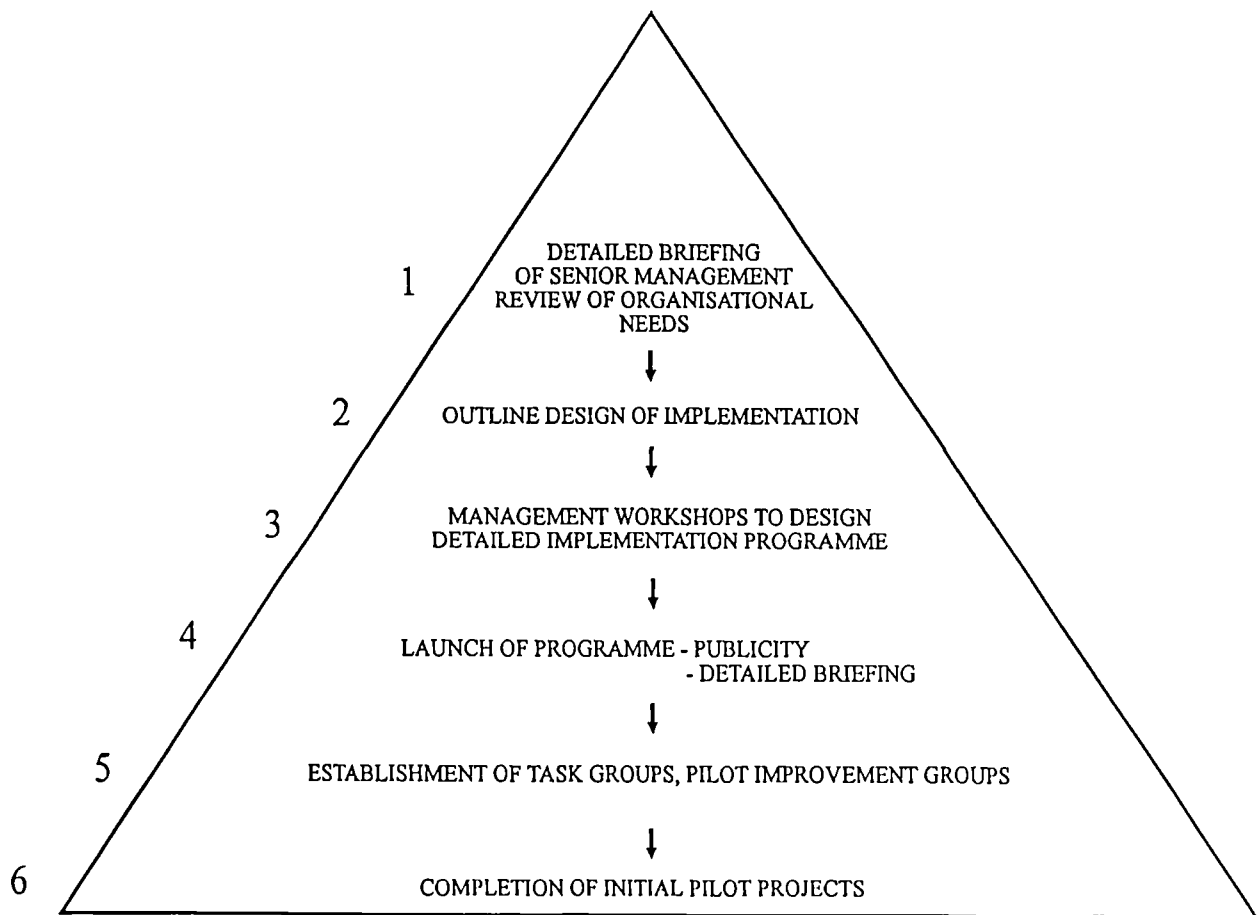
- Top management commitment
- Attitude change
- Continuous improvement
- Strengthened supervision
- Extensive training
- Recognition of performance

Collard further suggests that the implementation process involves the establishment of:

"A steering committee led by senior management and the quality manager, the facilitator and key functional heads. Its role is to set priorities and allocate resources and ensure that projects meet their objectives. An interdisciplinary task force should be set-up by management aimed at solving specific problems. Furthermore, improvement groups/quality circles should be set-up within the same work area, composed of operational or front line staff".

Collard notes that this group should be voluntary and allowed to choose its own improvement projects. Collard further suggests what he calls a typical TQM implementation plan:

FIGURE 18: A TYPICAL IMPLEMENTATION PLAN



Source: Collard (1989) Total Quality Success Through People, IPM Publication

Similarly Fenwick³⁶ suggests 'five easy lessons leading to the implementation of TQM':

- (1) Establish the foundation
 - Set strategic objectives
 - Define a vision statement
- (2) Build an infrastructure
 - Establish a TQM council
 - Appoint a TQM executive
 - Establish subordinate support committees

- (3) Educate the workforce
 - Conduct employee surveys
 - Hold executive workshops
 - Train management
 - Train other personnel
- (4) Initiate process improvement
 - Identify candidate processes
 - Establish benchmarks
- (5) Establish communication channels
 - Publish letters to employees
 - Establish other TQM media techniques

However, the model put forward by Collard and Fenwick respectively seems inappropriate for the implementation of TQM in the NHS because they fail to build into it the flexibility required for the integration of other numerous initiatives such as the Patient Charter and Executive Letter Communications, to name but two. Additionally, their model is based on the incremental continuous improvement approach which has been established as being inappropriate for the NHS³⁷. There are, however a number of divergent views among commentators about the best approach to the implementation of TQM. Beer and Walton³⁸ argue that 'change' (TQM), is not brought about by following a grand master plan but by continually adjusting direction and goals. The greatest obstacle to revitalization, they contend, is the idea that it comes through companywide change programmes. This assertion is consistent with the views of one quality manager in the NHS who the author interviewed as part of this research. She argued that 'organisationwide programmes are problematic because of the Department of Health's (DOH) constant intervention'. The question she posed was "Why design a five year implementation plan when you are not sure of government intention two months later?"³⁹ In practice, therefore, health service managers are bound to develop strategies to TQM based upon their existing working norms, practices, ethics and subjective understanding. As a result, a very diverse set of practices seem to be emerging within the rather 'empty shell' of the TQM process. Joss et al⁴⁰ identified three different practices in the NHS;

- (1) Technical quality, which is concerned with employment of specialist knowledge and expertise.
- (2) Generic quality, concerned with agreed standards of conduct, i.e. in relationship with patients and colleagues.
- (3) Systemic quality - making sure the organisation works well in a coherent fashion.

Joss et al, note that the NHS has made more progress in technical quality⁴¹. However, Joss et al, failed to note 'why' there exist three rather than one systematic approach to quality. From empirical evidence, it is the author's contention that what exists in the NHS is the professionals' approach to quality. The reason being that the NHS is still a professionally dominated organisation. The professional staff are yet to imbibe the holistic view of quality. Until such a time when there will be a change in the stratificated culture, the professionally oriented quality initiative will dominate. Moreover, the customer has no real choice, irrespective of whether or not a patient's needs are met, the patient has no reasonable alternative source of provision.

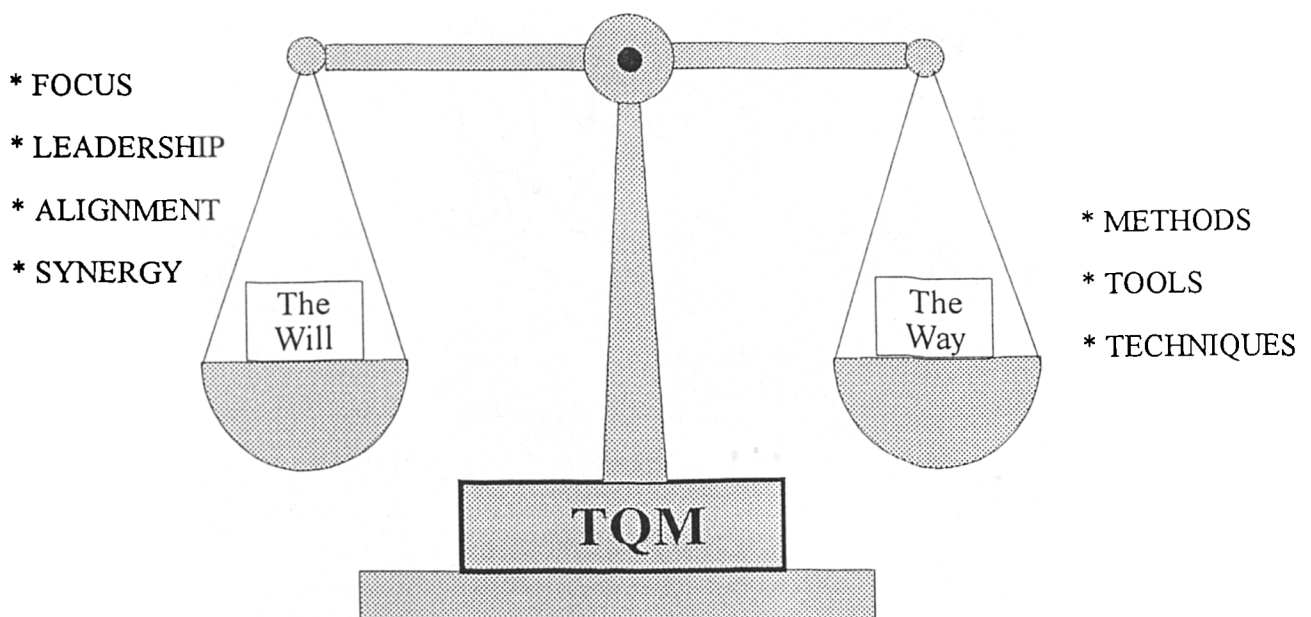
According to Beer et al,⁴² TQM is about culture change encompassing six steps:

- (1) Mobilize commitment to change through joint diagnosis of business problems
- (2) Develop a shared vision of how to organize and manage for competitiveness
- (3) Foster consensus for the new vision, competence to enact it, and cohesion to move it along
- (4) Spread revitalization to all departments without pushing it from the top
- (5) Institute formal policies, systems and structures

(6) Monitor and adjust strategies in response to problems

However, Beer et al, fail to establish 'why' TQM is about culture change, nor do they suggest in what context the six steps which they identify are to be implemented. Nonetheless, the sustainable transformation of an organisation to a TQM culture requires a balance between organisational systems, skills and techniques (the way) with the fundamental attitudes and values of employees (the will)⁴³:

FIGURE 19



Without the development of the will, the ongoing success of TQM requires a large amount of attention, effort and energy to work against the fundamental status-quo in an organisation which dictates that 'things should be done the way they have always been done'. The will can only be generated if TQM⁴⁴:

- Is adopted as a strategic focus for the organisation. However, in the NHS, the Patient's Charter rather than TQM seems the strategic focus.

- Is supported by committed and a fundamentally aware leadership. In contrast, in the NHS most Trust Boards are committed to winning service contracts. Thus, the leadership is financially driven.
- Is accompanied by a plan to ensure that the behaviours encouraged are aligned with those required. It has been argued that, in the NHS, there exists a failure on the part of management to effectively re-align the organisational culture behind quality initiatives⁴⁵.
- Generates synergy as a result of the alignment of the TQM concepts and philosophies with the organisation's systems and policies.

The 'why' aspect of the model can be taught. However, in the NHS, the 'WILL' for 'TQM' is yet to be fully developed due to a number of ongoing and conflicting quality initiatives and concurrent government restructurings. Thus, for TQM to succeed, a 'total' re-orientation of employee beliefs and values is required. This is consistent with the views of Thomas Watson Snr., the founder of IBM, who noted: "Any great corporation, one that has lasted over the years, will find that it owes its resiliency not to its form of organisation or administration skills, but to the power of values and beliefs and the appeal these values and beliefs have on its people"⁴⁶.

For Arikian⁴⁷ there are five steps to quality improvement;

- Empowering employees by providing feedback and reinforcing attitudes and behaviours that support quality and productivity.
- Committing to and supporting the TQM philosophy by top management, whose role is to set examples and guide change at all levels in the organisation.
- Creating an atmosphere of trust.
- Analysing and openly communicating and monitoring progress to improve decision making.

- Developing problem solving teams.

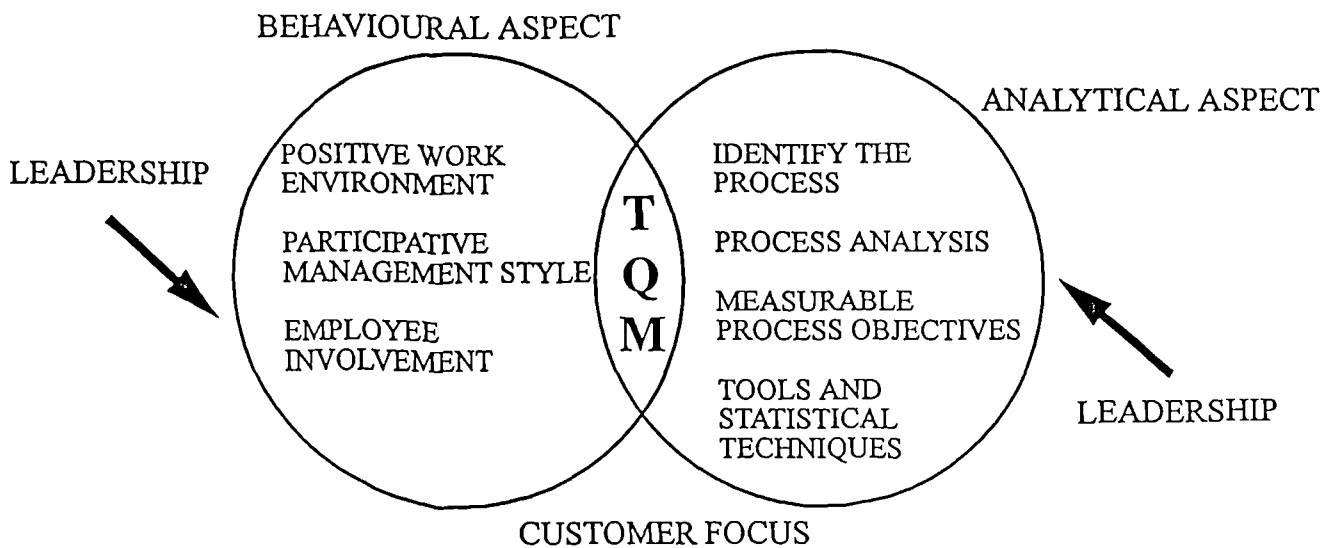
Nonetheless, Arikian notes that these steps to change should be undertaken by a nursing management team thoroughly committed to the TQM philosophy. The nursing team, she suggests, must demonstrate patience and persistence during the process of introduction and implementation. Graves⁴⁸ argues that, where management is concerned with culture change the following fundamental issues should be addressed:

- Behavioural change: change happens more quickly and more often when it concentrates on changing behaviours:
- Focus on a few objectives - on those things that matter most to the customers and to the company.
- Avoid oversimplification by use of slogans that convey the wrong message.
- Continuous process improvement groups should be developed to improve processes.

However, the author disagrees with the dicta of Graves⁴⁹ and Arikian⁵⁰ that TQM is about culture change. Culture change is as a consequence of an 'effective' implementation of TQM and not the 'be all and end all' of TQM. Any TQM initiative, particularly in the NHS, which adopts culture change as the first priority in its TQM process will falter. Thus, the process of change which TQM encourages, requires first and foremost active leadership and commitment from top management. This would ensure that TQM becomes the way the organisation operates, regardless of the nature of the cultural change process.

Littman⁵¹ identifies the hallmark of a quality approach as involving both technical and behavioural aspects. Technical issues include choosing and using the right quality tools and methods. He elucidates that using the best tools demands that an organisation should have systems that ensure management commitment, teamwork and reward systems that re-enforce appropriate action:

FIGURE 20



Source: Littman (1992)

Littman suggests that both behavioural and analytical aspects are needed for TQM to work. However, Ovretveit (1990)⁵² observed that it is the process quality element of health services which has been largely ignored in quality improvement programmes. Ovretveit contends that poor process quality can produce a downward spiral, where more and more is spent making up for mistakes and getting round inefficient and ineffective practices. Thus, process quality should be central to most organisations' quality improvement programmes⁵³.

Cullen and Hollingham (1987)⁵⁴ recommend six steps to the implementation of TQM;

- (1) Understanding - compare your organisation to the British Standard (BS 5750).
 - Note how far you are using statistical process control (SPC).
 - Conduct an attitude and awareness survey to find out your employees understanding of TQM.

- (2) Top management commitment - the direction the company should take is the prerogative of senior management, without their commitment any attempt to introduce total quality is a waste of time and effort.
- (3) Companywide awareness - explain TQM throughout the organisation using a top-to-bottom brief exercise.
- (4) Planning - identify a series of projects; this should cover education/training.
- (5) Implementation - each functional manager should set annual quality objectives. The sequence is: agree objectives; plan to meet objectives; identify resources to carry out the plans; decide priorities; allocate resources; execute the plans; review the results against objectives.
- (6) Review - every project reaching completion must be reviewed to determine if its objectives have been met.

To generate interest in continuous quality improvement, King⁵⁵ recommends a management system, 'The Right Way to Manage', which entails seven major activities:

- Education
- Leadership - people throughout the organisation become leaders and enablers of change
- Identify waste
- Human relations - all organisational and personal behaviour needs to be evaluated in terms of the new management system. "Do the organisation's policies, practices and procedures, both official and unofficial, support continuous improvement?".
- Training: everyone receives the training and tools required to work

- Projects: begin with modest projects

The core activity of the Right Way to Manage involves: Identifying; Quantifying and Eliminating waste. However, the author is of the opinion that King's 'Right Way to Manage' approach to TQM is inappropriate for the NHS because the model will fail to cater for the wider social, political, and economic context within which the NHS operates. Hence, any model with rigid prescriptive steps, is likely to fail in the NHS⁵⁶.

For Longenecker and Scazzero⁵⁷, the road to total quality generally includes:

- (1) Clearly defining what quality is and developing standards
- (2) Conducting quality training for the entire organisation
- (3) Developing meaningful measurements of quality for both work processes and for each member of the organisation
- (4) Establishing a system to take corrective action, when product quality problems emerge
- (5) Employing enlightened management practices to encourage employee involvement
- (6) Developing an organisational culture and reward system, which instils the belief that quality should be everyone's primary concern.

Similarly, Holt⁵⁸ suggests six key stages in the implementation of TQM. These do not have to follow sequentially, but all have to be set-up as continuous processes to achieve and maintain a TQM approach. The six key stages are:

- (1) Awareness and assessment: identify customers on a departmental basis. Identify gaps in meeting customer needs with all staff having a basic understanding of the meaning of TQM.

- (2) Organising for quality: the identification of a TQM strategy, formation of a formal structure, timetable and targets within which objectives have to be accomplished.
- (3) Education and training: to create a shared vision and to equip staff with the necessary tools.
- (4) Establishing the continuing process to monitor and evaluate activities and generating the appropriate actions.
- (5) Involvement: mainly on the part of management and filtering down to the shopfloor.
- (6) Continuous improvement - continuous customer satisfaction is the objective.

However, King, Longenecker and Scazzero, and Holt fail to contextualise their ideas by providing in a coherent format the 'what', the 'how' and the inter relationship of the elements in their respective step-by-step approaches. It is one thing to have a prescriptive formatting of TQM, but the practising manager is faced with the dilemma of 'how' to actually implement the process, particularly the issue of winning the commitment and involvement of the shopfloor, culture change, and the sustainability of the TQM programme. Because of these deficiencies, the models lack the essential characteristics of a 'holistic' approach. A holistic TQM model should be all-embracing, integrating the what, the how, and the way of implementation and the necessary infrastructural elements to support and sustain the process.

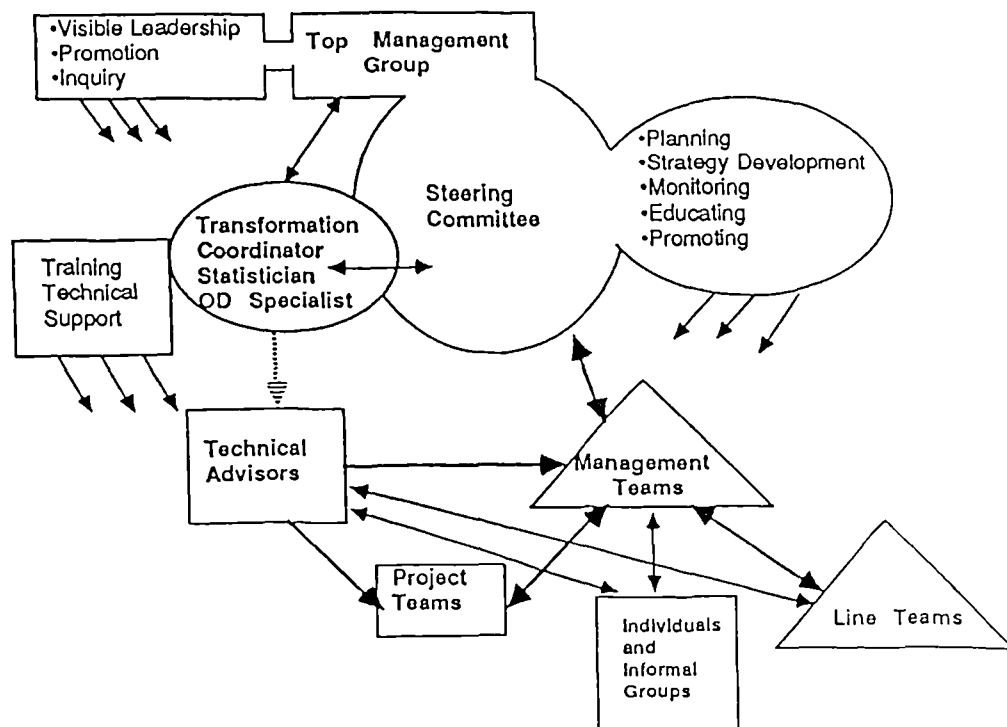
Scholtes and Hacquebord⁵⁹ offer 11 basic guidelines for quality:

- (1) Quality begins with delighting the customers
- (2) The quality organisation must learn how to listen to customers and help customers identify and articulate their needs

- (3) The quality organisation leads customers into the future
- (4) Flawless, customer-pleasing products and services result from well planned systems and processes that function flawlessly
- (5) In a quality organisation, the vision, values, systems and processes must be consistent with each other and complementary to each other
- (6) Everyone in the quality organisation ... managers, supervisors and operators must work in concert in order for all systems to work in a consistent co-ordinated complementary manner; a spirit of teamwork must pervade the organisation
- (7) Teamwork in a quality organisation must be based on a commitment to customers and to constant improvement
- (8) In a quality organisation, everyone must know his or her job
- (9) Use data and a scientific approach to plan, work, solve problems
- (10) Develop a working partnership with suppliers
- (11) The culture supports and nourishes the improvement efforts of every group and individual in the company

Scholtes and Hacquebord acknowledge the fact that transforming an organisation full of people is hard work and requires a carefully considered approach. They suggest six strategies to start a total quality management transformation⁶⁰:

FIGURE 21



Source: Scholtes and Hacquebord (1987)

The six strategies include:

- (1) Top managers learn to become leaders, exemplars and teachers of quality
- (2) Managers establish a series of improvement projects
- (3) Top managers engage in quality transformational planning starting with a two year blue print for preparation, start-up and early expansion
- (4) Managers establish processes for the internal co-ordination, oversight and technical training and assistance needed to support all quality improvement efforts
- (5) Managers undertake specific efforts to change the organisations's culture to one more supportive of total quality

In addition to these strategies, the authors offer further suggestions in the form of six changes which they argue must be carried out by the person responsible for the TQM process:

- (1) Recognize the informal organisation
- (2) Seek the active support of a critical mass
- (3) Allow people to deal with the need for change and the planning of change
- (4) Organisation change should be a mixture of gradualism and surprise
- (5) All efforts should be 'anchored', no isolationism
- (6) Change should be profound, comprehensive and widespread

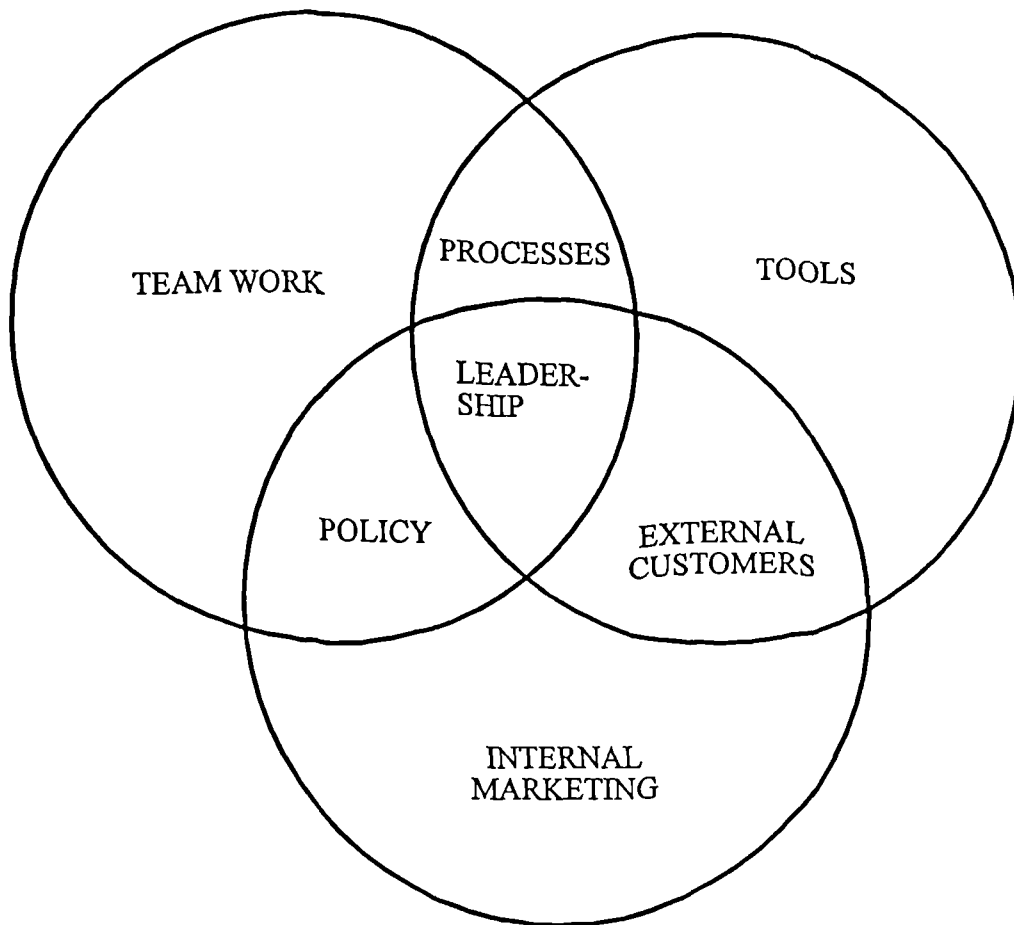
However, Scholtes and Hacquebord fail to show the relationships or the interconnectedness between their 11 basic guidelines, six strategies and the six changes. Their model is confusing and will not be useful in implementation of TQM; but it does have a place in creating awareness for TQM.

Feigenbaum⁶¹ notes that effective total quality control (TQC) requires a high degree of functional integration. TQC, he suggests, consists of four main areas;

- (1) Setting quality standards
- (2) Appraising conformance to these standards
- (3) Acting when standards are not met
- (4) Planning for improvements in these standards

For Wilkinson and Witcher⁶² there are four critical things that must come together for TQM to succeed; leadership, teamwork, TQM tools and internal marketing together with processes, policy and external customers. These elements must be fused together for the attainment of an holistic approach. If, for any reason, the implementers of TQM emphasize only the operational management and tools side at the expense of human resource management and teamwork, then, TQM will be at best partially implemented.

FIGURE 22
THE PARTS OF TQM



Source: Wilkinson and Witcher (1993) TQM Magazine Vol. 4 No. 1

In order for TQM to succeed, an organisation must unhook itself from its traditional hierarchical and functional moorings and then re-attach itself to horizontal and cross-functional processes⁶³ whilst integrating six sequential steps:

- (1) Trigger change by combining external competitive pressure with a clearly defined direction from the organisation's leadership
- (2) Develop, on the part of the top management team, an agreement on, and commitment to, the belief that quality improvement is the key strategic task
- (3) Form 'ad hoc' teams around processes

- (4) Create an organisation-wide change oversight team
- (5) Enable teams to analyze and take action through delegation
- (6) Align formal measurement and information to process management

TQM efforts that address only some subset of the above six ingredients will inevitably fade and disappoint. Moreover, the failure to achieve team consensus will move TQM down the path to programmatic change⁶⁴.

Similarly, Eskildson⁶⁵ suggests a four-step process for implementing TQM:

- (1) Establish demanding, customer focused improvement goals: this involves identifying the major priorities of customers and establishing goals that will meet or exceed them.
- (2) Involve everyone in accomplishing the goals.
- (3) Establish an aggressive transformation, profit-and-loss plan that summarises the intended costs and economic benefits associated with substantially improving organisational outcomes.
- (4) Restructure if appropriate.

From the healthcare sector, Godfrey et al,⁶⁶ suggest measures to help achieve TQM:

- (1) Physician involvement is extremely important: any healthcare organisation that begins a major TQM initiative without the involvement of consultants and consultant leaders does so at its peril.
- (2) Structure is critical if TQM is to work.

- (3) Training is not enough: TQM is not a training agenda, it should be, first of all, a leadership agenda and training per se is not a substitute for a comprehensive quality management programme.
- (4) Measurement drives TQM.
- (5) Customer focus is the bottom-line.

In addition Edwards⁶⁷, suggests six factors to achieve progress in the NHS:

- (1) Secure clinical excellence as the foundation stone
- (2) Empower the patient: let them manage more of their health, extend their choices and respect their time and privacy
- (3) Encourage locally generated standards to secure ownership
- (4) Search for continuous improvement, not short term effect
- (5) When guarantees are offered make sure they are always delivered
- (6) Quality is not an exclusive club, all staff need to share the commitment to it. Treat staff in the way you would like them to treat patients.

However, Swiss⁶⁸ notes that orthodox TQM as espoused by Feigenbaum; Wilkinson and Witcher; Eskildson; Godfrey et al and Edwards respectively can easily do more harm than good because it can encourage a focus on the particularistic demands of direct clients rather than the needs of the more important, but often inattentive, customers; the general public. Furthermore, orthodox TQM makes a number of demands for output uniformity and a strong, continuous organisational culture that a public sector health organisation is intrinsically unable to meet.

Macdonald and Piggot⁶⁹ offer 7 steps to the implementation of TQM but insist that a structure is established from the outset, in the form of a quality steering committee,

whose duty is to focus entirely on quality and should be chaired by the Chief Executive Officer. The 7 steps include:

- (1) Form TQM teams and train members
- (2) Initiate companywide awareness of TQM
- (3) Train the instructors
- (4) Implement the education element of the business plan, starting with senior management and cascading down the organisation
- (5) Develop TQM tools or documentation for work process analysis, requirements and measurement
- (6) Develop TQM systems for corrective action, recognition and improvement suggestion
- (7) Establish review procedures

However, the cross-functional quality improvement teams advocated by Macdonald & Piggot might produce significant resistance in healthcare organizations where power relationships are complex⁷⁰. Thus, in the light of the long-term commitment necessary to meet quality improvement challenge, how a company begins its quality programme is crucial. Commonsense demands that it be well thought out and right first time⁷¹. Before the start of TQM, senior managers should be aware of the cost of the programme and have the resources available. They should also be aware of some of the known pitfalls to be avoided. Rushing into full implementation without carefully laying a solid foundation for an organized evolution to TQM is a formula for failure⁷². Thus, TQM requires the need to start with a manageable pilot area, and a secondary objective to achieve. This entails five steps:

- (1) Focus on operations that affect critical issues that are important to customers
- (2) Start with pilot, departmentally owned processes
- (3) Start the improvement process under the direction and leadership of the highest organisational level possible
- (4) Cascade the process through the organisation
- (5) Predetermine early success levels

It is important in the implementation of any new management initiative that the people affected have a sense of ownership in the procedures adopted; hence a participative management approach is required⁷³. Moreover, the strategy adopted should be jointly developed and owned by everyone within the organisation, thus giving the people on the shopfloor a sense of ownership in the actions taken; irrespective of whether a Juran, Deming or Crosby approach⁷⁴ is adopted. The endorsement of TQM by top management alone is not enough. There must be strong endorsement by managers at all levels and these managers must infuse a sense of enthusiasm amongst subordinates. However, the problem with step-by-step, incremental approaches to quality, is that they are too daunting. Most managers faced with a mandate to implement TQM would ask, "Where do I start?", and "How do I proceed?". These models fail to provide such guidelines. They are better suited to a manufacturing setting and fail to meet the underlying characteristics of a public sector health organisation as identified by Kogan, et al,⁷⁵:

TABLE 7**Characteristics****Public Sector Health**

Structure and Culture	Decision making process through issue. Specific, multi-disciplinary groups of administrators and autonomous professionals negotiating consensus, process of change often diffuse rather than top-down or bottom-up. Welfare oriented and mainly non-competitive, though they increasingly compete for resources. Reactive rather than proactive.
Systems	Little experience of TQM and QA except in few areas such as X-ray, Pathology and Medical Engineering. No systems for managerial or financial accountability in medical specialism. Poor information systems and technology.
Staff	Most people still from era when welfare and service aspects dominated. Not primarily motivated by profit or efficiency motives, apart from specifically recruited managers, most higher level staff used to administrative or professional lines of control.
Customer Base	Customers use the service because they have to, not because they want to, little or no freedom of choice for most people.

Source: Kogan et al, (1991) 'The Evaluation of TQM initiatives in the NHS', Centre for Public Policy, Brunel University

According to Kanji and Barker (1990)⁷⁶ a practical approach to the implementation of TQM is more appropriate. The first stage is to identify the basic problems affecting the organisation's activities. The practical approach involves four processes;

(1) Identification and preparation

- Identifying and collecting information about the organisation in the prime areas where improvement will have most impact on the organisation's performance
- Preparing the detailed basic work for the improvement of all the organisation's activities

- (2) Management understanding and commitment
 - To make sure that the management understands the objective and methodology of TQM and is prepared to adopt them all the time
- (3) Scheme for improvement
 - By a process involvement of management and supervision in a proper scheme of training and communication, identify quality issues and effect a resolution of them by management led improvement activities
- (4) Critical analysis
 - Start a new initiative with new targets and take the complete improvement process to everybody indicating supplier and customer links in the quality chain
 - obtain information about progress and consolidate success
 - education and training must be dealt with by a combination of professional trainers and management

However, Voss and O'Brien⁷⁷ contend that the most widely used framework for quality within Britain is the British Standard; BS 5750. While excellent in its own right, BS 5750 does not provide a sufficiently broad framework for developing TQM. For example, the guidelines do not fully cover issues of leadership, quality commitment and customer satisfaction. It is not a sufficient condition for success in quality management⁷⁸. The adoption of BS 5750 by an organisation will not lead to overall improvements in quality⁷⁹. BS 5750 may well eradicate the plague of multiple assessment which has burdened companies in the past. However, the standard fails to include some of the essentials needed to attain world-class quality⁸⁰, such as:

- Personal leadership by the upper managers
- Training the hierarchy in managing for quality
- Quality goals in the business plan
- A revolutionary rate of quality improvement
- Participation and empowerment of the workforce

Thus, the failure of BS 5750 to lead to high quality levels and customer satisfaction makes it most inappropriate for the NHS, where it is the intention of government to ensure the services provided by the NHS are customer driven.

Peters⁸¹ puts forward 12 attributes of a quality system:

- (1) Management obsessed with quality: top management's obsession ensuring that quality is on top of every agenda
- (2) Guiding system, or ideology
- (3) Quality is measured: 'What gets measured gets done'
- (4) Quality is rewarded
- (5) Everyone is trained in techniques for assessing quality
- (6) Teams involving multiple functions/systems are used: it is vital to engage in multi-function problem-solving and to target business systems that cross several functional boundaries
- (7) Small is beautiful
- (8) Constant stimulation: create endless Hawthorne effects to prevent the programme from fizzling out after the initial 12-18 months period
- (9) Create a parallel organisation structure devoted to quality improvement: create a steering committee, a recognition committee or zero defect day; but ensure that this parallel structure does not merely become an additional layer of bureaucracy
- (10) Everyone plays
- (11) When quality goes up, costs go down

(12) Quality improvement is a never ending journey

Nonetheless, Peters' 12 attributes of quality lack any coherent or integrative framework that would enable the practising manager to determine the start and end points of the programme. Peters' work represents what the attributes of a good quality programme should entail, rather than a model for the implementation of TQM and thus leaves a vacuum where the structural and cultural complexities of the NHS are concerned.

According to Oakland⁸² there are 10 points for the management of an organisation to adopt in implementing TQM. These ten points constitute the foundation:

- (1) The organisation needs long term commitment to constant improvement.
- (2) Adopt the philosophy of zero defects to change the culture to right first time.
- (3) Train the people to understand the customer-supplier relationships.
- (4) Do not buy the products or services on price alone - look at the total cost.
- (5) Recognize that improvement of the systems needs to be managed.
- (6) Adopt modern methods of supervision/training.
- (7) Eliminate barriers between departments by managing the process, improve communication and teamwork.
- (8) Eliminate the following:
 - Arbitrary goals without methods
 - All standards based only on numbers
 - Barriers to pride of workmanship
 - Fiction. Get facts by using the correct tools

- (9) Constantly educate and retrain - develop the experts in the business.
- (10) Develop a systematic approach to manage the implementation.

In addition, TQM should not be regarded as a woolly-minded approach to running an organisation. Instead it should be viewed as requiring a carefully planned and fully integrated strategy⁸³. Oakland's methodology for TQM implementation could be broadly summarised as:

- (1) Identify customer supplier relationships
- (2) Manage processes
- (3) Change culture
- (4) Improve communication
- (5) Show commitment

It seems, however, that Oakland's methodology along with the other approaches to quality discussed earlier smack of 'flavour-of-the-month'. They show themselves not to be sustainable in the face of the 'shortermist' political and financial pressures prevalent in the public sector. Furthermore, their rigid step-by-step approaches are not sufficiently flexible to permit the integration of directives such as Patient Charter, purchaser requirements and clinical audit requirements, needed for NHS political survival. Most of the approaches are manufacturing models of TQM which lay emphasis on the elimination of waste in production, design and management, but they fail to provide advice about how to design mechanisms for improving the staff-customer encounter, empowering the user, or for improving access or equity which are important in a healthcare setting⁸⁴. What is strongly evidenced is the lack of a structured implementation sequence; the 'ends' tend to be defined but not the 'means'⁸⁵. In support of this contention, Pfeffer and Coote⁸⁶ argue that none of these approaches meets the broader welfare goals of equity and responsiveness and they call for a new, democratic model that would recognise the differences between commercial and welfare transactions and the multiple roles played by different shareholders in the NHS.

Furthermore, the approaches represent a plethora of prescriptions which, whilst informative per se, falls short of constituting a coherent and comprehensive set of actions which, if they were to be followed consistently would lead to the fizzling out of the TQM programme within 24 months. For example, what should a practising manager do to secure top management commitment? How is this to be manifested in terms of top management behaviour? The answers to these questions cannot be discerned from the approaches to TQM. Thus, the present approaches to TQM represent mere prescriptions that fail to provide the how, what, when, where, who and why of TQM implementation. What is implicit in the traditional approaches to TQM already discussed is the fact that in Western culture we are less interested in the intentions which predict action than we are in laying blame upon those whom we consider to be culpable: a sacrificial victim never goes amiss.

However, two distinct approaches to the implementation of TQM have emerged. The two approaches can be categorised as:

- (1) The 'Step by Step Approach'
- (2) Culture Change Route

TRADITIONAL TQM; A CULTURE CHANGE PERSPECTIVE

Whilst the literature is explicit on the 'step by step' approach, it fails to adequately advise organisations on 'how' to achieve, operationalise and sustain quality through culture change.

It has been argued that organisations implementing any new strategy should identify and change aspects of their existing cultures that are antagonistic to the ethos supportive of TQM⁸⁷. However, the TQM literature is bare on how an organisation could alter its existing culture to fit a new strategy. Numerous techniques are available to alter an organisation's culture⁸⁸. But, they are perspectives which adopt unitarist and highly contextual approaches to the understanding of the cultures which exist in an organisation and the ways in which it can be adopted⁸⁹. For example, Kilman⁹⁰ advocates generic solutions to bring about changes in culture, suggesting that the solutions can be applied, without any differentiation and without reference to the nature

of existing cultures within organisations⁹¹. This situation, has led the author to conclude that no-one really knows how to bring about culture change. Thus, orthodox TQM prescriptions which espouse culture change as their central focus have so far failed to equip the practising manager with techniques adequate to achieve culture change. Ever so often, TQM practitioners talk of TQM as culture change⁹². However, they consistently fail to provide 'ways' to bring it about. This has led to the situation whereby practising managers have failed to strike a balance between the existing culture and the new culture demanded by the holism of TQM. This apparent confusion has inevitably resulted in TQM being implemented as a 'bolt-on' to the existing culture rather than a philosophy to facilitate the eradication of the status quo and herald the dawn of a cooperative, win-win and empowered culture necessary to sustain TQM.

Furthermore, whilst the TQM writers propound methodologies for its implementation and also state the importance of measuring and monitoring the process of TQM, they fail to provide a framework as to 'how' an organisation can effectively measure its progress. For example, Haigh and Morris⁹³, have argued that 'What you cannot measure, you cannot manage' but, fail to provide the practising manager with a model for measuring progress. This represents a fundamental 'gap' in the literature. However, through interviews with fifteen quality managers, the author has established a need for an integrated model for the measurement and monitoring of progress in TQM. Quality managers in the NHS do not have the luxury of time to develop their own individualised approaches to measure progress. In consequence, TQM initiatives in the NHS have continued without adequate measurement criteria being utilised to determine whether the programme has or has not achieved the objectives set for it. In fact, some quality managers cannot categorically state whether their TQM programme is a success or failure because they have no way of knowing. Whilst some writers⁹⁴ have advocated the need to use the customer satisfaction index, most quality managers felt that it falls short of giving an overall systematic picture of where the organisation stands in relation to quality, largely because patient needs and expectations vary depending on how the patient feels at the time of completing a questionnaire. What these managers require is a practical, easy to use measurement model free of academic jargon.

The literature is devoid of such a model. The author feels obliged by this and by the demand for such a model from quality managers in the NHS, to provide an easy to read, easy to use measurement kit which will be part of the integrated approach to the implementation of TQM in the NHS. This will be addressed in Chapter Seven.

THE 'GURUS' ON IMPLEMENTATION

Total Quality Management represents the eternal search for continuous quality improvement in the product or service which is offered to both internal and external customers. Its characteristics are to be found in the work of such Gurus of the quality movement as Deming⁹⁵, Juran⁹⁶, and Crosby⁹⁷ and often summarised as being the presence of a formulative customer focus, employee empowerment and the instillation of leadership.

From the Gurus, the practising manager has inherited a legacy of ideas, Deming's 14 points, the 10 steps of Juran and the 14 steps of Crosby upon which to introduce and sustain a corporate quality initiative. In one way or another most of the quality improvement approaches discussed earlier reflect the work of each of the Gurus.

However, when the ideas of Deming, Juran, and Crosby on the theme of enhanced quality are amalgamated, coupled with a range of implementational techniques and then customized to suit the stated needs of a particular organisational culture such as the NHS, the result is a multiplicity of hybrids which have the appearance of a quality quagmire;⁹⁸ very easy to enter, very difficult to move through with any confidence and almost impossible to emerge from with a sense of direction intact. It has been noted earlier that "Crosby's 14 steps were over-long and a complicated process designed to achieve relatively simple ends⁹⁹. This is in relation to the number of steps and also in relation to the 'tedious' process of specifying suppliers and customers in the internal customer chain. Furthermore, a fair number of people in the NHS do not understand the concepts of zero-defects¹⁰⁰. For example, what is the practising manager to make of the exhortation to achieve "zero defects" whilst being encouraged, at the same time to "avoid campaigns to do perfect work"?¹⁰¹

The consequence is 'cafeteria management', a style of management marked by the tendency of practising managers to take into account only those aspects of quality management that appeal to them from each of the Gurus. The totality is forsaken in pursuit of the parts which are seen to have the most immediate relevance and return; the word 'total' is removed with only 'quality management' remaining. This selectivity inevitably results in the partial implementation of TQM. Perhaps such an outcome is not unexpected as most practising managers and the Gurus themselves share a professional, operationally oriented, managerial background in which broader organisational issues, such as the impact upon decision making of the intra organisational political dimension, were largely ignored¹⁰². The Gurus implicitly view management as a technical resource with management strategies including TQM, being viewed as a rational and linear progression¹⁰³. However, other writers perceive management as an inherently political process and organisations as social constructs in which groups compete for influence and power in order to determine the allocation of finite corporate resources. The absence of such contextual factors in the work of the quality Gurus, serves as a limitation upon the successful implementation of TQM, particularly in the public health sector, for, as Sinclair notes¹⁰⁴, the lack of attention directed to the 'people issues' within organisations ensures a reduction in rational prescription. The apparent absence of a realistic approach to organisational politics and, in particular, to the politics of organisational change, means that the Gurus have produced idealised concepts and prescriptions which are poorly suited to the demands and constraints of modern business¹⁰⁵.

The notion that TQM is holistic, as implied by the word 'total', is vital. Yet evidence exists which suggests that the Gurus and other business writers of the quality movement have not adequately contextualised their ideas. They have provided prescriptions as a guide to the practising manager seeking to launch his/her organisation along the road to continuous quality improvement without providing that manager with an adequately integrated framework within which the tenets of TQM can be operationalised, sustained and brought to fruition.

Prescriptions abound and are apparent by their prominence in the work of the Gurus; Deming's 14 points, Juran's 10 steps, and Crosby's 14 steps. Yet such prescriptions only resolve the specific questions asked by practising managers seeking to implement

TQM at the most general level and fall short of furnishing the specific details of an action plan. Little coherent advice is offered about how to design behaviours for improving the staff-customer interface, for empowering the user and for improving access or equity¹⁰⁶. Most approaches to TQM implementation, including the Gurus' ideas, fail to draw upon broader organisational literature and are particularly weak on how to operationalise the prescriptions which they so readily offer in differing organisational contexts. The most readily discernible consequence of this is the lack of conceptual understanding on the part of practising managers as to what constitutes the essential organisational elements and requirements for the successful implementation of TQM. That prescription dominates in the writings of the Gurus can be evidenced from a consideration of the salient characteristics of their work:

FIGURE 23: THE QUALITY GURUS COMPARED

	Crosby	Deming	Juran
Definition of quality	Conformance to requirements	A predictable degree of uniformity and dependability at low cost and suited to the market	Fitness for use
Degree of senior management responsibility	Responsible for quality	Responsible for 94 % of quality problems	Less than 20% of quality problems are due to workers
Performance standard/ motivation	Zero defects	Quality has many 'scales'; use statistics to measure performance in all areas; critical of zero defects	Avoid campaigns to 'do perfect work'
General approach	Prevention, not inspection	Reduce variability by continuous improvements; cease mass inspection	General management approach to quality, especially 'human' elements
Structure	14 steps to quality improvement	14 points for management	10 steps to quality improvement
Statistical process control (SPC)	Rejects statistically acceptable levels of quality	Statistical methods of quality control must be used	Recommends SPC but warns that it can lead to 'tool-driven' approach
Improvement basis	A 'process', not a programme; improvement goals	Continuous to reduce variation; eliminate goals without methods	Project-by-project team approach; set goals
Teamwork	Quality improvement teams; quality councils	Employee participation in decision making; break down barriers between departments	Team and quality circle approach
Costs of quality	Cost of non conformance; quality is free	No optimum, continuous improvement	Quality is not free, there is an optimum
Purchasing and goods received	State requirements; supplier is extension of business; most faults due to purchasers themselves	Inspection too late; allows defects to enter system through AQLs; statistical evidence and control charts required	Problems are complex; carry out formal surveys
Vendor rating	Yes and buyers; quality audits useless	No, critical of most systems	Yes, but help supplier improve
Single sourcing of supply		Yes	No, can neglect to sharpen competitive edge

Source: Oakland, J. (1989)

The fundamental message of the quality Gurus is essentially the same, although they might use different dialects¹⁰⁷. In essence, the message is: attack the system for the delivery of products and services and do not attack the employee; strip down the work process whether it be in the manufacture of a product or the delivery of a service; identify your customer and delineate customer needs; find and eliminate the problems which prevent the continual satisfaction of customer needs; eliminate waste; instill pride in performance and teamwork; create an atmosphere of innovation and continuous quality improvement¹⁰⁸. The Gurus claim that a process which exhibits such features will lead to increased corporate competitiveness and profit by increasing customer demand. In practice, such a scenario is naive. Quality is not a detached and generally recognised standard of excellence, but something which is agreed between the actors in the supplier-processor-customer chain in order to ensure that external customers are always offered that for which they are able and willing to pay¹⁰⁹.

To achieve this state of affairs requires a concise, comprehensive and holistic approach to the implementation of TQM; an approach which is notable by its absence from the prescriptions of the quality Gurus and a horde of other business writers in the quality field. This has led to several writers, for example, Jackson¹¹⁰, Chattergee and Yilmaz¹¹¹, pointing to the need to develop an 'overall' approach based on 'picking and mixing' the appropriate aspects of each of the main authorities on the subject. However, at the time of writing, no attempt has been made to produce this all-encompassing generic model. Against this background, the author has developed a five phased implementation model, 'What-to-do approach', based on the commonly prescribed activities which underpin the implementation of TQM as espoused by the leading proponents of the quality movement; Deming, Juran, Crosby, Oakland, Ishikawa, Collard, etc.

FIGURE 24: 'WHAT-TO-DO' APPROACH TO TQM

	PRESCRIBED ACTIVITIES	
Pre Set-up	*	Organisational assessment
Set-up	*	Develop infrastructure and specify roles, relationships and responsibilities of: a) quality council b) facilitators c) QI teams
	*	Train top management
	*	Train facilitators (limit numbers)
	*	Train QI teams (limit numbers)
Get-up	*	Identify customers: external to the organisation
	*	Identify critical work processes
	*	Identify key issues affecting delivery of quality service
	*	Identify pilot QI projects
	*	Nomination and selection of pilot QI projects
	*	Establish strong links between elements of infrastructure
Stay-up	*	Team maintenance activities to ensure continuity
	*	Integrate QI project(s)
	*	Consolidate lessons learnt from pilot QI projects into training
Move-up	*	Increase in number of QI projects and scope of projects
	*	Training and retraining at all levels
	*	Integration of QI projects into business plan

Source: Nwabueze, U. (1994)

It has been suggested¹¹² that the quality movement have failed to provide the practising manager with the 'what to' and the 'how to' approaches to TQM. In line with this contention the 'what-to-do' approach to TQM is provided. The framework encompasses five phases designated as: pre-set, set-up; get-up; stay-up; and move-up. These five discrete but interrelated stages are suggested phases organisations should go through en route to TQM. It also represents those activities required as a necessary condition for the successful implementation of TQM. The 'what to do' approach to TQM in the author's opinion, represents the quality infrastructure needed for sustaining the implementation of TQM. If the foundation of a TQM programme is not rock-solid, it is bound to collapse after the initial honeymoon period due to 'structural' problems. The five phases of the what-to-do approach are:

- Pre-Set-Up** - The Beginning; this calls for extensive organisational assessment of the organisation's readiness for change.
- Set-up** - Awareness stage where the organisation begins to learn about TQM. Assessing TQM's fit into the organisation. An infrastructure is created to support the TQM process. Foundation level skills that are required to sustain TQM are developed.
- Get-up** - Introduction of the management system - full streamlining of processes, team ownership and with middle management taking full responsibility for the quality process. Quality becomes everybody's responsibility and the initiative is led by management teams.
- Stay-up** - The period of holding the gains in improvements in quality.
- Move-up** - Integration: quality becomes the way work is accomplished. Self-directed work teams are created. This phase represents the completion of the first loop in the spiral of continuous quality improvement.

THE STRATEGIC APPLICATION OF TQM

In the author's opinion, the TQM literature is not very explicit on the 'strategic' application of TQM for, as Madu notes, "top management teams need systemic thinking and organisations need holistic visions to compete effectively¹¹³. Holistic vision can only be effectively developed, if organisations are aware of its strengths, weaknesses, opportunities and threats (SWOT)". This, Madu further notes, can only be achieved through a strategic management approach¹¹⁴. To Madu's list, the author would add the need for organisations to be aware of their external environment. It is essential that at the onset of a TQM programme a thorough assessment of the organisation's readiness for TQM is carried out. Invariably an internal audit which involves SWOT analysis is paramount and this should be undertaken together with an external audit to determine those external factors that might impede or provide opportunities for progress. In the NHS, for example, most problems are externally originated by government's constant interventions which, rather than providing opportunities for growth, have, at times, prohibited the progress of TQM by generating many competing TQM initiatives. The author is of the opinion that a strategic management input into TQM is essential, given that some organisations might use TQM only as a contingent approach to solving a particular problem and discard it once that problem is resolved. Until recently, the NHS did not have high expectations of patient service. 'Service' was often confused with servility, ignoring the fact that patients are concerned with at least three major attributes of the service process:

- Technical quality of care
- Availability of care
- Service - quality of caring

The strategic application of quality will enable the NHS to address and meet these three requirements and, in particular, move the service away from its insular thinking:

FROM WHAT THE NHS NEEDS → TO → WHAT THE PATIENTS NEED and

to a new strategic formula of:

ASK WHAT THE PATIENTS WANT → Manage, plan, organise, train and work to give the patients what they want and a little bit more

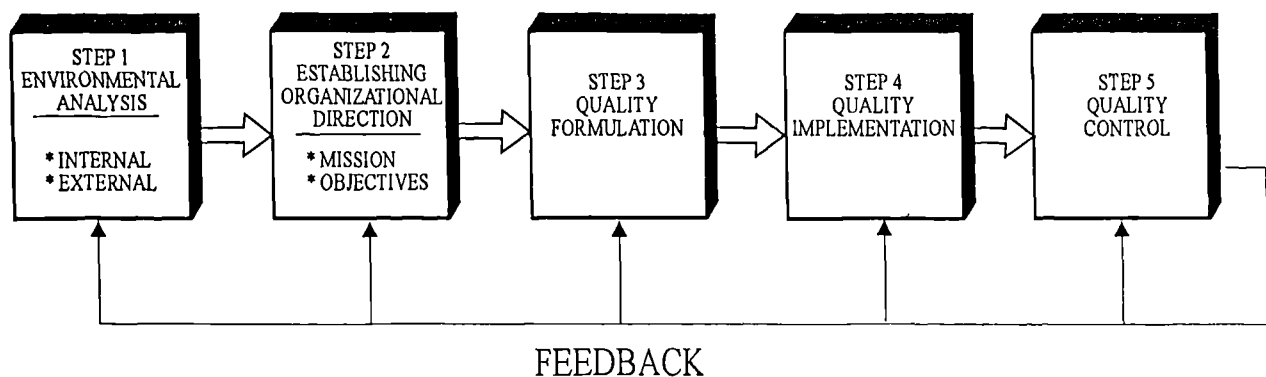
Furthermore, the strategic approach to quality will enable the NHS to effectively define:

- Where it is
- Where it wants to be
- and - How to get there

The answers to these elements can be established through a strategic assessment or an organisation-wide audit. In support of a strategic approach to TQM, Pryor and Pryor¹¹⁵ note that organisations are failing with their TQM programmes because they have failed to adopt a strategic approach to the implementation of TQM. Pryor and Pryor have suggested a strategic model for the implementation of TQM which they contend represents a solution to the failure of orthodox models of TQM:

FIGURE 25

THE STRATEGIC QUALITY MANAGEMENT PROCESS



Source: Pryor and Pryor (1994) A paper presented at the 10th Israel Society for Quality Management Conference

Although the author supports the need for a strategic approach to TQM, such an approach will be difficult to implement in the NHS because it will involve re-orienting existing managers to become strategists and to think strategically. This is not feasible. The NHS is cash strapped and cannot afford the luxury of retraining its managers to become strategists. Similarly, top executives are often too busy fighting fires to devote time to developing managers who can fashion and implement strategy. Furthermore, the managerial pay structure in the NHS is far below the industrial average and inadequate to attract the high calibre managers needed to manage an organisation strategically. Strategic thinking is not an easy task, it is beyond the scope of the calibre of present managers in the NHS who were raised in a service which demanded that they act as administrators rather than as managers.

Nonetheless, the strategic approach to quality management in other industries should be highly considered. Madu¹¹⁶ has compared strategic TQM (STQM) to orthodox TQM:

TABLE 8

Principles of Quality	TQM	STQM
Definition	Customer driven	Customer and environment driven
Priorities	Emphasis is on outcome and quality is the means	Organisational focus and vision is driven by overall quality
Decisions	Short-term and long-term goals are emphasised	Short-term and long-term goals that are environmentally sound and sensitive are emphasised
Objective	Prevent errors	Prevent errors in products and services and maintain socially responsible decisions that are environmentally sound and sensitive
Costs	Quality reduces costs and improves productivity	Quality reduces costs, improves productivity and corporate image
Errors due to	Common causes which result from failure of top management to manage effectively	Special and common causes as well as irresponsible management decisions
Responsibility for quality	Involves every member; improvement is emphasised and team work is the approach	Involves every member of the organisation but requires top management to take the lead to ensure that socially responsible decisions are made and effectively implemented; philosophy of continuous improvement is emphasised
Organisational Structure and Information Flow	Horizontal approach provides real time information, flexible	Horizontal/vertical approach, allows active participation of important stakeholder groups in making quality decisions
Decision making	Team approach is used with team members comprising of employees	Team approach with team members comprising of employees and important stakeholder groups

Source: Madu, R. C. (1994) Industrial Engineering, Oct.

The table indicates one key difference between TQM and STQM and that is the failure of traditional TQM approach to adequately address the external environment in which the organisation operates. Proponents of TQM tend to forget that external circumstances, beyond the control of either a manufacturing company or a hospital may lead to the failure of TQM. Thus, organisations should constantly monitor the external environment in order to keep in touch with the turbulent changes of the 1990s. In the author's opinion, TQM is a management process that should itself be managed strategically. This would ensure that TQM delivers on performance and particularly impacting on the bottom line. Managing the TQM process from a strategic perspective enables the organisation to focus on the external market place whilst facilitating the internal environment. This ensures that both the external and internal environment are congruent with each other.

TRADITIONAL TQM MODELS; A HEALTHCARE PERSPECTIVE

Some writers¹¹⁷ argue that there appears to be a move away from the development of an all encompassing, generic model of TQM towards the development of a more context-specific form. As an illustration, two healthcare models deserve attention because they represent the foremost healthcare context specific models in the U.S.A. The models include:

- (1) The George Washington University Medical Centre (GWUMC) continuous quality improvement transformation model¹¹⁸.

FIGURE 26

GWUMC TQM MODEL



Source: Chaufournier & Andre, Quality Progress, 1993.

- Structure:
- The programme was delegated to one senior manager
 - A formal structure established in the form of a quality council, led by the chief executive. An external visionary was appointed to guide the management team by providing proactive insights to TQM. Also appointed was a corporate coach to serve as the internal consultant and the organisation's quality champion.

The model encompasses a process improvement-led strategy. The GWUMC management team also chose the Focus-PDCA cycle as its guide to quality improvement. The Focus-PDCA involves:

- Find a process to improve
- Organise a team to improve the process

- Clarify understanding of the process
- Understand the source of variation
- Select interventions (plan, do, check, act)

Invariably, the GWUMC model is more of a Deming oriented approach rather than a context specific model. Its application to the NHS would meet with a lot of resistance because of its 'American' orientation. The model also has the demerit of being mechanistic. Furthermore, on the fourth dimension, 'select interventions', the model lacks a practical framework as to how this is to be accomplished.

- (2) The NKC (Norton Memorial Infirmary, and Kosair children's Hospital) model. NKC incorporated is a hospital in Louisville, Kentucky, USA, which undertook the implementation of quality using a 10 step approach¹¹⁹:

- (1) Develop mission, values, quality policy and corporate goals
- (2) Management commitment to the quality process
- (3) Organising for TQM
- (4) Education and training
- (5) Customers and their requirements
- (6) Improvement opportunity identification
- (7) Quality review
- (8) Recognition and reward
- (9) Communication
- (10) Integration of TQM with existing management programmes

However, the NKC ten steps are too prescriptive to constitute a concise and comprehensive model for the implementation of TQM in the NHS. In common with other prescriptive frameworks discussed earlier, it lacks the holism required for the implementation of TQM. It will also fail to adequately effect change to the organisational complexities of the NHS, particularly the stratified culture of the NHS. The ten steps may constitute a good 'awareness' model but, its rigid nature has absolutely no place in the implementation of TQM.

Furthermore, the two models were not developed based on empirical findings. Thus, it could be argued that the models lack problem specificity.

Earlier studies¹²⁰ evaluating the progress of TQM in the NHS suggest considerable variation on how managers are proceeding in the implementation of TQM. The studies note that some health authorities have placed great emphasis on the importance of improving customer relations, others have stressed the importance of improving clinical performance, whilst others have adopted a more guarded approach; conducting reviews across a number of service areas before making decisions about priorities and possible way forward, and others were influenced by, or seem to adopt, an approach compatible with Donabedian's model¹²¹. Correspondingly, there exists a major struggle between the dominant pre-1980's culture and more recent attempts to shift to a managerialist and consumer-oriented culture¹²². Pfeffer and Coote note chronological shifts in quality within the NHS; from the traditional approach of quality being reflected in perceptions of prestige and positional advantage, to expert approaches where standards are set by the professionals, followed by managerial approaches based on the pursuit of excellence through satisfying the customer, to the consumerist approach which emphasises the empowerment of the consumer¹²³. This underlines the confusion caused by the traditional approaches to TQM. Hence, managers are not sure on how best to approach the implementation of TQM.

Furthermore, Smith and Foster,¹²⁴ note a wide range of activities and approaches to quality management within the NHS which they classified into four generic quality management strategies:

Strategy 1	Strategy 2	Strategy 3	Strategy 4
Quality as a professional issue	Quality as a piecemeal activity	QM as a planned and co-ordinated activity	QM as strategic developments
<ul style="list-style-type: none"> • Quality emanates from a professional practice • Recruit the right staff and quality takes care of itself 	<ul style="list-style-type: none"> • Top management support • Departmental bottom-up initiatives • Opportunistic quality projects 	<ul style="list-style-type: none"> • Top-down co-ordination • Quality policy and structure 	<ul style="list-style-type: none"> • Quality a key organisational integrator • Quality focus on customer needs • Quality high on agenda

The authors note two fundamental needs to the enhancement of quality leadership in the NHS:

- (1) Senior managers to begin to know what they currently don't know about quality management
- (2) Top managers to translate the knowledge into action - to be able to formulate and implement strategies of QM.

However, what readily comes to mind in assessing Foster and Smith's two fundamental needs, is their failure to note the importance of clinical staff involvement, particularly 'consultants' participation and knowledge of TQM, which is central to quality management succeeding in the NHS.

Joss et al¹²⁵ identified nine hospitals with varied approaches to TQM, both conceptually and in the mode of implementation. Table 9 shows that the majority of hospitals have changed their approach once or, in some cases, twice. But Joss et al, failed to provide the reasons why some hospitals have changed their approach to TQM.

TABLE 9**DIFFERENT APPROACHES TO TQM IN NINE HOSPITALS**

Hospital	Features	Origins
1	Explicit Crosby complete with all 14 steps.	Crosby Management Consultants - 'hard'. Crosby Model - now self-driven by quality staff with modified language and steps
2	Crosby derivative, using much Crosby language but not explicit step leaders or his implementation stages.	Management Consultant led. They helped design and carried out much training. Still involved.
3	Mostly a self driven model of comprehensive and dynamic standard setting. Now in early stages of another change to Deming - training only but will implement in 3 lead departments.	Management Consultant led for original diagnostics and development of values etc.
4	Started with Deming theory but prescriptive approach. Faltering with loss of Chief Executive.	Following Deming but self-developed implementation.
5	Self-driven programme later moving to Deming but only in limited number of training events. No implementation in structures or processes.	Self-driven 'generic' initiative but now switching to Deming.
6	Strong customer service model supported by high profile management change programmes.	Management Consultant led. Change programme adapted from commercial sector service model.
7	Several Management Consultants with differing ideas involved in different parts of organisation.	Model adopted was part self developed and part based on Management Consultant.
8	Based on education-led changes through empowering managers and staff in professional development in groups.	Based on partnership with local University to develop training materials and approaches to professional development.
9	(a) Approach based on training critical mass of staff in customer awareness. (b) In another hospital under same management employed the personalising the services initiative - explicitly bottom-up in nature.	Self-developed and driven. Drew on expertise of ex-NHS consultant for advice and training then self-driven.

Source: Joss et al (1994) "Evaluation of TQM Projects in the NHS", Brunel University

The author's findings suggest that the reason for such changes in approach is the constant and increasing changes in personnel, i.e. most quality managers in the NHS move on to other jobs midway through the TQM programme. Hence, succeeding managers tend to change the approach to suit their instinctive understanding of TQM. This is the disadvantage of adopting individualised approaches to TQM. They lack continuity, whereas adherence to a structured specific approach would provide a constancy of purpose. Thus, a new manager would only need to continue from where the predecessor stopped rather than starting afresh and thereby disrupting the whole TQM process.

Nevertheless, the findings of Joss et al, seem to confirm that the implementation models adopted across the NHS have not adhered to the structural pattern of Pre-Set-up, Set-up, Get-up, Stay-up and Move-up identified by the author. What this means is that the management of the NHS has failed to put in place an organisational infrastructure to facilitate and sustain the drive for TQM.

Furthermore, Joss et al note that many Trust hospitals have failed to make any significant progress in implementing an orthodox model of TQM. On that basis, they suggest a mixed model of quality assurance for the implementation of TQM¹²⁶:

TABLE 10**GENERAL FEATURES OF THE MIXED MODEL**

Leadership of change	More even, multi-model leadership determined by needs, supported by specialist quality staff starting off with assessment of available skills and building on these
Modes of senior management action (including clinicians)	Determined about three elements of quality - technical, systemic and generic
Centre periphery relationships	Centre required services to implement quality systems but allows for variability in design of systems for each function or service
Mode of implementation	Iterative and helical style, multi-modal corporate planning, some synoptic/prescriptive, but also more incremental and developmental

Source: Joss et al (1994) 'Evaluation of TQM projects in the NHS' Brunel University

The mixed model, as proposed by Joss et al, suggests the need to develop effective quality assurance systems in each function or service and would require that three forms of quality - generic, systemic and technical - are assured. The model is suggested to allow for negotiation of the priorities and standards to be set for each functional area.

However, the mixed model has little relevance to the reality of change management required in the NHS. It fails to recognise the fact that, for TQM to succeed in the NHS, the NHS will have to go through some 'framebraking' changes that will affect the very nature of the organisation.

These would involve changes in structure, culture, managerial activities, processes, procedures and the skills required to manage in a new organisational context. Thus, what is required is not a mixed model that only describes the processes of transition planning, but a model that will help to fully prepare the NHS, its management and employees, to manage the assimilation of the complex 'messiness' of the paradigmatic change that TQM entails. In particular, such a model would address 'how' best to

deal with multiple levels of anxiety and resistance, how to manage the problem and processes of culture shock in a professional setting and how to win and sustain the support of the clinical staff. Furthermore, advocating three forms of quality - technical, generic and systemic - is to threaten a state of chaos. TQM is an integrated systemic process and should not be seen from any other perspective. On the basis of these shortcomings and upon recognition that the mixed model is a quality assurance model which will only perpetuate the dominance of the medical profession in the NHS, the author is of the opinion that, the 'mixed model' as proposed by Joss et al, is inappropriate for the NHS.

EMPIRICAL FINDINGS

Having developed a 'what to do' approach to quality improvement, the decision was taken to ascertain whether traditional approaches or models of TQM were in use in the NHS. In-depth interviews were conducted with three quality managers, and questionnaires were sent out to another twenty, asking them specifically to outline the approach(es) they adopted for the implementation of TQM. Of the twenty questionnaires sent out, twelve were returned. Thus, together with the data from the three interviews, the author had a total of fifteen responses from a sample of twenty-three, representing a 65% response rate.

Analysis of the responses from the fifteen quality managers, shows that the current situation with regard to the implementation of TQM in the NHS are of a diversity of approaches. The fifteen managers have opted for 'individualised' models of TQM based upon their own subjective experience. Table 11, shows a summary of the approaches of 12 hospitals, the remaining 3, will be discussed in-depth as the case studies of the research in Chapter Six.

TABLE 11

SUMMARY OF TQM MODELS IN USE IN 12 NHS HOSPITALS
AND REASONS FOR ADOPTION

Hospitals	TQM Features	Reasons for Adoption
1	No structured approach. 72 top managers attended 1 day quality awareness workshops. Written quality information for all staff. 3 day quality training for all managers. ½ day quality workshops for all staff. Quality project teams set up. Quality forum identified and a quality coordinator appointed full time. Quality emphasis on standards setting and monitoring of activities against standard.	No prior TQM knowledge. No time to study any particular approach.
2	In the first year undertook a review of the organisation (this was difficult as a new Trust) and identified a strategy for progression, training - training at Board and Directorate Manager level. Quality standing panel formed to review processes of TQM. Quality focus established over 3 years with Quality Department organisational issues addressed via quality panel and involvement of others, i.e. patient focus groups. Set professional standards to monitor quality of care.	We have not rigidly adopted any Gurus' method. Ours is the best of the best. Allows us to incorporate risk management.
3	As one of NHS TQM sites our programme chose to concentrate on standard setting with staff at the patient/staff interface level. Consequently we have been able to define 'quality' for the Trust taking into account the views of both service users and the providers.	Quality is best implemented according to organisational needs.
4	consultations prior to the launch to establish quality criteria that would support an audit of internal customer supply chains in order to motivate. The approach included: (1) Mapping of customer supply chains, (2) Launch of customer chain audit, (3) Customer supplier agreements, (4) Change to meet customer needs. Emphasis on auditing.	Addresses specifically our needs.
5.	Focus on the customer through: (1) Communications day, (2) Patient charter day. Adopted Wilsons and Maxwells' dimensions of quality. Used Maslow's hierarchy of needs to quality. Quality based on outcome measures and patient focused audit.	TQM models seen as bureaucratic. Hate to see Americanisation of healthcare issues.
6.	(1) Agyris work models 1 and 2 as a humanistic approach to TQM. (2) Team approach to problem solving. (3) Identifying indicators of quality to enable measurement across clinical and operational areas. (4) Training. Quality back into management through performance management.	TQM vague on the humanistic approach to TQM. Wanted a model with a humanistic slant.

Hospitals	TQM Features	Reasons for Adoption
7.	Assessment of all units position on quality (diagnostic). Appointed a facilitator group with representatives from each area. Development of mission, policy, principles and values. Training all 300 staff with specific training for managers and senior managers delivered by trained internal instructors. Emphasis on measuring and monitoring.	Limited knowledge of the Gurus. 'They appear boring'.
8.	No structured approach. Emphasis on standards setting and monitoring to meet Patient Charter initiative. A bit of the King's Fund organisational audit.	To meet external initiatives.
9.	Juran five product characteristic indicators. The trilogy in place looking at issues of teamwork, empowerment and measurement. Emphasis on 'fit-for-purpose', and 'fit-for-use' perspective. Biggest change agent is (1) the customer-supplier chain, (2) Planning, control - improvement, (3) Behavioural change - goodwill to deliver it. Constant and relentless efforts to change attitudes.	Juran's philosophy of 'Easy to understand, fits with the culture of the hospital'.
10.	Trained top management on quality over 2 days. conducted multidisciplinary training sessions over a 3 day period for staff on voluntary basis. Conducted departmental audits to identify problems. Carried out a survey of our patients. Set up a patients' complain team to monitor and rectify patient complaints. Set standards to meet Patient Charter initiatives. Implementing the Patient Charter.	'A lot of time spent on measuring of standards, no time for a systematic approach'.
11.	Lack of a full cycle mainly measurement. Individual departmental initiatives. Purely monitoring and assuring standards. Presently introducing problem solving approaches. Formed standard setting teams and groups. Involving patients in their care. Training staff on how to treat patients.	'Came from a nursing background believes in providing the patient with the best professional service.
12.	Quality objectives set and quality strategy communicated. Communication system specified. Training on problem solving, teamwork and auditing. A shared vision of healthcare clearly understood. Medical audit, standards quality, corrective action systems. Measurement against agreed standards is widely used with decision becoming fact driven on increasingly reliable information. Everybody has clear standards set and seeking ways of improving delivery.	'Chose to do it that way'.

Source: Compiled by the author (1994)

ANALYSIS

Table 11 indicates the differing perspectives of, and understanding of, the implementation of TQM among the respondents.

The individualised models, apart from one, (hospital 9), do not resemble any of the traditional approaches to TQM but have in common standard setting and monitoring, which smack more of professional quality than of holistic TQM. This means that quality managers within the NHS are working to evaluate the benefits that TQM can bestow upon their organisations on the basis of an idiosyncratic understanding of past, intra-organisationally determined experience. One quality manager was quick to further defend her decision to adopt her own personal approach, arguing that the existing models of TQM were too rigid and inflexible to deal with the unique characteristics of the NHS. She further argued that any 'rigid application of TQM in the NHS was a recipe for disaster, because the NHS is a politically led organisation with many new governmental initiatives going on simultaneously. Thus, any model of TQM should be sufficiently flexible to accommodate these other initiatives as well as the complex cultural ethos of the NHS'¹²⁷.

Whilst such 'personalised' models have the merit of affording recognition to those unique characteristics which all organisations possess, and which provide each with its own particular culture, they have the demerit of failing to ensure continuity of implementation; with successive quality managers adding their own preferred definitions and approaches to what should be a comprehensive, coherent and sustained drive for enhanced quality throughout the organisation. The obvious consequence is a loss of direction and momentum and ultimately, the lack of constancy of purpose. The very lack of adherence to a structured approach to quality in the NHS has invariably given rise to many Trust Hospitals encountering problems with their TQM programmes, resulting in a fragmented and partial implementation process. Nevertheless, what is apparent is the lack of conceptual understanding of the holistic requirements of TQM. In most cases, as the evidence indicates TQM is either seen as standard setting and monitoring, or specifically as a training exercise. This may itself be attributed to the fact that the traditional TQM paradigm is not definitive particularly, the lack of agreement upon the specific requirements and activities which must be

followed to operationalise TQM. This has led to doubts amongst NHS quality managers about the 'best' or appropriate approach to the implementation of TQM. Hence, quality managers have employed approaches that do not rigorously address the holism demanded by TQM probably because traditional TQM models lack the definitive action plan and flexibility of a context specific framework. Moreover, traditional TQM models are not sufficiently comprehensive and holistic to deal with the political, social, economic, and cultural dimensions of NHS organisations. The models maybe only appropriate for improving pre-service delivery processes but inadequate for improving the service and post service interface between the customer and the supplier¹²⁸. The problem that many managers, charged with the responsibility for the maintenance and improvement of quality in the NHS, encounter is that the TQM literature has bequeathed a legacy of 'prescriptions' for the implementation of TQM which, if not contradictory, falls short of being systematic and comprehensive. Furthermore, traditional models of TQM are partial as they omit from consideration the wider framework essential for the success of a TQM programme. What the quality movement has failed to deliver, in a readily comprehensive and coherent format, is a statement of the philosophy which both underpins and elaborates the approach which it is seeking to espouse.

Such a philosophy can, however, be made overt. All philosophies vary to the extent to which they seek to explain social, economic and political reality. They differ in the extent to which they are integrated, ie pragmatic, to the extent to which they are all encompassing. For instance, if a philosophical continuum were to be produced, then traditional right wing thought would be placed toward one end of the continuum and comprehensive, weltanschauung, radical critiques of the status quo would be placed at the alternate end. Yet all philosophies possess certain common characteristics and it is on the basis of this commonality that the present analysis focuses¹²⁹.

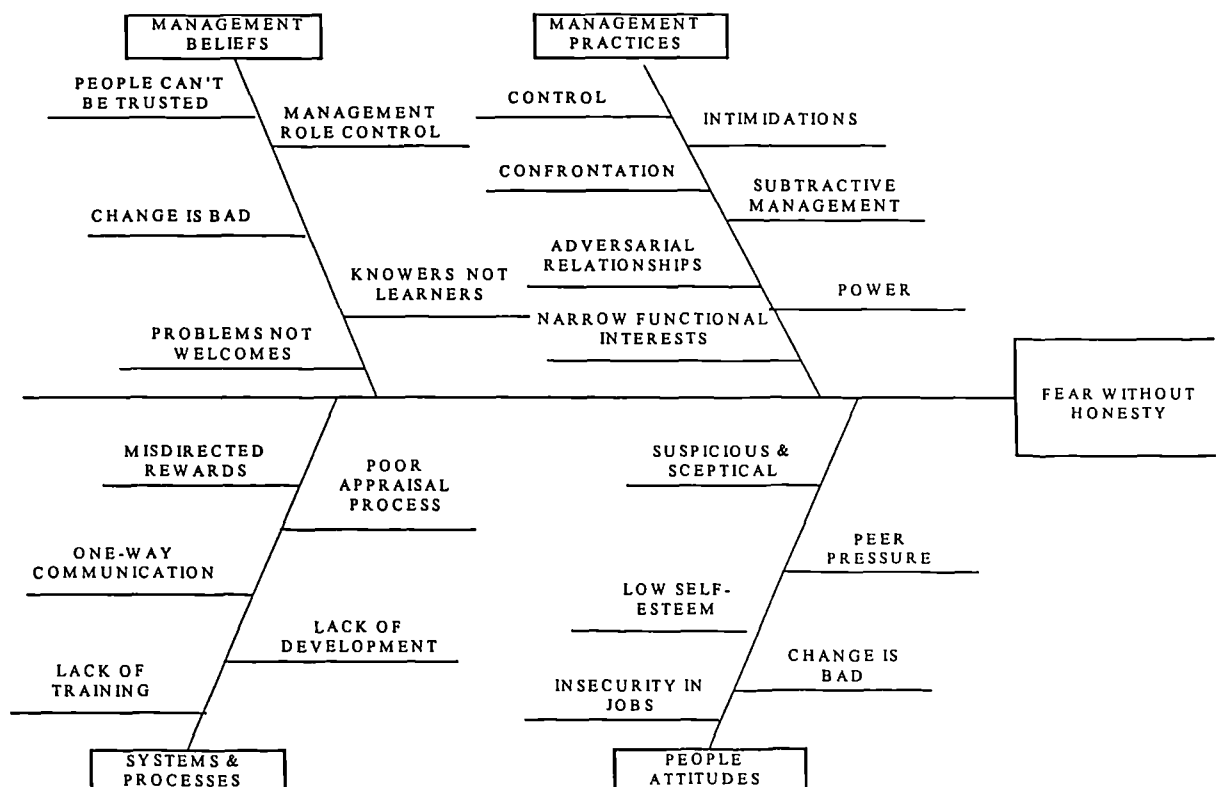
The first question which must be addressed is the commonality of all philosophies which is being posited. In doing so, it is accepted that all philosophies differ in content, but this fact should not be allowed to obscure the similarity which they possess. That similarity may be reduced to four elements:

- a challenge to the status quo: a critique of the past and present;
- a set of values'
- a vehicle for change: which facilitates the movement from the status quo towards:
- a future desired state.

Such a schema facilitates both an analysis of any one philosophy and a comparison between differing philosophies. When applied to the philosophy of Total Quality Management, the schema reveals the emergence of the following scenario:

A challenge to the status quo: Lowe and McBean¹³⁰ cogently represent the deficiencies of current management practice in both the manufacturing and service sectors of Western economies. They choose to do so through a detailed analysis of four key managerial indicators, namely management beliefs, management practices, management systems and processes and people attitudes:

FIGURE 27



A set of values: which serve as the cement which binds the components together and which further provides it with coherence and sustains its advocacy, adoption and implementation. Here the service sector, in general, is favoured by the work of Parasuraman et al¹³¹. They provide a comprehensive coverage of the expectations that customers may entertain of any service, and the values which they expect that service to exhibit:

- access: involves approachability and ease of contact;
- communication: means keeping the customers informed in language which they can understand and listening to them;
- competence: means possession by the organisation's personnel of the required skills and knowledge to perform the service;
- courtesy: includes politeness, respect, consideration and friendliness of the organisation's personnel;
- reliability: involves consistency of performance and dependability;
- responsiveness: involves the willingness, readiness and timeliness of employees to provider service;
- security: is freedom from danger, risk and doubt;
- tangibles: include the physical evidence of the quality of service production
- understanding/knowing the customer: involves making the effort to understand the customer's needs and expectations.

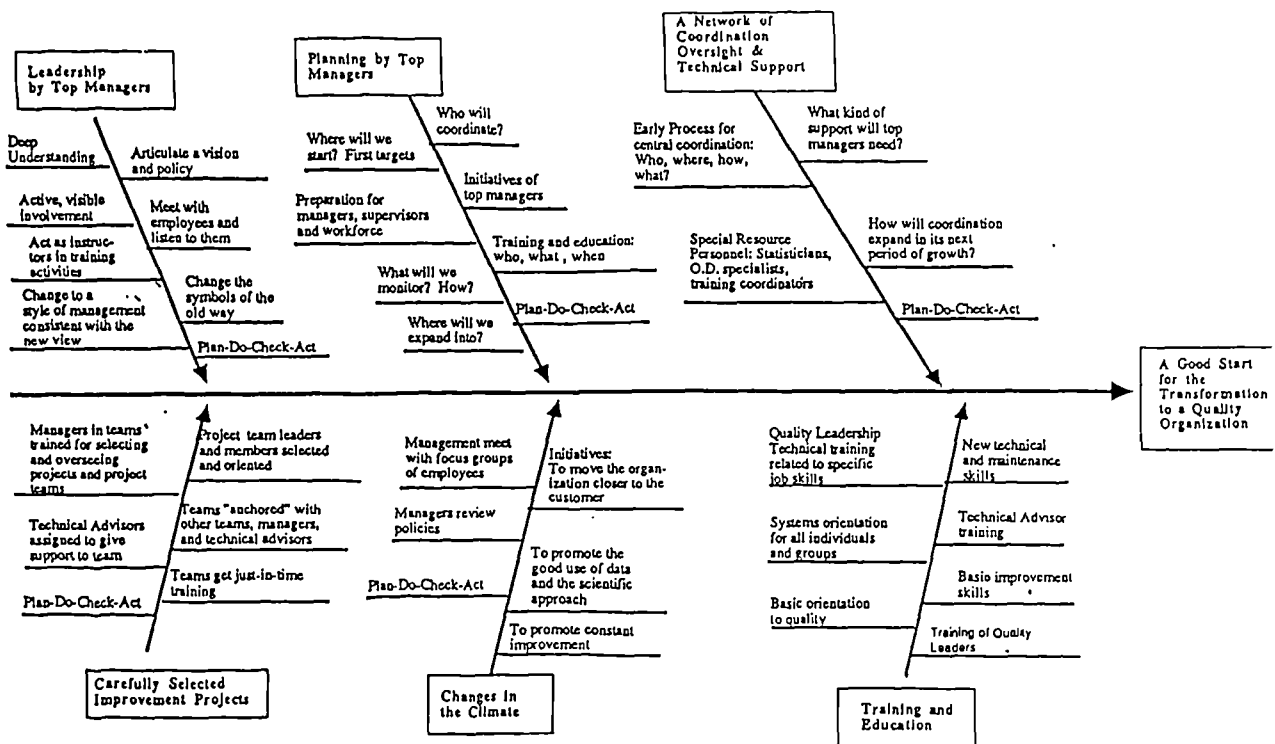
All of the above can be said to be values which, if manifested by an organisation's personnel, will serve to meet the needs and expectations of customers. However, these are not made explicit in the TQM literature.

A vehicle for change: TQM, through its effective implementation, is perceived as the vehicle of change which will sweep away the old management practices characteristic of the status quo and herald the dawn of a new era. Whilst the 'Quality Gurus' might differ somewhat in their prescriptions for the implementation of TQM, there is sufficient of a consensus for it to be possible to discern a number of agreed features of TQM as a vehicle for change:

- The customer is king: '... start(s) with the customer's requirements and end(s) successfully only when the customer is satisfied with the way the product or service of the enterprise meets those requirements'.¹³²
- Everyone participates in TQM: not just the senior and middle managers in the organisation and its first line supervisors but the entire workforce and, more recently, '... subcontractors, distribution systems and affiliated companies'.¹³³
- Quality measurement is essential: 'quality measurement for each area of activity must be established where they don't exist and reviewed where they do'.¹³⁴
- Align corporate systems to support quality: where '... existing systems and corporate structures... are found inappropriate for meeting cross functioning goals... necessary changes (must be made)'.¹³⁵
- Constantly strive for quality improvement: 'improve constantly and forever the system of production and service, to improve quality and productivity, and thus to constantly decrease costs'.¹³⁶

A future desired state: the goal which is being sought, through the critique of the status quo, the espousing of values which are customer focused and through rigorous and effective implementation of TQM as the vehicle of change, can be graphically displayed as follows:

FIGURE 28

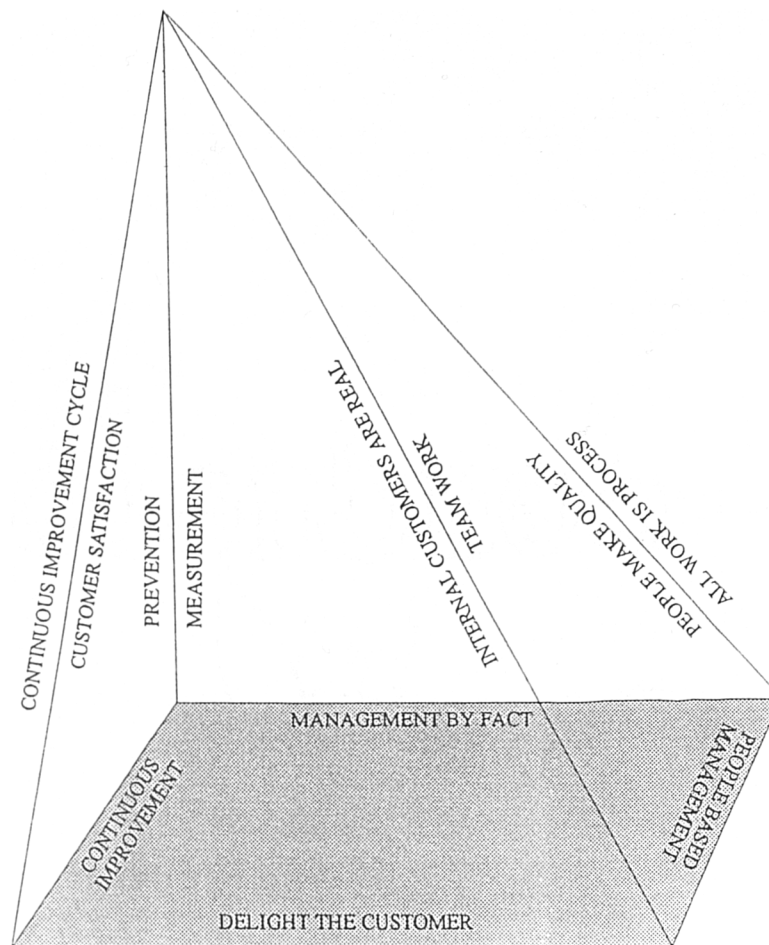


Source: Scholtes and Hacquebord (1987)

It is in pursuit of making the TQM philosophy manifest, in making it operational, that practising managers need help and guidance. To date there have been remarkably few, if any, empirical attempts made to offer an holistic implementational model of TQM that could serve as a reference point for their efforts. The paucity of such models has meant that managers, directed only by the generalised prescriptions of the Gurus, have adopted their own individual approaches to the implementation of TQM based upon their subjective, and by definition, idiosyncratic experiences. Far from being coherent and comprehensive, attempts to implement TQM have become, to a large extent, vague and partial.

An implementation model which does attempt to enforce the holism of TQM not to be found in the work of other TQM proponents is that developed by Kanji and Asher which links two operational concepts with each of the four basic principles of TQM which they discern in the literature¹³⁷:

FIGURE 29

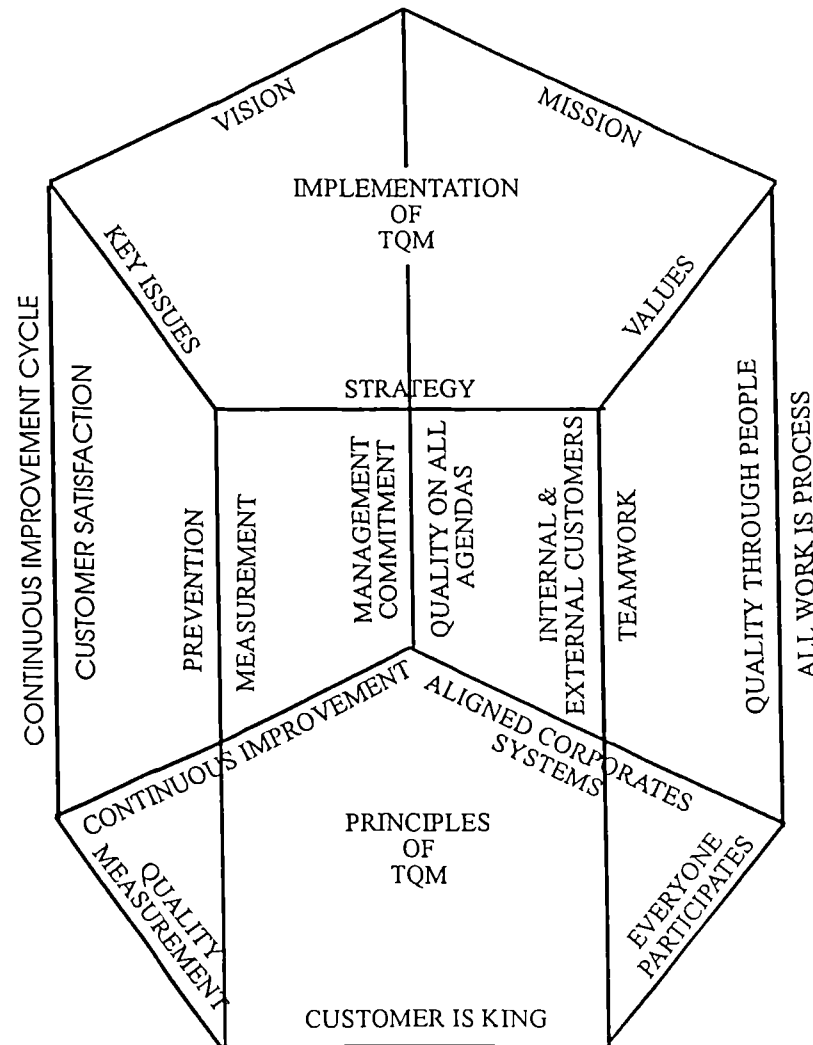


Source: Kanji, G. and Asher, M. (1993) 'TQM Process', Carfax Publishing

However, this model can be said to be partial as it omits from consideration the wider framework essential to the success of a TQM initiative.

The author's analysis of the philosophy underpinning TQM suggest that there are five such basic principles and not just the four discerned by Kanji and Asher. If the Kanji/Asher model is further developed to take account of this additional principle, the following model emerges:

FIGURE 30
HOLISTIC MODEL OF TQM



Source: Nwabueze et al (1994) A Paper Presented at the 5th EFQM Conference, Barcelona, Spain

It is contended that such a model, by revealing the interrelatedness between macro factors, the contextual, organisational requirements, for the introduction of TQM with the operational requirements, provided by the conceptual elements of the model, restores to TQM the holism to be found in its philosophy but which has not been manifested in the prescriptions of the traditional TQM models. Yet even this model, whilst affording a return to the holism demanded by the philosophy which underpins TQM, does not move beyond a position of considerable generalisation. To be of use to the practising manager in the NHS, it is imperative that its central sections are developed; those which link the principles of TQM with wider contextual activities of

vision, mission, strategy, values and key issues. It is these central sections which provide the basis for the day-to-day activities which make TQM manifest within an organisation.

Furthermore, it has to be conceded that any model which lays claim to providing a pathway to the implementation of TQM must have been designed to solve already identified problems and not the other way round. Hence, an implementational model of TQM should be developed on the basis that it will solve empirically determined problems. But what emerges is that most traditional TQM models are not 'problem-specific'; thus it is not surprising that most fail in practice. The author is of the opinion that the 'What to do' approach (Figure 24), which is a collation of the common elements of the various models of TQM, although not itself an implementational model, represents an infrastructural framework to lay the foundation of TQM in the NHS. Thus, to facilitate the success of TQM through the foundation level, what is required for the NHS, is a recourse to an implementational model of greater specificity, a flexible, concise, comprehensive and holistic model. The model need not be mechanistic, rather it should give cognizance to the fact that organisations are not mere apparati but are, instead, vibrant and ever changing human conceptualisations directed to the fulfilment of overtly stated purpose.

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CHAPTER FIVE

PITFALLS OF TQM

TQM literature is inundated with journal articles and conference papers, projecting very glossy and optimistic accounts of TQM practice; 'one hit wonders' of how some organisations are achieving continuous quality improvement. However, it has not been possible to identify any adequate study on the failures of TQM¹. This chapter will address this gap in the literature by exploring the potential 'pitfalls' to the effective implementation of TQM from three perspectives: the Commercial/Service, Public and Healthcare Sectors.

The pitfalls so identified will be contextualised into the four phases previously designated as: Set-up, Get-up, Stay-up and Move-up. It is hoped that this will afford the first comprehensive representation of the 'barriers' to TQM; although Hagan² has established the need for organisations to be aware of the potential 'barriers' to TQM prior to starting the initiating process. Thus, an elaborate study involving the use of questionnaires was administered to 23 quality managers to determine whether the framework embodying the pitfalls actually exist in practice and to establish, where appropriate, the 'significant' factors that have inhibited the TQM process in the 23 TQM demonstration sites. The expectation being that the analysis of the questionnaires would help to determine whether the 'pitfalls' to TQM have a 'generic' origin in the NHS.

Furthermore, total quality has become the management style of the 1990s. The outstanding achievements of many American healthcare organisations such as Beth Israel, George Washington University Medical Centre (GWUMC), Hospital Corporation of America (HCA) and the Mercy Hospital have motivated many others, particularly the British National Health Service (NHS), to undertake TQM³.

Ample proof exists that TQM can provide significant cost benefits by improving the use of materials, optimising people's time, reducing the cost of production and employing capital more effectively⁴. Most organisations emphasise the need for quality, but few can articulate precisely what it is and few firms have been able to consistently deliver it. There is a set of data which suggest that the 'failure rate' for

TQM within organisations remains relatively constant irrespective of the national location of organisations⁵.

The data include:

1. The American Electronic Association's survey which obtained responses from 458 members. The percentage of members with TQM programmes dropped from 86% in 1988 to 73% in 1991. In addition sixty-three percent of those with TQM programmes failed to reduce defects by 10% or more despite programmes being in effect, on average, for 2-4 years⁶.
2. A. T. Kearney found that only one fifth of more than 100 British firms it surveyed believed that their quality programmes had produced a significant impact⁷.

Furthermore, Joss et al⁸ in their evaluation of TQM projects in the NHS, suggest that most hospitals had failed to make any significant progress in implementing an ideal-typical or orthodox model of TQM. It has also been suggested that many organisations' TQM efforts failed after the initial 18-24 months honeymoon period⁹.

These findings seem to imply that an otherwise ideal TQM implementation will, in practice, result in failure. Hence, the question is 'What are the pitfalls that have resulted in TQM delivering little or no improvement in organisations that have adopted it?'.

The successful implementation of TQM relies on two models¹⁰. The first defines TQM and the second addresses the question of how to achieve organizational change. However, both are at worst, fundamentally flawed and at best merely inadequate¹¹. In most organisations, the person or people charged with the responsibility for implementation frequently possess but a superficial understanding of TQM. For example, claims are often made that if an organisation steadily improves quality, customer satisfaction will increase and everything else will take care of itself. This, in turn, has given rise to the situation where organisations concentrate on process-improvement efforts that overtreat symptoms and ignore root problems¹². However,

in the real world, customers emphasise value, inter-personal relations, price, reliability and not just quality. In the NHS, the superficial understanding of TQM has seen the adoption of standard setting and monitoring as the central focus; the understanding being that once the technical aspect, the treatment of illness, of the patient-consultant relationship has been met, the patient will be satisfied.

Despite the fact that the TQM literature emphasises the need to improve the customer-valued outcomes, a large number of organisations focus instead on creating a TQM culture through organisationwide training, self-managing teams, creating vision, mission, and value statements. These activities, however, are often embarked upon without clearly measurable goals and in-depth understanding of their interrelatedness¹³. The result is a state of confusion, long implementation time frames, frustration and resistance; the abandonment of the programme ultimately follows.

According to Laza and Wheaton¹⁴, a number of pitfalls to TQM can be readily discerned;

- Oversimplification and underestimation of the difficulty of bringing about culture change
- Failure to recognize that every company and every environment is different
- Lack of project management and/or the lack of management of the TQM implementation as a project
- Conducting mass training
- Over-emphasising technical tools at the expense of leadership and management issues
- Applying tools before needs are determined and direction is established
- Failure to provide an adequate sustaining structure.

However, Laza and Wheaton's reasons do not apply in the NHS. In contrast, money is not available for mass training nor are staff competent to handle project management and TQM tools. In fact, changes are happening so fast in the NHS that a void has been created in the form of a lack of adequately skilled personnel to match the momentum of change. This has created strain and stress for staff below Director level position who do not have the status and skill to drive change.

Harari¹⁵ notes that for every successful TQM project there are two disappointments due to an amalgam of the following 10 reasons:

- TQM focuses on internal processes rather than on external results
- TQM focuses on minimum standards
- TQM develops its own cumbersome bureaucracy
- Quality delegated to Czars and 'experts' rather than 'real' people
- Lack of radical organizational reform
- Lack of management compensation
- TQM does not demand entirely new relationship with outside partners
- TQM appeals to faddism, egotism and quick fixism
- TQM drains entrepreneurship and innovation from corporate culture
- TQM has no place for love

The author agrees with Harari on the issues concerning the bureaucratisation of TQM and TQM's lack of organisational reform. Within the context of the NHS, it is evident that, despite constant government reforms, the value system as identified by Harrison et al¹⁶ has remained the same:

- (a) management is still not a major influence despite the provider-purchaser split
- (b) the NHS is still largely reactive
- (c) pattern of change is still incremental and not far reaching
- (d) still very much professionally driven

In addition, the NHS environment is continuously changing due to the constant changes in policies by both government and purchasers. The NHS operates in an unstable environment with managers who are carry-overs from the old bureaucratic NHS.

This has led to a call by some business writers for a post-bureaucratic management system. This means a new public management, concerned with self-contained units with flat organisational structures involving a high proportion of professional staff working in self-directed work teams¹⁷.

Clemmer and Sheehy¹⁸ note that quality efforts fail because managers and chief executive officers of most organisations fail to "Walk-the-Talk". This means that, often, executives talk quality while rewarding volume, talk service while personally avoiding customer contact, talk about teamwork while behaving like lone rangers, talk about people as the most important organisational asset and then kick them around or kick them out, talk about the importance of improved communications and then retreat to their offices and boardrooms, or talk about the need for human resource development and then cut the training budget. Clemmer and Sheehy's arguments, which invariably imply that managements' actions are not consistent with what is preached, is consistent with the findings of Joss et al¹⁹, who note that in the NHS, the government initiated the implementation of TQM with the setting up of the 23 TQM sites and then introduced other, competing, compulsory initiatives such as the Patient Charter. Thus, the government talks of a patient-focused service and then retrenches staff and closes a number of medical facilities. Furthermore, a study by Dalley and Carr-Hill²⁰, identified 1,478 separate specific governmentally induced quality initiatives underway in 1989 in England and Wales. This situation has led to scepticism amongst NHS employees who saw 'changes' as being nothing more than 'flavour of the month' with any current initiative destined for the "back burner"²¹.

Many of the failures of TQM are the result of adding 'new' quality initiatives on top of the existing culture²². If TQM is approached in this way, it means extra work, increased costs and leads to the view that quality can be added or subtracted. Alloway²³ suggests that the main problems associated with TQM are:

- Organisations jumping right into a programme without first preparing the ground work
- Trying to treat symptoms rather than causes
- Never having enough time to do a job right first time but always enough time to do it over again
- Judging performance by isolated incidents
- Copying tools and programmes from others
- Blaming others when it goes wrong
- Believing that islands of success will spread without proper preparation rather than realizing that a successful operation will be overcome by unsuccessful ones if left unattended
- Drifting from one programme to another, hoping for a solution

The author agrees with Alloway that many organisations, particularly the NHS, see TQM as a bolt-on to their existing culture. Little or no attempt is made to realign the existing organisational culture to integrate the principles of TQM.

Seddon and Jackson²⁴, citing a survey by Develine and Partners, a management consultancy firm, suggest that the two greatest difficulties in introducing TQM are cultural change and changing management behaviour. Some business writers have consistently emphasised the need for cultural transformation²⁵. Crosby²⁶ states the need to fight the unreceptive culture found within organisations. It has been suggested²⁷ that Deming was able to achieve success in Japan because the values and culture of the Japanese were compatible with quality initiatives, but that cannot be said of the 'West', where the cultures are unpredictable²⁸. Thus, addressing cultural issues within organisations is critical to the success of any 'total' quality management transformation. However, most, if not all, TQM methodologies are particularly weak in this area²⁹.

In support of Seddon and Jackson's contention, Foster and Whittle³⁰ ascribe the failure of TQM in some organisations "to the failure to change organisational mindset". In support of that contention, the Managing Director of the European subsidiary of Milliken USA, asserts that the successful implementation of TQM in his company was as a result of the company's change in culture, by making a bold move away from a Tayloristic culture to a new culture that embodies customer responsiveness³¹.

Furthermore, Almaraz³² notes, "the implementation of TQM on an organisationwide level should represent a paradigmatic shift from the traditional form of management (Taylorism) to a new environment of empowerment, teamworking and customer focus". However, the traditional, individualistic paradigm of management and performance persists in most organisations. Almaraz suggests this is because of a number of factors:

- "Resistance to change: people are for the most part resistant to change of any sort especially transformational change. In organisations, many factors are contributory; fear of the unknown, economic insecurity, threats to social relationships, and failure to recognise the need for change. Such reasons will inevitably result in change that is ultimately stamped out and the status quo returned.
- Failure to adequately identify organisational parameters prior to change.

In order to prevent failure in the implementation of TQM, Cameron et al suggest a prior assessment to establish the degree to which a change (such as TQM) differs from the organisation's existing culture. It becomes imperative therefore, to create a need for change at the on-set by opening up the existing culture to be receptive to the new phenomena³³.

Similarly, Liberatore³⁴ argues that corporate culture must change in order for new ways of thinking and doing business to evolve. TQM fails because, in most organisations, the culture is so ingrained, it resists change and attempting to change the established culture will not work unless it is disabled³⁵. Pascale³⁶ sees the main barrier to TQM implementation as being the blind application of the tools of transformation, without a corresponding shift in managerial mindsets. He notes 'that 99% of managerial

attention in organisations is devoted to the techniques that squeeze more out of the existing paradigm. This has led to organisations holding on dearly to those things they best know how to do, upholding the adage 'stick-to-your knitting'³⁷. Thus, in the face of sagging fortunes, companies experiment with new ideas such as the Matrix, TQM, TQC, Decentralization, Delaying and Quality Assurance in order to improve efficiency. The problem, as seen by Pascale, is not which technique an organisation opts to use, but the piecemeal fashion and the frequent shifts from one to another. He suggests that what is fundamentally lacking in any change programme, such as TQM, is a good grasp of the larger context in which it must be embedded. Thus, it has become professionally legitimate to accept and utilize ideas without the in-depth grasp of their underlying concept and without the commitment necessary to sustain them. Unsurprisingly, ideas acquired with ease are discarded with ease³⁸.

Furthermore, top executives are often blamed for poor leadership and inadequate strategic vision. Managers have also failed to achieve a more fundamental shift in their organisation's capabilities, instead they opt for change programmes that only treat symptoms rather than providing a remedy for the underlying condition³⁹. What these managers need to do is not to improve an already dirty situation, they need to first uncover their organisation's hidden context, i.e. those underlying assumptions and invisible premises on which its decisions and actions are based. David Nadler⁴⁰ identified 15 of the most common "quality-hostile" assumptions that unwittingly doom TQM improvement efforts:

1. We're smarter than our customers - we know what they need
2. Quality is not a major factor in customer decisions
3. Our purpose is to make money
4. Our key audience is the financial markets
5. Emphasis on portfolio management and creative accounting
6. It costs more to provide a high quality product or service

7. We will never manufacture competitively at the low end
8. Managers are decision makers, workers are paid to do, not think
9. Success is based on innovative leaps, rather than continuous improvement
10. Senior management job is strategy, not implementation
11. Senior management personnel draw from finance and marketing
12. To err is human
13. Quality can be delegated
14. Don't dwell on mistakes
15. If it ain't broke, don't fix it

In addition, Deming⁴¹ identified five potential deadly diseases to the effective implementation of TQM:

- (1) Lack of constancy of purpose
- (2) Emphasis on short-term profits
- (3) The appraisal of performance
- (4) Job-hopping
- (5) Use of visible figures

However, Chattergee and Yilmaz⁴² attribute the 'pitfalls' encountered in the implementation of TQM to what they term 'the contradictory models of implementation devised by the Gurus', (Deming, Juran and Crosby). Whilst Juran advocates setting quality objectives and managing the quality plan according to those objectives, Deming is strongly opposed to management by objectives as well as to the use of merit ratings and slogans to achieve objectives. Crosby recommends zero defects as a quality

objective, whilst Juran and Deming are against it because they argue that the inherent variability in all processes renders such an objective unrealistic. These assertions by the Gurus, argue Chattergee and Yilmaz, have created a 'quality jungle', because managers are obliged to interpret and implement the Gurus ideas as they see fit. Therefore, the bad name TQM is receiving is a matter of execution, not intent⁴³.

Similarly, top management is often narrowly focused, lacking in vision and invariably fails to articulate how its myopic views affect the overall performance of its firm. Hence, top management is not committed in most cases to the sustainability of the TQM effort.

Gehani⁴⁴ identified four factors inhibiting TQM implementation:

- There is no single quality remedy. Most remedies represent 'Cookie-cutter' application of TQM practices. This he suggest is the main reason for the lack of consistent superior performance amongst organisations using TQM
- Focus on bottom-line results
- Non-linear, iterative path to quality
- Paralysis of planning under dynamic uncertainty. This means the rigid reliance on a formal planning process by most companies.

Whereas Wilkinson et al⁴⁵ noted that the difficulties encountered by the organisations they surveyed in the management of quality were:

- Resource limitations
- Cost constraints
- Emphasis on short-term goals
- TQM seen as production/operations concern
- Measuring quality
- Clash with other initiatives

- Communication

Wilkinson et al, further note that the economic recession intensified resource limitation which gave rise to cost-containment thus, undermining staff morale and the commitment to quality. In addition, the lack of a demonstrable impact on financial performance, made it difficult to justify and maintain the momentum for TQM. Hence, the high expectation and initial enthusiasm created by TQM risk contributing towards a feeling of disappointment when gains are less significant than had been hoped⁴⁶. This is congruent with the view held amongst some managers whom the author interviewed as part of the research, that the failure to achieve significant results in the short-term jeopardizes the commitment to quality.

For Schaffer and Thomson⁴⁷, the main pitfall to TQM is its 'activity' centred approach. They note six reasons why TQM fails:

- (1) not keyed to specific results - the TQM methodology fails to specify explicitly how its espoused activities, empowerment, training, awareness of customer requirements, are supposed to lead to results
- (2) too large scale and diffused
- (3) results is a four-letter word
- (4) delusional measurements
- (5) staff and consultant driven
- (6) bias to orthodoxy, not empiricism

Furthermore, Schaffer and Thomson note that, the absence of clear-cut beginnings and endings and an inability to link cause and effect serve to ensure that there is virtually no opportunity for TQM, or any other activity centred programme, to learn useful lessons and to apply them to future programmes. To that effect, Schaffer and Thomson advocate a more results oriented approach to accomplish measurable gains in TQM.

This is congruent with the author's view⁴⁸ that conventional approaches to the implementation of TQM, with emphasis upon incremental improvements, appears to be failing; particularly in the NHS, where instant and short-term results are necessary for survival in a climate of increasing external political change.

Gavin⁴⁹ indicates that most organisations have taken a prescriptive approach to TQM without pausing to analyze the causes of the problem. Quality problems, he suggests, might arise from a number of sources; including poor designs, defective materials, shoddy workmanship and poorly maintained equipment. However, anecdotal evidence suggests that very few managers and workers are trained in the principles of quality management and the connection between quality, productivity, and cost is often poorly understood⁵⁰. In these circumstances, the commitment of managers and workers to improving quality is likely to be much weaker than it is in Japanese companies; where most managers and workers have an in-depth understanding of the principles of quality control⁵¹. The essence of TQM is that it is a holistic concept⁵². In practice, however, to achieve the holism required by TQM is difficult⁵³, for three main reasons:

- (1) TQM advocates often hail from a quality management and operations background and tend to ignore broader organisational issues in their prescriptions for quality improvement. This view is consistent with that established by Joss et al⁵⁴, in their survey of TQM projects in the NHS. The authors note that one of the failures of TQM in the NHS is that implementation is based on commercial models of TQM which fail to take account of the realities of a professionally managed public service.
- (2) Consultants who oversee the implementation of TQM tend to give in too easily to pressures from client companies and submit to the implementation of a partial and cut-price approach and, by so doing, ignore longer term issues such as organisational politics and functional relationships.
- (3) The failure to see TQM as an integrated approach for the whole organisation.

Furthermore, whilst most companies claim to be running TQM, its form takes many shapes, which look like human resource management friendly versions of long established quality assurance systems or like technical quality assurance systems concerned with only professional or specialist knowledge⁵⁵. Hence, most existing forms of TQM are partial⁵⁶. Similarly, Glover⁵⁷ notes three general patterns to the failure of TQM:

- **Conceptual weakness** - managers pay 'lip-service' to quality, thus only superficial attempts to organisational change are realised
- **Design failure:** arises when TQM systems are not designed to fit the cultural circumstances of the organisation. The author entirely agrees with this view and is of the opinion that, TQM is not designed to fit with the circumstances of the NHS because of the unique differences between a public sector health organisation and the commercial sector. In addition, many well-intended TQM efforts have failed because those initiating the change did not adequately 'adapt/fit' the TQM system to its intended recipients and their operating environments.
- **Implementation failure:** when the concept and design are valid, but the change agent and or leaders of the organisation do not understand the complexity of organisational change and innovation.

However, if there is to be a transformation of TQM visions into reality, it will be necessary to protect and nurture the good things that are being done, while challenging traditional practices and replacing them with better methods. Thus, any model of TQM selected and/or developed by an organisation should fit the organisation's internal and external environment. It is also important that organisations realise that, the greatest obstacle to revitalization is the idea that it comes about through organisationwide change programmes⁵⁸. Change programmes, such as TQM, have implementational difficulties because they are guided by a theory of changer that is fundamentally flawed. The misconception is, the common belief amongst practitioners, that a change in people's attitude would lead to changes in behaviour and that this behavioural change will lead to companywide results measured in terms of organisational change⁵⁹. Thus

'change' is seen as a conversion exercise. However, individual behaviour is shaped by the organisational roles that people play. The most effective way to achieve behavioural change, in order to facilitate the success of TQM, is to put people into a new organisational context which imposes new roles, responsibilities and relationships on them⁶⁰. However, traditional approaches to TQM have so far failed to achieve this because they have generated a change in attitude rather than a change in behaviour. What is required for TQM to work, is a change in management style and employee behaviour, a radical and committed change in behaviour, directed towards the delivery of a quality focused service to the customer.

Brown⁶¹ identified 10 reasons why two-thirds of companies have failed in their implementation of TQM:

- (1) Disguising cost control as total quality
- (2) Measuring too many of the wrong things
- (3) Lack of support from the top. This has led to employees to view executives like we view politicians.
- (4) Too much too soon - most companies get too enthusiastic at the initial stages, they try to change everything too quickly.
- (5) Too little too late
- (6) Dual structures
- (7) Focus on activities rather than results. This has led to a situation whereby companies focus on killing alligators instead of draining the swamp.

- (8) Getting stuck at the initial training phase
- (9) No rewards
- (10) The feeling that TQM is a fad

Similarly, Voss and O'Brien⁶² identified three factors inhibiting the effective implementation of TQM in British organisations:

- (1) Gaining management commitment to quality
- (2) Conflicting messages - often company mission statement not consistent with actions and priorities of top management
- (3) Lack of leadership

Oakland⁶³ notes some obstacles to the implementation of TQM among which are:

TQM is time-consuming, bureaucratic, formalistic, rigid, impersonal, and/or the property of a specialist group. Oakland further notes that in most organisations, there exists resistance from middle level managers particularly where there is a fear of openness. In the author's opinion, the resistance by middle level managers, is understandable because traditionally TQM seeks to exclude middle managers and calls for self-directed work teams whilst forgetting that, apart from senior managers, everyone else within an organisation works for a middle manager. In consequence, the author advocates self-directed teams that are middle management-led. This should ensure the co-operation of middle management.

Traditionally, quality efforts have involved control, assurance, inspection or guarantee rather than ensuring that customers' needs are identified early in the process and guaranteeing a positive response to those needs. This is due to 10 irritants⁶⁴:

- Uncorrected vision: vision statements that are disconnected from values and behaviours

- Poor objectives: emphasis on limited, quantifiable goals
- Loose cannons: use of quality as an excuse to establish fiefdoms
- Wandering teams and lost supervisors: many cross functional teams have no clear charter
- Non statistical thinking
- New programme syndrome, a proliferation of well-intentioned but useless techniques which are designed to motivate workers
- What, more training?
- Double-crossed functional management
- Electronic management
- 1. 2. 3...change

However, these factors are particularly irrelevant within the context of the NHS. What seems to be a pertinent failure of TQM in the NHS, is the speed at which the central government has carried out its devolution policy. This has led to a shortage of managers within the NHS without the requisite skills to manage.

According to MacDonald⁶⁵ there are ten principle reasons for disappointment in TQM:

- Lack of management commitment to see the process through. Management tends to treat quality improvement as a short term programme rather than as a never-ending process.
- Lack of vision and planning. Many executives have little idea of the where, what, and how, of quality. There is no organised approach.

- Satisfaction with the quick fix.
- The process is tool bound.
- Quality is too constraining.
- Satisfaction with customer satisfaction.
- Culture change versus a project approach.
- Quality management becomes institutionalised.
- The people are not really involved.
- Lack of real business measurables. Many TQM processes are not measured in a meaningful way. Some companies mistakenly believe they are measuring the process by techniques, such as the cost of quality (COQ), but few apply real business measures as the criteria for success.

However, the author has identified empirically, that the potential for failure in TQM is typically a cultural, behavioural, and/or a strategic issue. When 'change' occurs, relationships may be strained or ambiguous, redundancies temporarily limit success because the people who remain are affected as other people leave. For example, in the NHS, services and work processes are complex and are continually changing, turnover and mobility within the workforce are continuous. The needs of patients and their families change. Regulatory requirements, both from the government and purchasers, are always changing. Relationships amongst management and clinicians, clinicians and employees, and the employees themselves are constantly changing. Some of these changes have created obstacles to quality improvement. Furthermore, longstanding sectional problems inhibit employees from crossing departmental lines to solve quality problems and strained relationships between the professional staff and management impede a sense of partnership in approaching the challenge of continuous improvement. Thus, specific behavioural interventions and team building activities are necessary to build momentum and support for the organisational change that TQM demands.

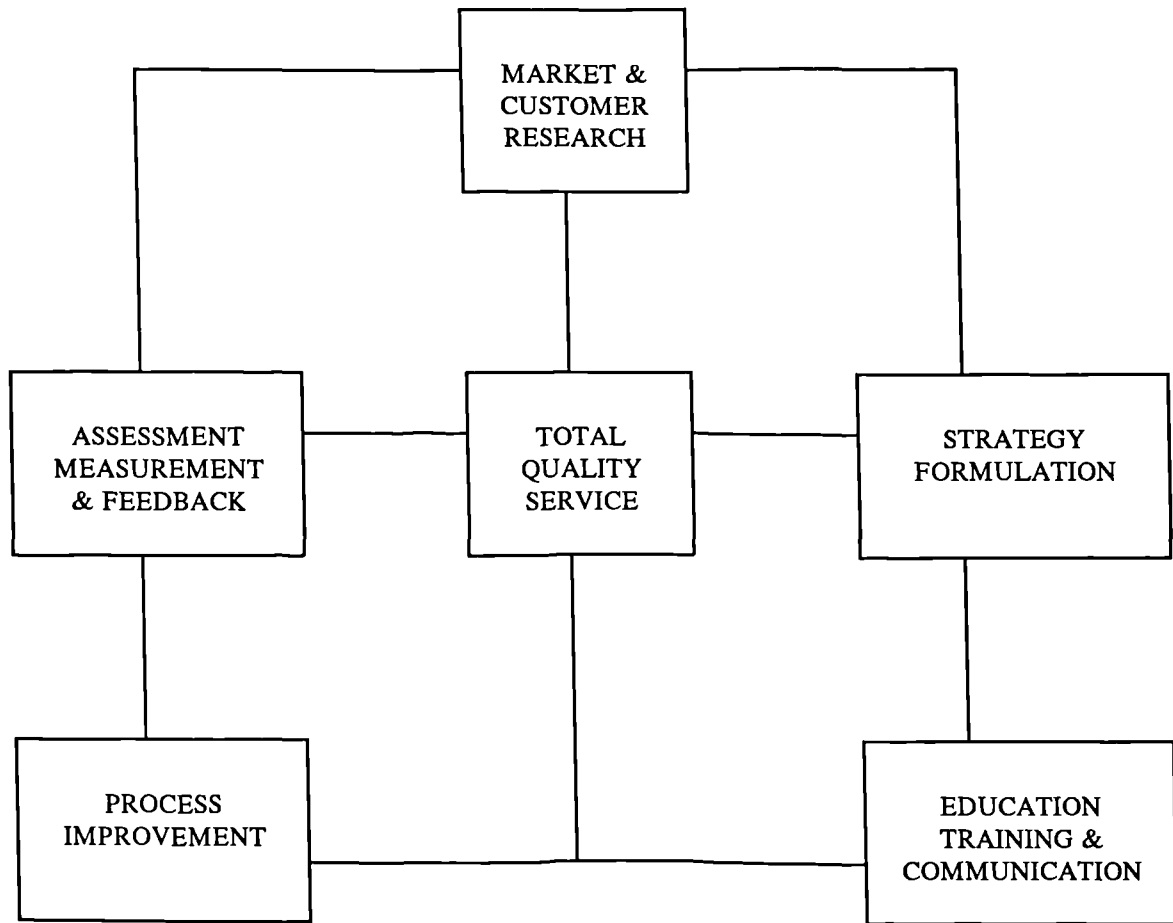
Albrecht⁶⁶ is of the view that one organisation after another has flirted with TQM and found it cumbersome, time-consuming and lacking in focus. Many are now looking for a philosophy and approach with a more natural feel and a more direct customer-value orientation. In comparing management-by-objectives to TQM, Albrecht states that 'TQM will soon be cornered to the mysterious graveyard of panacea that never quite delivered the goods'. He further states that TQM falls short of an ideal management strategy on four counts, namely:

- TQM is highly mechanistic; views the organisation as an apparatus rather than a vibrant and changing human culture.
- TQM focuses on procedural issues; ignoring the personal
- TQM requires a great deal of training, indoctrination and selling to get people to use it and a great deal of bureaucracy
- TQM tends to be management imposed rather than co-determined

He advocates a total quality service model which encompasses five critical elements to take over from the more traditional interpretation of TQM:

FIGURE 31

TOTAL QUALITY SERVICE MODEL



Source: Karl Albrecht (1988) TQM Magazine, Oct. 1992

However, Albrecht's TQS model is a representation of all the elements advocated by TQM. TQM calls for adequate market research, strategic planning, process improvement and monitoring achieved through education and training. What is evident is Albrecht's lack of conceptual understanding of what TQM entails. Furthermore, Albrecht failed to note 'how' the TQS model would be implemented within an organisation in order to avoid potential pitfalls.

Burdett⁶⁷ suggests that the problem with TQM is based on a Newtonian mindset, rooted in assumptions that to solve a problem it first has to be broken down into the smallest number of parts. Progress, is thus made by examining each of the parts, fixing those

that are broken and reassembling the 'now improved' parts into an effective whole. The criticism being that the dynamic interaction between the parts is, for the most part, ignored and the power of systems thinking overlooked. He notes that TQM has application to incremental improvement, but is of little value in supporting major discontinuous change. This is consistent with an earlier view expressed by Harrison et al⁶⁸, that incremental changes tend to be uncoordinated and without long-term continuity. Hence, TQM is a continuous improvement mentality that fails to question not only the status quo but the assumptions that underlie the current mindset, leaving the organisation captive to established paradigms of differentiation and hostage to the capability drawn out of past practice⁶⁹.

The author disagrees with Burdett, arguing that TQM represents a challenge to the status quo and through its effective implementation is capable of sweeping away the old management practices characteristic of the status quo and of heralding the dawn of a new era⁷⁰, the era of continuous quality improvement.

However, the predominant emphasis in the existing TQM literature is on quality assurance and, in the UK, on BS 5750⁷¹. According to Hill⁷², while solutions to the technical issues of designing appropriate systems and procedures are fully specified, the TQM literature remains lacunae to the treatment of social factors. The lack of consistency in management policy to quality has been noted by Oakland⁷³, with a gap existing between espoused quality policy and the competitiveness of the end product. There is little acknowledgement that there may well be tensions between the production oriented 'hard' aspects of TQM, Statistical Process Control - (SPC) and Taguchi design experiments which emphasize working within prescribed procedures, and the 'soft' aspects of TQM which emphasise employee involvement and commitment. This has led to the waning of employee support for TQM due to the relative neglect of its soft aspects⁷⁴. Within most organisations, management gives insufficient attention to the underlying values and needs of employees, with the result that there is a failure to achieve the cultural change which is necessary if TQM is to be successfully implemented⁷⁵.

Oliver and Wilkinson note that whilst many British companies are adopting Japanese style manufacturing techniques, the techniques are not being introduced in tandem with

personnel and industrial relations practices likely to encourage the levels of stability, commitment and flexibility required⁷⁶. Thus, if holistic TQM is to be fully implemented it requires considerable re-evaluation of existing personnel policy; this includes doing away with output related systems and placing greater emphasis on personal development and training and removing divisive barriers within organisations by introducing single status to encourage a move to high-trust relations⁷⁷. However, current British personnel management practice falls short of the TQM ideal⁷⁸. In line with the argument that existing TQM paradigms fail to emphasise the soft aspects - 'the people issues', Steingard and Fitzgibbons see "TQM as with most modernist approaches on what Morgan calls a 'machine metaphor'"⁷⁹.

This means that the organisation as a machine creates a system of interlocking parts each with a clearly defined use, centralised authority and high degrees of worker discipline culminating in the goal of routinised, efficient, and predictable systemic performance. Thus, design and implementation of any TQM system is mechanistic rather than humanistic⁸⁰. Steingard and Fitzgibbons contend that the main failure of TQM is that it rests on a managerial obsession with efficiency, productivity, consistency and control; usually at the expense of worker dignity and efficacy⁹⁸. Employees are therefore relegated to being simply attendants⁸¹.

The author would agree with the arguments of Steingard and Fitzgibbons that TQM has failed to address the needs of worker dignity. It is the author's opinion, that practising managers have failed to create the learning environment in which TQM will thrive. Most organisations are implementing quality under the old and tired Taylorist agenda. Many managers still manage autocratically, they are not delegating enough and the issue of empowerment of staff is still rhetorical and has little practical application, particularly in the NHS. Whilst the NHS grapples with the ideas of TQM, it is still basically a classical hierarchical organisation where day-to-day management is still based on 'Taylorism'.

Harari⁸² indicates that one complying reason for the failure of TQM is that "some managers tend to become internally focused, and lose sight of what is occurring in the external environment". One 1990 survey for the American Society of Quality Control (ASQC) reported that more than 36% of employees in the United States organisations

do not participate in quality improvement programmes, even when a quality programme exists in their department⁸³. Similarly, in the NHS, about 5 per cent of employees, mainly supervisors, are involved in TQM⁸⁴. For Cangemi and Miller⁸⁵, TQM has a number of problems associated with its implementation:

- (1) lack of total ownership of the TQM process: many managers fail to recognize that quality really must be the foundation of their company's strategy. To this point the author would add that the people nearest to organisational problems (employees) should be seen to own TQM whilst management leads the process.
- (2) lack of incentive for involvement.
- (3) trying to create TQM with the use of a consultant.
- (4) leadership failure: failure by upper and middle management to commit to the total quality process.

For Schein⁸⁶, leadership failure is the most commonly cited failure to implementing a comprehensive TQM programme, "A quality programme works only when the Chief Executive Officer (CEO) visibly backs it". A quality effort that does not have visibly and dedicated leadership is a recipe for disaster. It can thus be argued that the reasons for the failure of TQM may be directly attributable to the actions and inactions of top management include⁸⁷:

- Failure of the CEO to work with employees to develop a vision of what the company should be and where it is going
- Failure to focus the quality effort on customer service
- Emphasis on cost cutting
- Failure to question everything: procedures, ideas and way of operation

- Failure to create small teams: whereby employees develop the confidence to solve problems related to their jobs
- Failure to involve employees
- Overlooking the communication process

The author is of the view that most top managers still adhere to Milton Friedman's definition of a business. According to Friedman "the only legitimate business of business is business, to provide its owners with a return on their investment. It is therefore not surprising that the top management of most organisations view their employees as replaceable machine parts. Hence, there are no obligations to treat employees with any dignity since there is a plentiful pool of replacement parts⁸⁸.

In a study⁸⁹ of 300 manufacturing companies devised to track the root cause of quality problems, it was discerned that the seeds of quality problems were widely distributed within functional areas, with no one department being the main culprit:

TABLE 12

Activities	Scores
Workmanship/workforce	21.5%
Materials/purchases of parts	20.6%
Maintenance of process equipment	11.3%
Design of process equipment	7.3%
Product design	12.2%
Control systems	13.9%
Management	5.9%
Others	7.0%
	100%

Source: Leonard, F. S. & Sasser, W. L. (1982) Harvard Business Review, September-October

As indicated in the study, management was much more at fault than the portrayed response rate of 6% because management was solely responsible for all the other causes listed. This led to the suggestion that only a determined effort to manage quality throughout an organisation promises to be competitively effective; but such an effort requires fundamental changes in the way top management addresses the whole issue of quality.

The author agrees with the notion that only management can make TQM work. Top management must demonstrate its commitment and leadership to the TQM effort by a becoming 'process champion'. This requires the development of a vision for the organisation, identification of organisation values and beliefs and the development of a learning and customer focused culture. The signals senior management sends with its daily behaviour will determine whether or not quality improvement will be just another faddish programme. In a revolutionary change, a change in culture, leadership is not capable of being delegated. 'If there is no leadership from the top, stop promoting total quality control'⁹⁰. 'The TQM transformation must be led by top management'⁹¹. Similarly, the author is of the opinion that, there are few companies that can provide superior service without top managers who are fanatically committed to quality. This is consistent with the work of Hajime Karatsu who notes: "Quality control (TQM) is not nembutsu, i.e. repeating prayers to obtain salvation. Quality control has its own special methodology and if workers are expected to practice it, management must be prepared to show them how its done. Top managers must be the first to practice quality control, to nurture a shafu (way of doing things) that respects quality. Wherever quality control has been successful, the essential ingredient has been the active participation of top management. When examples of successful quality control in Japan are sought, it is discovered that only those companies led by presidents, who acknowledge the importance of quality control and implement it throughout the organisation, that achieve the promised results. An organisation which is continuously learning and improving cannot be built if the management team is not out in front showing everyone the way"⁹².

However, the poor performance of many businesses can be traced back to the poor implementation of TQM. In many instances, TQM implementation has lacked strategic focus, having been introduced as a 'bolt-on' to unchanged business culture⁹³.

If TQM is introduced with a sound plan, a clear mission and tangible goals, and if the whole process has been deployed in the right way, then it is reasonable to expect benefits to be derived over a period of five years. Thus, organisations should tackle the obstacles to the introduction of TQM through education, communication, participation, facilitation; all supported by a slow, planned, purposeful approach which engages top management to capitalise upon bottom-up involvement⁹⁴. However, it has been noted that the slow, incremental approach advocated by Oakland is failing to deliver the desired results, particularly in the NHS⁹⁵.

PITFALLS TO TQM; A PUBLIC SECTOR PERSPECTIVE

There seems to be widespread acceptance that even the most successful TQM programme does not deliver smooth continuous improvement but, is instead punctuated by a series of stages with the transitions within an organisation being experienced as points of crisis and uncertainty⁹⁶. TQM is most likely to fail or run out of steam within a period of 18-24 months. This seems to be the case irrespective of whether companies buy 'off-the-shelf' TQM products from consultancies or go down the Do-it-yourself (DIY) route to implementation. The suggested reasons are⁹⁷:

- The diversity of views about what TQM is and how it should be introduced
- TQM means many things to many people; most people agree it is about culture change but exactly 'what' this means, or 'how' it should be approached, is relatively unclear
- Lack of understanding together with the absence of managerial commitment and management's reluctance to learn and change.

It appears that many practising managers, charged with responsibility for introducing and implementing TQM, adopted 'Ad hoc' approaches to TQM, depending upon the implicit or explicit view as to what the managers thought were the central factors of TQM. In order to sustain a TQM effort, it is essential that companies, rather than reflect their fuzzy image of quality, should have a 'map' of the broader TQM world⁹⁸.

Milakovich⁹⁹ argues that simply privatizing public sector functions has led to elected officials constantly attempting to balance the multiple, vague and conflicting goals of diverse interest groups. In such an environment, service quality improvement would be unattainable.

The author agrees with Milakovich's assertion that privatizing the public sector is not the answer to improved quality of service. In the NHS, where the government has introduced a quasi form of privatization in the form of providers and purchasers of health services, the quality of services provided to the patients has not improved drastically due to the fact that the arrangement does not, and cannot, constitute an ideal market where the rule of the game is 'profit'/'competition'. The authors view is supported by Joss et al¹⁰⁰, who argue that 'the purchaser-provider split' is not a market in the full sense because:

- (a) hospitals do not have a personal profit motive
- (b) purchasing decisions are not made by the ultimate customer - the patient

The author notes that the provider-purchaser split within the NHS would provide a stronger mechanism for developing Quality Assurance rather than TQM.

In the same vein, Morgan and Murgatroyd¹⁰¹ cite five factors that inhibits the effective implementation of TQM in the public sector:

- (1) the nature of TQM inhibits its application to the public sector - the idea being that TQM is commercially oriented. This point is consistent with the work of Kogan et al¹⁰², who indicated that TQM models meet considerable difficulties in being transferred to the NHS because they have been generated within, and rely on, the context of manufacturing
- (2) the nature of the public sector itself is inimical to the reception of TQM - public servants are professionals
- (3) the work culture of professional groups

- (4) the notion of 'customer' is a problematic concept
- (5) public sector provision is complicated

Furthermore, Morgan and Murgatroyd note a key barrier to TQM to the introduction of in the public sector:

CONTRAPRENEURSHIP - i.e. the active resistance to change which involves the effective and creative use of skills and competencies to prevent significant change from occurring. Hence, the resistance to change is active, creative and effective rather than passive. The author acknowledges this notion because during the research he encountered elements of the active sabotage of some TQM programmes with the NHS by some professional staff who see TQM as a waste of time and as being strategically incompetent to bring about improved clinical outcomes.

Similarly, Drucker¹⁰³ identified six deadly sins that inhibit productivity improvement in the public sector:

- (1) lack of clear performance targets
- (2) trying to do too many things at once
- (3) solving problems by throwing people at them
- (4) lack of an experimental attitude
- (5) lack of evaluation, so nothing is learned from experience
- (6) reluctance to abandon programmes; Drucker states that if two or more of the aforementioned sins are committed simultaneously they would lead to a programme failure

It could be argued that certain essential features of the public sector limit the application of TQM:

- (1) the public sector is more resistant to change;
- (2) the resourcing of public sector provision is disconnected from performance. This means that revenue flow from a general revenue stream, being paid out of a budget, rather than allocated on the basis of results. This has led to a culture where performance is seen as the ability to maintain or to increase budget¹⁰⁴. Failing to spend the entire budget will probably lead to a budget cut. The argument posited is that quality performance cannot be expected of public service institutions because of their reliance on the politics of resource acquisition from the centre¹⁰⁵. However, it would have been expected that the creation of an internal market within the NHS would have given rise to a performance related service, but what is obvious, in the author's opinion, is that success is now based on the politics of 'contracts' acquisition rather than resource acquisition from the centre. Some quality managers hinted to the author that many chief executives of trust hospitals are more inclined to securing contracts from purchasers than they are with improving patient services; as 'contracts' pay the bills.
- (3) managers in the public sector are not free to enact changes in the same way as are managers in manufacturing or commercial service provisions.

In addition, the public sector is imbued with an over-commitment to regulation and the enforcement of precedents. As Morgan and Murgatroyd¹⁰⁶ have pointed out there are at least three cultural dimensions in the public sector:

- the multiplicity of professional specialisms
- the primacy accorded the individual professional transaction
- the authority of seniority and status hierarchies

However, these cultural dimensions stand in opposition to the principles of TQM. TQM seeks the breaking down of professional barriers and the flattening of organisational hierarchies. TQM emphasises the primacy of empowered self-directed

teams. Hence, the professional environment of public sector organisations is inappropriate for the effective implementation of TQM. Unless and until the 'professional culture' in existence in public organisations are re-aligned to the ethos of quality management any attempt at implementing TQM would only be partial.

PITFALLS TO TQM; A HEALTHCARE PERSPECTIVE

A number of factors have been identified as being unique to the healthcare industry¹⁰⁹

- The relatively long learning curve leading to the acceptance of TQM
- The search for the perfect plan
- The advanced lip service paid to TQM
- The fragmented effort as a result of a lack of vision
- The general resistance to change
- The opportunity cost involved
- Short-term orientation

Hence, quality assurance (QA) has been the dominant thinking in healthcare rather than TQM¹³⁸. QA activities have been described by Berwick as being limited to inspection rather than improvement, focused on what has been done, outcomes, rather than how things should be done, concerned with meeting requirements rather than expectations, focused on monitoring and surveillance instead of on quality improvement¹⁰⁸.

Another obstacle to the successful implementation of TQM identified by Claus¹⁰⁹, namely, the professional dominance by consultants in teamwork, coupled with the emphasis on the personal responsibility of the consultant. This could severely impede the true collaborative efforts of teams. There is also the issue of professional resistance from many professional groups that are represented in healthcare. This is because of their affiliation to their professional bodies. In the NHS, very little support for the TQM process has yet to come from the major Royal Colleges and Associations representing Consultants, Nurses, Pharmacists and other Therapists in guiding their members with regard to their contribution and involvement in the TQM process. Furthermore, the precarious budgetary situation facing many hospitals is not conducive to monopolising the resources necessary to implement a continuous improvement

process. This, coupled to the long term nature of TQM, can create an attitude of procrastination amongst decision makers.

Godfrey et al¹¹⁰ report a common set of bottlenecks that decelerate progression to mature quality management:

- (1) insufficient facilitation - either too few facilitators or too little progress in facilitative management to support quality improvement methods
- (2) insufficient Board involvement and education
- (3) rapid turnover in medical staff
- (4) restructuring
- (5) excessive word crafting of both mission statements and TQM policy documents
- (6) executive turnover is a potentially lethal factor on healthcare quality. When a change in CEO, for example is imminent, few managers have the confidence to carry on TQM, until the name and agenda of a new executive are known. This view is consistent with the author's opinion, that some TQM efforts in the NHS have consequently derailed as a result of either a CEO, or the quality manager, moving on to another organisation
- (7) key processes in healthcare organisations are complicated, often interdepartmental
- (8) limited commitment to the TQM agenda by the CEO

Similarly, Merry¹¹¹ contends that systemic deficiencies, in the form of poor information transfer between support services and patient and the lack of co-ordination between the various diagnostic and therapeutic services inhibits TQM. He further suggests that the

relative isolation of consultants and virtually all clinical staff, heretofore characteristic of healthcare quality is antithetical to TQM. Therefore, consultants may well prove to be the 'killer-lymphocytes', opposing the quality process in healthcare organisations¹¹².

The author agrees with Merry that consultants may well be the stumbling block to the successful introduction and maintenance of TQM in healthcare. However, what is required of a healthcare organisation, and of the NHS in particular, is that any form of TQM should start from a profound understanding of the perceptions of quality held by clinical staff, probably clinical effectiveness, and lead to the development of a programme compatible with those perceptions.

Reeves and Bednar¹¹³ report that the greatest barrier to TQM in healthcare is 'territorialism' which produces dysfunctional consequences for both individuals and organisation". Reeves and Bednar identify a number of other barriers which impede the adoption of TQM:

TABLE 13

BARRIERS TO TQM

Lack of consistent support from executive
Fear/resistance to change
Failure to implement solutions in a timely manner
Inadequate planning for TQM
Ineffective communication
Faulty group process
Sabotage/lack of commitment from both middle/top management
Politics/turf battles
Turnover/changes in key personnel

Source: Reeves and Bednar (1993) Quality Progress, April

Similarly, in the NHS, territorialism has led to battles between functional areas over resources thus, creating a functional dependence culture which undermines the spirit of team-working that TQM seeks to promote.

Shortell¹¹⁴ states that the major barriers to the integration of TQM into healthcare are:

- (1) the inability to overcome the hospital paradigm
- (2) the failure to understand the new core business of healthcare
- (3) the inability to convince the 'cashcow' to accept a systems strategy
- (4) the inability of Board members to understand the new healthcare environment and their responsibilities
- (5) ambiguous roles and responsibility throughout the system
- (6) the inability to 'manage' managed care
- (7) the lack of strategic alignment of the quality initiative into corporate planning

However one of the key principles of TQM, which many quality practitioners have struggled with in the NHS, is the continuous improvement of work processes. This is because managers and staff, clinicians included, have consistently failed to see their work as processes and this has adversely impacted on their ability to meet patient needs. This signifies the lack of knowledge and wisdom in the practice of TQM across the NHS.

Furthermore, the deliberate approach by some healthcare organisations to change the behaviour of their employees rather than the system, represents a misconception of what is required to affect TQM. Many managers forfeit the obvious, that it is the system, and not the people, which is responsible for 85% of all quality problems¹¹⁵. Unless there is a quality system, there can be no quality outcomes¹⁵⁰. If behaviours are

to change, in the author's opinion, the system must also change in order to sustain the ethos of TQM. In contrast, in the NHS, the Department of Health (DOH), in its desperate attempt to alter the NHS mindset, has tampered and tinkered with a variety of reform efforts and has yet to distinguish between best efforts and being effective. One reason for this failure is the failure of leadership. The DOH is working in the system rather than on the system, dealing with the 'trivial many' rather than the 'vital few' factors that would make a difference. If TQM were to be properly implemented, the implementer(s) should ensure it focuses on improving the quality of the system so that organisational behaviours would be improved and effective quality outcomes would be achieved¹¹⁶. Furthermore, the author is of the view that in the NHS, the traditional employee evaluation and reward systems which emphasise individual technical competence rather than the overall quality of team performance and productivity, have created a cadre of tunnel-visioned front-line supervisors, middle managers and, in some cases, senior managers concerned only about the activities of subordinates under their immediate control, with little interest in, or influence over, broader organisation-wide quality and improvement.

As a consequence, most NHS managers and first-line supervisors frequently have well-developed technical skills but lack training in, and understanding of, basic people management and problem solving skills. This has led to the situation where the incorporation of quality management methods is frequently viewed by clinical staff as incompatible with the highly individualised nature of patient needs, hospital services, and delivery mechanisms¹¹⁷.

These reasons for the failure of TQM in healthcare are congruent with the author's research in the NHS and particularly with the issue of vertical hierarchy. In the NHS, due to the provider-purchaser split, more multiple levels of managerial hierarchy have developed; first line supervisors, department managers, directors of directorates, service managers, CEO, non executive directors, chairmen, etc. As these managers focus on a portion of the hierarchy, a more "vertical" rather than "horizontal" approach to issues has developed. In consequence, the NHS is further removed from meeting the needs of its main customer - the "patient".

PITFALLS TO TQM: NHS PERSPECTIVE

Edwards¹¹⁸ states that the NHS achieves more clinical excellence than almost any comparable organisation in the world. This is true where successful clinical outcomes (technical quality) are concerned. However, from the patients perspective this superior clinical excellence is often tarnished by a poor overall experience; long waiting times, lack of privacy, little attempt to personalise care for patients and poor communication between professionals and patients. Edwards notes that first class healthcare combines professional excellence with superb personal service, but this is virtually non-existent in the NHS due to the rationalisation of services. This has led to an unhealthy organisational and professional arrogance that is inimical to quality. The grave danger that Edwards notes is that the NHS has become focused around the needs of those who have the tough job of rationing, rather than around the needs of those who receive the service; the patients. These attitudes have led the NHS to:

- Block booking of outpatient clinics to conserve the time of the professional staff at almost any cost to patients
- Routine late cancellation of admissions
- Long waits in accident and emergency departments

Thus, the lack of a patient focused service is one of the failures of TQM in the NHS¹¹⁹.

Morgan and Murgatroyd¹²⁰, suggest that health services have traditionally emphasized quality assurance and externally imposed regulatory standards from a strict clinical-medical standpoint, because it has generally been assumed that monies will become available to meet these requirements on a demand-led basis. Hence, Morgan and Murgatroyd note that the difficulties of TQM in the NHS are;

- (1) early cynicism
- (2) issues of cultural fit to the complex nature of the health sector itself

- (3) resistance from the traditional professional identities of key role-holders
- (4) TQM is seen as management's ploy to reduce costs and cut standards
- (5) stratification culture; professional domain
- (6) the existing culture and structure in the public sector
- (7) language and cultural symbols
- (8) the problem of fragmentation due to (a) lack of awareness of how the system as a whole works, (b) the challenge of effective linkage at the interfaces and (c) narrow/restricted professionalism

Furthermore, Morgan and Murgatroyd suggest that unless the government treats the NHS, or any other public sector provision, as a real internal market and rewards productivity by allowing hospitals to keep and use a significant slice of the cost benefits of quality, health service professionals will remain shy of the process of quality and suspicious of TQM¹²¹.

Morris and Haigh¹²² identified the barriers to TQM in the NHS from two perspectives; macro and micro. The macro barriers include:

- (1) inefficiency; poor management, under utilization of human capital, and a very high proportion of costs in salaries
- (2) excessive interference by government
- (3) the NHS still reflects and adheres to the old administrative culture and gives little credence to the new managerial ethos

The micro barriers include:

- (1) the NHS is 'different' and/or the NHS is 'unique'

- (2) a marked reluctance to delegate; a reluctance by the delegator to delegate because of insecurity, a lack of ability and a lack of confidence in subordinates
- (3) the threat posed by any change that was not structural in nature i.e. a change in current processes

For Morgan and Everett¹²³ the barriers to the implementation of quality management in the NHS include:

- Time needed for new quality management activities
- Securing participants commitment to change and adoption of the approach
- Authoritative leadership
- Poor existing documentation
- No agreed values and aims
- Fear of losing professional independence
- Anxieties related to monitoring individual performance
- Users views - very little is currently done to elicit their views and incorporate them into service provision

Whilst, for Dalley and McIver¹²⁴, the following barriers can be discerned:

- (1) **conflict and resistance**
 - hostility between management and professionals and amongst groups of professionals; cynicism and scepticism amongst staff; quality assurance too mystified, too much jargon, low morale, medical

dominance; punitive approach seen as threatening; difficulties of maintaining common standards across professional or agency boundaries

(2) organisational

They identified a lack of clarity over lines of responsibility. NHS staff feel they do not own the initiatives in which they are involved. There was also marginalisation of quality activities; lack of organisational culture committed to quality; failure to secure the co-operation of middle level managers; fear of failure amongst staff; poor communication across service functions with quality assurance tending to be nursing focused. Besides the organisational structure within the NHS has led to the situation where doctors have looked down on managers, who have themselves often been sidelined by politicians and civil servants. Managers, meanwhile, have seen medics posing as superior beings not prepared to recognise the legitimacy of managerial decisions about resources. Therefore, consultants have managed to create for themselves autonomous fiefdoms within hospitals, giving allegiance to their medical specialism, their own list of patients and their own professional body. They are employed by the Regional Health Authority rather than the hospital in which they work and on life-time contracts. For this reason, consultants are left free to divide their time between the NHS and private patients; hence, they fail to see themselves as part of the hospital team and lack a corporate commitment.

Dalley and McIver further identified barriers in the form of lack of resources and time for quality activities. In one Trust hospital, the quality manager had a budget of only £9000.00, implying that other things take precedence over quality in times of crisis.

Brooks¹²⁵ notes that the NHS is under siege. Resource management, the introduction of a market mechanism and technological advances, all place immense demands on managers and professionals. Moreover, the competing professional and managerial agendas provide difficult territory on which to build a TQM approach.

Similarly, Joss et al¹²⁶, have identified the following barriers to the implementation of TQM in the NHS:

- Vague or personal definitions of quality: They report a lack of a comprehensive definition of 'Quality'. Some staff defined quality as 'give a good standard of service' or to provide the best possible service given our resources. Other definitions included the need to be adaptable, patient, and cheerful and to present many faces. The authors also identified varying interpretations of the term, 'quality of care'. A catering manager stated that quality of care was 'seeing that meals were delivered properly and on time'. No mention was made as to whether the food met the patients needs and expectations.
- Lack of understanding: Many NHS Trusts were embarking on TQM with only the sketchiest understanding of the different models which could be utilised and with little clarity about the organisation's or the customers' requirements.
- TQM, unlike the Patient Charter, is not a formal requirement for the whole of the NHS.
- The failure of the Department of Health to offer expert advice; particularly the NHS Management Executive's failure to establish an enabling unit to advise, guide and monitor TQM developments.
- TQM implementation is based on commercially derived models of TQM which fail to take account of the realities of a professionally managed, public service.
- Process improvement: TQM requires a dynamic model for the monitoring of continuous improvement in all work processes. This is markedly absent in most NHS hospitals. What is in use is a standard-setting process which is not compatible with the principles of TQM. Standards have generally been set as minimally acceptable markers of

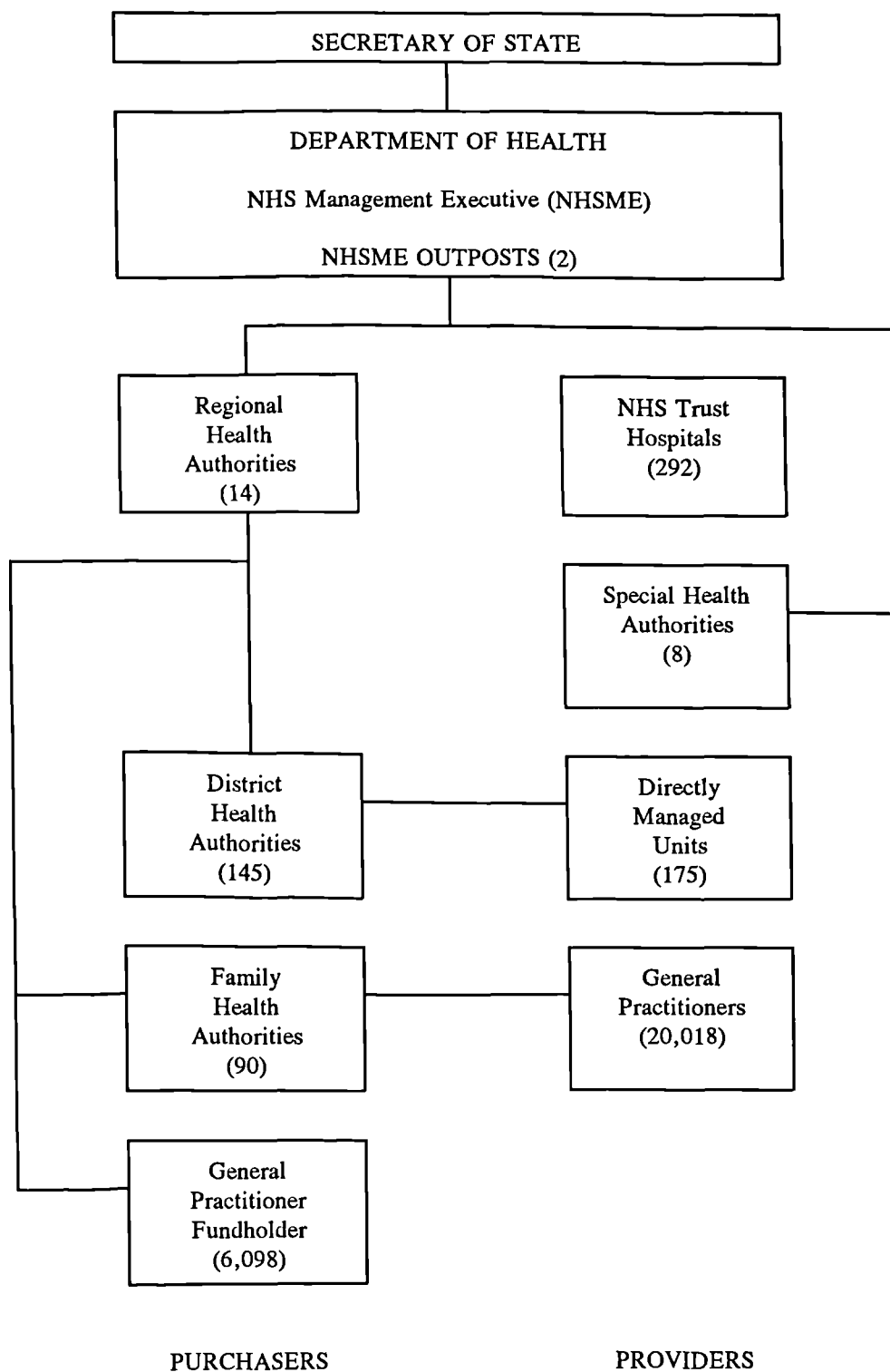
good practice which are then audited once or twice a year. Providing these were met, they would remain unchanged.

- The complex, multi-professional nature of healthcare work, the different cultures and knowledge bases and the distancing of relationships between many groups, make it difficult to secure consensus on quality or on organisational mechanisms for improving quality¹²⁷.

Furthermore, as a public health sector organisation it does seem that the government is the main 'customer' of the NHS. The government, through the Department of Health, is constantly initiating new projects, such as Patients' Charter, Medical Audit, Clinical and Nursing Audits and BS 5750.

This bewildering array of activities has led to a situation where the NHS has lost sight of the ultimate customer; the patient. This 'patient' focus issue has not been helped by recent and concurrent government restructuring of the NHS which has created more customers in the form of 'purchasers' of service provision:

FIGURE 32: THE STRUCTURE OF THE NHS



Source: NHSME Newsletter (1994)

This had led to a situation where the NHS has to meet the needs of multiple stakeholders.

However, it must be stressed that the Patients' Charter has the regulatory requirement of ensuring that hospitals get more patient focused. Prior to the Patients' Charter there was no incentive on the part of hospital management to improve services but with its advent, hospital staff know that they have to meet set service standards. For example, in out-patients, the standard requires that a patient must be seen within 30 minutes of appointment time, whereas before the Charter patients had to sometimes wait for up to two hours before being seen by a doctor. Thus, the Charter has instituted some element of service sanity amongst staff. In addition, Quality managers use the Charter standards to ensure that the professionals, especially the consultants, comply with its requirements. In the author's opinion, the Charter has come to stay and should be incorporated into an ideal TQM model for the NHS. However, rather than be called Charter standards, the standards should be renamed 'quality standards'. This would enable a more results-oriented TQM process. Hence, the quality process would be strictly measured against the standards; after all, the standard encompasses what hospitals should be doing in the provision of medical services.

For Osborne and Gaebler,¹²⁸ the 'contracting' process is a common method of injecting competition into public services but is one of the most difficult methods a public health organisation can choose. However, whilst market mechanisms may make efficiency gains at the margins, they lead to spiralling administrative costs, fewer resources for patient care and the lack of adequate information for managers. For example, the salary of NHS general managers' increased ten-fold in the five years between 1987-1991, from £25.7m to £251.5m. Thus, privatising a monopoly is not only senseless but extremely expensive¹²⁹. Similarly, the speed of change in the NHS lacks any form of operational guidelines. This is evidenced by the lack of financial resources to manage change and improper experimentation and evaluation of the TQM process prior to implementation. Whilst the government carries through its devolution exercise, a vacuum is created in the NHS by the lack of managers with the requisite skills to successfully carry through the exercise¹³⁰.

Furthermore, the author established from quality managers that despite the rhetoric of devolution, central government continues to dictate the managerial agenda in the NHS. The introduction of initiatives such as short-term employment contracts linked to performance-related pay, staff appraisal, performance indicators, resource management,

budget holding, the contracting-out of non-core services and the politicisation of non-executive health authority appointments, have all contributed to ideological imperialism¹³¹. In such an environment the implementation of TQM will be besieged with problems. In addition, the creation of several Trusts, the majority of which are acute hospitals, and some of which have sought Trust status in an attempt to escape closure or service rationalisation plans, could lead to the dominance of the acute sector and the professions within it over the main goal of the NHS. Whilst the NHS remains a national service committed to particular values of meeting need in an egalitarian manner on demand, the commitment to provide a range of patient focused services is seen as less important because of the intricacies of the quasi market¹³². This has given rise to a situation where district health authorities are individually deciding which services they can afford to fund and where providing hospitals are deciding what they can afford to offer, the absence of a customer focused service becomes more endemic. Thus, good management in any form is seen in the NHS to constitute a solution to what is simple bureaucratic inadequacy¹³³. Furthermore, medical audit has been set-up by the Department of Health in such a way that the management of hospitals is largely uninvolved and the patients totally excluded. In consequence, substandard practices go unpunished, except by way of a few stern, but ultimately ineffectual words, from colleagues¹³⁴. It becomes difficult to explain government's simultaneous espousal of a consumer-oriented doctrine, such as TQM. One possible interpretation is that the Department of Health has sought to use TQM as a facade to tighten its grip on most other professional groups by preaching Efficiency, Effectiveness and Economy whilst allowing the medical elite; the consultants, to do as they choose¹³⁵. Consequently, consultants do not see themselves as answerable to the management of Trusts. This assertion is congruent with the views of Boje and Winsor, who have argued that in some organisations TQM is used as a 'conspiracy to de-humanise the worker. This means that the interests of the workers are subjugated or trivialised in relation to the 'performativity' requirements of the firm'¹³⁶.

Boje and Winsor state that the failure of TQM is not the result of improper implementational efforts but that the core cause of its failure lies in its foundation in the same tired manipulation and productivity agenda which fills the diary of modernist business history. Thus, TQM represents a rhetorical inversion of Taylor's basic

principles. In consequence, in most organisations, TQM promises what it cannot deliver¹³⁷. Furthermore, under the banner of empowerment, TQM conveys a misconception that workers are empowered to design their own tasks. However, the real 'rhythm' or pace of the worker forever remains outside the worker's control. Work tasks become meticulously regulated and enforced in a manner which is indistinguishable from scientific management. In fact, TQM represents a fanatical dedication to the meticulous execution of tasks in exactly the manner prescribed by management¹³⁸.

Whilst the author would agree with a number of points made by Boje and Winsor, particularly on the issue of empowerment, the problem with TQM is not with its espoused principles but the way organisations have chosen to interpret and implement them. Analogously, a comparison could be made to the teachings of the Bible. Whilst the 'teachings' of the Bible can be said to be clear cut, most preachers interpret its tenets to suit their particular purposes.

The author would argue that the difficulties TQM is facing is not due to any form of a Taylorist agenda but to a lack of conceptual understanding on the part of most executives of 'what is required' for the successful implementation of TQM. There seems to be a confusion as to what are the main requirements of TQM. Most hospitals seem to be focusing on the quality assurance requirements of standard setting and monitoring and think, that by so doing, they are implementing TQM. What the NHS hospitals are actually doing is installing methods to inspect performance and to correct performance that are below standard, rather than embarking upon an organisation-wide drive to improve quality of care. Nevertheless, whilst many proponents of Total Quality Management may differ in their prescriptions for surmounting the barriers to the implementation of TQM, there is sufficient consensus for it to be possible to discern a number of agreed 'pitfalls' of TQM:

**TABLE 14: SET UP
PITFALLS**

1	Top Management not aware of its quality improvement responsibilities because of inadequate knowledge and understanding of TQM.
2	No comprehension within the organisation of quality as a management tool.
3	No organised approach to TQM hence a lack of constancy of purpose. Failure on the part of top management to lay the ground work which will enable the right changes to be made.
4	Failure by management to adequately adopt the new philosophy. Quality is still hidden in manufacturing or engineering departments. Inspection of quality still the norm.
5	Wrong choice of facilitators due to lack of understanding/ambiguity about role of facilitator.
6	The initial TQM approach too vague to sustain growth.
7	Insufficient commitment on the part of top management.
8	Lack of involvement by middle level managers.
9	An initial lack of confidence in the programme by all employees.
10	Unclear definition of TQM goals, authority and boundaries due to failure by management to adequately communicate with the entire workforce.
11	Lack of active personal involvement by upper level managers is by far the most common reason why quality efforts fail at the SET UP stage.
12	Lack of strategic direction and executive leadership.
13	The tendency to choose only a few people to be responsible for the implementation of quality management; most times someone who is isolated, lacks authority, resources, and respect i.e. Quality Manager or the Human Resources Department.
14	The tendency to hire a Consultant with a pre-package approach rather than one tailored to the organisation.
15	The tendency to use slogans, zero defects or conformance to specification forgetting the continuous improvement stuff.
16	TQM initiative locked into the formal hierarchical structure. Nobody knows where he/she stands in relation to quality responsibilities, this leads to turf battles.
17	A tendency in some organisations to implement TQM from the bottom (bottom up approach).
18	In most cases stakeholders are ignored.
19	The tendency of top management to create unrealistic expectations and goals.

20	A belief by management that they know everything and don't need to learn anything else.
21	Senior management creates mission statement and implementation strategy without input or feedback from people at different levels of the organisation.
22	A tendency by management to wait until it is too late to adopt TQM.
23	Conflicting messages in mission, vision and value statements.
24	A total lack of leadership and management effectiveness.
25	Insufficient facilitation.
26	Insufficient board involvement.
27	Failure by top management to act as ROLE MODELS.
28	A confusion on what quality really means. This has increased the danger of people trying to take action in order to obey words before developing understanding.
29	Enthusiasm for TQM after the CEO attends a one or four day conference on TQM; hasty action.

**TABLE 15: GET UP
PITFALLS**

1	Training programme too vague.
2	Training needs incorrectly identified.
3	No organised approach to training.
4	Lack of money for training - limited funding.
5.	Skills shortfall.
6	Organisational evolution.
7	Lack of a good education in TQM, methods and problem solving.
8	Many companies assume that managers intuitively understand how they must change once quality improvement becomes an organisational priority.
9	A tendency to give boring lectures telling employees about continuous improvement and then telling them to go out and start taking responsibility for improving.
10	Senior leaders stay away from the little guys during training. A lack of a multi-disciplinary participation during training.
11	Employees are put through lengthy training sessions that keep them away from their work. Then penalise employees for not completing assignments on time.
12	A tendency for people to read one or two books and consider themselves experts.
13	People are asked to begin process improvement work and participate in team meetings despite inadequate training.
14	Mixed messages are given during training regarding team work, process improvement, continuous improvement, customer needs, zero defects, quality measurement, quality improvement etc. This leads to an overload of information.
15	Training sometimes conducted on voluntary basis.
16	A tendency to hire a training company to come in and train all the employees as fast as possible so they can get to work improving the company.
27	The trainer never bothers to ensure employees bother to understand theory. Just stick with How To's.
18	Poor teaching of tools of TQM especially statistical methods.
19	A failure by management to institute modern methods of training on the job.
20	People are given tools before theory. A tendency to show employees how before they understand why.
21	Teams are started by having them solve world famine type of problems rather than quality problems.

22	Q.1. teams select own projects to tackle. A lack of use of PILOT schemes.
23	Trying obvious motivational short range efforts to win employees commitment.
24	Failure to adequately identify why quality problems exist and persist.
25	Problems are fought as they occur; no resolution; inadequate definition; lots of yelling and accusations.
26	A lack of knowledge of the actual percentage of cost of quality.
27	A failure by the Training programme to institute an environment of Honesty, Openness and Trust.
28	A failure by everyone to understand their own role, and how it relates to the organisation's mission and objectives.
29	A lack of conviction on the part of management on what culture change to institute.
30.	A lack of understanding of the customer-supplier relationship.
31.	Failure by top management to identify the pathways/obstacles that need to be cleared before certain action becomes appropriate.

**TABLE 16: STAY UP
PITFALLS**

1	No accepted recognition and reward system in place.
2	Lack of integration of Q.I. process.
3	Make team participation and quality improvement second in importance to "getting the work out".
4	Expect people to do things they have not been trained or prepared to do.
5	Tell the customer what they need rather than asking them (internal/external customer).
6	A failure to tell others "thank you" or "great job" withholding of praise and a tendency to criticise publicly.
7	Implementing new ideas on a large scale without testing them first.
8	Require numerous levels of approvals before employees can take action.
9	Placing people in positions they have no training or experience in.
10	Failure to implement solutions in a timely manner.
11	Faulty group process.
12	Turnover/changes in key personnel.
13	Apathy/lack of commitment by all employees.
14	Ineffective communication.
15	time for meetings and problem solving made voluntary.
16	Inadequate planning on the part of Q.I. teams, this leads to confusion on start up process improvement.
17	Failure to break down departmental barriers.
18	A tendency to create barriers and competition between departments, between teams and between individuals.
19	The use of exhortations and numerical quotas, such as demanding zero defects or 25% increases in productivity, especially when employees have no means of achieving those results.
20	Failure to provide or incentivise people to advance in their education or self-development, learning is hard, useless and boring.
21	Failure by management, TQM Steering Committee to turn the organisation into a friendly and learning environment which breeds cooperation, teamwork and joy in work.
22	Employees despite empowerment still not allowed to question authority. People are allowed exercise or do things that contribute to their general mental and physical health.

23	Decision making still based on intuition or experience rather than on statistical data.
24	A failure to plan ahead. Organisations are totally spontaneous or where plans are in existence they are inflexible, rigid and impossible to understand and carry out.
25	Quality measurement too vague. Some companies begin by measuring everything all the time, particularly those things that are unknown and unknowable.
26	Measuring the wrong things with wrong measurement systems.
27	A tendency to relax once a number of improvements have been made or giving up as soon as there is any indication that the process is not working or that it seems to be harder than you thought.
28	Over enthusiasm on the part of the Q.I. teams to tackle quality problems hence the tendency to be very internally focused forgetting the external - A tendency to do it all at once. Starting with a BIG BANG. Creating suggestion systems before you have a way of responding to the suggestions. Creation of teams before having facilitators.
29	Lack of coordination between various Q.I. teams.
30	The use of only enumerative instead of analytic methods to analyze data.
31	Treatment by Q.I. teams of common causes as if they were special causes.
32	Treating special causes as if they were common causes.
33	Lack of commitment to anything ever. Lip service paid to many hidden customers and users.
34	A failure by management to drive out fear.
35	Failure to permit pride to workmanship.
36.	Teams are set up to attack major problems. Long range solutions are not solicited.
37	A lack of coordinated corrective action system put in place. Managers pulling at different directions, this leads to failure to tackle the most immediate key issues.
38	Lessons learnt not acted upon.

**TABLE 17: MOVE UP
PITFALLS**

1	Poor coordination.
2	Gains in knowledge taken for granted.
3	Use of management to control people. Do not be a guide or mentor. If people need guides, supporters and mentors, let them go back to school.
4	Management still managing by numbers. People are given numerical goals and quotas and dates. Employees threatened with redundancies or promotion loss if they don't meet the goals, no matter how unreasonable they are.
5	Use of annual merit rating systems to evaluate people and determine salaries, bonuses and other benefits. Creation of internal competition within and between departments.
6	Failure to focus on both internal/external customers.
7	Top management begins to doubt the ability of the TQ programme to succeed. Failure to integrate two way communication.
8	Meeting the needs of the wrong customers.
9	Meeting the wrong needs of the right customers.
10	Failure to recognise many hidden customers and users.
11	A tendency not to worry about dissatisfied customers who will tell 15 others. Focus only on the satisfied customer who may tell 3 others.
12	A reluctance to change a standard or regulation once it appears to work. A few new regulations and procedures are added but old habits die hard.
13.	Standardise for control rather than communication and consistency.
14	Suboptimise whenever possible.
15	The blame factor whenever possible. Management blame workers for poor quality. Workers blame management.
16	Telling the customer (internal or external) what they need rather than asking them.
17	Cloning. Status quo people are hired.
18	Creation of policies in secret and reorganise often and unexpectedly.
19	Failure on the part of management to drive out fear. Organisational segmentationalism still existing.
20	SEARCH FOR EXAMPLES.
21	Hope for instant PUDDING based on the supposition that solving problems, automation, gadgets and new machinery will transform industry.
22	Failure to continuously educate and retrain staff.

23	Lack of systematic effort at managing the T.Q. process.
24	Wandering teams and lost supervisors.
25	Double-crossed functional management - when some failure of support, training, clear goods or individual performance measures drives people apart.
26	New programme syndrome - benchmarking.

Source: Compiled by the Author (1994)

EMPIRICAL FINDINGS

Having identified the established barriers to the implementation of TQM common to most writers on quality management, the author feels that there is still a missing link. Can these barriers be classified as 'generic' factors inhibiting TQM? To find the answer to this question, the author sought to verify whether, for example, the identified barriers are impinging upon the implementation of TQM in the NHS.

Against this background a postal questionnaire survey based on 40 pitfalls selected from Tables 14 - 17 above was designed and administered to 23 Quality Managers representing the 23 TQM demonstration sites.

The Quality Managers were asked to indicate which barriers they felt were; Most Significant, Significant, Least Significant, Not Significant or Does Not Apply within the context of their TQM programme. Of the 23 questionnaires sent out, 15 were returned; representing a 65 percent response rate.

Analysis of the returned questionnaires using the Statistical Package for the Social Sciences (SPSS), revealed some interesting characteristics. Table 18 shows actual frequencies (number of hospitals) and the percentages scored in each of the identified 40 factors.

TABLE 18

**COUNT, ROW PERCENTAGE AND COLUMN PERCENTAGE OF HOSPITALS
BY OBSTACLES AND OBSERVATION RATE USING SPSS**

ROWS	OBSTACL 1	COLUMNS: 2	OBS-RATE 3	4	5	ALL
1	4 26.67 3.96	4 26.87 2.01	2 13.33 1.82	4 26.67 3.15	1 6.67 1.59	15 100.00 2.50
2	2 13.33 1.98	5 33.33 2.51	6 40.00 5.45	0 - -	2 13.33 3.17	15 100.00 2.50
3	2 13.33 1.98	10 66.67 5.03	2 13.33 1.82	0 - -	1 6.67 1.59	15 100.00 2.50
4	2 13.33 1.98	6 40.00 3.02	2 13.33 1.82	4 26.67 3.15	1 6.67 1.59	15 100.00 2.50
5	7 48.87 6.93	5 33.33 2.51	2 13.33 1.82	1 6.67 0.79	0 - -	15 100.00 2.50
6	3 20.00 2.97	8 40.00 3.02	3 20.00 2.73	3 20.00 2.38	0 - -	15 100.00 2.50
7	4 28.87 3.96	5 33.33 2.51	4 26.67 3.64	2 13.33 1.57	0 - -	15 100.00 2.50
8	1 6.67 0.99	1 6.67 0.50	4 26.67 3.64	8 40.00 4.72	3 20.00 4.78	15 100.00 2.50
9	2 13.33 1.98	1 8.87 0.50	6 40.00 5.45	4 26.67 3.15	2 13.33 3.17	15 100.00 2.50
10	2 13.33 1.98	3 20.00 1.51	7 46.67 6.36	2 13.33 1.57	1 6.67	15 100.00 2.50
11	7 46.67 6.93	4 28.87 2.01	0 - -	4 28.87 3.15	0 - -	15 100.00 2.50

ROWS	OBSTACL 1	COLUMNS: 2	OBS-RATE 3	4	5	ALL
12	4 26.67 3.96	9 60.00 4.52	0 - -	2 13.33 1.57	0 - -	15 100.00 2.50
13	1 8.87 0.99	1 6.67 0.50	3 20.00 2.73	6 40.00 4.72	4 26.67 6.35	15 100.00 2.50
14	1 6.67 0.99	5 33.33 2.51	1 6.67 0.91	7 46.67 5.51	1 6.67 1.59	15 100.00 2.50
15	2 13.33 1.98	6 40.00 3.02	4 26.67 3.64	3 20.00 2.36	0 - -	15 100.00 2.50
16	3 20.00 2.97	6 40.00 3.02	3 20.00 2.73	2 13.33 1.57	1 1.59	15 100.00 2.50
17	1 6.67 0.99	1 6.67 0.50	1 6.67 0.91	7 46.67 5.51	5 33.33 7.94	15 100.00 2.50
18	2 1.33 1.98	6 40.00	0 - -	7 46.67 5.51	0 - -	15 100.00 2.50
19	2 13.33 1.98	3 20.00 1.51	4 26.67 3.84	2 13.33 1.57	4 26.67 6.35	15 100.00 2.50
20	1 8.87 0.99	6 40.00 3.02	1 6.87 0.91	5 33.33 3.94	2 13.33 3.17	15 100.00 2.50
21	1 6.67 0.99	6 40.00 3.02	4 26.67 3.84	1 6.67 0.79	3 20.00 4.76	15 100.00 2.50
22	1 6.87 0.99	7 48.87 3.52	2 13.33 1.82	3 20.00 2.36	2 13.33 3.17	15 100.00 2.50
23	2 13.33 1.98	8 53.33 4.02	1 6.67 0.91	3 20.00 2.36	1 6.67 1.59	15 100.00 2.50
24	2 13.33 1.98	8 53.33 4.02	1 6.87 0.91	3 20.00 2.36	1 6.67 1.59	15 100.00 2.50

ROWS	OBSTACL 1	COLUMNS: 2	OBS-RATE 3	4	5	ALL
25	1 6.67 0.99	1 6.67 0.50	2 13.33 1.82	5 33.33 3.94	8 40.00 9.52	15 100.00 2.50
26	3 20.00 2.97	7 48.87 3.52	3 20.00 2.73	2 13.33 1.57	0 - -	15 100.00 2.50
27	2 13.33 1.98	8 53.33 4.02	4 26.67 3.84	1 6.67 0.79	0 - -	15 100.00 2.50
28	3 20.00 2.97	4 28.87 2.01	4 26.67 3.64	3 20.00 2.36	1 6.67 1.59	15 100.00 2.50
29	4 26.67 3.96	4 26.67 2.01	2 13.33 1.82	4 26.67 3.15	1 6.67 1.59	15 100.00 2.50
30	2 13.33 1.98 1.98	3 20.00 1.51	1 8.87 0.91	7 46.67 5.51	2 13.33 3.17	15 100.00 2.50
31	3 20.00 2.97	5 33.33 2.51	4 26.67 3.84	1 6.67 0.79	2 13.33 3.17	15 100.00 2.50
32	1 8.87 0.99	4 28.87 2.01	5 33.33 4.55	3 20.00 2.36	2 13.33 3.17	15 100.00 2.50
33	2 13.33 1.98	4 26.67 2.01	5 33.33 4.55	1 6.67 0.79	3 20.00 4.76	15 100.00 2.50
34	2 13.33 1.98	2 1.33 1.01	2 13.33 1.82	4 28.87 3.15	5 33.33 7.94	15 100.00 2.50
35	2 13.33 1.98	5 33.33 2.51	3 20.00 2.73	1 6.67 0.79	4 26.67 6.35	15 100.00 2.50
36	3 20.00 2.97	10 88.87 5.03	1 8.87 0.91	0 - -	1 6.67 1.59	15 100.00 2.50
37	3 20.00 2.97	5 33.33 2.51	3 20.00 2.73	3 20.00 2.38	1 6.67 1.59	15 100.00 2.50

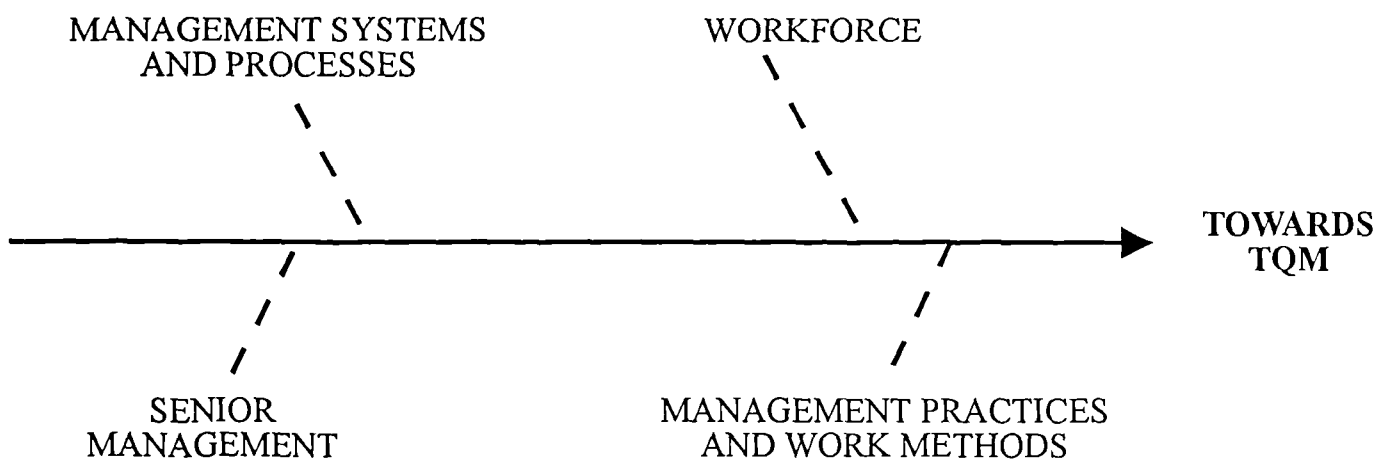
ROWS	OBSTACL 1	COLUMNS: 2	OBS-RATE 3	4	5	ALL
38	2 13.33 1.98	4 26.67 2.01	3 20.00 2.73	6 40.00 4.72	0 - -	15 100.00 2.50
39	3 20.00 2.97	7 46.67 3.52	3 20.00 2.73	2 13.33 1.57	0 - -	15 100.00 2.50
40	6 40.00 5.94	4 28.87 2.01	2 13.33 1.82	3 20.00 2.36	0 - -	15 100.00 2.50
ALL	101 16.83 100.00	199 33.17 100.00	110 18.33 100.00	127 21.27 100.00	63 10.50 100.00	800 100.00 100.00

Source: Compiled by the Author

In line with Stoner and Freemans¹³⁹ four typical managerial activities of planning, organising, leading and controlling, the author has further identified four key but interrelated elements of any managerial process. The way in which the top management of an organisation 'manages' these key elements will contribute to the success and sustainability of TQM. The author is of the opinion that for TQM to work in the NHS, its top management must optimise and realign the four key elements of; management systems and processes, workforce, senior management, and management practices and work methods to the underlying ethos of TQM.

FIGURE 33

FOUR KEY ELEMENTS OF ANY MANAGERIAL PROCESSES



The four key elements will be used to analyse the identified pitfalls in the NHS. From Table 19, if the highest scoring statements are collated using 40 percent (6 out of 15 hospitals) as the least score or median, the following picture emerges, which shows the identified barriers to the implementation of TQM in the NHS represented in percentages as pertaining to each of the four key elements of: **Management Systems and Processes; Workforce; Senior Management, and Management Practices and Work Methods:**

TABLE 19**THE PITFALLS OF TQM IN THE NHS FROM 4 KEY ELEMENTS**

1	MANAGEMENT SYSTEMS AND PROCESSES
67%	identified hospital processes designed for the convenience of staff as a 'significant' pitfall
47%	saw the hierarchical structure of the NHS as a most 'significant' factor
40%	identified difficulties in establishing measures and quality indicators in the NHS as a 'significant' pitfall
53%	identified organisational segmentalism as a 'significant' pitfall to TQM in the NHS
67%	identified difficulty of overcoming the 47 year culture of the NHS as a 'significant' pitfall
2	WORKFORCE
40%	identified the professional nature of the workforce as a 'significant' pitfall
47%	identified resistance from professional staff, particularly Doctors and Nurses as 'significant'
53%	identified departmentalism (fortress mentality) as a 'significant' problem
47%	identified turnover/changes in key personnel as 'significant'
53%	identified fear and resistance to change as a 'significant' problem
3	SENIOR MANAGEMENT
40%	saw no coordination and support from the centre, i.e. DOH and NHSME as a 'significant' pitfall to TQM
40%	saw failure to identify who the main customer of the NHS is as a 'significant' barrier
4	MANAGEMENT PRACTICES AND WORK METHODS
47%	saw the NHS as being very much financial and contracts driven as a 'most significant' barrier
40%	saw lack of involvement by professional staff in the TQM process as 'significant'
60%	saw so many initiatives going on at the same time as TQM to be a 'significant' pitfall to TQM
40%	identified the emphasis on Standards Setting and Monitoring as a 'significant' pitfall
47%	identified failure on the part of management to walk the talk of quality as a 'significant' problem
40%	acknowledged redundancies and streamlining of services as a 'most significant' pitfall

This analysis indicates that the 'pitfalls' of TQM in the NHS are mainly 'managerial'. This is compatible with Crosby's¹⁴⁰ view that 'there is no such thing as a quality problem'; a quality problem is seen by Crosby as a series of managerial 'problems'. Thus, top management should take the responsibility in motivating for quality improvement throughout the organisation. What Table 19 suggests is that the managerial activities, i.e. the way top management manage, is responsible for most of the quality problems in the NHS. Top management in NHS hospitals should, therefore, plan, organise, control and lead the quality improvement process. Top management should make certain that work processes are optimised and in statistical control to meet and, at times, exceed patient expectation. Furthermore, until top management, particularly Directors of Services, have the commitment and the leadership for quality, the system will remain unresponsive to the needs of the patients and staff. Due to the centrality of power within the NHS, it is important that top management adopts 'quality' as a top priority and not as an after thought. The author has identified that staff at the frontline and middle management levels are prepared to work for quality, all they need is the support and encouragement from the top. Therefore, the Chief Executive should exert pressure on the Directors of Services to adopt quality improvements as a key achievable target alongside other managerial activities.

The deduction that can be made from Table 19, is that there are 18 pitfalls common to the fifteen hospitals from a "most significant" and "significant" perspective.

TABLE 20: 18 PITFALLS INHIBITING TQM IN THE NHS

The Most Significant Factors Inhibiting TQM in the NHS:-	
1.	The hierarchical structure of the NHS*
2.	The NHS is very much financial and contracts driven*
3.	Redundancies and streamlining of services
The Significant Factors Identified by the 15 Quality Managers Representing 15 Trust Hospitals as Inhibiting Their TQM Programme:-	
4.	Hospital processes designed for the convenience of staff*
5.	Difficulties in establishing measures and quality indicators*
6.	Organisational segmentalism
7.	Difficulty in overcoming the 47 year old culture*
8.	No coordination and support from the centre, i.e. DOH and NHYSME
9.	Identifying who the customer is
10.	The professional nature of the workforce
11.	Resistance from professional staff, particularly Doctors and Nurses
12.	Departmentalism (fortress mentality)
13.	Turnover/changes in key personnel*
14.	Fear and resistance to change
15.	Lack of involvement by the professional staff in the TQM process
16.	Many other initiatives going on at the same time as TQM
17.	Standard setting and monitoring seen as the basis for quality*
18.	Failure on the part of management to walk the talk

Source: Compiled by Author, 10/1/95

* Represents factors not recognised in the TQM literature or established in earlier studies in the NHS as 'pitfalls' to the TQM process

From the analysis in Table 20, seven factors not recognised by earlier studies have been identified as significantly inhibiting TQM in the NHS. These include:

- (1) Standards Setting and Monitoring
- (2) Hierarchical Structure of the NHS
- (3) Contracts and Finance Driven
- (4) 47 Year Old Culture
- (5) Turnover/Changes in Key Personnel
- (6) Difficulty in establishing Measures and Quality Indicators
- (7) Hospital processes designed for the convenience of Staff

It is of particular interest to note that earlier studies^{141,142} have failed to identify:

- (a) the 47 year old culture of the NHS as a problem; 67 percent of 15 hospitals saw it as a potential inhibitor to the progress of TQM
- (b) another 67 percent identified the design of hospital processes, which are fundamentally staff focused, as a barrier
- (c) 47 percent saw the hierarchical structure of the NHS as an impediment.

Whilst Joss et al¹⁴³ earlier identified three types of quality in the NHS: technical, generic and systemic, the author's findings as revealed by the analysis (Table 20) is not consistent. 40 percent of the respondents identified standards setting and monitoring, i.e. professional quality, as a significant pitfall. Hence, what is prevalent in the NHS is the professional aspect of quality. This is the only aspect of quality the NHS understands. Professional standards are set in the NHS without recourse to patient needs because staff believe they know what patients require.

Furthermore, if reference is made back to Table 19, it is possible to delineate that the pitfalls are evenly spread between the four key elements of the managerial process. Under "Management Systems and Processes", five factors were identified from the sample. Five factors were also identified under "Workforce": and six factors under "Management Practices and Work Methods", while only two factors were identified

under "Senior Management". However, it should be noted that it is the responsibility of senior management to manage and control the other key elements to prevent the pitfalls from occurring. What Table 19 reveals is that the four key elements share the responsibility for the 'pitfalls' occurring in the NHS. It thus establishes the fact that for TQM to succeed in the NHS, the Trust Board and Director level managers of each hospital should ensure that the four key elements are working in unison, optimised and aligned with the ethos of TQM. Similarly, any model for the implementation of TQM must be flexible enough to deal with the identified variations within the context of the four key elements and with senior management demonstrating active commitment to the process. It is only the demonstrable and lasting commitment of top management to TQM, together with a structured approach to its implementation, which is capable of eradicating the identified pitfalls.

Furthermore, a number of factors identified by earlier studies as constituting the failure of TQM in the NHS are not congruent with the author's findings:

Limited funding for TQM, identified by Joss et al, Dalley et al and Kogan et al, as a problem was seen by 47 percent as a "least significant" factor for the success of the TQM initiative in the NHS. Whilst Kogan et al¹⁴⁵, saw the diversity in the meaning of quality in the NHS as a barrier, 40 percent of respondents acknowledged it as "not significant". Other writers on quality management have identified 'we already practice quality' as a barrier, 47 percent see this as "not significant". Deming identified lack of constancy of purpose as a deadly disease common in TQM, however, 47 percent of the Quality Managers in the NHS disagree, noting it as 'not significant'. Although 40 percent saw identifying the 'customer' of the NHS as a significant problem, 47 percent also saw it as "not significant"; implying that the existence of pitfalls varies from one hospital to another. This suggests that 'pitfalls' are not really generic across organisational boundaries.

In addition, whilst the TQM literature acknowledges the apathy/lack of commitment to TQM by employees as a generic barrier to the implementation of TQM, 40 percent of the sample noted that their employees are committed, but rather institutional barriers have hindered commitment. The most interesting point of all, is that whilst many TQM writers¹⁴⁶ have noted ineffective implementational methods as the most common

factor inhibiting TQM, 40 percent of NHS Quality Managers do not think they have employed an ineffective model. This is not surprising for were they to do so they would run the risk of jeopardising their positions as effective managers in the context of leading the culture change espoused by TQM.

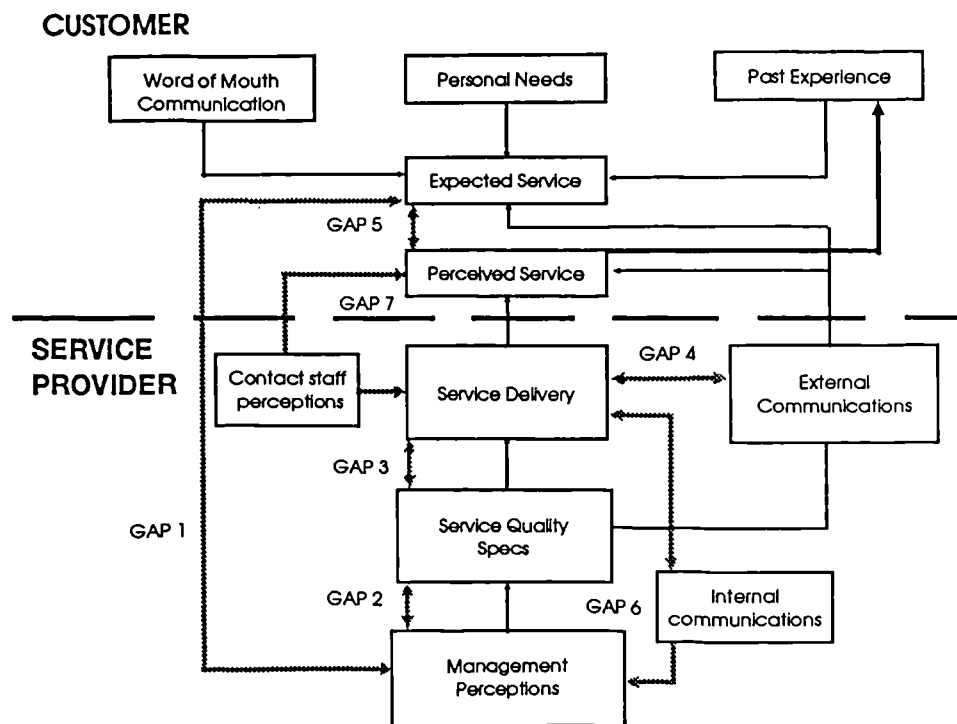
Furthermore, the literature recognises the confusion organisations face in adopting any one of the Gurus' approaches, but 47 percent of the sample respondents saw it as a non-significant factor. The implication being that Quality Managers in the NHS are not interested in adopting orthodox TQM models. Their approaches have been influenced by their own subjective knowledge of TQM.

If all the responses were analysed individually the pattern of identified barriers to TQM implementation varies substantially from hospital to hospital. Most of the 'barriers' to the TQM process in the literature are identified as being generic across industries; an assumption not grounded in empirical data. This represents a dangerous precedence because it has led to many business writers in the TQM field developing TQM models that are not problem specific. What the findings of this study reveal is that most, if not all, models for implementation of TQM in existence are inappropriate for the NHS because of their irrelevance to problem specific issues. For any model of TQM to work in the NHS, it has to be a context specific model designed to deal with identified problems. As the analysis shows, the barriers to the implementation of TQM vary from one hospital to the other. Each hospital should, therefore, be at liberty to make adjustments to the model to suit and meet its specific needs. Hence, one essential attribute of such a model will lie in its 'flexibility' and particularly in its capacity to facilitate a 'change' in the 47 year old stratification culture of the NHS.

Parasuraman et al¹⁴⁷ and Speller¹⁴⁸ have identified seven 'gaps' in their service quality model. The presence of the 'gaps' in an organisation's quality effort represents a significant barrier to the achievement of satisfactory service quality. The model shows that customers assess quality by comparing their expectations with the perception of service performance. It identifies sets of links between the key activities of the service organisation in its aim to deliver services of satisfactory quality to the customer. Thus, the service quality model, in the author's opinion, could be used as a quality assessment model to assess whether 'gaps' actually exist between the services provided

by the organisation and the customer's expectation of the service received. It is in this way, as an assessment tool, that the author used the Parasuraman et al model to further identify barriers that exist in the NHS but which were not identified within the context of the earlier questionnaire survey.

FIGURE 34
SERVICE QUALITY MODEL



Source: Parasuraman, Zeithaml and Berry, 1990; Speller, 1992

Bearing in mind the fact that questionnaires are not exhaustive, a fourth questionnaire was developed based on the service quality model and sent out to the fifteen Quality Managers who had collaborated in the earlier surveys. This fourth questionnaire asked Quality Managers to rate their organisation on each of the seven gaps by circling a code of 3, 2 or 1; 3 for high ranking ("we're good at this; I'm confident of our skills

here"); 2 for medium score ("We're spotty here; we could use improvement or more experience"); and 1 for low score ("we've had problems with this; this is new to our organisation). All the fifteen questionnaires sent out were returned representing a 100 percent response rate.

Analysis of the data generated by this fourth questionnaire revealed further 'pitfalls' inhibiting the progress of TQM in the NHS.

TABLE 21: RESULTS OF 15 TRUST HOSPITALS' RESPONSES USING THE SERVICE QUALITY MODEL

GAPS	QUESTIONS	SCORES			TOTAL (n)
		3	2	1	
Management Perception (Gap 1)	Do management understand correctly what patients expect of the service?	27 %	47 %	27 %	15
Service Quality Specification (Gap 2)	Do you translate knowledge of patients' expectations into quality specification, standards or guidelines?	33 %	33 %	33 %	15
Service Delivery (Gap 3)	Are guidelines and specifications for service quality adhered to?	33 %	33 %	33 %	15
External Communication (Gap 4)	Do you communicate effectively to patients about the service?	27 %	60 %	13 %	15
Patient Expectation - Perception Gap (Gap 5)	Are you able to map the cycle of the patients moments of truth; that is the patients journey through the service, ensuring that the patient's expectations equate to his/her perception of the service provided?	33 %	33 %	33 %	15
Internal Communications (Gap 6)	Does your organisation listen to contact staff about what the patient thinks of the services delivered?	27 %	53 %	20 %	15
Contact Staff Perceptions (Gap 7)	Are staff empowered and trained in delivering quality service to patients?	33 %	40 %	27 %	15

Source: Compiled by the Author, January 1995

From the table, the highest scores, using 40% as the least score, reveal the following 'gaps' as critical barriers to the provision of satisfactory service quality in the NHS:

- Gap 4 (External Communication) was seen by 60 percent of the respondents as scoring 2 points - "we're spotty here; we could use improvement or more experience".
- Gap 6 (Internal Communication) 53 percent scored two points, hence requiring improvement and more experience.
- Gap 1 (Management Perception) 47 percent also required help.
- Gap 7 (Contact Staff Perception) 40 percent identified that they need more improvement and experience.

What the analysis reveals is that the services provided by the NHS falls short of customer expectation. The NHS is not delivering a quality service to its customer; 'the patient'. As Parasuraman et al noted, "the presence of the gaps in any organisation suggest that the organisation is not providing a quality service"¹⁴⁹. As the analysis indicates, the seven gaps exist in the NHS even though Gaps 2, 3 and 5, with a score of 33 percent respectively, fell short of the required 40 percent. The assumption could be made that the NHS needs 'help' to resolve all the seven gaps and bring them under managerial control. From the results of Tables 20 and 21 the NHS is obviously stumbling in the dark with regard to quality management, hence, service gaps and pitfalls are appearing everywhere.

This is not surprising given the fact that sixty percent of the respondents noted that they need help with external communication; indicating that the NHS is not adequately communicating with its patients. This statistic is congruent with the reports in newspapers and earlier studies highlighting patients' concerns about the lack of adequate information about their state of health or the concerns of patients' relatives or friends. In some hospitals, the author was able to establish on the few occasions on

which he was the recipient of a guided tour, there are inadequate information leaflets; particularly in the reception areas and out-patient departments. In some cases, it is difficult to chart a course through the hospital because of inadequate and imprecise sign posting. There is a fundamental need to tackle the issue of lack of communication between NHS staff and patients.

Correspondingly, 53 percent saw internal communication as a problem. The situation is exacerbated by inter-professional and recently inter-directorate rivalries over resources. This has led to disillusionment amongst staff, whereby some groups feel outdone by others, with nobody listening to contact staff who work on a daily basis with patients. Furthermore, the hierarchical structure of the NHS has not helped matters. Managers are only used to handing down rules and regulations rather than listening and empowering contact staff to make changes and deal with the barriers that prevent the deliverance of quality work. As Zemke and Schaaf¹⁵⁰ argued, 'the success of an organisation depends on how you treat, train and motivate the shopfloor. If you treat them badly, it would have a knock-on effect on the way the customer is treated and vice versa'.

Table 21, also indicates that the management of hospitals across the NHS do not correctly understand what patients expect of the service. In the NHS, the managerial hierarchy is far removed and isolated from patient needs. This makes it paramount that the contact staff should be the central focus and the only route through which the NHS will be able to deliver quality. The contact staff know the problems. What they desperately need is the empowerment to effect changes. Management should call on the shopfloor including the various support services, to get on the bandwagon for change. The decision of the Chief Executive of Southforke Hospital (Case Study 1), to introduce a Rewards System within the hospital is a laudable gesture and a recognition of the efforts of staff who champion the course of improved patient care.

As Table 21 suggests, the central focus of quality in the NHS should be to improve Gaps 1-4 which represent shortfalls within the services provided by the NHS and Gaps 5-7 which denote a shortfall in the services as perceived by the customer. Although, staff at the shopfloor know the problems they cannot affect changes unless they have the support of top management.

The improvement in the services provided by the NHS depends on how much the top believes in improving processes that would have an impact on the bottomline. But it must be emphasised that no matter how much a hospital strives to meet regulatory requirements, failure to meet patients' needs is a travesty of the ethos of good patient care. After all, the business of any healthcare organisation is to cure the sick but, in meeting such clinical outcome, the processes which the patient undergoes should be optimised in order to facilitate recovery.

Furthermore, ten additional pitfalls to the implementation of TQM in the NHS were uncovered by the author through the face-to-face in-depth interviews. Such pitfalls are common to NHS hospitals and include;

- (1) Many NHS managers, particularly the Chief Executives, are on short term contracts. Thus, they are under immense pressure to perform and this hinders long term planning; hence the emphasis on short term planning. The CEO's emphasis on short term planning is further exacerbated by constant edicts from the Department of Health. Overall, there is too much external pressure on Trust hospitals to secure the effective and efficient use of resources but, due to the fact that most employees are on short term contracts, many do not care how patients are treated.
- (2) The structure of most Trust hospitals does not reflect their main business; 'treating patients'. The composition of a Trust Board is made up of people who do not have the faintest idea of how to treat or deal with a sick patient. A typical Trust Board is comprised of eleven people; five executives, a chairman and five non-executive directors. The five executives are usually:
 1. The Chief Executive
 2. A Nursing Manager
 3. Medical Director
 4. Finance Director
 5. Either the Operations or Personnel Director

The Chairman and the five non-executive directors are drawn from outside the NHS. Therefore, in most NHS hospitals there is less than one-tenth representation of medical staff on the Trust board. It would have been thought that a medically-led organisation would have the following 8 members:

1. The Medical Director
2. Head of Nursing
3. Clinical Director
4. The Contracts Manager
5. The Human Resources Manager to serve as Secretary
6. The Finance Director
7. The Chief Executive - Chairman
8. A Community Representative

The author is of the opinion that, the organisational structure across the NHS is inappropriate for a healthcare organisation. It does seem as though the government does not understand the main business or purpose of the NHS. If it did, then what are the exact functions of the non executives and the chairmen? Probably to ensure that the figures add up. No wonder, as Table 20 indicated, the NHS is very much finance and contracts driven rather than medically driven.

- (3) Too many external directives. Managers spend too much time measuring things that are unrelated to patient care and this has resulted in the failure to adopt a systematic approach to quality. Staff are not sure of which directives to meet. This conveys some element of demotivation to the workforce. The culprit is the recent Patients' Charter released on 17th January, 1995 and which employs hospitals to meet the following standards:

- 13 weeks for awaiting appointments
- Patients to be admitted 18 months after initial contact
- A patient requiring admission from the Accident and Emergency should be given a bed within 3 hours.

In addition to these directives, hospitals also have to comply with their respective purchasers' requirements. One Quality Manager referred to the new standard requirements both from the government and purchasers as unattainable and unrealistic and incapable of being met. These regulatory requirements put a lot of pressure on staff with the result that less than satisfactory quality work at times becomes the norm. Inevitably in such a situation, the provision of quality care is inhibited.

- (4) Many NHS staff have the feeling that the organisation is under seige by the government. They feel that there is a hidden agenda in operation to privatise the NHS. One Quality Manager in his early fifties told the author that the 'purpose' for which the NHS was established has changed from a 'public service organisation designed to provide a service free at the point of delivery and providing beds and treatment for the sick, to a market economy'; thereby killing the spirit of:

- sharing ideas
- information
- contact with other managers at Sub Regional meetings

which represented the norm prior to the introduction of the market economy.

This has led to a 'Macho Competition' amongst Trusts which, rather than being to the benefit of the patient, has consistently failed to adequately represent or meet patient needs and those of the community. Amidst the present confusion, the Quality Manager quoted above has decided to take early retirement. Replication of this scenario will mean that in a relatively short space of time, the NHS will lose most of its experienced managers.

- (5) Quality is seen as a political game rather than an integrated approach to improving the quality of care. Unlike a private sector health organisation, the NHS is ultimately linked to politics. This has led to organisational complexities and to a point where there exists confusion as to what are the main priorities of the NHS. However, it does seem the Patients' Charter is the main

priority of the government but, the Patients' Charter has met with stiff resistance from Trust hospitals. The Quality Managers interviewed by the author see standard processes, as emphasised by the Patients' Charter, as the by-products of poor quality care due to the fact that patients want different things depending on their state of health. Hence, in the words of one Quality Manager, subscribing to a set of standards is 'absolutely barmy'. However, the author disagrees, and discerns that the reason why Quality Managers dislike the Patients' Charter is that it makes them work for their money. Many of the Quality Managers are not disciplined to measuring results, but the Patients' Charter ensures they have to do so on a consistent basis.

- (6) Lack of facilitation in the NHS. The NHS is devoid of a culture of questioning things. This has led to the situation where the NHS is far removed from the needs of the patient. Staff fail to question things even when it is affecting the provision of good healthcare.
- (7) Lack of cultural fit between the way the NHS is managed and the ethos of TQM. Whilst Trust hospitals are implementing TQM, they still maintain the status quo; the command and control structure. Most employees feel it is perfectly acceptable to meet the standard requirements of their respective bodies rather than comply with the stated goals of the NHS.
- (8) Many staff, particularly Quality Managers, are disparaging of academics. They feel that there is a lot of theory about TQM, without the provision of the supportive, practical tools. They note that the literacy level in the NHS is low, most staff cannot think laterally and as such do not understand or comprehend academic methodologies. Thus, they call for a more practical, easy to use model as a guide to the implementation of TQM.
- (9) TQM is being implemented in a vacuum, i.e. in a piecemeal fashion, due to the fact that NHS staff do not have the time for detailed long term planning. There are frequent changes in direction because of the influence of central government. In addition, managerial agendas are set nationally. Thus, there is a lack of stability or a common sense of purpose.

- (10) The delaying of the NHS has led to fear amongst middle level managers. Thus, they see the NHS as an organisation managed by fear.

Haigh and Morris¹⁵¹ echo the findings of this study when they contend that the NHS has the characteristics of a very unhealthy organisation:

- (1) Little personal investment in organisational objectives except at top levels.
- (2) Some staff see things going wrong and do nothing about it. Nobody volunteers. Mistakes and problems are habitually hidden or shelved. People talk about office troubles at home or in the corridors, not with those involved.
- (3) Extraneous factors complicate problem-solving. Status and boxes on the organisation chart are more important than solving the problem. There is an excessive concern with management as a customer, instead of the real customer. People treat each other in a formal and polite manner that masks issues, especially with the boss. Non-conformity is frowned upon.
- (4) Managers at the top try to control as many decisions as possible. They become bottlenecks and make decisions with inadequate information and advice. People complain about managers' irrational decisions.
- (5) Managers feel alone in trying to get things done. Somehow orders, policies, and procedures do not get carried out as intended.
- (6) The judgement of people lower down in the organisation, in particular contact staff, is not respected outside the narrow limits of their jobs.
- (7) Personal needs and feelings are side issues.
- (8) Staff compete when they need to collaborate. They are very jealous of their area of responsibility, seeking or accepting help is felt to be a sign of weakness. Distrust reigns high in the NHS.

- (9) When there is a crisis, people withdraw or start blaming one another.
- (10) Feedback is avoided in the NHS.
- (11) Relationships are contaminated by maskmanship and image building. People feel alone and lack concern for one another. There is an undercurrent of fear.
- (12) NHS staff feel locked into their jobs. They feel stale and bored but constrained by the need for security. Their behaviour, for example in staff meetings, is listless and docile.
- (13) "One mistake and you're out".
- (14) Poor performance is glossed over or handled arbitrarily.
- (15) The structure, policies and procedures encumber the NHS. Staff take refuge in policies and procedures, and play games with the organisation structure.
- (16) Most staff swallow their frustrations; the attitude is: "I can do nothing. It's their responsibility to save the ship".

The evidence, from both the postal questionnaires and the semi-structured interviews with Quality Managers, suggests the partial implementation of TQM. Added to this, is the fact that the NHS is a very complex organisation in which can be found different managerial patterns at all levels. The main patterns include:

- Management by formality
- A reliance on procedure and rules
- Management by committee
- Settlement and decisions by negotiation
- Team consensus management

The existence of these different managerial patterns reflects the complex way in which the NHS has to work. When this is coupled to the political dimension of the

environment in which the NHS operates, it becomes imperative that any model of TQM capable of resolving the identified problems, must recognise all of the sub cultures found in the NHS by creating a balance, capable of ensuring representation of all of the functional areas which are involved.

In order to solve the 'pitfalls' identified, it is the author's opinion that only a structured, systematic approach which integrates TQM and uses the Patients' Charter as its standard guide is capable of solving the problem of mobilising the NHS towards the delivery of a customer focused service. However, it must be emphasised that unless top management, here identified as the Trust Board, takes the empowerment of contact staff and professional staff on board seriously, the TQM initiative is bound to fail.

The model must include exactly 'how' this should be done, because NHS managers have neither the time nor the finance to allow them to acquaint themselves with the methodology of any particular Guru. The TQM model should have all the necessary ready-to-use kit and should also include a standardised measuring tool, probably a set of questionnaires for the monitoring and assessment of the progress towards TQM. The measurement kit, as the author was told by Quality Managers, should not be statistical because most NHS staff are ignorant of statistical analysis. This problem is exacerbated by the fact that the pay structure in the NHS inhibits it from attracting the best personnel. Only very few graduates will accept £9,000 for a management trainee job when they can earn more elsewhere.

In the final analysis, the author is of the opinion that the main 'cause' for the avalanche of pitfalls inhibiting the introduction of TQM into the NHS are namely:

- (1) The NHS is under-led both from the centre and from within. Table 19, indicates that managerial activities or inactions are responsible for most quality problems. This underlines the fact that the NHS lacks effective management. A management that is customer driven with a strategic vision to move the services nearer to its users. A management that would listen and empower its staff to provide good quality care. A management that would lead

by example. A management that would 'walk-the-talk'. Overall the issue is where to find good management in the NHS.

- (2) Most of the pitfalls identified are symptomatic of the lack of a managerial understanding of the holistic nature of TQM; due to the absence of a comprehensive, holistic and context specific model for TQM. Thus, a model is required in the NHS which would offer an understanding of the essential requirements for the success of TQM; a model which is notably absent in the work of other TQM writers. However, before such a model is offered, it is pertinent to draw further lessons from an in-depth analysis of the implementation of TQM in three NHS Trust hospitals. It is this matter which is next addressed.

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CHAPTER SIX

BACKGROUND TO THE CASE STUDIES

The three cases that will be discussed in this Chapter represent Trust hospitals chosen from the 23 TQM sites established by the government in 1989. They were chosen because the 'Quality Team' at the NHSME considered them to be 'excellent' sites for the implementation of TQM¹. They were amongst the first to achieve Trust status and their Quality Managers were willing, at the initial contact made by the author, to serve as collaborators to this study. Two of the hospitals are based in the Southeast of England and the third is in the North.

Additionally, the recently published Patients' Charter League Table seemed to confirm this assessment with the three hospitals scoring either 4 or 5 star ratings in all the five categories surveyed.

The cases, will be designated Southforke Hospital, Desmond Hospital, and Brookside Hospital, respectively, to preserve the anonymity which was promised by the author at the beginning of the study.

The objective of this Chapter is to -

- (1) examine, in-depth, 'how' three Trust hospitals implemented TQM; i.e. to explore the model of implementation adopted and to explain 'why' that model was chosen against other competing approaches to TQM.
- (2) identify the difficulties experienced by the Quality Managers in overseeing the implementation process.
- (3) determine whether the cases have adopted any of the traditional approach(es) to TQM.
- (4) compare the three cases to determine:
 - (a) similarities, if any, in the approach to TQM

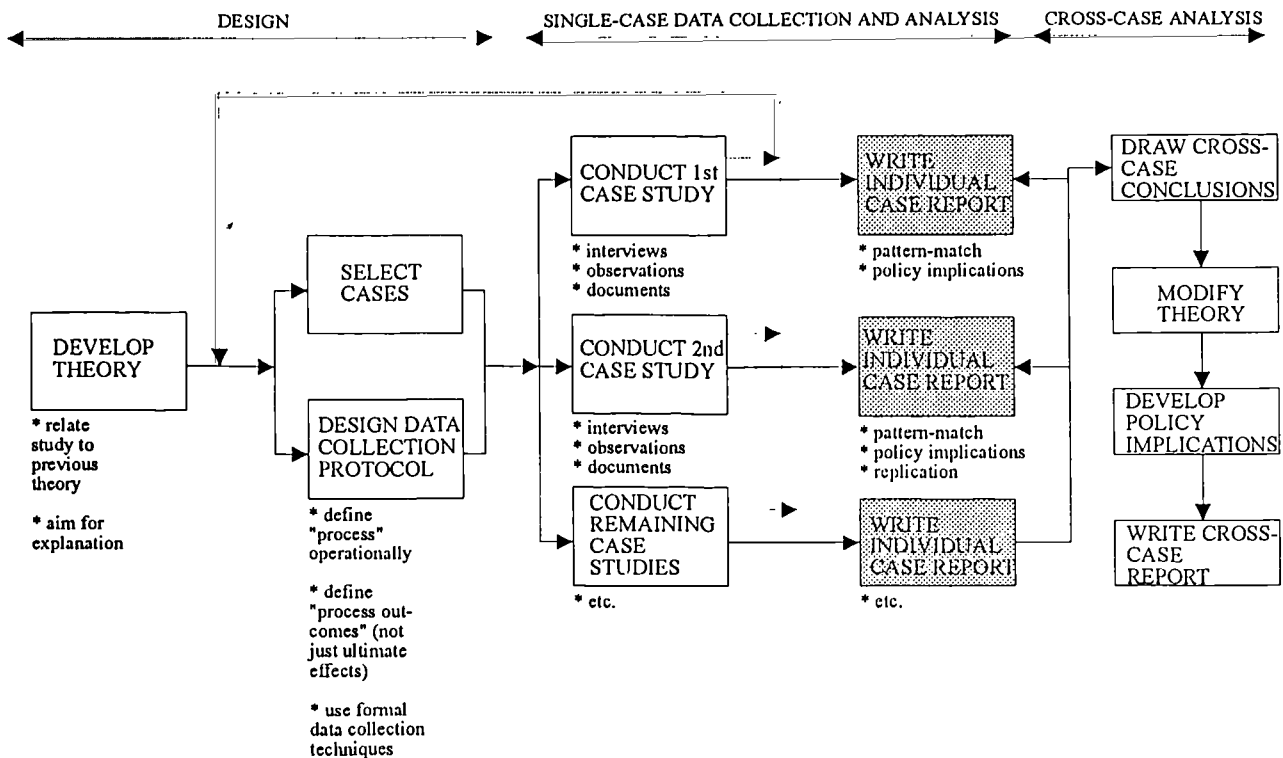
- (b) identify commonality in the barriers experienced in the implementation of TQM.
- (5) establish if a context specific model of TQM is required.

In addition, the Crosby² Quality Maturity Grid will be used to establish where the NHS stands in relationship to quality. For this to be done, it seems appropriate to provide a systematic overview of quality programmes as they appear in the TQM pilot sites.

Nonetheless, the cases will serve as an illustration of the process of TQM implementation in the NHS. The intention is to show that the NHS has adopted strictly individual approaches to the introduction of TQM rather than having recourse to more orthodox models.

The approach to the cases offered is congruent with Yin's³ replication approach to multiple case studies:

FIGURE 35



Source: Yin, K. R. (1989) "Case Study Research, Design and Methods", Applied Social Research Methods Series, Vol. 5, Sage Publications

ANALYSIS

The analysis of the three case studies will be based on Yin's⁴ theory of 'Explanation Building in Multiple Case Studies'. This entails the development of a general explanation that fits each of the three cases, even though the cases vary in their detail. The cases are analyzed from the perspective of comparability, that is the replicational logic which exists among the three cases⁵. A separate section discusses the common elements amongst the three cases.

CASE STUDY I

SOUTHFORKE HOSPITAL

Background

Southforke has been in existence since 1948. The hospital is situated in the North East of England. It provides a range of services associated with any typical district hospital, with a combined acute and community unit treating about 24,000 day cases and in-patients and over 128,000 out-patients per annum. It was one of the first wave of Trust hospitals in Britain. Thus, the hospital has semi-independent status which means that its staff, including consultants, are now direct employees of the hospital rather than employees of the Regional Health Authority as they were under the old dispensation. Trust status affords the hospital the responsibility of managing its own budget. Southforke employs about 2,700 people.

The hospital's decision to go down the TQM route may be attributed to two reasons:

- (1) It was one of twenty-three healthcare organisations chosen by the Department of Health (DOH) in 1989 to act as 'centres of excellence' for the introduction and implementation of Total Quality Management (TQM) which emphasised the need for a focus on 'quality' within the National Health Service.
- (2) The hospital was given Trust Status, thus it was imperative to have a TQM programme.

Like most Trust hospitals, Southforke has a typical Board of five executives, five non-executives and a chairman. Southforke is structured along five Directorate lines:

- Medicine
- Surgical
- Community
- Obstetrics and gynaecology
- Paramedical

Southforke is essentially a general hospital, i.e. it provides general medical services.

Data Collection:

The author made the initial approach to Southforke Hospital on 22nd February, 1993 when a letter was sent to the Quality Coordinator asking for her hospital to serve as a collaborator in the research. An acceptance letter, together with a pack of information on the Hospital's TQM programme, was received at the end of February. However, it stated that collaboration would be on that of absolute confidentiality.

Having received the acceptance letter, the decision was made to use the semi-structured interview format as the instrument of data collection; an instrument which would be used on a four monthly basis.

(a) The Interviews

A set of 24 questions was worked out in advance, but the author felt free to modify their order based upon his perception of what seems most appropriate in the context of the conversation. Hence, the author undertook six series of two hour interviews with the Quality Coordinator of the hospital. The first was on 26th April, 1993. The central theme of that initial interview was an overview of the Hospital's TQM programme with a particular focus on the background, aims and objectives of the TQM programme and the process of implementation. The second interview was conducted on 26th August 1993. This concentrated on the process, the model of TQM implemented and the reasons for its adoption. The third interview was undertaken on 5th January, 1994; the next on 23rd May, 1994. The fifth occasion was on 26th September, 1994 and the sixth visit took place on 2nd February, 1995. In total the author held 12 hours of interview time with the Quality Coordinator of Southforke. The last four interviews between 5th January, 1994 and 2nd February, 1995 concentrated on the TQM process and changes which had been made to the programme.

(b) Surveys

In June 1994, a survey was carried out through the use of postal questionnaires. Three questions were posed:

The first questionnaire comprised the forty factors established in the TQM literature as 'generic' to the failure of TQM. The aim was to establish whether these factors actually existed in practice. Furthermore, the Quality Coordinator was asked to add to the list any additional factors she felt were inhibiting the TQM programme but had not been included on the questionnaire.

The second questionnaire was based on the Crosby Quality Management Maturity Grid. The aim was to assess where the hospital was in relation to quality after five years experience of TQM.

The third questionnaire was based on Parasuraman et al's Gap Analysis model, the intention being to further identify the 'pitfalls' of TQM within the hospital.

(c) Documentary Sources

The Quality Coordinator provided the author with a wide range of documentary evidence, including the Hospital's TQM programme manual, which set out the strategy, model of implementation, the five year plan, quality policy and the training programme. On one of the author's visits, in August 1994, she took the author through the wards and for the first time the author had a twenty minute conversation with nurses on the orthopaedic ward and the opportunity to ask general questions about 'life' within Southforke.

To kick start Southforke Hospital's TQM programme, the Chief Executive Officer appointed a TQM Coordinator in 1990. The new incumbent was charged with responsibility for implementing an organisation-wide quality management programme. She came with private sector experience and a statistical background. On joining the hospital, her first move was to set up the quality department; a team of four comprising herself, a secretary and two quality officers. Prior to the start of the programme, the

hospital had no experience of TQM. Most of the 2,700 employees had no idea of what TQM involved. In the words of the manager, "it seemed a herculean task". At the beginning the attitude of the majority of staff was 'we are already doing quality, our patients are happy with our services'.

Furthermore, there were underlying barriers to be surmounted by recourse to the implementation of TQM within the hospital;

- Poor communication: between doctors outside the hospital (general practitioners) and the hospital administrators; between patients and consultants within the hospital; between consultants and nurses; between clinical and non-clinical staff.
- Skills shortage: in both clinical and non-clinical areas.
- Lack of resources: human, financial, equipment.
- Sectionalism: the hospital was structured along functional areas, this led to constant turf battles for resources.
- Lack of customer awareness: at this stage the concept of 'customer' was alien to hospital staff; customer needs were undefined or ill-defined.
- Lack of an effective information system: customers were not given adequate information and there was evidence of lost data; particularly patient records.
- Constant shifting of resources: between clinical areas.
- Poor employee morale: as a result of the constant and concurrent reorganisation of the NHS by the DOH.

Against this background, the Quality Coordinator opted for an 'individualised' approach to the implementation of TQM guided by her past experience. Her justification for such an approach was that 'quality' is best implemented according to

the local understanding and the personality of the quality manager⁶. She defined quality as 'a methodology to improve the activities of an organisation, to ensure a more effective and efficient use of resources and not an end in itself. TQM can only be implemented by a combination of strategies and is just one tool from among the numerous other tools for the management of change'. However, no specific definition of quality was adopted hospital-wide.

As she held the view that TQM would work best in combination with other strategies, she put in place a Quality Assurance System based on:

- Standard setting
- Auditing
- Measurement
- Facilitation
- Statistical process controls (SPC) tools

An infrastructure for the TQM programme was established which comprised:

- (1) A Steering Group made up of the CEO, the Director of Medical Audit, TQM Coordinator, a trade union representative, the Director of Nursing and Patient Services, Director of Clinical Directorate, a Senior Nurse, and the Director of Personnel. The group was charged with the responsibility of overseeing the TQM programme and identifying processes for improvement.
- (2) A Quality Department: a team of four comprising the Quality Coordinator, a secretary and two Quality Officers.
- (3) A Quality Audit Team: which had 28 auditors charged with auditing departmental standards.

The hospital adopted a Mission Statement:

"To provide and develop high quality service which meets the needs of our patients, our GPs and our purchasers in the community and beyond".

This Mission Statement was to be achieved through:

- Commitment to getting it right first time.
- Ensuring that all employees are aware of the Trust's values.
- Realistic approach by all employees to achieving a quality service.
- Effective use of all of the Trust's resources.
- The adoption of Patients' Charter standards and a continuous improvement process as the means of measuring quality.

The implementation of TQM within Southforke started with four pre-implementation phases:

Phase 1

- (a) An internal audit measure was taken to identify how the hospital was viewed by the internal management staff. Using this measure, the quality coordinator was able to identify the critical processes and service shortfalls. The aim of the audit was to identify the issues of non-conformance, using visible data as a tool, and to show managers the extent to which the services provided were meeting, or failing to meet, the needs of customers.
- (b) An external quality audit was carried out to establish; the perceptions held by general practitioners, suppliers and customers and to ascertain their views on the quality of care and services provided by the Hospital.

The data collected was used to establish quality problem areas, service gaps and the processes critical to meeting the patients' needs.

Phase 2

Training; every department was to send one person for audit training. Twenty-eight people were trained as Auditors. Eighty-four persons were also trained at this initial stage to serve as facilitators for departmental audits. Prior to training a decision was taken that all facilitators had to be junior staff who showed enthusiasm for TQM. Middle managers were also invited to the training sessions on a voluntary basis. The training lasted for three and a half days. The trained facilitators were given the remit of setting and monitoring standards against departmental objectives. They were to ensure that every department had at least a minimum of four and a maximum of six standards. The monitoring and auditing of departmental standards was carried out on a quarterly basis with notice to the departments in order to encourage continuous improvement. The facilitators were able to produce a comprehensive 'standard' manual for the hospital.

Phase 3

A Focus Group was formed to randomly interview about fifty patients to establish their views on the quality of service provided at the out-patient department. A questionnaire was designed based on the outcome of the random pilot sample. 550 patients were given the questionnaire of which 363 were returned; representing a response rate of approximately 66 percent. The questionnaire highlighted the following deficiencies in the quality of service: long waiting lists, lack of adequate information at the out-patient clinic, long waiting times at the local clinics, late starting times at the clinics, unnecessary consultancy protocol, poor communication between patients and clinical staff. A further survey of in-patients was carried out within the months of June/July 1992 which revealed that in-patients needed information about diagnoses which doctors and nurses were unwilling to provide.

The results of the internal surveys were considered together with the views expressed by staff on areas of service shortfall. Hence, the questionnaire responses became the catalyst for change within the hospital.

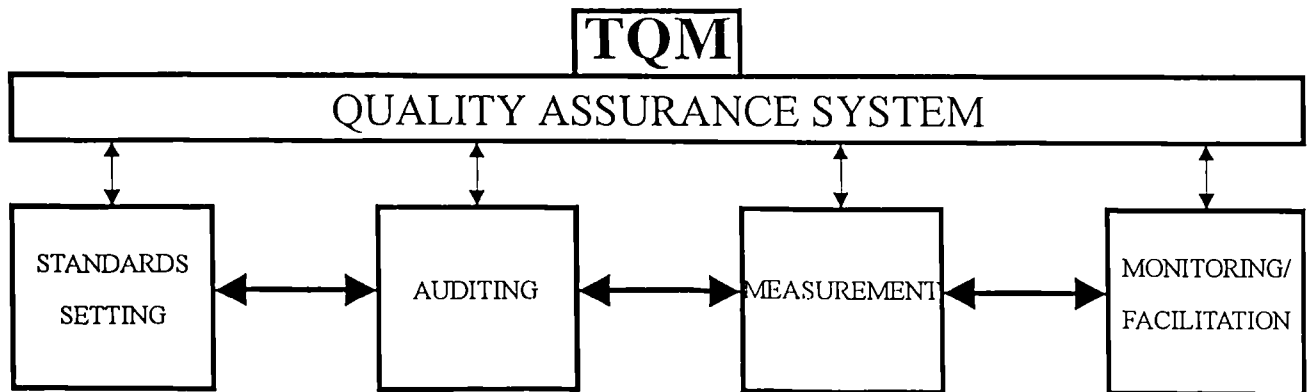
Phase 4

Further training was provided for all managers on the Deming Management Approach over a three day period. They were introduced to Deming's 14 Points and the use of SPC. The training highlighted the need for openness, trust and cooperation within and between functional areas and between managers and their immediate subordinates. The need to delegate some functional responsibilities and the empowerment of staff was particularly stressed to the departmental managers. These managers were to manage and control, in cooperation with trained facilitators, the implementation programme and were charged with ensuring that accurate documentation was kept on all quality issues, processes and costs. Six managers out of the twenty-seven who attended the training programme were chosen and together with the Quality Coordinator, became the hospital's watchdog against the provision of poor quality care.

The TQM Implementation Process

The Hospital's implementation programme was based on four sequential steps, reflecting the Quality Coordinator's view of the need for a quality assurance system to be put in place to support the implementation of TQM.

FIGURE 36
THE TQM MODEL



The diagram shows the introduction of the TQM programme being supported by a Quality Assurance System comprising:

- Standard setting: which emphasised professional and clinical standards.
- Auditing: focused on assessing present and changing patterns of process management on an annual basis, and of the progress made towards meeting the internally set standards.
- Measurement was based on quarterly and annual surveys of patients, employees, and clinical staff to determine their changing needs and the extent to which the services provided meet their expectations.
- Monitoring/facilitation; was undertaken by functional staff contributing to change within their areas of expertise, and the hospital's processes were redesigned so as to meet patient needs'/expectations.

It took the Hospital three years, from 1990 to 1993, to complete the four phases of the programme. In 1993, five objectives were identified which would ensure the continuous improvement of services:

- (1) to be more patient focused

- (2) to achieve a market focus; targeting peripheral services
- (3) to achieve the central focus of the Patients' Charter in a "Southforke" manner
- (4) to continuously improve the quality assurance system
- (5) management style/structure: creating a good working environment by improving management style and organisational structure

The Hospital has developed a three year plan which would take it to the year 1997.
The focus being:

Year 1

- Customer orientation
- Coordination of services
- Investigating out-patient services
- Launching of further training on standard setting and auditing

Year 2

- In-patient surveys
- Undertake further process improvement work at the Accident and Emergency Department
- Improve process management by reducing waste
- Survey general practitioners and purchasers of services to ensure that services provided meet with their referred patients' needs.

Year 3

- Prepare an action plan for further work through surveys of internal/external customers to gauge their views regarding the standard of services provided.

The questionnaire, comprising forty factors, identified in the TQM literature as the main factors affecting the implementation of TQM was sent to the Quality Coordinator of Southforke Hospital with the instructions to identify the 'most significant' through to the "does not apply" factors that inhibited progress to the effective implementation of TQM. The Quality Coordinator was also asked by the author, baring in mind that the list was not exhaustive, to 'add-on' to the list any additional factor(s), she felt to be important.

The analysis of the returned data revealed the most significant factors inhibiting TQM within Southforke to be:

- Lack of strategic direction and executive leadership
- Very much financial and contracts driven
- Lack of appropriate vision
- Difficulties in establishing measures and quality indicators that truly reflected the objectives of the organisation: senior management tended to impose quality indicators
- Turnover/changes in key personnel
- Inadequate planning for TQM implementation
- Unclear definitions of TQM goals, authority and boundaries; lack of constancy of purpose

In addition, the Quality Coordinator at Southforke Hospital identified the following factors as exerting a significant, adverse effect upon the implementation of the TQM programme:

- A tendency to deal with specific episodes that constitute bad clinical care instead of removing the underlying causes.

- Hospital processes designed for the convenience of staff and practitioners.
- No coordination and support from the centre, i.e. DOH and NHSME.
- Difficulty in identifying who is the customer of the NHS.
- The attitude that standard setting and inspection is the basis for quality in healthcare.
- Turf battles between departments.
- Organisational segmentation.
- Inadequate knowledge about, and understanding of, TQM.
- The lack of market pressure.
- Failure by management to work-the-talk.

The Quality Coordinator further identified the following factors as 'not significant' barriers to the implementation of TQM at Southforke;

- Personal involvement by upper level managers
- Lack of involvement by professional staff
- Lack of communication
- Ineffective method for introducing TQM
- Lack of adequate education and training
- The hierarchical structure of the NHS
- Many other initiatives
- No agreed upon meaning of quality
- We already have TQM
- No agreed upon implementational process
- Resistance from professional staff

- Lack of commitment by all employees
- Fear and resistance to change
- Staff shortage
- Failure to implement solutions in a timely manner
- Lack of involvement by middle managers
- Lack of confidence in the TQM programme
- Approaches to TQM too mechanistic
- Organisational culture
- General management coming late to the NHS
- Fear of losing jobs

The additional barriers she identified, which were not covered by the questionnaire, included:

- (1) Lack of gearing for the programme from the Chief Executive signifying the absence of top management commitment to the TQM programme; particularly by the Hospital's Trust Board.
- (2) The organisational structure, which she saw as being too complex.
- (3) Quality, she felt, could not be delivered from an advisory position. She held the view that her position as the Quality Coordinator was too remote and with virtually no leverage on top management. Hence, she could not influence policy decisions affecting TQM.
- (4) No desire or pressure to change on the part of the Hospital due to the lack of market pressure; patients have not been very vocal about poor quality service.
- (5) No 'reason' why TQM should be done.
- (6) Lack of emphasis on process improvement.

In September 1994, a new Quality Coordinator was appointed. The author arranged an interview, in February 1995, with the new Quality Coordinator, at a time when she was exactly four months into her new job. It is interesting to note that the new Quality Coordinator has adopted a new strategy for TQM within Southforke. Her reason being that the former Quality Coordinator's approach was strictly academic, relying on statistical analysis, which was not well received by the shopfloor. The new quality approach is based on system and process thinking which is two fold:

- The 'got to do's' by which is meant meeting the requirements of the Patients' Charter and the,
- Want to do's, which entails cultural shifts in attitudes and behaviour.

In improving processes, the new Quality Coordinator has embarked on the mission of winning the allegiance and commitment of support staff; which includes catering staff, porters and the professional groups. These groups, she noted, were ignored by her predecessor. Thus, the new approach is based on 'common touch', to speak the language of the shopfloor in order to ensure its commitment.

Quality Activities

- The Quality Coordinator has set up four groups to help with the facilitation of quality throughout the Trust. The groups include:
 - Clinical Effectiveness Group
 - Quality Sub Group
 - Risk Management Group
 - Human Resource Management Group

Each of the groups has a senior member of staff as chairman whilst the Quality Coordinator herself chairs the Quality Sub Group. The Quality Sub Group coordinates quality activities within Southforke. The Risk Management Group is to manage risks, to prevent and minimise litigation cases against the hospital. Whilst the Clinical Effectiveness Group and Human Resource Management

Group have the function of coordinating the human aspect of the TQM process through empowerment and delegation.

- A re-training programme has been introduced for all staff. The training sessions are held within departments in order to maximise attendance.
- Frequent meetings with department heads, to sell the need for quality, are to be the focal point of service provision. The departmental heads have agreed an annual quality plan with the Quality Coordinator. The annual plan contains an agreed set of quality indicators against which the departments would be monitored and benchmarked.
- The Chief Executive of Southforke has set aside £10,000.00 for a reward system to be instituted. But, at the time of the interview, the Quality Coordinator had yet to determine the modalities of the quality reward.

Currently, at Southforke, the drive for quality is a continuous improvement process. The new Quality Coordinator notes that the best approach to quality is the 'adoption of a system and process driven strategy'. The Hospital is presently concentrating on improving inter-directorate relationships and the Quality Coordinator says that 'TQM is a never-ending process and the management of Southforke is totally committed to it'.

DISCUSSION

The demand for TQM within the Hospital was not problem led, rather it was as a result of a Department of Health initiative. This is not consistent with what is widely held in the TQM literature to constitute reasons for an organisation embarking on TQM. Those widely held reasons are:

- To improve profitability
- To be more customer focused
- To be a low cost producer by eliminating waste, snags and re-work

The dangers of embarking on TQM when it is not problem-led, is that the workforce wonders why do TQM? This ultimately results in sloppy commitment on the part of management and the rest of the workforce. It is no wonder that the following factors were identified as barriers to the implementation of TQM by the Quality Coordinator:

- Lack of direction and executive leadership
- Very much finance driven
- Lack of commitment by Board and top management

These are implicit barriers that TQM seeks to solve. Its origins are organisationally inspired. Nevertheless, a significant point indicated by the case study is that out of the 40 barriers, the Quality Coordinator sees 18 as a problem; representing 45 percent of the total pitfalls. This shows that Southforke indeed has a problem with its TQM programme.

The Hospital's approach to TQM with an emphasis upon Standard Setting, Auditing, Measurement, Monitoring and Facilitation is not consistent with the holistic nature of TQM. It fails to meet some of the principles of TQM as earlier delineated in Chapter Four.

Additionally, the quality assurance system used to support TQM is limited to 'inspection' rather than quality improvement. It is concerned with meeting the requirements of the professional staff rather than the expectations of the customer⁷. This strategy is consistent with the traditional quality paradigm in healthcare which ignores the fact that healthcare quality is that "quality of care which has the capability to meet the needs of those who depend on the care"⁸.

The TQM approach utilised at Southforke Hospital can be argued to be fragmented and, therefore, only partial success would ensue because it omits from consideration the wider framework essential to the success of a TQM initiative:

- (a) Vision
- (b) Mission
- (c) Strategy
- (d) Identification of values/beliefs

- (e) Meeting customer needs
- (f) Realigning organisational processes, and
- (g) Measurement

The approach is further flawed by the Quality Coordinator's failure to adopt an organisation wide definition of TQM. A definition which would have created a platform for total employee involvement. She lost sight of the classical definition of quality of care as defined by Donabedian:

Quality of care is "that kind of care which is expected to maximise an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts"⁹.

Had the Quality Coordinator taken account of this definition, she would have understood that quality is what the customer says it is and not what the professionals within the Hospital feel it to be. In the literature, culture change is held to be an essential element for the successful implementation of TQM, but no systematic effort was made by Southforke to integrate a cultural change process into its TQM approach. Turf battles between departments and sectionalism were noted as a barrier to the TQM programme. This leaves, as an open suggestion, whether the Quality Coordinator has a conceptual understanding of what is required for the implementation of TQM.

The training programme emphasised mainly Auditing and Standard Setting. The question that arises is, what is the relationship between Auditing, Standard Setting and TQM? The answer, in the author's opinion, is absolutely 'none'. TQM is an integrated management approach that calls for continuous and relentless improvement in the 'total' process that generate patient care, not simply in the improved actions of individual professionals but in improvements based on both outcomes and processes¹⁰.

Therefore, training and education at all levels are vital to the success of TQM. Training and education should cover all aspects of TQM from the general concepts, through the development of a customer focus, to the measurement of quality and should include information about effective teamworking and the use of problem solving techniques¹¹. Thus, the training programme at Southforke falls short of the holism

demand of TQM. Training should be one of the central mechanisms for creating a conceptual understanding amongst top management and employees of the requirements for TQM, in particular, of the need for them to be committed and: 'to deliver to the customer a service which meets his or her requirements/needs'.

For Haigh and Morris¹², there are twelve key elements which any public sector organisation should utilise if the intention is to successfully implement TQM:

- (1) Quality awareness
- (2) Management leadership
- (3) Organising for quality improvement
- (4) Creating a participative environment
- (5) Training for quality improvement
- (6) Involvement of every function at all levels
- (7) Customer and supplier (both internal and external involvement)
- (8) Problem prevention and solving
- (9) Statistical process control
- (10) Measurement of quality performance
- (11) Recognition for achievement
- (12) Continuous improvement

In relationship to Southforke's approach to TQM, only a few, if any, of the above mentioned elements, vital to any successful implementation of TQM, were integrated. What is required at Southforke is a comprehensive, concise and coherent strategy which would embody the aforementioned elements; thus leading to the attainment of the holistic requirements of TQM.

The case study further reveals a number of factors which have hindered the implementation process. It is interesting to note that the Quality Coordinator identified:

- Lack of appropriate vision
- Difficulty in establishing measures and quality indicators that truly reflect the objectives of the organisation
- Inadequate planning
- The attitude that standard setting and inspection is the basis for quality in healthcare

These barriers are as a consequence of the chosen pattern of implementation rather than arising from any other institutional cause. It is improbable that a TQM programme would be structured around a quality 'assurance system'. This obvious limitation supports the earlier contention that there existed a lack of conceptual understanding of what is required for the implementation of TQM.

The 'barriers' identified by the Quality Coordinator do, however, suggest that integrating a specific model of TQM into Southforke would not be enough to ensure success. A corresponding change in the culture of the Hospital is also required i.e. a fundamental change in the way work gets done in the organisation.

This assertion is consistent with the work of Kanji¹³, who noted that "culture change is the key to any successful TQM programme". It must also be stated that the individualised approach adopted by the Hospital does not allow for leverage to integrate other essential elements for TQM, particularly 'changing people's attitude'.

In addition, the introduction of a new Quality Coordinator indicated a perceived need to restart the Hospital's TQM programme. This is the disadvantage of not having a specific structured approach. Thus, in order to justify her position, the new Quality Coordinator has introduced her own individualised approach based on "systems and

process improvement"; condemning the earlier method as being too academic. This chopping and changing of approaches can only lead to a state of confusion, where employees become disillusioned with the whole idea of TQM. Some sceptics might argue that anything that lacks a defined strategy or method is not worth doing. The NHS needs more than ever, a specific approach for the implementation of TQM to stem the tide of the proliferation of individualised piecemeal approaches which currently characterise TQM initiatives.

CASE STUDY TWO

DESMOND HOSPITAL

Background

The Desmond Hospital was established in the early 1950s. The Hospital is situated in the South East of England. It provides a range of services, with a combined Acute and Community Unit made up of seven care groups, treating 20,000 day cases and in-patients and over 120,000 outpatients per annum. Desmond Hospital is one of the largest Trust hospitals in England, employing about 4,000 people.

The care groups include:

- (1) Elderly
- (2) Women and children
- (3) Mental
- (4) Learning/disability
- (5) Surgery
- (6) Medical
- (7) Primary health directorates which include general practitioners (GPs) and nursing services

The Board of the Hospital comprises five Executive Directors, of whom the Chief Executive is one, four Non Executives and a Chairman.

Desmond Hospital was one of the 23 hospitals chosen by the department of health as a TQM demonstration site.

The management of Desmond Hospital was aware that it was not alone and unique in facing problems relating to the provision of quality healthcare. Furthermore, the Hospital's management was in agreement as to the barriers which they were seeking to surmount by recourse to the implementation of TQM:

- Poor communication: between different groups of staff; in particular, between doctors and nurses, between doctors and management and

between clinical staff and non-clinical areas such as medical records, admissions, catering and laundry services.

- Lack of accurate information: information systems within the hospital were manually operated. This tended to hamper attempts to systematically improve aspects of the patient service delivery process.
- Financial constraints: a general lack of resources to finance improvement projects which resulted in the lack of adequate training for staff. Specific training took place only when resourced.
- There were many competing priorities and a tendency to tolerate less than satisfactory standards of work. Poor staff morale contributed to poor time keeping and the misplacement of patient files.
- Sectionalism: each department had its own method which resulted in a culture of professional segregation.
- Skills shortage: existed in both clinical and administrative areas to the extent that nurses were being replaced by unqualified care assistants.
- Absence of top management commitment: senior management is only committed in principle, not in practice, to enhanced quality. It is more concerned with winning service contracts.
- Poor staff morale: due to redundancies and, especially, service cutbacks. Recently, the Hospital carried out a two percent cutback on clinical services and a three percent cut on all other service budgets.
- Poor building stock: refurbishment needed but regularly delayed.

Data Collection

In February 1993 Desmond Hospital agreed to serve as research collaborator. The same method of data collection used at Southforke Hospital was employed. This involved the use of semi-structured interviews, a postal survey and documentary sources.

The TQM Programme

The Hospital embarked on its TQM programme in 1990 with the appointment of an Assistant Quality Director. He came from the manufacturing industry. The Assistant Quality Director had, prior to taking this position, engineered a TQM programme within his company; a photocopier manufacturing plant. Although quality initiatives had been an earlier feature of the Hospital, the Quality Director decided to ignore them and to launch his own programme for quality improvement based on his recent, prior, experience. He defined quality as "providing internal and external customers with innovative products and services that fully satisfy their requirements". He further defined TQM as:

T = Total, i.e. "involving every aspect of the business, all staff, and including suppliers and customers".

Q = Quality, i.e. "understanding and satisfying all customer needs".

M = Management, "meaning TQM has to be managed to achieve the flexibility and effectiveness required".

On the basis of his definition of Total Quality Management, he identified these three areas;

- (1) People (staff)
- (2) Process
- (3) Patients

as the key to any successful TQM programme.

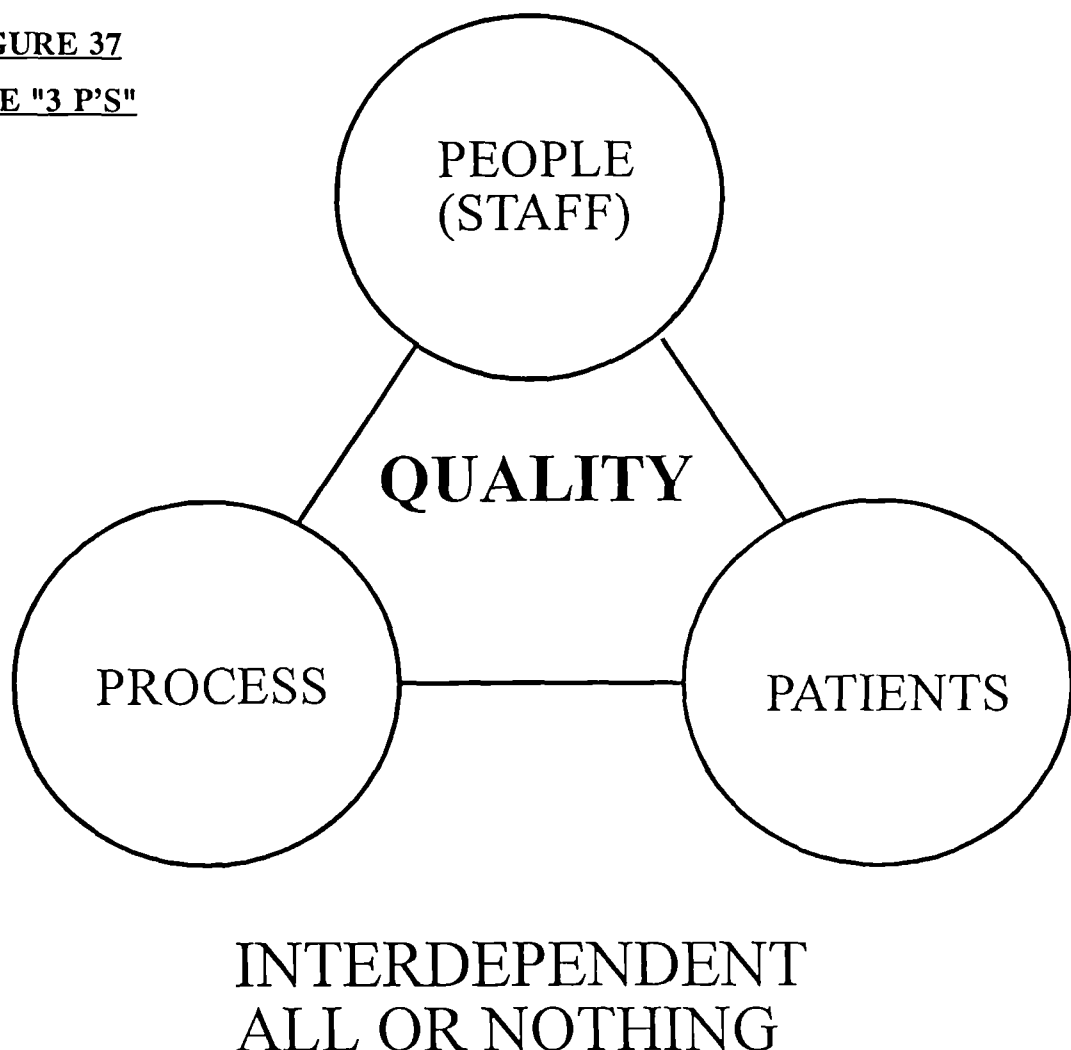
The Quality Approach

His approach to quality he termed the "Small Pebbles" Approach. From this he developed:

- Customer surveys
- Cultural and disability awareness
- Staff support through stress management
- Quality improvement fund
- Quality awareness training.

He designed a framework for implementation based upon what he termed the Three P's:

FIGURE 37
THE "3 P'S"



The 3 P's encompassed the following:

People:

- Training (skills awareness)
- Reward and recognition
- Team approach
- Employee satisfaction focus
- Roles and objectives clarified

Process:

- Identify internal customer chains
- Work processes defined and documented
- Team work to eliminate errors and defects
- Standards set and monitored
- Continuous improvement

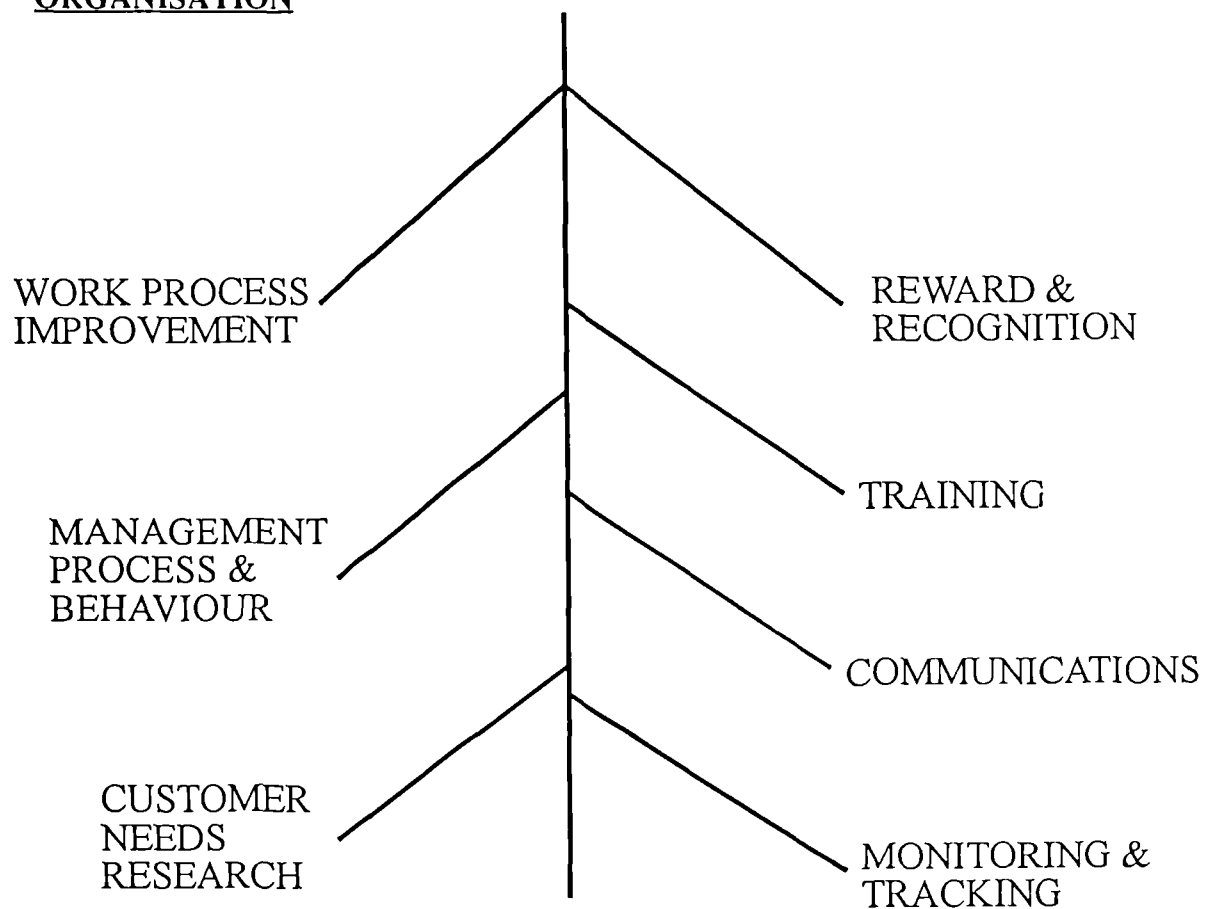
Patients:

- Consumer needs research
- Satisfaction tracking
- Complaint management

The Assistant Quality Director also chose the cascade and bottom up approach to implementation, arguing that it represented 'the best method to introduce TQM into an alien organisation'. He established steering groups in each of the main departments within the Hospital. Each steering group was to be headed by a departmental manager and six members of staff. They were charged with overseeing and facilitating process improvement projects. From experience, he had identified seven elements that must be addressed in an organisation in order to bring about a smooth transition to a new way of doing things; thereby creating a new organisational culture.

FIGURE 38

QUALITY PROCESS - DESMOND HOSPITAL IS A QUALITY ORGANISATION



Source: Desmond Hospital's Strategic Plan 1993-1994

Training

In December 1991, the Assistant Quality Director started a training programme designed to create an awareness of, and the need for, a TQM culture.

The training programme was designed in three stages:

1. Needs assessment of staff
2. Creation of quality awareness, identifying cross-departmental quality improvement processes

3. The tools and techniques of TQM to address the process issues identified from the needs assessment

The training programme was administered in a cascade fashion starting with the Trust Board over a full three day period. The Board was introduced to the principles of TQM, the tools and techniques, TQM process improvements and project management.

The next training programme entailed two, of one day sessions for:

- (1) Staff of the Accident and Emergency Department
- (2) Staff at the out-patients department, and
- (3) Another one day session was held for departmental managers on a multidisciplinary basis. A total of 82 managers attended. The training was centred around the following theme:

Communication: with an emphasis on the KEY ELEMENTS:

- Effective communication
- Two way/cross functional communication because of the need to pull together in the interest of the organisation and the wellbeing of patients.

Monitoring and tracking of patient needs and the identification of service gaps.

Standard Setting.

Principles and tools of quality management.

The managers were to return to their respective departments and instructed to 'champion' the cause of TQM. They were to establish departmental standards reflecting the needs of:

- Patients
- Clients
- Internal customers

After the initial training programme, a new organisational structure was established for the hospital with a network of quality specialists being introduced in each Care Group/Directorate: a total of six. The Quality Specialists, a new name for Departmental Managers, were charged with further responsibilities:

- Preparation of Quality Plans
- Facilitation of Quality Improvement Projects
- Coordination, Monitoring and Tracking of the patients journey through the service
- Organising training for staff
- Networking across Care Groups/Directorates to further the quality culture

A quality improvement team, comprising the Director of Nursing and Quality, the CEO, Director of Medical Audit, six Care Group Managers, the Director of Personnel and the Assistant Quality Manager was formed. This team was to:

- Manage the quality network
- Manage the 'corporate' quality processes e.g. complaints, patient communications, benchmarking
- Produce the Trust's annual quality report
- They were also to ensure that the hospital, as a whole, was organised to address the needs and expectations of identified market segments.

The next step was the introduction of a number of organisation-wide process improvement schemes:

Management Process

As part of the new organisational structure, top management was to visibly support the changes by:

- (a) Managing the business in a 'quality way'
- (b) Monitor quality indicators, Analyze, Set targets, Act and Re-monitor organisational activities
- (c) Demonstrate their commitment through;
 - Visible presence and actions
 - Role modelling
 - Fostering quality processes
 - Leadership
 - Empowerment of the shopfloor

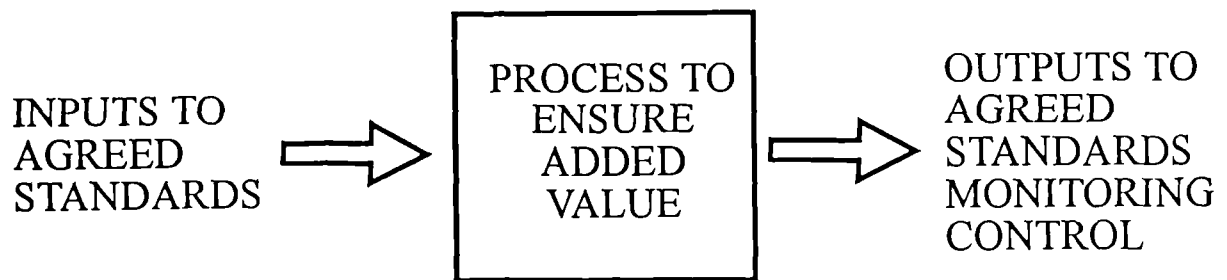
Work Process Improvement Scheme

A work process improvement scheme was also initiated. Six multi-disciplinary teams were established to ensure the following:

- Understanding and acceptance of the concept of the internal customer
- Use of flow charting by all staff
- Step by step descriptions/inputs/outputs
- Negotiating on outputs and standards with professional staff; consultants, nurses and paramedics
- Agreeing the elimination of errors and defects
- Monitoring and control

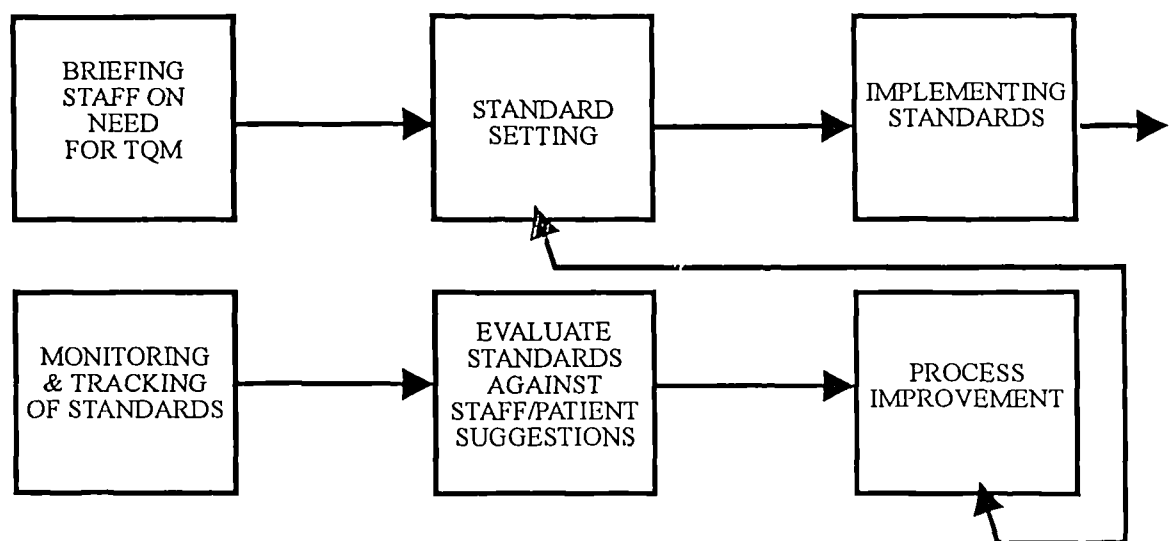
Departments were used as the basis for the process improvement framework designed by the Assistant Quality Manager:

FIGURE 39
PROCESS IMPROVEMENT FRAMEWORK



A TQM framework was developed by the Assistant Quality Manager in June 1992:

FIGURE 40
THE TQM FRAMEWORK



Within departments, managers were to ensure that 'standards' were:

- Relevant to area to which they applied
- Understandable by those working in the area
- Measurable with minimum time and effort
- Flexible (could be cranked up)
- Locally owned
- Based on current good practice
- Reflecting the needs of both professionals and patients

The Hospital set process improvement targets for the year 1994-1995. For example, to reduce "drastically" the waiting list for surgeries. A new compulsory three day training programme was introduced for any new staff joining the organisation which centred on:

- (1) The organisational culture
- (2) TQM principles/tools
- (3) Teamworking

The Assistant Quality Manager was made redundant in December 1993 and was replaced by his assistant, a Senior Quality Officer.

In answer to questionnaire 2, the Senior Quality Officer identified the following as the most significant factors impeding the TQM programme:

- Very much financial and contracts driven.
- Limited funding for the TQM programme.
- Apathy/lack of commitment by all employees to the TQM process.
- Inadequate planning for TQM implementation.
- Staff shortage; no spare time to attend meetings and to problem solve.
- The lack of market pressure; patients did not have a choice in a service free at the point of delivery.
- Fear of losing jobs.

Under the theme, 'significant factors', she identified:

- Lack of strategic direction and executive leadership.
- A tendency to deal with specific episodes that constitute bad clinical care.
- Lack of active involvement by upper level managers.
- Hospital processes are designed for the convenience of staff and practitioners.
- Ineffective method of introducing TQM.
- The lack of adequate education and training in TQM methods and problem solving.
- Many other initiatives going on at the same time.
- No coordination and support from the centre.
- Lack of appropriate vision.
- Difficulties in establishing measures and quality indicators that truly reflect the objectives of the organisation.
- The attitude that standard setting and inspection is the basis for quality in healthcare.
- Resistance from professional staff.
- Departmentalism.

- Organisational segmentation.
- Fear and resistance to change.
- Inadequate knowledge about and understanding of TQM.
- Unclear definitions of TQM goals, authority and boundaries: lack of constancy of purpose.
- Failure to implement solutions in a timely manner.
- Lack of involvement by middle managers.
- Lack of confidence in the TQM programme by most employees.
- Approaches to TQM mechanistic.
- Difficulty in overcoming an organisational culture of over 40 years.
- Failure on the part of management to work the job.

In addition to the forty generic factors included in the questionnaire, the Senior Quality Officer noted a number of barriers impeding TQM progress within the hospital:

- 65-70 percent of the pressure for quality improvements came from outside.
- Getting staff, particularly frontline and first-line managers, to attend training sessions was very difficult.
- Difficulty in integrating the elements of the strategy into the organisation.

- The culture of the NHS is semi-militarist: fear of giving wrong clinical judgements resulted in stressful workloads for Nurses and Doctors.
- Professionals formed stereotypes of each other.
- Strategy for TQM, in most cases, did not connect with grass roots.
- Consultants did not care about what patients thought of them. They are only concerned with the technical outcome of their performance.
- Shortage of funds for the main purchaser of services. This had led to job redundancies and the closure of some facilities. Thus, employees viewed TQM with suspicion.

As a result of the change in personnel, a number of changes to the TQM programme at Desmond Hospital were made by the Senior Quality Officer. The first was a move towards a flatter organisational structure. The Hospital removed the position of "Assistant Director". This resulted in an increased work load for Directors of Services and caused further organisational chaos when people within the organisation felt their jobs to be threatened. Inevitably, this affected the TQM programme. Thus, training for TQM suffered because two training officers were made redundant. Improvements in work processes within the Hospital, were driven by patient standards rather than on the needs of patients and staff. However, a more structured approach to TQM, in the form of complaints handling, had been instituted and this was personally monitored by the CEO and the Quality Team. In order to make sure that the complaints handling process remains the central focus of TQM, a Trustwide Patient Satisfaction Survey is presently being carried out in order to determine where the organisation stands in relation to patient needs. In addition, a quality newsletter has been introduced. Through the newsletter, the Senior Quality Officer intends to publish departmental quality achievements and reiterate the Hospital's commitment to TQM. The newsletter will be a bi-monthly publication in which staff will be encouraged to raise issues about the failures of the system and the corrective action to be taken. These concerns will then be transferred to the complaints panel for action to be taken.

The Senior Quality Officer intends to build on the bits and pieces of quality initiatives within the various departments, rather than initiate a new organisationwide programme. She feels that the former Assistant Director's approach to quality was not popular with the grass roots. Her approach is to departmentalise quality by allowing departmental staff to own the process.

Since the Senior Quality Officer took over, working to meet the requirements of the Patients' Charter initiative has become the central thrust of the Hospital's TQM programme. In particular, the focus is on the measurable specifications which are determined external to the organisation. The approach adopted to meet the Patients' Charter encompasses:

Agreement on an incremental approach to standards and monitoring, action for improvement and reporting on these.

Emphasising meaningful links between targets 'externally' required and approaches to quality already recognised in the Trust - e.g. professional standards, TQM, client-centred service.

Consolidating and extending good 'quality' practice already followed in the Trust; for example:

Quality as a regular item on management meeting agendas.

Staff working groups to address quality targets and problem areas identified in monitoring.

Improved support from the Quality Unit staff to Care Groups - e.g. Quality Unit staff members to attend some meetings.

Regular reports tailored for each Care Group/Directorate on monitoring complaints, and the need for a Trustwide survey of patients. This, and other steps, are intended to enhance the use of information in bringing about improvement.

Development of simple monitoring/progress reporting forms for some 'new', previously unmonitored, standards. Initially, these will be exclusively for internal use.

Management training for middle/senior managers to include quality processes. Reconsideration of ways of providing focused, relevant training for front-line staff.

Continued improvement of data on quality for monitoring purposes.

Introduction of an 'action taken' report form for return to the Complaints Department.

Steps for accomplishment:

The Quality Network meeting in December 1994 was charged with:

Agreeing responsibilities, priorities and timescales for meeting new Patients' Charter and Purchaser standards.

Improving internal publicity on standards, demonstrating their relevance for patients and staff and indicating the progress being made.

Recommending steps to strengthen intra- and inter-departmental communication and action for quality.

DISCUSSION:

From the Case Study, it could be inferred that the demand for the implementation of TQM had originated from the demands of a central governmental department: the Department of Health. Thus, the TQM programme, at Desmond Hospital, was also not problem-led but rather externally imposed on the Hospital. If quality is not problem-led, people believe it is a management ploy leading to downsizing.

The Assistant Quality Manager's decision to base his approach on his past experience within the manufacturing industry, whilst ignoring the prevailing Hospital's quality initiative, represents an authoritarian approach to TQM. He seemed to have no appropriate vision and longer term strategy as to how to operationalise and sustain the TQM programme. In the author's opinion, this represents a lack of understanding of the holistic nature of TQM. Whilst the Assistant Quality Manager opted for what he referred to as the 3P's, no systematic attempt was made to survey patients in order to establish their needs/requirements or wants, nor to discern how the services provided by the Hospital met patients expectations. Instead, the examination of quality of service provision focused on outcomes; the technical aspect of the interactive process were emphasised whilst the interpersonal elements, those which mattered most to the patients were ignored. In addition, the Hospital's approach to TQM was standards focused which is consistent with the traditional quality paradigm in health care. Thus, Monitoring, Standards Setting and control of processes came to have pre-eminence whilst no attempt was made to monitor the patients' journey through the process. Furthermore, process and outcome measures were internally set without recourse to patient needs and expectations. Similarly, the needs of internal customers were not taken into account.

Nevertheless, what the case study signifies maybe summarised as follows:

- The lack of understanding of the holism of TQM. TQM is held in the literature to be a strategy that should permeate all organisational activities; getting things done through people. However, the case reveals an approach where the Assistant Quality Director tried to get things done through himself. No attempt was made on his part to involve the shopfloor with the approach to implementation.
- The failure of his manufacturing experience to adequately deal with the organisational complexity of the Hospital; thus highlighting the inadequacy of manufacturing models of TQM to bring about a new quality culture within healthcare.

- The need for a framework/model to be provided for senior management as an entry point into the cycle of continuous quality improvement in healthcare.
- Lack of conceptual understanding of what constitutes quality healthcare.
- Whilst the TQM programme within the Hospital could be argued to be very detailed it nevertheless, omits the essential characteristics necessary for the success of a TQM initiative; as exemplified by the five essential principles of TQM¹⁴.
- The absence of a comprehensive, concise and coherent strategy for change, of which TQM is the essential vehicle or change agent, has given rise to the factors identified by the Senior Quality Officer as inhibiting the TQM programme. The barriers are symptomatic of an approach that failed to adequately adhere to the 'holism' of TQM.
- Although the Assistant Quality Director's approach to TQM emphasised a top down -bottom up approach, which is consistent with the TQM literature, he overtly failed to create a joint agenda with those working at the base which represents an essential characteristic of a top down, bottom-up initiative¹⁵. He further failed to understand that, in a 'top-led and bottom-fed' approach, an organisation does not begin to move towards the more formal description of requirements, standards and conformance until it has recruited the support of the operational level staff who know the problems¹⁶. The case study represents a traditionalist implementation process where objectives were mainly set by the Assistant Quality Director without recourse to the organisation's external and internal needs.
- A further defect in the implementation process was the absence of a steady, gradual and consistent process of transformation. The method of application of TQM in the hospital reinforces the chain of command concept. The implicit message conveyed to employees by the actions of the Assistant Quality Director was; "All ye who enter, take off your brains and put on fear"¹⁷. No wonder

that one of the significant barriers acknowledged as impeding TQM was 'apathy/lack of commitment by all employees'. Another factor identified as a barrier to TQM, which is itself symptomatic of the hospital's partial approach, is 'inadequate planning' for TQM. The Assistant Quality Director made no concerted effort to assess whether his approach, based on his past experience, was transferable into a complex hospital setting. His attitude was consistent with Juran's view that, "many companies are facing serious losses and wastes that have their main origin in deficiencies in the quality planning process"¹⁸.

The emphasis on professionally based standards, rather than upon standards that are derived from customer expectations, represents a lack of understanding on the part of the Assistant Quality Manager as to what matters to patients in a service delivery process. This negates the fostering and development of the ethos of continuous quality improvement.

Furthermore, the new approach of adding bits and pieces of TQM to the existing organisational structures and practices is inadequate as a means of sustaining TQM in the long term. It is wrong to give employees ownership of the TQM process when the commitment and leadership from the top is absent. Why concentrate TQM around employees who can only, in Deming's¹⁹ word, affect about 4 percent of change. The ownership of TQM should be by those who can effect 96 percent change and that is senior management.

CASE STUDY 3

BROOKESIDE NHS TRUST

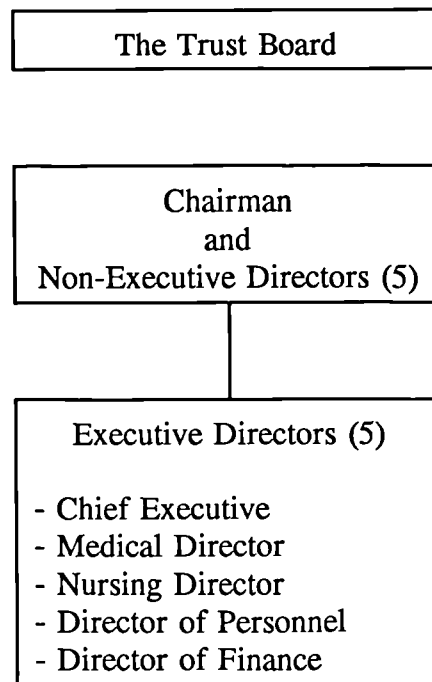
Background

The Brookside Hospital is situated in the South West of England. It is a 487 bed hospital spread across the following specialities:

- General medicine
- Haematology
- Renal medicine
- General surgery
- Trauma and orthopaedic
- Urology
- ENT
- Oral surgery
- Neonatal care
- Maternity
- Well Baby Cots
- Elderly care
- Gynaecology
- ITU - adult and paediatric
- Acute cardiac care
- Private

Brookside is basically an acute hospital with other small hospital sites. The hospital employs 2,771 people. The structure of the hospital is depicted in Figure 41:

FIGURE 41: THE STRUCTURE OF BROOKESIDE HOSPITAL



Prior to the introduction of a TQM programme, the Hospital adopted a policy of purpose; i.e., to respond to individual patient needs.

Aims of statement of purpose included achieving individual patient needs by:

- offering a comprehensive range of specialised healthcare services
- continuously improving the quality of our services
- being a progressive employer and by enabling staff to realise their full potential
- providing a high level of medical and professional education
- growing through the provision of quality services to an increasing number of patients

Data Collection

Data was collected through semi-structured interviews with the Quality Manager between 1993 and 1995. Each interview lasted for a period of 2 hours. The Quality

Manager provided the author with documentary evidence to back up his arguments. He gave the author the profile documentation of the hospital to read through over a period of seven days. The Quality Manager participated in the postal questionnaire survey. The collection of data at this particular site was concluded on 3/2/95. A total of 12 hours interview time was held with the Quality Manager.

The TQM Programme

The Total Quality Management Programme at Brookeside hospital, "The Way We Work", was a concept developed by the Chief Executive (CEO) in April 1990. It represents a structured approach to the implementation of TQM. It calls for continuous improvement for the benefit of patients and other clients, and encompasses techniques and tools for delivering quality services throughout the hospital. 'The Way We Work' also emphasises the need for all levels of staff to have ownership of the service delivery process.

In April 1989, the Chief Executive made an application to the Department of Health to become one of the initial TQM demonstration sites. His vision was to use the funding from this initiative to launch a radical quality drive throughout the hospital. He was allocated £70,000 by the Department of Health for the introduction of TQM into the hospital.

The Chief Executive contacted REL Consultancy, led by John Macdonald, who was formerly the Chief Executive Officer of Philip Crosby's Associates, based in Richmond. After an assessment of the different TQM approaches it was felt that Philip Crosby's philosophy was more practically based and would compliment the culture of the organisation. Thus, REL were appointed to assist the Hospital in developing its approach to TQM. Initial assessment by the consultancy firm was designed to assess the position of quality issues in the hospital. This led to the formation of a facilitator group comprising representatives from departments. Next came the development of the Trust Hospital's mission statement, policy, principles and values. The Hospital's quality policy states:

"We will identify and respond to the health needs of each of our patients and strive to exceed their expectations of us". It was hoped that this would be achieved through:

- (1) responding to individual patient needs
- (2) providing specialised healthcare services
- (3) improving the quality of services
- (4) empowering and enabling staff to realise their full potential
- (5) providing high levels of medical and professional education
- (6) providing quality services to enable growth

During this stage a 3 day training programme was organised by REL for 10 senior managers, including the CEO. The principles and tools of quality management and Crosby's 14 Steps to quality were covered. This group of 10 managers formed the Quality Improvement Team and were charged with responsibility for overseeing the quality programme throughout the Hospital. The REL consultants left after concluding a 3 day training session, delegating the continuity of implementation to the Quality Improvement Team.

In June 1990, a Quality Manager was appointed whose task was to further develop the TQM programme hospital- wide.

In November 1990, the Quality Manager trained a group of Nine management instructors who, prior to training, knew nothing about TQM. The group included:

- The Patient Service Manager
- Clinical Service Manager
- Nursing Service Manager
- Clinical Pharmacist
- A Senior Midwife
- Outpatient Service Manager
- Pathologist
- 1 Consultant
- Radiologist

They were taught, over a 3 day period, presentation skills, principles and tools of TQM and the mechanics of delivering a patient focused service. This group became the team of internal trainers, charged with responsibility for carrying out further training of staff in their respective departments.

In December 1990, another training session was organised for the Hospital's Board and senior medical consultants. The training programme were of 2 hour duration over a period of ten weeks. Forty medical consultants in total attended the training programme. The training session for the Senior Managers also focused on the principles of TQM, tools and techniques, the advantages of TQM in the Hospital's setting and the 14 Steps of Crosby.

In January 1991, a further six hours of training was organised for 550 employees on a multi-disciplinary basis. The Quality Manager stressed the importance of quality improvement in the provision of services, the need to improve cross functional communication and the need for staff to work within teams to meet the needs of patients as well as regulatory requirements. It was also stressed at this training session that staff should continually cooperate in identifying problem areas within the Hospital. Subsequent training sessions were organised until all 3000 employees were trained. A corrective action team was set up through which staff could raise any issues concerning poor quality. All a member of staff had to do, was to fill in a form and send it to the action team, which acknowledged receipt of the complaint within 24 hours. The member of staff was also informed within 48 hours of what actions were being put in place to resolve the problem. The corrective action team included:

- The Director of Service Contracts
- A Senior Medical Consultant
- Operations Manager
- Quality Manager

The corrective action team had responsibility for carrying out surveys to determine customer perceptions of services, and of organising monthly meetings with a cross section of staff to determine issues of non-conformance. Staff opinions were sought

on how to rectify problems of non-conformance. Based on the information received from staff, a working party was formed to solve the problems.

The TQM programme at Brookeside NHS Trust, "The Way We Work", is seen as a strategic framework for all. The Hospital's other quality initiatives, 'Patient Focused Care', 'The King's Fund Organisational Audit', accreditation initiatives such as 'BS5750' and 'Investors in People', all came under the umbrella of TQM.

In 1993, a number of refresher training sessions were organised. In October 1993, six sessions of three hours duration were organised over a one week period for departmental managers. In the training sessions, managers were asked to develop departmental action plans. The action plans were kept by the Quality Manager and used as a measure to monitor each manager's progress against the quality indicators. The action plans ensured that managers were committed to meeting their set targets. The plan was reviewed every year and new performance targets were set and monitored on a continuous basis. Refresher training sessions were used as a medium to remind departmental managers of the key principles of TQM and to reinforce the Hospital's commitment to exceeding patients' needs and expectations. The Hospital has an on-going refresher training programme for all staff to attend on a voluntary basis. Every two weeks, a quality improvement meeting is organised and attended by the Chief Executive. The meeting provides a forum for any member of staff to raise any quality issue.

In responding to the questionnaire, the Quality Manager of Brookeside NHS Trust Hospital felt that there were no 'most significant factors' inhibiting the progress of the Hospital's TQM programme. He felt that the barriers were either 'significant' or 'does not apply'. The significant factors specific to the hospital include:

- Hospital processes designed for the convenience of staff and practitioners
- Lack of personal involvement by upper-level managers
- Very much financially and contracts driven
- Lack of involvement by professional staff
- Lack of communication
- The hierarchical structure of the NHS

- Many other initiatives going on at the same time
- "We already practice quality; TQM is not important"
- Professional nature of the workforce
- Difficulties in establishing measures/quality indicators
- Standard setting seen as the basis for quality
- Resistance from professional staff
- Turf battles between departments
- Organisational segmentation
- Approaches to TQM mechanistic
- Organisational culture of over 40 years
- Failure of management to 'work the talk'
- Fear of losing jobs, i.e. redundancies

The quality manager identified 18 factors as inhibiting the Hospital's TQM effort. This is consistent with the findings from Southforke Hospital and again, in the author's opinion, represents a problem area for it. This seems to suggest that the Hospital's environment was not adequately prepared before the advent of the TQM initiative. What has happened is that the management of the Hospital has embarked on TQM without adequate preparation.

Other additional factors identified by the Quality Manager as constituting impediments to the effective TQM implementation within the hospital, not covered in the questionnaire include:

Levels of management below Chief Executive were not entirely committed to TQM

Customer care initiatives were not seen as important

Fortress mentality

Arrogance on the part of consultants

Lack of cross functional communication:- the patient moves horizontally across hospital functions, while communication within the hospital is vertical

Polarized conflict between managers and medics

Traditionally within the Hospital, customer complaints were seen as a nuisance; a tendency for professional staff to take offence if a complaint was made by a patient

There is not enough dissemination of information within the NHS

Discussion

It has been argued that an NHS-style TQM approach should be built on the following principles²⁰:

- clear purpose and shared values
- led from the top
- patient and client focused
- investment in staff

However, Brookeside's approach fails to integrate any of the aforementioned principles but emphasises the beliefs of the Quality Manager. The fundamental flaw of this case is the Quality Manager's erroneous assumption that TQM could be achieved through a hospital-wide training programme. This is referred to as the fallacy of programmatic change, i.e. failure to recognise the limited power to mandate corporate renewal through training which falls short of the holistic nature of TQM²¹. It is contended that every change programme, particularly TQM, should start with a clear purpose and shared values, an attack on the formal structures and systems and the realignment of internal processes to meet with the needs of the customers²². This cannot be said to be the case with the implementation approach adopted by Brookeside Hospital.

An essential element for TQM is putting in place the basic infrastructure which will create a climate conducive to continuous improvement and following this with training and education. Any approach to change not based on task alignment, starting at the periphery and moving steadily towards the corporate core is doomed to failure²³.

The author feels that this situation will arise sooner rather than later at Brookeside. The Hospital, like Southforke and Desmond, emphasises a rigid application of a top-down mechanism without winning the confidence and commitment of the shopfloor. Anchoring a TQM programme on the basis of training alone will lead to partial implementation. In addition, training programmes may target competence, but rarely do they change an organisation's pattern of coordination²⁴. Corporate training programmes frequently lead to frustration when employees get back on the job, only to see their new skills going unused in an organisation in which nothing else has changed²⁵.

The danger which emerges for instance in the NHS, is that employees begin to view further training as a waste of time and resources and, this undermines the involvement and commitment to change the TQM programme may have initially aroused.

Furthermore, the case reveals a lack of conceptual understanding of the requirements of a TQM change programme. To be able to achieve holistic TQM, Wilkinson and Witcher²⁶ note that four critical requirements must be fused together; leadership, teamwork, tools of TQM and internal marketing. However, the case does not integrate any of the four critical elements. In addition, Brookeside Hospital failed to create and put in place an appropriate infrastructure to support its TQM initiative. Its TQM approach represents a compartmentalized approach to organisational change which lacks constancy of purpose. The case suggests a need for a model of TQM to serve as a guide to the holistic implementation of TQM.

Cross-case Analysis

From the three cases the following may be inferred:

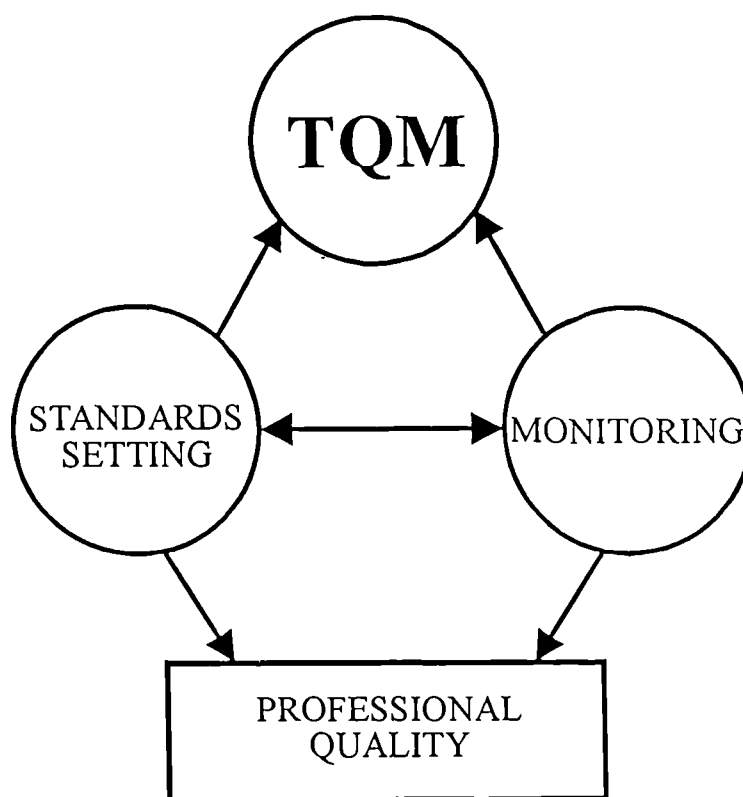
The three hospitals made the decision to go down the TQM route for two reasons. Firstly, they were among the 23 healthcare centres chosen by the Department of Health in 1989 to act as centres of excellence for the implementation of TQM and to facilitate the attainment of "quality" within the NHS. Secondly, their Trust status made the introduction of a TQM programme mandatory. Such a rationale stands in contrast to the motives for the introduction of TQM in the private sector where the need for a customer focus and improved competitiveness are of primary importance. Hence, the TQM initiatives were led by external pressure and not by the need to resolve intra-organisational problems arising from poor quality.

The differing implementation models adopted by the three hospitals represent individualised approaches based on the subjective understanding and experiences of the respective Quality Managers. Although Southforke and Brookeside seem to have held training sessions on the Deming and Crosby philosophies respectively, these were not major influences on the overall approach. What the author fails to understand is why such sessions were conducted in that way when it was known the two approaches to TQM were not to be integrated into the hospitals' overall schemes for quality improvement.

The approach adopted by Southforke was quality assurance-led, emphasising standards setting and monitoring. Desmond Hospital adopted the '3 Pebbles' approach, emphasising standards setting and monitoring. Brookeside adopted a diluted form of the Crosby approach and also emphasised standards setting and monitoring. Thus, it seems as although 'standards setting and monitoring' is seen by the three hospitals as the 'basis' for TQM. The individualised approaches adopted by the three cases can be modelled to show what seems to be the implementational pattern which followed:

FIGURE 42

PARADIGM 1 (CASE STUDY 1, 2 & 3)



What is evident is that none of the cases have doggedly followed any of the traditional/orthodox models of TQM. Although Brookeside Hospital used a consultancy firm which was Crosby led, its overall 'approach' cannot be termed "Crosby" because the hospital had not applied or implemented Crosby's 14 Steps to quality. Table 11, page 209 shows that the emphasis in the NHS is on the professional aspect of quality, standards and monitoring, rather than on an holistic application of quality. This is in contrast to the earlier study by Joss et al²⁷ which noted three types of quality in the NHS; technical, generic and systemic. That study also concluded that orthodox models of TQM have failed in the NHS because they were manufacturing based. However, the evidence, as revealed by the 3 cases and the survey of 12 other hospitals, repudiates this claim. What the evidence suggests is that orthodox TQM has not failed. It is yet to be tried. None of the 15 Trust Hospitals interviewed or surveyed had strictly modelled their TQM programme on any of the traditional approaches. What is evident amongst the approaches adopted in the NHS is what Brocka and Brocka²⁸ call 'cafeteria' management - a tendency by Quality Managers to

subjectively pick and choose from the TQM literature what they consider relevant to the context of their specific organisational culture. Whilst there is nothing intrinsically wrong with such an approach, the failure by Quality Managers in the NHS to systematically follow any prescribed approach has created a vacuum because of their lack of a conceptual understanding of the holistic nature of TQM. This, in turn, has led to the 'partial' implementation of TQM. Similarly, individualised models result in a lack of constancy of purpose in implementation because successive managers are apt to make changes which affect continuity in the implementation process. In contrast, a systematic approach would provide continuity within a structured plan. The author is of the opinion, that this preference for individualised approaches is responsible for the avalanche of 'pitfalls' to TQM in the NHS. Unless Quality Managers adapt their models to take cognizance of the holistic requirements of TQM, the attainment of quality will remain a pipe dream.

It can also be discerned from the case studies that due to the external imposition of quality, the respective Quality Managers had not prepared their hospital environments for the changes required for TQM at the onset. There was inadequate planning and awareness sessions to sell the 'ethos' of TQM to the workforce. Hence, most NHS employees saw TQM as a government programme designed to rationalise services. It has been argued that it is fundamentally essential that, at least six months before an organisation attempts to implement TQM, all key parties, particularly senior/middle managers and supervisors, must be fully aware and involved in understanding TQM²⁹. This was not done in any of the three hospitals, although staff audits were carried out to determine shortfalls in services, this is not the same as communicating the 'need' for TQM and winning employee commitment to the process prior to the introductory process. Hence, the hospitals established no clear case for action on TQM. The case for action should state 'why' the organisation must do TQM. It should be a compelling argument, supported by evidence, spelling out the cost of doing anything short of TQM, and what the organisation stands to gain from TQM. However, the management of the 3 hospitals readily appointed Quality Managers from outside the NHS to implement TQM without any recourse to winning staff support for the initiative. What is most striking

from the cases, is the failure to carry out an assessment exercise to determine the hospitals' strengths and weaknesses and also their readiness to embark upon TQM. As the author has earlier stated, the NHS is primarily an organisation structured along functional lines. A prior assessment exercise would have revealed the need to make some substantial changes to the way 'work gets done' within the hospitals, the need to realign the culture to accommodate the ethos of TQM and the need to motivate staff through a change in the value system; moving away from the classical structure to a more holistic flatter structure which would have, as its central managerial principle, Follett's definition of management as "getting things done through people"³⁰. Thus, it is the author's belief that the failure to adequately plan for the TQM programme led to the adoption by the three hospitals of an ill-defined strategy for the implementation of TQM.

Furthermore, there appears to be a failure on the part of the Quality Managers to address the issue of culture change. As the case studies reveal, TQM appears to have been 'bolted-on' to the existing culture. This means that Quality Managers in the NHS have failed to assimilate the paradigmatic change that TQM entails. This may also be attributed to the fact that the 'Gurus' and other quality writers have failed to adequately contextualise any empirically determined format for culture change. Additionally, the three hospitals established an infrastructure to support the TQM programme. They set up a quality steering committee to manage and oversee the programme, a quality improvement team and a team of facilitators to help with the facilitation of TQM. The hospitals also involved their departmental managers and assigned to them responsibility for further training of their respective staff but, what is less evident from the cases, is the level of involvement by senior management. The Quality Manager of Southforke told the author: "I spent most of my time running after the Trust Board, particularly the Chief Executive, to ensure he stays committed to the TQM process". She believes that having a steering committee to oversee the TQM programme was not such a good idea because if it lost interest then it could entirely derail the TQM programme. The author also established from the Quality Manager at Desmond Hospital that, "the steering committee was usually very enthusiastic at the beginning but that this

enthusiasm waned with time and the Trust Board turned its attention to other matters". This is congruent with the view of another Quality Manager of a mental hospital unit who commented that "'quality' gets mentioned at Trust Board meetings only if the 'debts and credits' add up. If not, quality takes a secondary role". What the evidence suggests is that whilst the need for a steering committee is seen in the TQM literature as a compulsory requirement for the TQM process, Quality Managers within the NHS are not so sure that it is a good idea because of the failure of the steering committees to sustain their enthusiasm and commitment to TQM over the long run; thereby jeopardising the whole programme.

The Quality Managers of the three hospitals all hail from outside the NHS. They came from the private sector without any knowledge of how the NHS operates. The other 12 hospitals surveyed by the author had eight formerly trained nurses as Quality Managers and four from the private sector. Thus, most Quality Managers within the NHS were either formerly nurses or from the private sector. One Quality Manager, a former nurse, pointed out to the author that most directors or senior nurses were given the remit to manage quality not because they are the most qualified to do the job, but because "senior nurses in most cases have no other function to perform". The tendency to choose people who have had no previous training in quality management nor the experience of managing a TQM programme within a hospital setting has necessitated the need to opt for 'individualised' approaches to TQM. These Quality Managers find it difficult to understand and assimilate the technicalities of some of the traditional approaches to TQM; particularly the philosophies of Deming and Juran. It is no wonder that Brookeside's approach to TQM represents a partial imitation of what is known as Crosby's philosophy. This shows that there is a lack of a conceptual understanding of what is essential for the effective implementation of TQM. This apparent limitation calls for a healthcare model that is flexible and easy to understand and follow, without any quality jargon which these managers will have to buy into and relate to. The flexibility of such a model will allow for adjustments to suit the specific needs of individual hospitals.

Apart from the Quality Manager of Brookside Hospital, the other two have since left their jobs. The Assistant Quality Director of Desmond Hospital was made redundant, whilst the Quality Manager of Southforke Hospital moved to another job. The author was able to arrange a meeting with the ex-Quality Manager of Southforke to find out why she left. In answer to the question, she stated that her former job had become untenable because of the failure of the Chief Executive to continually support the TQM initiative. She felt the Chief Executive of the hospital was more contract focused rather than showing a continued commitment to the TQM programme. The Chief Executive felt the hospital was already a quality organisation and needed to re-focus its attention and energy on winning service contracts. The lesson to be drawn from this, is that most Chief Executives and their Trust Boards are not overtly committed to TQM. What message is being sent to the workforce when an Assistant Director of Quality is made redundant; we do not care about quality.

In addition, the three cases are significant examples of the improper implementation of TQM. The strategies adopted are consistent with the traditional quality assurance paradigm, which emphasises the superiority of 'professionals'. Thus, the setting and monitoring of internally set standards have pre-eminence over patient needs and expectations, whilst no attempt is being made to incorporate the monitoring of the patients' journey through the process or of at least ensuring that the standards which were set were based on patient needs and expectations. Furthermore, the three cases ignored Deming's warning:

"If attention is focused on performance measurements and standards then continuous improvement is unlikely to be achieved"³¹

Similarly, Laza and Wheaton³² have developed the following principles of TQM:

quality is a customer perception
quality is dynamic

quality is process oriented
quality requires total involvement

They indicate that failure to meet the customer's expectation of standards of quality results in dissatisfaction for the customer and usually indicates poor quality. Therefore, it is vital that standards are set with the customer in mind³³. However, as the implementation process of the three case study hospitals shows, standard setting has been drawn mainly from a professional perspective without recourse to patient in-put. This confirms that the historical paradigm of quality of care still exists in the NHS and that the issue of a more customer focused service is mere 'rhetoric'. It is obvious that the NHS has failed to adapt to the ethos of TQM due to improper and partial implementation of TQM.

The management in each hospital was aware that it was not alone and unique in facing problems relating to the provision of quality healthcare. In consequence, the three sets of management seemed in agreement as to the barriers which they were seeking to surmount by recourse to the implementation of TQM within their respective hospitals:

TABLE 22**COMMON BARRIERS IN THE 3 CASE STUDIES**

Significant Factors Common to Southforke and Desmond
<ul style="list-style-type: none"> • Hospital process designed for the convenience of staff • No coordination and support from the centre • A tendency to deal with specific episodes that constitute bad clinical quality
Significant Barriers Common to Desmond and Brookside Hospitals
<ul style="list-style-type: none"> • Lack of personal involvement by upper level managers • Approaches to TQM mechanistic • Organisational culture of 47 years
Significant Barriers Common to the 3 Hospitals
<ul style="list-style-type: none"> • Standard setting seen as the basis for quality • Turf battles between departments • Organisational segmentation • Failure by management to work the talk

Source: Based on the Second Questionnaire which dealt with the 40 generic factors impeding TQM. Compiled by the author, 14/1/1995.

From the above table, it can be deduced that the problems and opportunities to improve quality within the NHS further relates to problems of Process, Culture and Structure. However, these are managerial activities, because it is management's responsibility to ensure that the NHS is process oriented, that its culture is re-oriented to accommodate the ethos of TQM and that a flatter organisational structure is required if the dynamics of the NHS are to be mobilised towards the continuous improvement of patient care. It is imperative, therefore, that managers who have the responsibility to implement TQM in the NHS start their TQM effort from the premise that the requirements, needs and expectations of the customer are understood and met. They need to move from the 'prescribed perspective' of professional quality to the 'felt perspective' i.e., rendering services according to customers' felt needs and expectations rather than according to the 'professionals' ordainment. Therefore, the key to effective patient service resides in:

- identifying the specific requirements, needs and expectations of the patient
- continuous improvement of all organisational processes
- delighting the patient
- continuously improving services - the Patient/Staff interface

The belief should be that providing quality service to external customers, 'the patient', starts with treating the employees right. This will have a knock-on effect on how the patient is treated, and as a consequence result in an optimised system where staff would not be put in the situation where they have to say sorry to the patient for falling short of meeting their needs. This represents the ideal state of continuous quality improvement.

On the question of why 'individualised' models, based on their personal experience, were adopted by the three Quality Managers, the common response was that existing models of TQM were not sufficiently comprehensive to deal with complex organisational requirements. A further common complaint among the three Quality Managers was the rigidity of the application which orthodox models of TQM required. For example, the Quality Manager of Southforke stated to the author that any rigid application of TQM will fail in the NHS because of constant governmental intervention in the form of directives. Therefore, for any model of TQM to succeed it must be sufficiently 'flexible' so as to accommodate other initiatives as required by legislative statute.

The case studies suggest a vital factor for the successful implementation of TQM, not recognised in the TQM literature: "the demonstrated commitment, leadership, and the will to succeed personified by the Quality Managers". Even though one lost his job, and one other has since moved on, whilst they were in their health service jobs they showed exemplary commitment. In other hospitals, the author spoke with committed and well-informed Quality Managers who were fanatical evangelists of the quality movement. However, their efforts were being hindered by institutional scepticism about the whole idea of TQM; particularly the absence of managerial commitment.

The case studies reveal that hospitals embarked on TQM without any acquaintance with all of its characteristics and their respective Quality Managers never went to the length of visiting any hospital which had been successful in adopting TQM to learn of its implementation process, the problems to be expected and the adverse side effects which ensued if thorough preparation was not undertaken. Thus, they embarked on TQM with no guidelines as to its application to healthcare. However, none of the Quality Managers in the three cases saw the implementation of TQM as a problem, even though their approaches smack more of a quality assurance model.

From the three cases, it is important to note a number of barriers to TQM which were specific to each hospital. Thus, it is a dangerous precedent, as noted earlier, to consider the barriers to implementation as generic; even though some commonalities were identified. The point is, that any implementational model, or training programme for TQM, should be adapted to fit the specific characteristics of that organisation into which it is being introduced. The generic application of TQM is wrong. The implementation of TQM should be context specific. Nevertheless, what is common to the 3 cases, is the use of individualised approaches to TQM. This has resulted in partial implementation of TQM because none of the hospitals have met the holistic requirements of TQM which represent the involvement of all strata of personnel within the organisation. As the author conducted the interviews, he noted the non-participation of the professional staff in the TQM process. This raises the question of "How TQM could succeed without the professional staff being part and parcel of it?". Although the individualised approaches centre around standard setting and monitoring, TQM is a holistic and systematic process that adheres to measurable standards that reflect the needs and requirements of both internal and external customers. The setting and monitoring of standards in the NHS has the disadvantage of expressing only the 'will' of staff. Therefore, it could be argued that the preference on the part of these hospitals for individualised models is due to the lack of a specific model for implementation which will serve as a guide and as an entry point into TQM. In addition, as two of the cases have shown, Southforke and Desmond Hospitals, there has been a change of direction since the new Quality Managers came on board.

They have opted for their own individualised approach. This confirms the fact that individualised approaches lack continuity as successive managers would chop and change the process of implementation to suit their idiosyncratic understanding; whereas a specific model would have offered a continuity of purpose. Had this been done, Deming's constancy of purpose requirement would have been met. The obvious disadvantage of individualised or personal models lies in the need for a context specific model that would serve as a structured and systematic approach to the continuous improvement of quality across the NHS. The changes of quality personnel in both Southforke and Desmond Hospitals, are congruent with the findings of Joss et al³³, who noted that some hospitals have changed their TQM approaches on more than one occasion. The reason for this may be attributed to constant changes of Quality Managers.

Where is the NHS in relationship to TQM?

In order to systematically assess 'where' the NHS stands in relation to quality, the author used the Crosby Quality Management Maturity Grid (QMMG)³⁴:

FIGURE 43

QUALITY MANAGEMENT MATURITY GRID

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

Source: Crosby (1979) 'Quality is Free'

The QMMG was chosen because it represents an effective diagnostic and evaluative tool to determine where an organisation stands in relation to quality³⁵. The grid encompasses a progressive movement through five stages, which Crosby claims an organisation goes through in its quest to achieve a fully developed Quality Management Programme. This is achieved at the stage of certainty (stage 5), which implies the presence of quality management as an integral part of the organisation's culture. The five stages of the QMMG are:

- (1) Uncertainty: Problems are dealt with as they occur. No comprehension of quality as a management tool.
- (2) Awakening: Management begins to ask why they do not have quality. A quality leader is appointed and teams are formed to attack quality problems.
- (3) Enlightenment: Corrective action and communications are established; problems are resolved in an orderly manner.
- (4) Wisdom: Defect prevention becomes the organisation's main value system.
- (5) Certainty: Quality management becomes part of the culture and a continuous activity.

For Crosby, the definition of quality management in any organisation is the consensus view of managers and the professionals. He states that "quality is too important to leave to the professionals. Professionals must guide the programme, but the execution of the programme is the responsibility of the people who manage the operation"³⁶. In line with this view, a questionnaire based on the Maturity Grid was designed and sent out to the 23 Quality Managers. The questionnaire specifically asked the Quality Managers to 'tick' the appropriate box on the Grid to indicate 'where' their organisation was, after five years down the TQM route; as it has been argued that organisations should start seeing the benefits of TQM in five years³⁷. Of the 23 questionnaires sent out, fifteen were returned, representing, yet again, 65 percent response rate.

The analysis of the responses is based on Crosby's scoring format of awarding a point value for each stage according to its number; one point for an Uncertainty mark, two points for each Awakening, three points for each Enlightenment mark and so on. The maximum score according to Crosby is 30. If an organisation attains that it should have an awards dinner... The analysis of the results show the scores recorded by each of the 15 hospitals.

TABLE 23**SCORES OF 15 NHS HOSPITALS IN RELATION TO QUALITY
USING THE QMMG**

Hospitals	Comments by the Quality Managers	Scores	Total	Percentages
1*	The Quality Manager assessed Desmond's TQM programme as spanning Stages 1, 2 and 5 i.e. Uncertainty, Awakening, and Certainty	11	30	37 %
2*	The TQM was assessed overlapping the stages of Uncertainty, Awakening and Enlightenment, although largely at Awakening stage	10	30	33 %
3*	The TQM assessed as spanning stages of Enlightenment and Wisdom, but largely at the Wisdom stage	15	30	50 %
4	The TQM programme spanned the stages of Awakening and Enlightenment but, predominantly Awakening	11	30	37 %
5	TQM programme overlaps the stages of Uncertainty, Awakening and Enlightenment, but largely in the Uncertainty stage	8	30	27 %
6	The TQM programme spanned stages of 1, 2 and 3 but largely at the stage of Uncertainty	8	30	27 %
7	The Quality Manager assessed the hospital TQM programme to be at the stage of Enlightenment	15	30	50 %
8	TQM assessed as spanning the stages of Uncertainty, Enlightenment and Wisdom. Cannot be said to be largely at any particular stage	9	30	30 %
9	Largely at the Wisdom stage	20	30	67 %
10	TQM programme overlaps between the stages of Awakening and Enlightenment	13	30	43 %
11	The Quality Manager sees the TQM programme as largely in the Enlightenment stage	15	30	50 %
12	The TQM assessed as spanning the stages of Awakening, Enlightenment and Wisdom. Largely at Awakening and Enlightenment	14	30	47 %
13	The TQM process spans the stages of Enlightenment, Wisdom and Certainty. Largely in the stage of Certainty	26	30	87 %
14	TQM spanning the five stages 1, 2, 3, 4, 5	14	30	47 %

Hospitals	Comments by the Quality Managers	Scores	Total	Percentages
15	The TQM is seen by the quality manager as having movements between the stages of Awakening, Enlightenment and Wisdom but, largely at the Enlightenment stage	14	30	47%

Source: Compiled by the author, 15/1/1995

- 1* represents Desmond Hospital
- 2* represents Southforke Hospital
- 3* represents Brookeside Hospital

The pattern of responses as shown in the table is consistent with Crosby's view that 'the Grid represents a fluid process; over time there may be movements in both directions'³⁸.

Analysis

Table 23, indicates that nine hospitals have made meaningful progress in TQM. This means that they have achieved, in five years, between 43-87 percent quality maturity. Although Crosby does not set targets for achieving quality maturity, targets for the implementation of TQM are given by some business writers as five years. Thus, it can be argued that, for nine hospitals to score more than 40 percent maturity in TQM, which is itself an alien organisational strategy in the NHS, is a noteworthy achievement despite the barriers confronting these hospitals in their search to be a true quality organisation. However the result refute, and are inconsistent with, the findings of Joss et al who concluded in their evaluation of TQM initiatives in the NHS that:

- TQM has failed in the NHS
- Only 2 TQM sites have made a significant progress in TQM

Nonetheless, the QMMG analysis reveals that nine hospitals, rather than the 2, suggested by Joss et al, have made some progress in TQM. The author is of the opinion, that an average score of between 43 and 87 percent quality maturity scored by the nine NHS hospitals, which implemented TQM without guidelines as to its application to healthcare, is meaningful progress. However, six hospitals seem to be

struggling with their TQM programmes. They failed to achieve at least 40% maturity. This result also confirms the need for a systematic model that would facilitate the effective implementation of TQM across the NHS.

It is interesting to note that two of the case studies Desmond and Southforke Hospitals are among the six hospitals having problems with their TQM programme. They achieved 37 percent and 33 percent quality maturity respectively. The Quality Managers of the two hospitals scored their hospitals as follows:

Desmond Hospital - 11 points out of 30 representing 37% maturity

Southforke Hospital - 10 points out of 30 representing 33% maturity

What this suggests is that the two hospitals, when viewed from the perspective of their Quality Managers, are not 'excellent' in TQM. This is in contrast with the view of the head of the quality team at the NHSME who informed the author that Desmond and Southforke were two of the three excellent TQM sites in the NHS. What the QMMG results confirm is that, although nine hospitals are progressing, a number of other TQM sites need help to facilitate their TQM initiative. If the hospitals delineated by the NHSME to be centres of excellence are not doing well, a lot is left to be desired in terms of achieving excellent TQM. The third case study, Brookeside Hospital only managed 50% quality maturity. This proves that there is an inadequate information flow and coordination of quality activities between the NHSME and Quality Managers in the NHS. As a result, the NHSME quality team is not aware of which hospitals are pioneering 'excellence' in quality. Particularly disgraceful is the fact that the quality team was not aware of the excellent strides made in TQM by two hospitals who had scores of 67% and 87% maturity respectively. These latter two hospitals, as the analysis indicates, represent excellent centres for TQM; in advance of both Desmond and Southforke Hospitals. The lack of coordination of TQM initiatives in the NHS, by the NHSME, was noted by Joss et al as one of the reasons for failure of TQM in the NHS. The author could not agree more. In a public sector health organisation, where changes in policies and organisational strategy is externally driven, it would have been expected that the DOH, through the NHSME, would take a central role in seeing that TQM succeeds. However, what seems obvious is that the NHSME has lost

interest in TQM. The progress being made by nine hospitals shows that TQM has not failed in the NHS. However, in the author's opinion, improper implementation has hindered progress.

Furthermore, it is easy for people, particularly academics, based on their 'gut-feel' rather than on empirical evidence, to erroneously suggest that TQM is non-existent in the NHS, or that the management of the NHS has no clue as to the nature and requirement of TQM. As the author has identified, one of the problems is constant governmental interventions in the form of new initiatives which have, in some cases, derailed TQM entirely or impeded progress and further resulted in confusion as to what is the 'best' approach to meeting patient needs. Hence, Quality Managers, in their desperate attempt to meet regulatory guidelines, have not had the time to adopt a systematic approach to TQM. In consequence, what is prevalent in the NHS are ad hoc, highly individualised approaches to TQM which have inadvertently led to the improper implementation of TQM. For example, the process of TQM implementation in both Desmond and Southforke Hospitals was primarily based on standard setting and monitoring rather than on a patient focused approach. From the results of the QMMG, it is clear that their preference for 'standards setting and monitoring' has effectively hindered progress in quality in the two hospitals. It can therefore, be argued that, what is required for TQM to function more successfully, is a comprehensive, concise and holistic model for the implementation of TQM in the NHS. This will help facilitate the progress; "to the stage of 'Certainty' in the Quality Management Maturity Grid. The Certainty stage is where 'quality' management becomes part of the culture and a continuous activity. Such a model would enable the integration of regulatory requirements. The view that a holistic model for TQM is required for the NHS is consistent with earlier studies. Joss et al³⁹, noted that a more 'eclectic approach to quality is required than that offered by 'orthodox' TQM'. Whilst for Pfeffer and Coote, 'a new democratic model that would recognise the difference between commercial and welfare transactions ... is required'⁴⁰. However, they failed to note 'why' either an eclectic or democratic model for TQM is required. Nonetheless, the author is of the view that, based on the identified pitfalls, the structural complexity of the NHS, and as indicted by the QMMG analysis, a model integrating TQM and the Patients' Charter should be adopted as a formal implementation requirement for the whole of the NHS. This is because the Patients' Charter would afford the measurable

quality standards against which hospitals could be monitored. This approach would enable a results-oriented quality initiative throughout the NHS. In addition, all other initiatives would have the improvement of quality of care as their central focus; which would be integrated under the 'total' umbrella of TQM. This will enable a contextual specific approach to TQM; thereby focusing the energies of the whole workforce on the success of any TQM project.

Furthermore, as earlier identified in the case studies and the questionnaire survey, there is a failure on the part of the Quality Managers to address the issue of 'culture change'. The author is of the opinion, that for any model of quality improvement to work in the NHS a fundamental change in its institutionalised culture is required. However, it is evident that currently the implementation of TQM in the NHS is 'bolted-on' to the existing culture. Therefore, to facilitate a change in the culture of the NHS, to make it supportive of TQM, a series of managerial practices must change in order to permit the development of a suitable environment in which a holistic model of TQM can then be implemented.

TABLE 24

MANAGERIAL PRACTICES THAT HAVE TO CHANGE IN THE NHS

FROM	TO
Focus on government initiative	Patient focus
Controlled workers	Empowered, involved process workers
Hierarchical	Flatter team organisational structures
Activity based	Results/process orientation
Supervising and managing	Mentoring, coaching and leading people
Finance and contracts	Operations centred on the patient
Function (vertical)	Processes (horizontal and cross functional)
Fortress mentality	Visionary leadership
Bureaucratic processes	Simple, streamlined processes

Source: Nwabueze, U. (1995)

The author hopes that were these managerial changes to be made in the NHS, the culture will change as well. As employees understand the vision for a better future, with better capabilities and results, they will be able, both individually and as members

of teams, to contribute positively to making the vision of continuous quality improvement a reality. However, the change in managerial practices is a necessary, but not a sufficient, reason for TQM to succeed in the NHS. Added to that, is a need for a demonstrated commitment to TQM from both the CEO and the service directors who must bring the medical consultants on board the TQM train. This is because powerful consultants can block quality from succeeding but, if they are on board, they will help enormously because they would be able to carry a lot of the clinical support staff into the TQM fold. The same goes for the nursing staff, in particular senior nursing managers, who would be able to win the support and commitment of their colleagues. Thus, the argument being posited is that, despite culture change, a context specific model of TQM would still not succeed without the support of the senior professional members. Hence, top management has to be supportive of the quality initiative and elicit support from all staff. A piecemeal approach to TQM will not work because staff will ignore, or deliberately sabotage, the implementational process.

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CHAPTER SEVEN

EMBARKING ON TQM

Before proceeding to a model for the implementation of TQM, which the findings of the study suggest is required to facilitate the progression to the future desired state, i.e. the state of continuous improvement, the author feels compelled to establish the critical success factors for the implementation of TQM in the NHS. It is fundamental that models for the implementation of TQM should be problem-specific, i.e. be designed to solve empirically defined problems, but also it is essential that they exhibit the essential characteristics for success.

Against this background, a fifth questionnaire was designed, and modelled upon the eight critical success factors for the successful implementation of TQM identified by Porter and Parker¹. Those factors are:

- (1) Necessary Management Behaviour: clear leadership, commitment and vision is required of senior management.
- (2) A strategy for quality implementation.
- (3) Organising for quality: quality requires an organisational structure which harnesses the full potential of the workforce.
- (4) Communication for quality: provides awareness, involvement and reinforces the quality message.
- (5) Training and education.
- (6) Employee involvement as a key determinant of the successful programme.
- (7) Process management as a key determinant of TQM.
- (8) Quality techniques such as SPC, quality costing and benchmarking necessary to reduce variation.

Twenty-three postal questionnaires were sent to the Quality Managers of the 23 TQM sites. The questionnaire asked the Quality Managers to simply answer yes or no to whether each of the eight factors was a critical success factor in their hospitals' TQM programme. In addition, they were to add any other factor(s), which they considered 'critical' for quality to succeed in the NHS. Of the 23 postal questionnaires 20 were returned, representing an 87% response rate.

ANALYSIS:

TABLE 25

**RESULTS OF RESPONSES FROM 20 QUALITY MANAGERS IN THE NHS
TO THE CRITICAL SUCCESS FACTORS IDENTIFIED BY
PARKER AND PORTER**

Parker & Porters' Critical Success Factors	Responses				
	Yes	Percentage	No	Percentage	Total (n)
1	16	80%	4	20%	20
2	18	90%	2	10%	20
3	14	70%	6	30%	20
4	17	85%	5	15%	20
5	16	80%	5	20%	20
6	18	90%	2	10%	20
7	12	60%	8	40%	20
8	8	40%	12	60%	20

Whilst 80% of those Quality Managers in the NHS responding to the fifth questionnaire feel that leadership and commitment from the top is a necessary condition for TQM to succeed in the NHS, 20% do not agree. The Quality Managers point out that leadership and commitment from the top is a necessary but not a sufficient condition for success. They note that, if senior managers have really understood the quality message then they can demonstrate the desired change by changes in their behaviour; in particular in the way in which they manage. The Quality Managers note that this is not currently happening in the NHS and that, in the absence of a radical change in the behaviour of senior managers, the NHS is "just going through the motions" with regard to TQM.

Therefore, it is critical that, prior to the adoption of TQM, the reasons for going down the quality route are very well thought out by senior managers and honestly discussed at the set up stage. By so doing, money can be saved and disillusionment with quality prevented. In addition, the Quality Managers noted that the leadership and commitment of consultants is important to the survival of TQM. The contention is that medical consultants deal with patients, whilst senior managers are far removed from the customer. If the consultants understand and are committed to quality, it will have a knock on effect on how the 'patient' is treated. In other words, Parker and Porter's first critical success factor when applied to the NHS is inexhaustive. For TQM to succeed in the NHS, leadership and commitment is required at various levels of the organisation; the board level, directorate levels, service managers level and the professional level. This is because of the hierarchical structure of the NHS. In the words of one Quality Manager, the Chief Executive must show exemplary leadership and commitment to quality. The leadership must be supportive of the TQM culture and shared with staff; macho management no longer works.

For Parker and Porter's critical factor II, 90% of Quality Managers acknowledge the need for a strategy for the implementation of TQM. However, as the three case studies in Chapter Six indicated, the Quality Managers had no strategy in place prior to the implementation of TQM. They seem to have embarked on TQM without any prior acquaintance with, or conceptual understanding of, the holism of TQM. In the author's opinion, a systematic strategy is required before embarking on TQM but, of more importance, is the need for an adequate infrastructure to support and sustain the drive for TQM. In addition to Parker and Porter's critical success factor II, the Quality Managers noted the need to put adequate systems in place before embarking upon a TQM initiative and a robust audit system to support it. The robust audit system, they suggest would involve:

- Setting standards
- Sharing standards
- Measuring outcomes on an ongoing basis

The author fully supports a system and an infrastructure to sustain TQM, because no matter how organisations radically redesign and streamline processes, if the system is

not optimised it will fail to deliver a quality service. Deming² has argued that poor quality is due to 85% failure in the system. This contention was verified and found to be true in Chapter Five where the analysis of the pitfalls of TQM in the NHS revealed four elements of the managerial activity to be responsible for TQM problems in the NHS. Hence, for TQM to succeed, not only is a strategy for implementation required but also a change in managerial activities via systems management is a fundamental requirement. Thus, the NHS should not only concentrate on redesigning processes, it should also redesign and optimise the entire system of INPUT → PROCESS → OUTPUT, in order to ensure that there is indeed a departure from the status quo. In an organisation as hierarchical as the NHS, a redesigned and optimised system that would lead to a flatter organisational structure is required. This would facilitate the flow of communication between the various directorates, thereby ensuring a 'joint quality agenda' for every member of the workforce.

For critical success factor III, 'quality requires ... an organisational structure which harnesses the full potential of the workforce', 70% of the respondents felt the need for an organisational structure for TQM. One Quality Manager noted that 'the TQM structure in most hospitals in the NHS is such that most Quality Managers do not have high profile positions in order to effect changes'. She advocates a structure where the Quality Manager should be seen by the rest of the workforce as the 'sidekick' of the CEO. This means that the Quality Manager has the full support of, and reports directly to, the CEO. From such a position of strength, the Quality Manager could harness the full potential of the shopfloor staff and win the respect and support of the other service managers. Furthermore, the respondents suggest that "the organisational structure in the NHS is a carry over from the bureaucratic NHS". Most managers who are now directors were trained as administrators rather than as managers. Thus, authority within the NHS is still centralised. This has led to a culture in which people do not take initiatives. The majority of Quality Managers note that the way forward is to move towards a flatter organisational structure which would entail a change in culture and the empowerment of staff to 'take risks'; but not medical risks. Taking risks here would imply having a forum whereby good ideas are explored from whatever quarter they come and not just exploring those which emanated from the upper levels of a rigid hierarchy. For example, at the time of writing, one Trust hospital had axed the positions of assistant directors and some service managers over a period of twelve

months. The post holders were simply given early retirement. This action, according to the hospital's Quality Manager, would bring about 'a flat paradigm structure required for the effective implementation of TQM'.

For critical success factor IV: "Communication for quality". The need for communication for quality is a rather obvious factor for the successful implementation of TQM in particular in an alien organisation such as the NHS, where the terms 'customer' and 'quality' are rather vague phenomena. From the case studies, it can be discerned that the implementation of TQM lacked adequate communication when it came to conveying to staff the idea/philosophy of TQM. The Quality Managers made no prior attempt to communicate widely across their respective hospitals the 'why' and 'what' of TQM. Thus, in most cases, employees came to see TQM as a managerial ploy to facilitate downsizing. As one Quality Manager noted; 'a two way communication system in the form of negotiating and influencing, supporting and guidance is central to TQM's evolution in the NHS'³, whilst another pointed to the fact that 'both cross functional and horizontal communication does not exist in the NHS'⁴. They contend that quality should become a way of life; demonstrated in the behaviour of senior managers and facilitated through cross functional and horizontal rather than vertical relationships. 85% of the respondents note that good communication is the key, whilst 15% feel that ensuring that all employees are aware of the hospital's values/beliefs are more important than communication for quality. Nevertheless, communication is a vital component of the TQM process. It is the key to providing the knowledge, assurance and trust required of top management in order to create a joint agenda with the workforce. A failure to communicate extensively across the organisation on the 'why' and 'what' of TQM leads to 'suspicion' and scepticism amongst the workforce of top management's intention. In the author's opinion, the failure to communicate both with internal and external customers has led to many of the failures of TQM. Communicating within and across functional boundaries would enable the organisation to drive out fear and break down barriers between departments. Top management must break down the class distinctions between consultants, nurses, paramedics and non clinical providers if TQM is to succeed in the NHS. This can only be achieved through a dependable communication system.

Furthermore, in response to Parker and Porter's critical success factor V; Education and Training should cover all employees as part of an ongoing process suited to each group's needs. Although 80% of the respondents agreed that education and training was significant for the implementation of TQM, half of these felt that training and education is very piecemeal within the NHS due to a lack of finance and time on the part of staff to attend training sessions. But, they agreed with Parker and Porter that education and training should be done on a needs assessment basis rather than organisation wide; the contention being that whilst shopfloor staff know what are the problems, they lack the delegated authority to effect changes. However, the author is of the opinion that one of the failures of TQM in the NHS is inadequate training for senior managers. There seems to be an implicit assumption that senior managers, particularly service directors, know about quality; a fact that is not supported by the evidence. The author's suggestion, which Parker and Porter fail to indicate, is the need to extensively train and educate top managers on the basics of TQM in order for them to be aware of and to acquire conceptual and holistic requirements of TQM.

For Parker and Porter's critical success factor VI, 'Employee involvement ... is a key determinant of a successful programme'. 90% of the respondents felt that employee involvement was a key factor for TQM. The remaining 10% of the respondents were of the opinion that top management's involvement was paramount to the involvement of employees because only the positive influence of top management can bring about culture change in the hierarchically structured NHS. One Quality Manager quoted Deming's question, "why involve people who can only make minimal changes to the system, whilst the status quo remains very much intact"⁵. She suggested that employee involvement should be further down the line about 1-2 years into the TQM programme. The first eighteen months of the TQM process should be devoted to management involvement⁶. The author agrees with the Quality Manager. As the author found, in the NHS the problem is not with employees and middle level managers but with top management and the professional staff. The involvement of senior managers and the professional staff should be one of the key elements for the successful implementation of TQM. They should be involved from the onset of the process.

Table 25, also indicates that in response to critical success factor VII: 'Process management and systems are a key part to TQM'. Only 60% of Quality Managers in

the sample felt that process management and system are a key part of TQM. This is consistent with Ovretveit's suggestion that "process management is the most neglected aspect of quality in the NHS"⁷. This means that NHS employees fail to recognise their work activities as processes which impart on each other. The understanding of how work flows through the system is critical in the NHS, where the provision of service is distanced from the customer. There is a fundamental need to reappraise the process of service provision in the NHS. The Patients' Charter is a way in which the government is trying to refocus attention on process management and this has met with stiff resistance from the professional staff, who consider the Charter as failing to integrate the important elements of the service, i.e. clinical outcomes. As one Quality Manager noted, "complex and bureaucratic work processes have hindered his organisation's TQM programme"⁸. However, the author would add that in as much as streamlined processes and robust systems for monitoring and measurement are a key requirement of any TQM programme, in a healthcare setting, the 'system' should not be devoid of process improvement.

In relation to Parker and Porter's critical success factor number VIII; "Quality techniques such as SPC, quality costing and benchmarking are necessary to reduce variation". 60% of NHS Quality Managers disagree with Parker and Porter that quality techniques are necessary to reduce variation in the NHS. They contend that what is required in reducing variation in the NHS is that:

TQM should not be a bolt-on to the organisational structure, it should be part of organisational development linking behavioural change to organisational change but, emphasising systems management. This implies that most Quality Managers have so far failed to address the stratified culture of the NHS as a special cause of variation in TQM.

Although seven of Parker and Porter's critical success factors were seen by 20 Quality Managers as significant and of importance to ensuring the successful implementation of TQM in the NHS, the author suggest that there is neither enough time or nor staff to carry out three of the essential seven factors satisfactorily; in particular, numbers 4 (communications for quality), 5 (education and training), 6 (employee involvement) and 7 (process management). This failure arises because of the staffing levels in the

NHS. Staff are only released from their duties for what their departmental managers consider 'essential' training, for example, training in infection control. Quality issues are not seen as essential when staff time is at a premium. To deal with these issues, top management should provide more money for training. Departmental staff need to be given time to attend quality training sessions because these are essential if patient needs are to be met. Nevertheless, the 20 Quality Managers who responded to the questionnaire, identified further, additional critical success factors specific to the successful implementation of TQM in the NHS which were neither acknowledged by Parker and Porter nor recognised in the TQM literature. The analysis of these additional factors revealed ten features common to the twenty hospitals:

- Managers working in partnership with clinicians in order to create a more genial environment by improving the polarized relationship between administrators and clinicians. The Chief Executive Officer must drive quality. There is no substitute for a strong leader.
- Restructuring of the hospital's management structure in particular the Trust Board. Its composition does not reflect that of a medical-led organisation. The Board membership is akin to that of private businesses. In the author's opinion what would constitute an appropriate medically led organisation, which remains the only guarantor of the provision of quality care in the NHS, is an executive structure which would comprise:

The Chief Executive, **as Chairman**

Director of Medical Services

Director of Nursing

Clinical Director

Director of Finance

Director of Personnel or Human Resources, **as Secretary**

The five non-executive directorship positions, although political appointees should go to people with healthcare experience because they are in the best position to contribute meaningfully for a better healthcare system within the community. There is no basis for appointing a chairman to the Board from

outside the NHS. Furthermore, it is fallacious to include on the Board people who do not have an idea how a healthcare organisation operates. This negates the fundamental ethos of providing good quality care because such people only concern themselves with balancing the books rather than with ensuring patient satisfaction. The appropriate representation of medical staff on the Board will enable the 'opening up' of the management structure, thereby ensuring an open and transparent style of management. This will free NHS employees from organisational bondage.

- Trust hospitals and self managing units must work closely with their main purchasers, District Health Authorities, GPs and GP fundholders, to enable negotiation and integration of their service specifications into the TQM programme. This will also enable good relations to be developed between purchasers and providers with the ultimate beneficiary being the patient.
- Streamlining of processes by proactively ensuring that services meet purchasers' requirements and meet the expectations of the patients. In addition, streamlining of processes would help curb the sometimes cumbersome and bureaucratic red tape inherent in the NHS. People can only be as good as the systems which they operate, hence, streamlined process will lead to service efficiency. Furthermore, streamlined processes will facilitate the breaking down of barriers between departments and put an end to the 'we've always done it this way' argument.
- The TQM programme should be centred around consultants because they represent clinical quality, which has direct clinical relevance to the patient, and because they represent the most stable element in the NHS; usually being appointed at the age of 38 with most staying in the same hospital until retirement at the age of 65. Thus, it is only commonsense to make TQM attractive to them. The Quality Manager should, in the initial stages, organise training workshops exclusively for consultants with a respected well known consultant, who must have engineered 'change' in his or her own hospital settings using TQM, as a guest speaker or facilitator. In addition, the hospital, through its Chief Executive, should solicit improved relations with the various

Royal Colleges such as the British Medical Association (BMA), the Royal College of Surgeons, Royal College of Physicians and the Royal College of Nursing. It is an established fact that medical professionals owe their allegiance first and foremost to these bodies. It is imperative, therefore, that the commitment and support of a vital few of the consultants is assured before quality is floated organisationwide, i.e. to all clinical departments.

- Empower groundfloor staff, the people who deal on a daily basis with patients. The use of the term 'empowerment' should be avoided if there are no plans to realistically employ it. In most organisations, top management talks about empowerment whilst holding on dearly to the command and control style of management. If an organisation employs empowerment, it is imperative that staff are involved in the decision making process on issues that affect them and in essential changes to their work areas. They are the people closest to the problems. Thus, their ideas should be sought before fundamental changes are made. One of the pitfalls to TQM, as identified in Chapter Five using the Parasuraman's gap analysis framework, was the failure of most hospital's management to listen to their contact staff. 67 percent of the respondents said they needed help with this. Since lack of empowerment is an acknowledged problem in the NHS, management should take the necessary steps to get its contact staff more involved in the TQM process. As Kogan et al⁹ noted, 'in some cases where the district had led strongly, and had not yet secured the beliefs and commitment of those at the operational levels, the TQM initiative remained at the level of training and raising of consciousness'. TQM survives on devolution rather than on a centralist, top-down agenda. It is through people that TQM can be made to work. NHS managers should learn to empower through greater delegation.
- Agree yearly quality measurement criteria with the purchasers of service. A systematic audit of the progress of the programme should be conducted on an annual basis against pre-determined hospital indicators in order to ensure that the TQM programme is on track. An annual audit would constitute the platform for further quality improvements.

- The preferred TQM model should be sufficiently flexible to permit it to accommodate the complex nature of the NHS. The NHS is constantly changing direction due to external government intervention; hence, the TQM model should have the flexibility of accommodating the various external requirements. A rigid application of TQM would, therefore, not succeed. In addition, the Chief Executive Officer should, on occasions, shield the hospital from any conflicting governmental requirement that would either derail or impede the TQM process. A balance should be struck between internal and external requirements. The author is of the opinion that the TQM process should be 75 percent internally and 25 percent externally driven. Currently, the reverse seems to be the case.
- Honesty: top management should always be honest about its intentions. There should be no hidden agendas, such as changing clinical practices, which have the capacity to impede the successful introduction of TQM. As the author learnt, many of the NHS staff believe the NHS to be under seige. They see the hospital setting as being ruled by fear; hence, staff are unwilling to question, or express an opinion, even when something is going fundamentally wrong. As Deming noted, 'management should eliminate the barriers that rob workers of their right to pride of workmanship, it is the job of management to create 'joy' in work for every employee'¹⁰. It is imperative, therefore, that the management of the NHS refrain from ruling by fear. Furthermore, quality activities and involvement should be included in all job prescriptions. The objectives of TQM should be filtered through all employee levels to enable the achievement of departmentally based and Trustwide objectives.
- Reward all good efforts in quality. Quality should be integrated into performance management. This achieves the motivational element of ensuring shopfloor commitment.

These findings could be represented in the form of a table:

TABLE 26**THE CRITICAL SUCCESS FACTORS OF TQM SPECIFIC TO THE NHS**

PHASES	CRITICAL SUCCESS FACTORS
Set-up	<ul style="list-style-type: none"> • Organise for quality: institute an organisational structure. • Management behaviour: ensure demonstrable leadership, commitment and vision from top management and Trust Board. • Adopt a holistic strategy. • Communicate across functional areas: to all staff within departments and directorates.
Get-up	<ul style="list-style-type: none"> • Institute education and training. • Institute a corporate quality agenda with main purchaser. • Process management: redesign and streamline critical work processes • Optimise the system. • Involve the professional staff on a continual basis.
Stay-up	<ul style="list-style-type: none"> • Involve and empower employees. • Institute honesty: management should 'create joy in work'. • Managers must 'walk-the-talk'. • Institute robust systems for monitoring and measurement. • Establish partnership with the Royal Colleges. • Institute reward system.
Move-up	<ul style="list-style-type: none"> • Review on a continual basis the quality process. • Integrate into strategic Business Plan: quality should be a way of life.

Source: Compiled by the author, 1995

The extensive identification of the critical success factors will enable the practising manager to be aware of the underlying requirements for the successful implementation of TQM in the NHS. Hence, a quality manager can benchmark his/her approach in order to ascertain that the relevant factors for success are adequately represented in the chosen model of implementation. However, caution has to be exercised to avoid the fizzling out of the programme. All too often organisations start with speed, only to stall after 18 months due to a lack of sustainable commitment and ignorance of the interlinked critical factor requirements.

EMBARKING ON TQM IMPLEMENTATION

A number of business writers¹¹ have pointed to the importance of organisations developing an appropriate infrastructure prior to implementing TQM as such an infrastructure will support and sustain the TQM initiative. However, these writers have failed to provide a contextualised infrastructural model for practising managers to emulate or against which to benchmark progress. The extensive review of the literature in Chapter Four failed to identify any TQM approach that integrates the 'what', 'how' and 'why' of TQM in a concise/coherent form. Whilst most TQM paradigms are step-by-step approaches, they represent vague and piecemeal efforts towards the implementation of TQM. To use the classical term of Glaser and Strauss, the literature is inundated with quality models that are not grounded in empirical data¹². Quality models have evolved from mere 'gut feel' or consultancy showmanship. Nonetheless, a coherent, comprehensive model of TQM should be holistic; encompassing the 'what', 'how' and 'why' elements. This will provide a systems perspective essential for integrating the differing quality initiatives in the NHS. Quality Managers in the NHS have alluded to the fact that what is required to facilitate quality improvement is a ready-to-use TQM kit. However, academics, practitioners and consultants in the quality management field have failed to provide such a kit. What is available are ad hoc approaches which are symptomatic of the lack of understanding of the essential characteristics of TQM. This is congruent with Hydes view 'that the implementation of TQM is not defined at all'¹³. He suggests that 'no one knows how-to-do Total Quality Management, many know what quality management should be like in general, but no one knows what it should be in any particular case'¹⁴.

The warning is clear. If TQM is to avoid the fate of previous management systems that promised revolution and true reform and failed, then an appropriate, contextualised, holistic model for implementation is required¹⁵.

In view of the problems identified as the pitfalls to the implementation of TQM in the NHS and the gap in the literature as to what the 'best' approach to implementation should be, a context specific model is offered as a guide to achieving the goal of continuous quality improvement. It is hoped the model will have applicability beyond the confines of the National Health Service. As the author has earlier suggested, the

incremental approach contained within the traditional TQM paradigm appears to be failing and is unlikely to succeed in the NHS since long term planning is not a part of the NHS managerial ethos and because of constant and concurrent governmental interventions. Furthermore, the NHS is an institution 'where instant and short term results are necessary for survival in a climate of increasing external politic change'. To remedy this situation, the suggestion is now made for a series of sustainable 'quick short term results' which can be achieved through a process-led strategy. Hence, the proposed model is an integration of some specific aspects of business process re-engineering (BPR) and TQM. The author is of the opinion, that a hybrid model of BPR and TQM represents the best way of providing a holistic model for the implementation of TQM. Whilst traditional TQM models call for process improvement, they fail to establish process redesign and improvement as the central thrust of their ideology. Thus, many TQM initiatives became mainly activity based without a central focus. This has resulted in what Argyris calls 'preaching change while maintaining the status quo'¹⁶. Hence, traditional TQM programmes make progress primarily around the routine issues¹⁷. This is the case in the NHS. Whilst the NHS has sought to implement TQM, it is still basically a classical organisation with chains of command, clearly delineated levels of authority, written policies and procedures, specific rules and regulations for employees. As the analysis of this study reveals, only a process-led strategy will enable vital changes in the systems associated with the delivery of patient care.

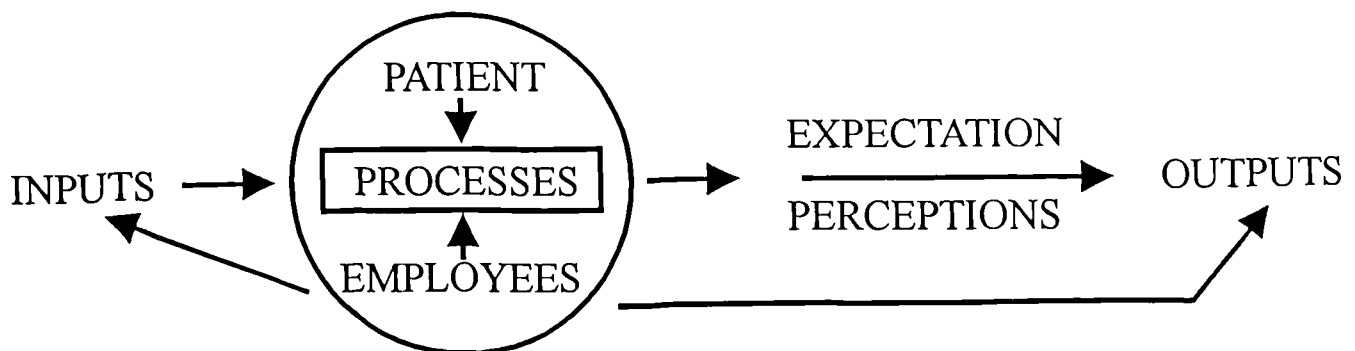
A process led strategy will have the advantage of enabling the NHS to focus on its main business; arranging care, delivering care and managing care. Part of the problem is that the NHS is too task-oriented. For example, one worker takes the patient's registration information and another handles admissions. A process-led model will reorient work activities so that when a staff member is arranging care for a patient, he or she follows that patient all the way through the provision of care; thus ensuring that there is no loss of communication, no missed opportunities and that the entire system works much more efficiently to the patient's advantage.

Furthermore, in a time of cost containment and staff shortages, task reorientation becomes imperative to achieve the same volume of work with the staff available. Thus, the proposed model, unlike most TQM models that focus primarily on increasing

customer satisfaction with the implicit expectation that it will improve organisational performance, calls for a greater emphasis on achieving systems improvements in measurable performance in the quality of care, quality of caring and clinical outcomes. The model represents a result oriented approach to TQM. This must not be misconstrued as a call for 're-engineering'. For the author has argued elsewhere that 'BPR lacks a holistic view of the enterprise'¹⁸. It is concerned only with the throughput aspect of the business process, thereby emphasising only the process element of the system. The argument being posited here is that the NHS should use the process model to align and fundamentally eradicate the flaws in the internal and external environment, in order to meet the expectations and needs of the patient.

FIGURE 45

SYSTEMIC REPRESENTATION OF ORGANISATION PROCESS



Source: Nwabueze et al (1994) Proceedings of BPR Conference, Cranfield University.

Using the above figure as an illustration, the author is suggesting that not only should the NHS concentrate on improving processes, it should ensure the holistic integration of the entire system; the inputs, throughputs and outputs. To do otherwise, would lead to a situation whereby organisational structures will fail to work in a consistent, co-ordinated and complementary manner. The model proposed if properly implemented, will create an environment of continuous improvement by ensuring that those with the primary responsibility for caring of patients will work in concert. Therefore, the author warns that 'concentrating only on streamlining and improving

processes without adhering to the holistic nature of the model will lead to internecine disputes primarily between management and clinicians. It must also be emphasised that in improving the organisational processes, attention should be focused on the improvement of those critical processes that impact on the bottom line. For example, no matter how clean a hospital ward is, it cannot serve to win contracts from purchasers. Thus, the hospital environment should, whilst integrating all other elements of the system, concentrate on those critical issues that would attract business contracts and impact upon the bottom line. TQM must be made to deliver on financial performance for otherwise interest in it will be lost.

The NHS should use the model not only to meet the regulatory requirements emanating from government and purchasers, but also to meet the expectations and requirements of all their customers. The goal should be to advance quality in order to provide high-quality patient care as well as the efficient use of resources. This means that rather than focusing on the traditional approach to quality assurance, the NHS should focus on 'prevention'. Even when performance meets national and purchaser specifications, the NHS should strive further to improve the provision of services, driven by a "good enough never is" mentality. From a TQM perspective, the NHS should direct its attention and expend substantial energy and resources on the 'key' inhibitors of the current performance level. If attacked, these would enable the improvement of everyone's level of performance thereby improving overall organisational performance. The focus should be on improving processes and eradicating errors so that service improvements are secured from all practitioners, not just those from those at the sharp end of the performance spectrum, but also from staff in departments with non-clinical responsibilities, i.e. Catering Services. In addition, to favourable clinical outcomes and cost containment, the interpersonal relationship between staff and patients and the quality of the environment all present opportunities for quality improvement. It is, therefore, essential to create a seamless NHS in which patients and staff communicate efficiently and without barriers, across departmental and/or directorate lines.

IMPLEMENTATION: INFRASTRUCTURAL MANAGEMENT

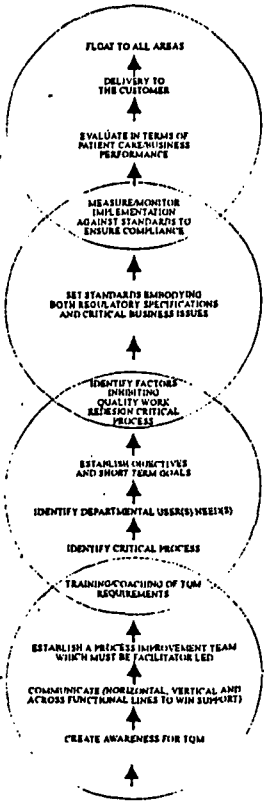
The next stage of the TQM process is the what-to-do?, i.e. the building of the organisational infrastructure that is necessary to sustain the programme.

It is important to note, that TQM is an educational and communications process that can only be achieved through people. In the NHS, this would be the staff who deal with the patients on a daily basis and not the high profile manager locked away in the office. Therefore, the first thing to do in implementing TQM is to build an organisational infrastructure, laying the foundation stone which will support and sustain the TQM process. The infrastructural aspect of the proposed process-led model is designated pre-set up, set up, get up, stay up and move up:

FIGURE 46

**A SYSTEMATIC OVERVIEW OF 'WHAT-TO-DO' APPROACH TO TQM
AND THE 'HOW-TO-DO' APPROACH**

PHASES	PRESCRIBED ACTIVITIES		PITFALLS	
Pre-Set-up	* *	Organisational assessment (SWOT Analysis): use the Gap Analysis Model by Parasuraman	*	Not aware of organisational readiness for change, difficulty in establishing key weaknesses, strengths, opportunities and threats
Set-up	* * * *	Develop infrastructure and specify roles, relationships and responsibilities of: a) quality council b) facilitators c) QI teams Train top management Train facilitators (limit numbers) Train QI Managers (limit numbers)	* * * * * *	No organised approach; due to lack of conceptual understanding of TQM Quality initiative locked into formal hierarchical structure Lack of corporaticism Top management not aware of its QI responsibilities Training programme too vague, and Training needs incorrectly identified
Get-up	* * * * * * * * * * * * *	A case for action (objectives) Identify a vision Establish a mission Identify strategy(ies) Identify value system Identify key issues Adopt a definition of quality Identify customers: external to the organisation Identify critical work processes that impart the bottom-line Identify key issues affecting delivery of quality service Identify pilot QI projects Nomination and selection of pilot QI projects Establish strong links between elements of infrastructure	* * * * * * * * * * * * * * * * * * *	Lack of clarity of purpose Does not reflect actions of management Confusion as to the meaning Mostly adhoc, lacks systematic focus Not important Not aware of the problems; detached from the source of problems No organisationwide definition Difficulty in establishing the ultimate customer Wrong choice due to lack of understanding/ambiguity about work processes Not based on facts Too vague and too extensive QI teams select own projects No organised approach: tends to be ad-hoc

How-To-Do-TQM	<div data-bbox="347 241 703 282" style="border: 1px solid black; padding: 2px; text-align: center;">CONTINUOUS PROCESS IMPROVEMENT</div> 	<ul style="list-style-type: none"> * Confusion as to what the 'best' approach is * Individualised approaches * Partial implementation of TQM
Stay-up	<ul style="list-style-type: none"> * Team maintenance activities to ensure continuity * Integrate QI project(s) * Consolidate lessons learnt from pilot QI projects into training 	<ul style="list-style-type: none"> * No accepted recognition and reward system * Lack of integration of QI projects * Lessons learnt not acted upon
Move-up	<ul style="list-style-type: none"> * Increase in number of QI projects and scope of projects * Training and retraining at all levels * Integration of QI projects into business plan 	<ul style="list-style-type: none"> * Poor coordination * Gains in knowledge taken for granted * Everything treated as tactical

Source: Nwabueze, U. (1994)

HOW IT WORKS: PRE-SET-UP PHASE

The Quality Manager, or whoever has the responsibility for the implementation of the TQM process, should first conduct an in-depth organisation-wide audit. This would involve:

- (1) Internal audit: to identify the key organisational strengths and weaknesses, and determine the critical flaws in the system.
- (2) External audit: to identify opportunities and threats. In the NHS, this will mean focusing on and creating a balance between, governmental directives and purchaser specifications and marrying them to the hospital's key strengths whilst eliminating the weaknesses. The external audit should focus on critical business survival issues. In view of the constant changes in the external environment in the NHS, the external audit should also assess how fit the organisation is in relation to meeting the requirements of:

Patients' Charter

Purchaser specifications

Audits

Patient needs

In addition, the assessment should determine those factors which might impinge upon the organisation in the following year and entail a comparison of how the internal environment relates to the external environment. This will enable it to be determined where the organisation stands in relation to pressures emanating from external sources.

The organisational audit is an important aspect of quality that traditional TQM approaches have tended to ignore. However, in the author's opinion, it forms one of the most essential parts of the TQM process. An audit exercise affords the organisation, in particular the NHS, an account of where it stands in relation to quality. From this premise, the NHS can establish:

- Where it is
- Where it wants to be
- How to get there

The organisation should know, in empirical terms, whether its culture is conducive to the ethos of TQM. It can then build on its strengths to further the philosophy of TQM. It is the author's belief that, the lack of an organisational audit by NHS hospitals prior to the implementation of TQM has resulted in TQM being implemented without a total revision and restructuring of managerial activities. Furthermore, the audit process will provide the Quality Manager with 'hard' evidence about existing practice, values, beliefs and assumptions within the hospital and end reliance on the opinions of management. Through analysis of this data, the organisation will be in a position from which to develop a systematic means of enhancing its future performance. A valuable audit instrument is the Gap Analysis Model developed by Parasuraman et al¹⁹. This would enable a hospital to identify whether or not the seven gaps exist. It would serve to guard against those gaps as potential roadblocks to TQM. Most of NHS Quality Managers in the survey did not know the magnitude of the gaps which existed in their organisations until the author asked them to complete the questionnaire. Thus, the need to identify what is the exact situation in the organisation, with regard to the gaps, is a good starting point for TQM. The Gap Analysis framework would enable the organisation to deal with the problems of:

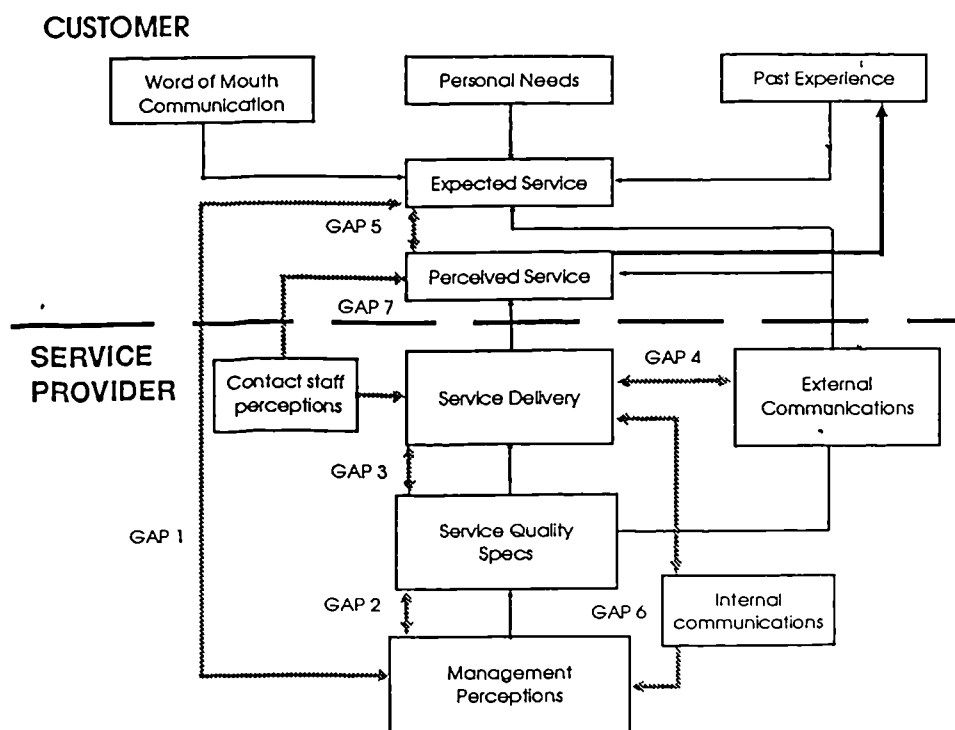
Lack of management perceptions of patients needs and expectations
 Failure to listen to contact staff
 Shortfalls in general communication across the hospital setting

In the author's opinion, in order to use the Gap Analysis Model effectively, a questionnaire based upon it should be designed by the Quality Manager and administered to patients, staff, support staff and professionals so that the data collected in the hospital can be used to exactly determine the key strengths and weaknesses, and permit decisions to be made how best to eradicate the revealed weaknesses.

Furthermore, the Gap Analysis framework would enable the Quality Manager to ascertain whether the hospital is providing a patient focused service. As Parasuraman

et al noted, 'the gaps represent the major discrepancy between customers' expectation and what the organisation perceives to be the needs of the customer'²⁰. Thus, as an assessment tool, the organisation would be able to determine and ensure that the services it provides meet with the expectations of the customer. Presently, the NHS has a problem with all of the seven gaps and, in consequence, reveals that the NHS is not providing a quality service to its customers; the patients.

FIGURE 47
THE GAP ANALYSIS MODEL



Source: Parasuraman, Zeithaml and Berry, 1990; Speller, 1992

In the final analysis, the author would suggest that the organisational assessment be done at different levels within the structure to determine the various needs and worries concerning the system of healthcare delivery. These levels include:

The Board level

The Director level - Heads of Services

Service Manager level
Consultants/medics
Staff
Support Staff
Patient

Thus, the assessment team should comprise:

- The Quality Manager
- Director of Nursing
- Service Contracts Manager
- A Medical Consultant

Having undertaken the assessment exercise, the team should prioritise suggestions but ensure that the focus is on the critical mass of the business as it relates to the needs of the patient and the market. Realistic targets should be set which would have an immediate impact on the bottom line and consequently, improve organisational performance.

SET-UP PHASE

In the set up phase, the Quality Manager institutes the TQM structure comprising:

the Quality Council
a team of facilitators
the quality improvement team (QIT)

The Quality Council in an NHS hospital should have the following as members:

- the Chief Executive as Chairman
- Quality Manager as secretary
- the Medical Director
- Nursing Director
- Operations Manger

- Director of any of the clinical services

and two non-executive directors from the Board. The Quality Council should have in total eight members. The composition of the Council should be such that it represents the diverse professional groupings.

As Juran²¹ suggested, the responsibilities of the Quality Council would include:

Formulate the quality improvement policy, eg, priority of quality; need for annual quality improvement audit; and mandatory participation..

Establish the pilot selection process.

Establish the team of facilitators selection process.

Provide resources: training; time for working on projects; diagnostic support.

Provide recognition.

To Juran's list, the author would add the need to integrate all the five functions under the broad heading of planning. Furthermore, the Quality Council should provide a documented plan for the TQM programme which encompasses the systematic approach, measures and boundaries of the process. It must also provide leadership and commitment in terms of providing visibly demonstrated support to the Quality Manager. The rest of the organisation should be encouraged to see and know that the Quality Manager has the total support of the Quality Council and particularly that of the Chief Executive. It is only then that the Quality Manager can influence the actions of his or her fellow senior managers at departmental level.

The Quality Council should also oversee the implementation process and continuously provide facilitation in the form of taking part in training sessions. This will send out a strong message that top management is 'serious' about quality and that it is not a new attraction that will fizzle out with the passage of time. The Quality Council must be

seen by the rest of the workforce to 'walk the talk'. It is pointless to embark on a TQM initiative if top management is not prepared to change its style of managing.

In addition, the Council should review reports by the team of facilitators and present awards to those who have made exemplary contributions to the TQM process. Nonetheless, its involvement will be restricted to the planning role. This is because in most cases the early enthusiasm of the Quality Council tends not to last the full course.

The Team of Facilitators should be composed of senior ward sisters because the senior ward sister oversees the day to day activities within wards. They serve as the 'middle women' between management and the shopfloor. Thus, they have the confidence of the staff and are, by the virtue of their strategic positions, better placed to facilitate quality at the bottom. They know the problems, the fears and what needs to be changed.

The facilitators will:

- become the hospital's 'quality champions'
- assist in establishing a quality team in their respective departments.

As guide²¹, the facilitators will:

- aid in training of the quality departmental members (peers). She will ensure that every member of the department possess all of the analytical tools necessary for the team to discover and analyze the presence of a problem of poor quality and to solve, implement and monitor the solution to that problem.
- recount, both as an aid to training and as a means for maintaining motivation within the department, the lessons which have been learned from the experiences of other such teams both within and without the organisation.

- chart the essential interactions between the department quality team and the Quality Council, between the team and other such teams and ease the way for cross-team exchanges.
- ease resourcing, resource allocation and accountability for resource management.

As philosopher, the facilitators will:

- explain the hospital's quality vision, mission, values and strategy, delineate the departmental quality team's term of reference as these were devised by the corporate Quality Council and help to foster the team's awareness of top management's commitment to the quality initiative.

As friend, the facilitators will:

- assist in the building of a cohesive, viable and enduring set of relationships between the department team members.
- advise on the directions which the department quality team may elect to follow in order to effectively, efficiently and economically focus its collective quality improvement efforts.
- advise the Quality Council through six monthly reports of departmental quality initiatives and concrete improvements.

As educator, the facilitators will:

serve as the hospitals in-house quality instructors²².

The team of facilitators should meet regularly, at least monthly, to compare and share experiences but, in particular, to establish quality improvement initiatives across functions. To enable the team of facilitators to accomplish its herculean responsibilities it must be thoroughly trained in quality methods, principles and team dynamics.

The role of the team of facilitators is imperative for the success of the TQM programme. As Juran noted, the facilitator is an integral part of the infrastructure necessary to the attainment of continuous quality improvement²³.

A quality improvement team (QIT) comprising the Quality Manager, and the heads of the main departments should be instituted. The responsibility of the quality improvement team is to serve as a watchdog unit to guard against the provision of poor quality healthcare in all of the hospital's operations. The Quality Improvement Team should also:

Assist in pilot scheme nomination

Conduct training in quality improvement

Co-ordinate the activities of the team of facilitators and departmental teams

Provide support services to departments

Assist in the preparation of reports to the Quality Council.

Serving on a QIT should be a part-time job that supplements, not replaces, other duties. The members of the QIT should lay out the entire TQM process, represent their departments on the team, represent the team to their departments, cause the decisions of the team to be executed in their departments and actively contribute to the implementation of improvement objectives.

The QIT should also, as part of its responsibility, attend to quality problems that cannot be resolved at the individual or departmental level and to problems that require significant resources. When such a problem(s) gets referred, the QIT should prioritise and assign to a team of employees working in, or on, the process, who have the expertise to:

- define the problem;
- put a fix in place if necessary;
- identify the root cause;
- take corrective action; and
- monitor the process

These steps, in the author's opinion, should be used for the biggest and the toughest problems; those deeply entrenched in the hospital, for example, conflict between consultants and management, or the issue of sectionalism. These are issues that cross departmental lines and which shopfloor employees are unable to affect change. Thus, one responsibility of QIT is to ensure that such problems are addressed.

Having completed the composition of the TQM structure, the Quality Manager should embark on extensive training and education of the three main groups: The Quality Council, Facilitators and the Quality Improvement Team.

EDUCATION AND TRAINING

The Quality Manager should provide the required facilities for teaching courses in quality management to all employees depending on their degree of involvement. This will enable the sharing of a common language amongst employees, the acquisition of the tools of quality management, the ability to work in teams, in order to foster cooperation as members of the same hospital, to solve problems and to continuously improve the quality of care provided. The Quality Manager should be responsible for facilitating the education and training sessions. All employees must attend. There should be no excuses. Often in the NHS, managers prevent their staff from attending training sessions and cite staff shortages as an excuse. This should not be allowed. Rotas for training sessions should be adapted to suit each staff work schedule.

The training session should teach courses in problem solving, team working and process improvement. These represent the basic tools staff need to bring about change in their immediate work place. Anecdotal evidence suggests that in most teams in the NHS, senior medics are bound to dominate, their views reign supreme to the detriment of the view of other staff. As the case studies revealed, most NHS hospitals started TQM without first establishing a firm educational and cultural foundation. It is important therefore, that every employee receives a good foundation in the ethos of TQM. In addition, in order to ensure maximum attendance at the training sessions, ward training should be the preferred method of facilitation. This will guard against the normal excuses made by department managers of not having sufficient staff to cover for absences occasioned by attendance at training workshops.

Thus, the education of the Quality Council, Facilitators and Quality Improvement Team should not be on an ad hoc basis. The hospital should elicit the support of a team of management consultants not to draw up a plan, but to help the Quality Manager in facilitating the training programme. The training session should be run on a multidisciplinary basis with members of each group attending. The session should concentrate on the basic principles of TQM, the underlying assumptions, the seven basic statistical tools, problem solving, team building and what the organisation stands to gain from the TQM process. The key functions of the three groups should be explained in detail, in particular their interdependent roles and what is expected of them. The training session should not be concerned with the Gurus' message nor with the evolution of quality. These are known to be boring as participants switch off and there is always a tendency to forget the Gurus' message. The theme should always be 'what and how' the hospital will improve using TQM. Here, the results of the organisational audit are of importance. The Quality Manager, on the first day of the training programme, should use the data to explain the organisation's position relative to quality. He or she should flag up the weaknesses of the organisation in quantifiable or concrete figures. Such hard evidence has a way of giving the message straight to top management that the organisation is indeed sick and needs urgent help. The involvement of the outside consultants should be limited in order to limit cost. They are not to help in drawing up plans for the introduction of TQM, as that is the function of the Quality Council but, is intended to teach and to explain the basics and tools of TQM.

At some stage, the Quality Manager, should involve a practising medic who believes in, and has been involved with, TQM within a healthcare setting, to talk to the group highlighting 'how' his or her hospital implemented TQM and the roles played by its Quality Council, Facilitators and Quality Improvement Team. This will convince, or help to persuade, the medical consultants on the Quality Council that TQM actually works. It is important that the invited medical guest concentrates more on 'how' TQM is of clinical relevance to patients and the hospital organisation as a whole. It has been argued that consultants usually view as irrelevant, or as a waste of time, TQM activities that lack direct clinical significance²⁴. It is important that, at the training session, TQM is not presented as something new but, is portrayed as a continuation and an expansion of collaborative processes that have already been used successfully

in most health organisations²⁵ i.e., TQM establishes, through the empowerment of individuals, a mechanism for developing better group problem-solving skills and the reformalisation of more effective policies²⁶.

After the training session is completed, the Quality Council, together with the Quality Improvement Team, should meet to draw up the organisation quality improvement plan. At this stage, the assumption is that the participants will be equipped with a sound grasp of the theory of TQM and are clear in their minds as to the way forward for the organisation. The quality improvement plan should establish²⁷:

- a case for action
- the vision
- mission
- strategy
- values
- key issues

The case for action: encompasses the organisation's objectives, and short term goals. As a public sector health organisation prone to incessant government intervention having long term goals is wasteful. However, the plan should include where the organisation is expecting to be in 3 to 5 years. The case for action should say why the hospital must do TQM. It should be concise, comprehensible and compelling. It will embody a persuasive argument stating:

where the hospital is
why it cannot remain static
what the hospital needs to become

and show how, through the attainment of the stated objectives, the hospital will move towards a new lease of life; the life of continuous quality improvement.

The case for action must be so persuasive that no one in the organisation will think that there is any alternative to TQM. It must convey a forceful message that TQM is essential to the hospital's survival.

The vision: should be the future desired state, the situation which is being sought, to which the organisation and its personnel are committed. It should provide the central focus against which the managerial process of planning, leading, organising and controlling can be coordinated. Its acceptance should serve to give purpose to day-to-day actions and activities at all organisational levels and to all organisational functions. The vision should appeal to all and must be sold to every member of staff for them to feel a part of it, understand it and act on it. The vision should represent the unifying force that brings the diverse professional functions into acting like one big family which is an essential requirement for the success of TQM. The vision should contain three elements. Firstly, it focuses on work activities; secondly, it includes measurable objectives; and thirdly, it should set new milestones for the organisation. The vision should be posted in every public room of the hospital for managers, employees, volunteers, consultants, patients and other members of the community to know what the future holds for the hospital in the context of quality improvement.

Mission: represents a series of statements of discrete objectives, allied to vision, the attainment of all of which will ensure the attainment of the future desired state which is itself the vision. Thus, the mission is the necessary steps along the way to continuous quality improvement. How we are going to get there? The mission is imperative to the success of TQM. Many organisations embark on TQM without being clear how they will achieve it. It is like embarking on a journey without knowing where to begin and how to get to your destination. The consequence is a journey that never took place.

Strategy: should comprise the sequencing and added specificity of the mission statements to provide a set of objectives which the organisation has pledged itself to attain. The strategy should entail the milestones from which is gauged the progress towards accepted goals.

Values: should serve as a source of unity and cohesion between the members of the organisation and also serve to ensure congruence between organisational actions and external customer demands and expectations. Without such congruence no organisation can expect to attain efficiency, effectiveness and economy let alone ensure its long term survival.

One of the problems highlighted by the case studies, that probably inhibits shared beliefs in the NHS, is the issue of inter-professional conflict for resources. To solve this problem, the new value system should build-on existing strengths of inter-professional communication and cooperation; which should have been revealed in the organisational audit; making sure that the facts of inter-professional conflicts are understood by all parties and of ensuring that TQM implementation addresses internal resource allocation issues. To do this, the Quality Manager should identify areas of conflict and recognise and address the inherent problem of the organisation to maintaining the status quo, by making certain that implementation teams, particularly the team of facilitators, represent all functions of the hospital bureaucracy.

Key issues: these are the organisational weaknesses which must be addressed in pursuit of the quality which is demanded by customers to meet their needs and expectations. A key issue can be characterised as one which is:

- important to the customer
- creating substantial cost arising from poor quality
- happening frequently
- having substantial impact upon the organisation
- creating substantial delay in the delivery of a service

After establishing what are the key issues, the Quality Council should adopt an organisationwide definition of quality. This will provide a central focus for the TQM initiative and mitigate against differing interpretations of quality. In the author's opinion, Juran's definition of quality is appropriate; 'quality is fitness for use'²⁸. This is because in the provision of care, services provided should be fit for the purpose of the customers. It is also congruent with the government's policy whereby hospitals have to address the health needs of their immediate community. In addressing those needs, services must be fit for the purpose for which they are provided. Once an organisationwide definition of quality is agreed and adopted, the Quality Manager must ensure that every member of staff, including those engaged in support services, receives a copy of the definition, together with the vision statement. In addition, it is pertinent that the Quality Manager is aware of the common pitfalls at each phase of

implementation and learns to avoid them. "The mistakes are all there, waiting to be made". Avoid them and the organisation can't help but get it right²⁹.

GET-UP PHASE

At this stage, the first thing to do is to identify who are the internal and external customers of the organisation. This should be the responsibility of the team of facilitators, in its capacity as the quality champions. It is important that no common assumption is made as to customers' needs and expectations. Ever so often, NHS staff, because they provide services to the patients and make daily decisions about medical care, assume they know the patient. Similarly, many managers believe that their internal professional standards are adequate assurance of customer satisfaction. However, quality standards developed by staff are often designed to reduce inefficiencies or conform to policies rather than being focused on meeting patient needs. Thus, it is imperative to identify the customers in order to determine their requirements. The team of facilitators should involve other members of staff in developing a list of the hospital's external and internal customers. This process will enable contact level staff to develop and reinforce their patient focus. One of the ways in which the team of facilitators will carry out this process is through a brainstorming session with departmental level staff. The team of facilitators should know that the external customers are people not employed by the hospital, patients, patients' family, friends, government purchasers, General Practitioners (GPs), GP fundholders and others, who do business with the hospital and who have some choice about where to take their business. So it is important to establish their requirements. This will enable the drawing up of guidelines, policies and standards to meet and exceed the identified requirements. Internal customers are employees and departments within the organisation which contribute to the hospital's overall vision and who depend on internal services for 'outputs' with which to furnish external customers.

The next step is for the team of facilitators to identify the critical work processes. These are the processes staff have to undergo to provide and improve quality of care. Often in the NHS, processes are either too bureaucratic or designed for the convenience of staff. For example, in one hospital which the author visited, it took the surgery department between seven to eight weeks after a patient had seen a consultant

surgeon to get an appointment letter if the patient required surgery and a further delay of between fifteen to twenty four months on the consultant's waiting list before surgery was performed. This is unacceptable.

To avoid this unfortunate situation, it is important that those critical processes that impact upon the patient should be identified and resolved. Therefore, the team of facilitators should concentrate on identifying the critical systems and processes used to produce, deliver and support patient care in order to achieve improvements across all hospital activities.

After the identification of the critical systems and processes, the next logical step is the identification of pilot quality improvement projects. This is the responsibility of the Quality Council. Based on the report of the team of facilitators, which should embody the external and internal customer requirements and the critical systems and processes that need to be improved, the Quality Council, in liaison with the Quality Improvement Team, should nominate the improvement projects. It is important that the number of projects are limited at this initial stage so as to allow for total commitment to the improvement process rather than have many improvement projects going on at the same time; each being partially accomplished. Nevertheless, the selected projects should be those projects that would have an immediate impact on the customers and the rest of the organisation. It will be worth starting with those common projects which are the origin of the majority of customer complaints:

- waiting time at outpatient clinics
- waiting time at the Accident and Emergency
- lack of information
- poor catering services
- missing medical records
- wrong diagnosis

It is always best to start with the simple schemes and then graduate to the harder ones. Success with the first few pilot projects will create a new and committed enthusiasm for TQM.

The Quality Manager should make sure that there is a strong link between the elements of the infrastructure. If there is a waning of commitment on the part of any of the three main groups, Quality Council, Facilitators and the Quality Improvement Team, it might derail the TQM programme. It is essential therefore, that an honest flow of information and communication exists between the three groups. This is the responsibility of the Quality Manager.

At the end of the Get up stage, the Quality Manager should carry out an audit exercise to ascertain that all the various elements of the infrastructure are in place before the on-set of the implementation process proper. The result of the audit should give the Quality Manager the confidence to proceed with implementation. If there are a few snags, such as lack of commitment on the part of management, it is important that it is resolved before implementation is undertaken. Frequently, because of external pressure, Quality Managers in the NHS have embarked on TQM initiatives after too brief an acquaintance with the tenets of TQM. Therefore, it is not surprising that most have failed to adopt a systematic approach; with the consequence that many TQM programmes have been only partially implemented.

THE 'HOW-TO-DO' APPROACH TO TQM IMPLEMENTATION

The modus operandi of the 'How-to-do' approach suggests that TQM in the NHS should be implemented on a pilot-by-pilot basis. This is because Quality Managers in the NHS have indicated that an organisation-wide approach will be difficult to integrate into a workforce of at least 3,000 people. In addition, they have argued that it would be difficult to manage and coordinate quality activities across the various hospital units. Thus, in order to prevent the programme from fizzling out, and to maintain the manageability of TQM, the pilot scheme approach is most appropriate. This role model approach, with its emphasis on short term success and structural gains, should serve to win over institutional sceptics and fence sitters, and in the longer term, have a domino-effect on the rest of the organisation. Pilot schemes also have the advantage of ensuring that the organisation stays focused on the key processes rather than having many quality initiatives going on at the same time. As the pilot schemes are being introduced, one at a time, the process of assimilating the paradigmatic change that TQM entails become less unsettling to employees. The "how-to-do" approach to TQM

differs significantly from other approaches to quality. It represents a departure from the activity centred approach of most traditional TQM paradigms to a more short term, results oriented approach. By results orientation, the model signifies the need to redesign, improve and streamline processes that would have an immediate effect on the bottom line. In addition, the model represents the first empirical problem specific model for the implementation of TQM in the NHS which has, as an integral part, an infrastructural/measurement element. As Figure 48 shows, the model encompasses four interrelated cycles:

Planning → leadership

Doing → process redesign

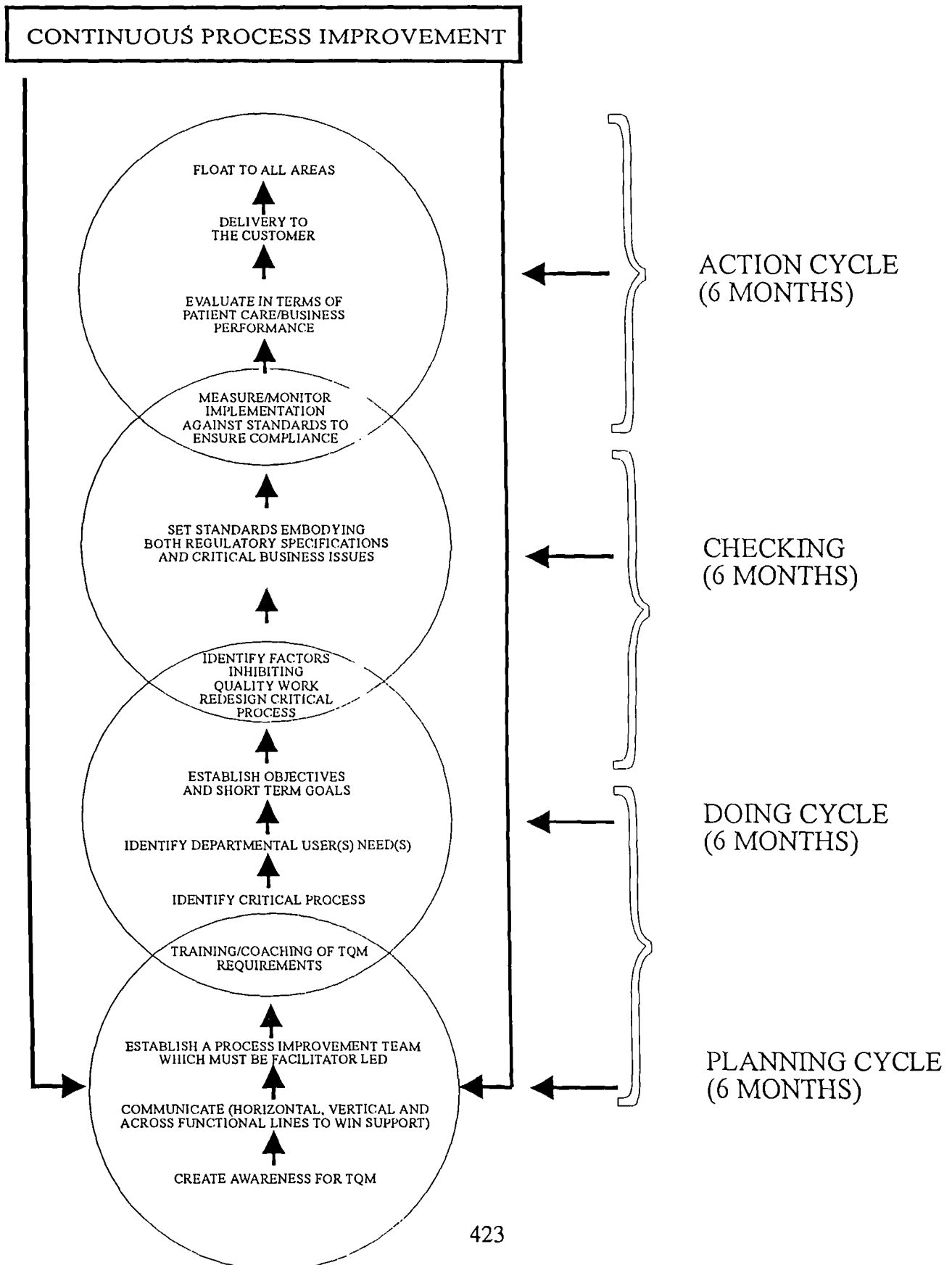
Checking → measurement

Action → customer focus

The absence of any one of these sequential activities is a recipe for disaster.

FIGURE 48

SPIRAL LOOP OF THE 'HOW-TO-DO' APPROACH TO TQM
TQM IMPLEMENTATION FRAMEWORK FOR THE NHS



The model adopts a bottom-up approach. This is because commitment has to come from everyone within the organisation. Once the seal of approval is given from the top, the Quality Manager can facilitate the bottom process. In addition, because the NHS is still structured along functional lines with a hierarchical structure, it makes sense that the need, commitment and leadership for change has to come from the top. However, in facilitating the bottom aspects, employees should be empowered to generate ideas for improvement. One way of sustaining employee commitment to TQM is to let employees feel that it is their idea and that they have a stake in its success.

It should be noted that although the model adopts the Deming Cycle (Plan, Do, Check, Act), Deming failed to contextualise the key activities organisations should embark on en route to TQM. Deming's Plan, Do, Check, Act Cycle represents a limited approach to TQM because it does not provide insight into the core activities required, for the holistic application of TQM. Hence, the Plan-Do-Check-Act cycle is open to subjective managerial interpretation. However, the 'How-to-do' approach to TQM represents a fluid, context specific, approach which the study has indicated is required by the NHS. The flexibility lies in its ability to be implemented across functional areas. Although the logistics are prescribed, the implementation process can be adapted to fit any specific organisational characteristics. By implication, Quality Managers should not stick to a rigid application of the model. Nonetheless, it is important should the model be operationalised, this has to be correctly done. A piece meal application would result in partial implementation. Thus, a thorough understanding of the various elements or activities within the model is required of the Quality Manager prior to implementation.

SUCCEEDING WITH THE 'HOW-TO-DO' APPROACH TO TQM

Overview

The first requirement is committed leadership. The successful implementation of the model is impossible unless the Trust's Board, senior managers, and the professional staff are actively involved from the early stages and throughout the whole process. Top management, especially the Chief Executive Officer, should demonstrate

commitment and leadership to the TQM effort by becoming the process champion. This requires the development of an empowered workforce and the realignment of the organisation's value system to conform to the ethos of TQM. The CEO must be seen by the rest of the organisation to walk his job, he should provide the resources for training and participate in the education of the workforce. He should also ensure the creation of a non-threatening environment conducive to the quality process. This requires the 'real' empowerment of individuals and teams with the ability to affect the changes which will collectively result in continuous improvement. The CEO must ensure that departmental managers are actually empowering those staff who deal with patients on a daily basis to suggest and implement changes to processes that inhibit the quality of care. Once this is achieved, the other activities, process redesign, measurement, and customer focus, would, as a matter of consequence, be implemented and successfully accomplished.

USING THE MODEL; IMPLEMENTATION

As earlier identified the failure of the NHS to adhere to a systematic approach has led to the partial and improper implementation of TQM. To launch TQM into departments requires many start up decisions. For example, which of the departments within the hospital should serve as the first pilot initiative. Thus, the quality of these decisions will determine how well a department focuses on the process. It might be appropriate to start the initial pilot at the Accident and Emergency or the Outpatient Department which are the main problem areas in hospitals. The first stage of the model is the planning cycle.

The Planning Cycle: The first task is to form a planning group to coordinate quality activities within the pilot project or projects. In addition to its other responsibilities, the Quality Council should constitute the planning group. The planning cycle should not last beyond six months in order to maintain interest, commitment and momentum. The first activity in the planning stage is to create awareness of the TQM process. As quality management requires that everyone be encouraged and empowered to address and improve processes, it is then necessary to create employee awareness as to what TQM is about and what is expected of all employees. Thus, a one day awareness session should be held in the chosen pilot led by the CEO and two other members of

the Quality Council, preferably the clinical and nursing directors. By their presence, these top managers would be signalling to the workforce that there is a serious commitment to quality in the hospital. To further awareness of TQM, regular departmental and medical staff meetings should be mandated to address quality issues. By so doing, this would ensure that quality is in all of the hospital's operational agenda. The Quality Council, team of facilitators and the Quality Improvement Team (QIT), should publish minutes of every meeting and communicate it to employees in order to prevent the suspicion of a hidden agenda. An in-house quality bulletin should be created through which management can communicate its quality agenda to the workforce. Deming³⁰ has argued that organisations should drive out fear, hence, an intensified awareness campaign would give confidence to the fact that management really wants to change and would enable it to overcome fears and suspicion on the part of the staff. The awareness campaign should state, in concrete terms, to the pilot project employees why the hospital is embarking on TQM and the gains envisaged. Management should hold formal and informal meetings with departments and with medical staff personnel to explain the new management commitment. To achieve continuous awareness for TQM, the hospital should provide quality information, communicated through posters and articles in hospital newsletters and through the improved actions of managers. Quality awareness is the most important aspect in the initial phases of the TQM process. Inadequate awareness of TQM might lead to employees seeing TQM as the flavour of the month that would fizzle out with time. The second step in the planning cycle is to communicate extensively the 'need' for TQM across all functional areas. This will prevent the development of negative attitudes toward TQM among employees.

The third step in the planning cycle is the setting up of a process improvement team (PIT) within the department. The members should be limited to six, including the department's facilitator, who should chair the team. It is the responsibility of the process improvement team to identify the following:

- who are the department's customers
- what are the customers' needs/expectations

- set professional standards
- what to do to meet the operational requirements of the customers and purchasers
- identify and improve processes (streamlining and redesign)
- set measurable and achievable objectives

The department's representative in the Team of Facilitators, the Senior Ward Sister, should chair the process improvement team rather than the department manager. This is because employees would feel inhibited by the presence of their manager to express 'what' they really feel are the shortcomings in the service provided by the department whereas, in the presence of their peers, they are less likely to hold things back. Thus, a facilitator-led process improvement team, empowered by management, would 'hit the nail on its head', by going to the source of service problems and bringing about improvements. Most staff in the NHS love their job, but they hate a system which, rather than encourage exceptional quality care, inhibits staff from delivering to the patient a quality service through excessive protocols.

Because of the task that awaits the Process Improvement Team, it is essential that its members also undergo extensive quality training facilitated by the Quality Manager and the facilitator. The Process Improvement Team should meet regularly in consultation with the departmental manager to discuss quality issues and review progress. The Process Improvement Team is the vehicle through which TQM will succeed within departments.

Furthermore, the Process Improvement Team should always engage other staff in a discussion of the consequences of both satisfying and falling short of customer expectations. Improvements should be based on the audit of both internal and external users' needs and requirements. It cannot fulfil its function without the support of the rest of the staff. It is also the function of the Process Improvement Team to train their fellow colleagues in the tools, principles and techniques of TQM and how best the department should work as part of one team to move services nearer to the patient.

The Departmental Manager, with the support of the CEO should establish a department reward system for selfless efforts and contributions to the improvement of the quality of care. Such a reward system, which is not common in the NHS, would help motivate staff and change the culture whereby managers find it impossible to praise subordinates. At the end of the planning phase, the Process Improvement Team should make certain that its colleagues are fully aware of the requirements of TQM and what is expected of them.

Doing Cycle

A Doing Group should be established within the hospital. Its members should comprise:

- a senior consultant
- service managers
- the Quality Manager

The consultant should be a respected and knowledgeable professional, who has an interest in improving the quality of care. It is hoped that the consultant, would champion the TQM process amongst colleagues to allay fear of suspicion, resistance and hostility. The mistake most NHS hospitals have made is not to involve the medical staff in an operational role early in their TQM programme. This has led to conflicts of interest among medics and managers. Their involvement in the actual Doing process would enable them to determine at first hand that TQM represents a strategy to improve and provide the best possible care for patients.

The Doing Group are to meet regularly, probably once every month. Their functions should include:

monitoring, managing and facilitating the actions of the department Process Improvement Team in order to ensure that the various activities within the Doing Cycle are successfully accomplished. The Process Improvement Team, in association with other staff, should provide a monthly 'Doing Report' showing its achievements against the stated objectives. The report should be reviewed at the monthly meetings of the

Doing Group and corrective action taken on any issue(s) the Process Improvement Team could not resolve i.e. those which cut cross departmental boundaries.

The main activities in the Doing Cycle include:

The training and coaching of TQM requirements. It has been stated earlier that every member of staff should at least receive training on the principles, tools and techniques of TQM, in particular on problem identification, problem solving and teamworking. However, the training session should not be a rehash but a coaching exercise used to allay staff suspicion of TQM. The session should stress in clear terms 'why' the organisation is embarking on TQM, what is expected of staff and 'how'; their contributions to the quality efforts would be rewarded. In fact, the expectation of the management is for the staff to be the custodians of improved quality across all functions. The training session should be compulsory for all staff. It has been noted that due to staff shortages, contact staff would find it difficult to find the time to attend training but, the author holds, if the organisation is to make excuses for staff, it is signalling that there are other issues that supersede TQM. In the initial stages of TQM, there should be nothing more important than 'quality'. The training session should be conveniently spread over time to suit the working hours of staff. It is important that the CEO attends the first day's training session to talk to staff about his expectations and the organisation's vision. He or she should also attend the last day of the training session. This would reinforce the message that management is serious about quality. Oakland³¹ has stated that training is the single most important factor in actually improving quality, once commitment to do so is present. Quality training must be continuous to meet not only changes in technology, but also changes involving the environment in which an organisation operates, its structure and perhaps, most importantly of all, the people who work there³².

Oakland further suggests that, before an organisation sets training objectives, three essential requirements must be met:

senior managers must ensure objectives are clarified and priorities set

objectives must be realistic and attainable

main problems should be identified for all functional areas in the organisation

However, the author is of the opinion that Oakland's essential requirements should be identified in training by employees themselves and not before training. By setting departmental objectives, and by identifying problems through a brainstorming session with the Process Improvement Team, staff will be in a better and privileged position to effect changes. It has been argued, that employees know the problems because they live with them, they also very often have a pretty good idea of, or are quick to ferret out, excellent solutions³³. Thus, in training sessions, the Quality Manager should present the chance to these capable people to go back to their departments and revolutionise the processes by moving them closer to the patient. The training sessions should be fun. It should not be a boring lecture but an interactive process whereby employees are encouraged to voice their feelings and insights to the way work gets done within and without departments. The training strategy must not be training by rote, but through the workers understanding how the TQM process will improve organisational activities.

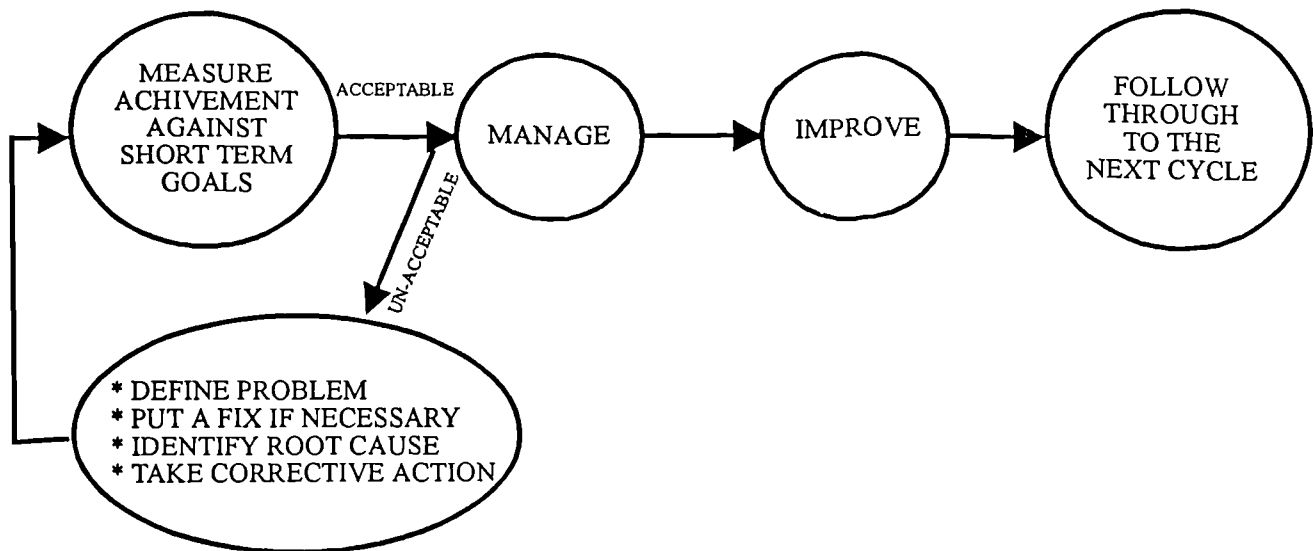
On completion of the training programme, the Process Improvement Team, together with the input from other staff, should establish departmental objectives which should be attainable within finite resources. The departmental objectives should be reviewed by the Department's Manager and the Doing Group to ensure consistency with the organisation's overall objective. Having set major objectives, the process improvement team should set short term goals. These should be the accomplishment of those immediate issues that have inhibited the deliverance of quality. In addition, the short term goals should concentrate on meeting regulatory requirements, in particular the Patients' Charter specifications. The next step is the identification of departmental users, both internal and external, and their requirements. Employees as members of informal teams, should be encouraged to identify the customers, processes and suppliers of their own jobs and make recommendations to the Process Improvement Team. On completion of the recommendations from all departmental staff as to who are their key customers and as to the critical processes that impart their work, the Process Improvement Team should then prioritise the suggestions and

identify between 5-6 key processes that would be tackled head on in order to align processes with the new quality culture.

At the end of the Doing Cycle, which should be over a period of at least six months, but which may be less depending on the specific requirements of the department, a measurement and monitoring exercise should be carried out using the suggested framework to make certain that the various activities have been achieved against set objectives; and that, overall, regulatory requirements have been met. The measuring exercise has the advantage of giving information as to how the organisation is doing against set goals. It is intended to reveal any snags in the provision of quality care so that corrective action may be taken. The Process Improvement Team should be aware that 'what you cannot measure, you cannot manage'. Through measurement, all processes become manageable in a concise, systematic and comprehensive manner.

FIGURE 49

THE MEASUREMENT FRAMEWORK



Source: Designed by the Author, 1995

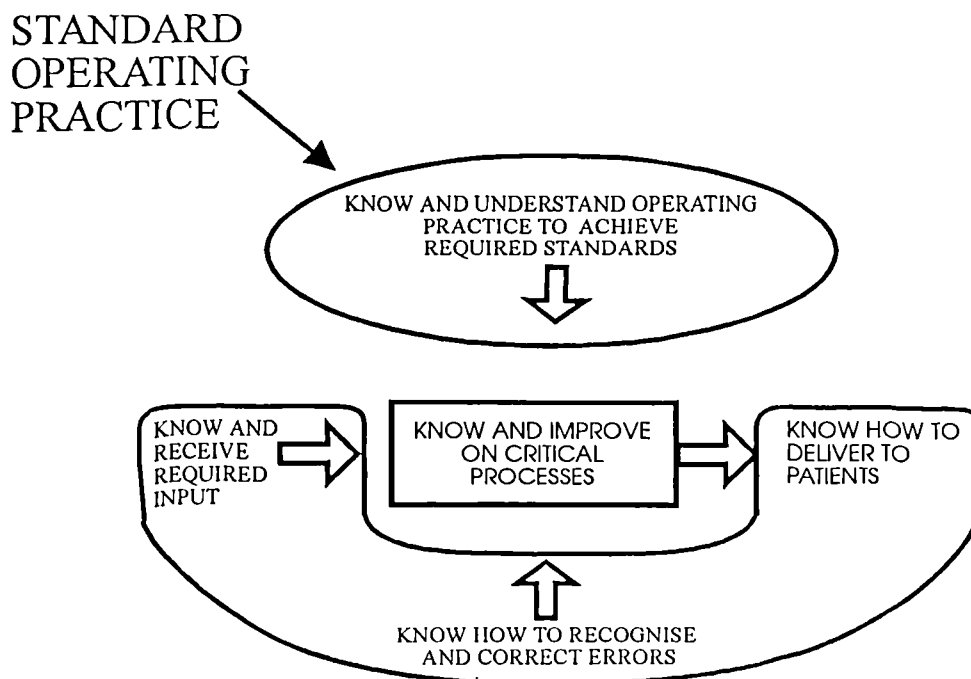
It is hoped that the measurement framework will serve as a guide for a hospital to continuously monitor progress at all stages of each cycle.

There is really no excuse for a manager not knowing what is happening in his or her own workplace. In the NHS, most staff do not have reliable data by which to identify problems in order to help them improve processes. Invariably, the measurement and monitoring of organisational processes must be performed where the job is being done and by those doing the job. This will enable the organisation to know whether or not progress is being made.

The results of the measurement exercise should be reported to the key players i.e. the contact staff within the department or those working in the process, so that staff will see that TQM actually delivers results. Lastly, the Process Improvement Team should make certain that every single, member of staff understands 'best practice' as that has been specified as a result of the quality initiatives:

FIGURE 50

EVERY EMPLOYEE SHOULD UNDERSTAND



Source:

Compiled by the Author (1995)

The Checking Cycle

A Checking Group should be formed. It should be led by either the medical director or the Chief Executive. Other members should include the:

- contracts manager
- a non executive director
- a nurse

This group should critically assess the progress of the various quality initiatives. Its main function is to carry out systematic audits of departmental quality initiatives to make certain that they are addressing central issues, i.e. meeting the overall organisational objectives. The Checking Group should also ensure that each and every department carries out a mini, monthly audit of its processes. Measuring the TQM process is the most effective way to note the successes and failures of TQM.

The main activities of the Checking Cycle are intended to:

Critically assess all quality initiatives. A further survey of the external customers should also be undertaken by the Checking Group to identify, from the patient's perspective, those areas of service provision which they feel should be a focus for future improvement.

On the basis of the data collected, the process Improvement Team should redesign and if need be streamline the identified problem areas to re-align them into the previously set objectives. The redesigned process(es) should be grounded in data as revealed by the surveys and not on managerial 'gut feel'.

One of the greatest temptations is to believe that, because of years of experience in managing 'care', it is known what the patient wants and needs better than does the

patient. Time and again, this is found not to be the case. Staff logic is not necessarily the patients' logic, nor is staff perception of quality care the same as that of patients. To manage efficiently and effectively the services provided by the department, the realignment of service processes to meet and exceed patient needs is critical³⁴. If process redesign takes place, the Process Improvement Team should set measurable standards against which to measure data with the intention of fulfilling patient needs.

It is also the responsibility of the Checking Group to ensure that standards set within departments represent what the patient wants and what he/she medically needs. Thus, after clarifying customer expectations, professional standards based upon customer expectations should be the key to the provision of effective and appropriate quality care and service.

Lastly, measurement criterias should be set across all departments. Southforke Hospital provides an illustration of this with each department within the hospital setting a minimum of 4 and maximum of 6 standards on which performance could be measured. The attainment of this minimum standard seemed to enable the departments to keep abreast of its TQM programme.

The Action Cycle

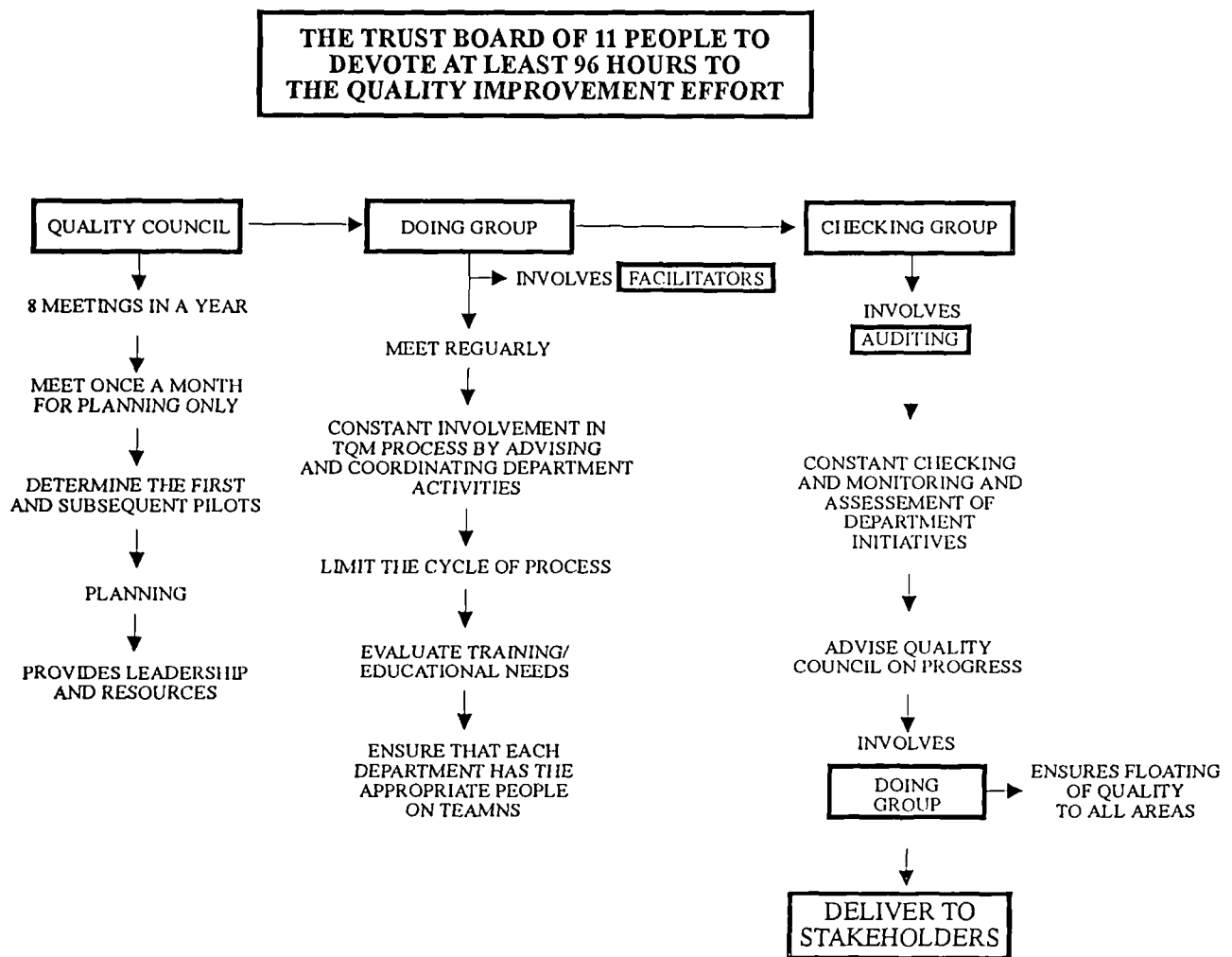
At the completion of the Checking Cycle, which should also last for a period for six months, the beginning of the Action Cycle entails a systematic evaluation of the entire TQM process to establish the extent to which the improved processes are meeting set standards reflecting patient needs and to identify the impact on business performance. This is also the function of the Checking Group. If performance is encouraging, the organisation should float quality to all areas within the hospital, if not, areas for further improvement should be identified and corrective action taken. This would ensure the delivery of quality to every patient thereby constituting the first full cycle of the programme. The first full cycle of the model should take at least 24 months to complete.

For TQM to become established within the hospital, there should be a meticulous revisiting, via auditing of the new processes to eradicate any remaining quality

inhibitors in the system. It is expected that TQM should have arrived organisationwide within a period of 5-6 years; provided that the four cycles are revisited several times to continuously improve performance against set targets which reflect changing customer and regulatory requirements.

It should be noted once again, that the model does not require a rigid application. Nevertheless, no TQM model requires adhoc implementation. TQM is systemic, requiring the adaptation of the 'entire' organisation system, not 'part' of the system to the modalities of TQM. For example, an automobile is a system when all its constituent parts are working together, no part of an automobile can function independent of the other parts. Thus, the argument being posited by the author is that the how-to-do model will result in effective implementation of TQM, if it is systematically introduced. This will enable improvement to the critical processes that would improve the whole organisation. The managerial requirements of the model are depicted in Figure 51. Nevertheless, to institute a full blown cultural change in the pursuit of quality, top management, in particular, the Chief Executive Officer, should create the demand for quality within the organisation by insisting that autocratic styles of managing are abandoned. As a consequence, delegation through the empowerment and involvement of staff should become the new way of managing. This is because the workers' effectiveness is determined largely by the way he or she is being managed. Hence, top management must stick to the requirements made upon it, if the benefits of a new quality culture are to be realised.

FIGURE 51: THE MANAGERIAL REQUIREMENTS



Source: Compiled by the Author, 1995.

Once the first complete cycle of the implementation process is complete, the next phase of the model is the stay up phase.

STAY-UP PHASE

This is the period of holding the gains derived from the quality improvement effort. This is where every employee and every staff meeting is focused on quality. At this phase, it is important that the quality improvement team make certain that:

- Team maintenance activities take place as planned: this will ensure that the changes in people's attitudes and behaviour to work, which should have improved as a result of the quality effort, do not revert back to the

maintenance of the status quo. It has been argued by a number of business writers³⁴ that organisations only succeed in rearranging boxes, and after 18 months, staff revert back to the old ways. Through team maintenance activities, the quality manager would re-emphasise the achievements so far and the need to continue to improve on the services provided until the organisation can attain, in Crosby's words, 'an environment of zero defects'³⁵. In addition, through team maintenance activities, which will involve monthly meetings with the various departmental teams, awards ceremonies and corrective action groups, a continuity of purpose will be maintained. Thus, ensuring that TQM becomes part of the organisational culture. The second step in the stay-up phase is the integration of quality improvement projects. The essence of integrating the whole initiative is that it presents the foundation upon which to build an organisationwide audit which permits the appraisal of the quality programme. Using the Crosby quality maturity grid, the hospital can actually measure where it has reached on its journey to continuous quality improvement. The grid will also reveal whether there are some areas that need further improvement. Through surveying the entire staff and patients, the organisation can also identify whether gaps still exist between services provided and the perceptions of the patient. The integration exercise has the advantage of offering, in quantifiable terms, whether the processes have been a success or a failure. This is followed by the next step:

- Consolidate the lessons learnt from the pilot schemes and integrate that learning into new training sessions. This encourages a constancy of purpose across the whole of the organisation.

MOVE-UP PHASE

This is the phase where quality becomes the way work gets done within the organisation. The move up phase involves:

- increase in pilot schemes

- retraining for top managers, facilitators and the quality improvement team
- further training for all staff, and
- the integration of TQM into the organisation's business plan.

These elements should be addressed by the Quality Improvement Team in association with the Quality Council. The organisation should not rest on its laurels at this stage. It should continually improve on all work processes and move toward exceeding patient needs. However, at this stage there is always a tendency for organisations to feel that they are already a quality organisation; an attitude which leads to the abandonment of the quality initiative. This should never be the case because patients' needs and expectations are not static, but continually changing. What satisfies one patient may be an anathema to another. Hence, the hospital's effort and energy should be channelled towards continually improving the services provided, in pursuit of a dynamic quality of care which meets the changing needs of patients.

Further departmental training for all staff will show that management has maintained its commitment to quality. At this stage, training should be more exciting because the staff must all have had first hand experience of TQM and should be in a better position to share their knowledge and critic departmental approaches. This will afford the organisation a further insight into a new cycle of quality initiatives as it moves forward with the TQM process, particularly, the integration of TQM into the organisation's business plan. This represents the fact that TQM is now firmly ingrained on the managerial agenda. It is the testimony that management is fully committed to quality. Thus, quality becomes an integral part of both the organisation's short and long term planning processes.

Additionally, it is fundamental that top management creates the proper environment, stays involved and exhibits its responsibility through managing the TQM process.

A cultural shift must occur if the NHS is to enjoy the benefits of TQM. But that shift will not happen without management's perpetual, enthusiastic and demonstrated

commitment to TQM. Getting people involved in TQM without top management's commitment and leadership, as is the case in most NHS hospitals, is a recipe for disaster. As previously identified, most of the problems of TQM in the NHS are managerial in origin, thus TQM implementation should be geared towards changing the 'system'. But, this can only be achieved by the top, hence, the Chief Executive Officer and the Trust Board must be overtly committed to quality improvement.

COMPARISON BETWEEN THE HOW-TO-DO APPROACH AND THE MIXED MODEL

In order to establish the reliability of the study's proposed model (**How-to-do approach**) it is necessary to compare it to an NHS model earlier developed by the Brunel University - **the mixed model**. The aim of the comparison is to show that the How-to-do approach being suggested by the author represents the most complete and comprehensive model available for the implementation of TQM within the NHS. It is the first systematic and holistic model grounded in empirical data and thereby representing a problem-specific approach for implementation. The mixed model approach proposed by Joss et al, was chosen for comparison because it represents the most up to date study (May 1994) on TQM initiatives in the NHS. The criteria for comparison will be based on those used by Joss et al, to compare the mixed model against orthodox models³⁷; the justification for such a comparison being to rule out any form of unfair comparisons, or bias.

Before the comparison is made, it is important to note that two significant differences exist between the two models:

- (1) The **How-to-do approach** is an holistic TQM model whilst the mixed model is a quality assurance model which represents a traditional, professional approach to quality. On the basis of this significant difference, it could be argued that the mixed model is inappropriate for the implementation of TQM. The Department of Health wants to encourage a systematic and not a professional approach to quality across the NHS. Thus, a recommendation for a hospital to adopt a quality assurance model defeats the objectives on which the 23 demonstration sites were first set up in 1989. What the author cannot

reconcile is the fact that the remit of the Brunel team was to explore the success of what they called orthodox TQM in the NHS. The Brunel Report concluded that orthodox TQM paradigms have failed in the NHS because they are manufacturing based and recommended a mixed model approach.

However, this study, through a systematic analysis of TQM initiatives in the NHS, concludes that orthodox TQM has not failed. It is yet to be tried. The problem is not with orthodox models of TQM but the lack of understanding of the holism of TQM which has led to improper implementation. In healthcare settings across the globe, TQM has moved-on from quality assurance, which is inspection focused, to holistic TQM. This means that quality assurance models are antithetical to the ethos of getting things done through people which is the central thrust of most TQM initiatives. Thus, to suggest a reversion back to quality assurance, smacks of a lack of understanding on the part of the researchers of what is required in making quality happen. It is disappointing to note that at a time when quality practitioners, such as the author, are advocating moving beyond TQM, a team of Department of Health sponsored researchers is suggesting a quality assurance model. The NHS as it stands, has enough problems. What is needed is a systematic model that shows 'how' TQM can best be implemented and not one that shows how one group of people (professional staff), would continue to dominate the scene through a retrogressive quality model.

- (2) **The issue of validity.** In order to ensure the validity of the How-to-do approach, the author developed the model after conceptualising the pitfalls, and key success factors for the successful introduction of TQM into the NHS. The model was sent to fifteen Quality Managers in the NHS for critical appraisal to learn if it was able to deal with the problems which they had identified over the two year research period as constituting barriers to the implementation of TQM. The Quality Managers who replied, suggested a number of improvements. The improvements were made but rather than send the revised model back to the respondents through the post, the author elected to meet them on an individual basis to discuss their respective comments. Interviews were arranged and the author visited each manager for discussion. On completion of the interviews,

a revised model was developed (Figure 48) based on the suggestions of these managers. The justification for the author's action is that the Quality Managers, after five to six years in their jobs, know which models can work. It is like the popular saying; 'the best people to bring about changes in an organisation are those who work in the system'. Thus, the How-to-do approach represents an accepted, valid, context specific model for TQM in the NHS. In fact, one manager commented "I wish I had the model five years ago, I would have used it as an entry point to TQM"³⁸. He further noted out that although he had spent much time reading the literature in order to choose the best approach for his hospital, he had failed to identify an appropriate implementational model for TQM. On the other hand, the mixed model does not appear to have been validated in this way. It is a theoretical TQM model, developed in an academic fashion after a piecemeal exercise. As earlier stated, Quality Managers are suspicious of academic models. They argue that many people theorise about TQM without any practical knowledge of how it is done. Nevertheless, the How-to-do approach will be highly received in the NHS because, as the saying goes, it speaks the language of the shopfloor; in this case, the language of the Quality Managers in the NHS. It is a practical, easy-to-use model. Furthermore, the Brunel Report noted that an infrastructure was required for the successful implementation of TQM in the NHS, but failed to provide an example of such a framework. In contrast, the 'How-to-do' approach encompasses an infrastructural framework and goes a step further by providing a measurement framework for the auditing of processes in the NHS to facilitate the monitoring of progress in TQM. The analysis of the key differences between the How-to-do approach and the mixed model is shown in Figure 52.

FIGURE 52**GENERAL FEATURES OF THE TWO APPROACHES TO QUALITY**

	HOW-TO-DO APPROACH	MIXED MODEL
Leadership of Change	Must be led by the Trust Board supported by medics and staff. Starting off with an organisation audit (SWOT Analysis).	More even, multi-model leadership determined by needs. Supported by specialist quality staff. Starting off with assessment of available skills and building on these.
Modes of Senior Management Action (including clinicians)	<p>Must stay involved and lead the message through the Quality Improvement Team. Must deal with cross-functional issues and help the facilitators, to determine with the Quality Council pilot schemes.</p> <p>The clinicians to be involved from the outset of the TQM programme involved in the Quality Council, Quality Improvement Team, Doing Group and Checking Group. The TQM programme to be centred around consultants.</p>	<p>Determined about three elements of quality - technical, systemic and generic, looking to encourage advances in each having regard to starting points.</p> <p>Support and enable developments of local systems within broader organisational requirement for quality systems.</p> <p>Handle tensions between individual variations and systemic prescription. Role is developmental and multi-model. Able to move across boundaries.</p>
Centre - Periphery Relationships	Requires departments through the process improvement team to implement quality. structured cycle approach for each function although adaptations are allowed.	Centre requires services to implement quality systems but allows for variability in design of systems for each function or service.
Mode of Implementation	A process led strategy (a hybrid of TQM and BPR) on a pilot-by pilot - basis. Results oriented.	Iterative and helical style multi-model corporate planning - some synoptic/prescriptive, but also more incremental and developmental.
Concepts of Change	People can only make quality happen. Achieving quality through people.	Mainly normative re-educative prescription would be last resort.
Structural Differences	Quality improvements through departmental process improvement teams assisted by the Quality Council, Quality Improvement Team, the four Cycle Groupings. The Process Improvement Teams to be led by a facilitator. Separate reporting structure with the Quality Manager coordinating affairs although the checking group audits the TQM process.	Majority of quality improvement effort would come from line managers, supported by strictly staff role of facilitators located in services. No separate meeting structure but would be central quality person with evaluation skills and brief.

	HOW-TO-DO APPROACH	MIXED MODEL
Quality Assurance Approaches	Condemns it. Encourages a pluralistic approach. Involvement of everyone. The CEO should shield the organisation from concurrent external intervention.	Centre requires periphery to assure quality against a range of central, service and external criteria.
Overall Definitions of Quality	Advocates the primacy of the fit for purpose definition of quality. The key variable is customer is king.	Multiple definitions but with similar key elements. Balance and content of generic, systemic and technical quality determined by services. Key variables might be customer, professional and management quality. Generic and systemic might be weaker than technical.
Cross Functional Process Improvement	Key function of the Quality Improvement Team and the Quality Council. Focus on improving interprofessional rivalry and sectionalism.	Moderate focus on cross functional activity but always starting from the particular base. By definition, it would focus on systemic quality.
Organisational/ Departmental Performance Review	A continuous activity at the completion of every cycle. A mandatory requirement. Chaired by the checking group.	Diagnostics/benchmarking more targeted and specific. Issue, thematic, heuristically based.
Individual Performance Review	Not advocated.	Customer requirements would also figure strongly but be mediated by professional and process concerns. Development of performance indicators would be by identifying the contribution made by knowledge, values and skills of each group towards the achievement of requirements. Harnessing skills would be the overriding concern.
Education and Training	The most important aspect. Extensive training for staff and retraining. Extensive training with the use of outside consultant for the: Quality Council Team of Facilitators Quality Improvement Team Emphasis on: Problem solving Problem identification Team building Tools Principles An interactive process is advocated.	Sees education as re-educative, starting from where people are and building on their current knowledge, values and skills. Top dictates requirements for quality assurance system then engages in meta evaluation. Training would be based on a personal development approach in which quality, including tools and techniques training would be built into all courses. Emphasis would be built on developing open learning approach with strong element of monitoring and evaluation building on what was already available at the base.

	HOW-TO-DO APPROACH	MIXED MODEL
External Customer Focus	Empowered workforce to make process improvements and streamlining of activities in order to move the services closer to the customer.	Open management which seeks to empower staff and users. But problem of technical jargon and technical nature of QA may make it difficult for them to contribute. Notion of informed user groups may be relevant here.

Source: Compiled by the Author (1995)

From Figure 52, a number of key differences can be identified between the two models:

- (1) **The mode of implementation.** The How-to-do approach is specific and clear cut about its advocacy of a process led strategy for TQM, whilst the mixed model advocates a multimodal, synoptic approach which will be difficult for NHS Quality Managers to comprehend. These managers noted that they required a simple, easy to use, practical kit for TQM. The elements of the multimodal approach are not established and it may be contended that it, like the traditional models of TQM, has left the interpretative steps of implementation to the practising manager. Thus, the mixed model is not adequately contextualised. This means that it lacks a concise formulation of the precise elements or activities to be undertaken by an organisation en route to TQM.
- (2) **Concepts of change.** The How-to-do approach emphasises a people focused approach to implementation, whilst the mixed model adopts academic jargon and makes reference to normative re-education; a concept which would mean absolutely nothing to managers in the NHS. The mixed model smacks of a lack of understanding of how the NHS actually operates.
- (3) **Leadership for change.** The mixed model advocates that leadership should be determined by need and supported by specialist quality staff, whilst the How-to-do approach indicates that the Trust Board should lead the way for quality.

Quality initiatives would falter if the Trust Board is not committed to the process. Through its actions and only through its leadership can any hospital move forward to achieve and sustain TQM. One of the problems confronting the NHS is that most Trust Boards are still finance driven. Once their commitment and focus becomes quality orientated, TQM becomes feasible in the NHS. In suggesting that leadership should be determined by needs, the mixed model fails to establish 'whose' needs; the needs of the government, of the patient or of other stakeholders. The view of most quality writers seems to fully support the How-to-do approach, advocating the need for leadership for change, to come from the Board, exemplified by the CEO. Furthermore, the mixed model suggests the need for individual performance review; disregarding Deming's warning that performance review demotivates the workforce³⁹. Consistent with Deming's view, the How-to-do approach emphasises organisational/departmental reviews rather than a review of the individual. This will enable employees to work better in teams and without withholding vital information that would enable improvements in the provision of quality care.

In the final analysis, the author is of the opinion that the mixed model resembles a good model for presentation at an academic conference rather than an actual model for the implementation of TQM in the NHS. This is because the mixed model made the same mistake for which its creators criticised the orthodox model of TQM, i.e. its inappropriateness for dealing with the complexity of the NHS. In addition, the mixed model fails to address the complex, functional requirements of the NHS which necessitates integrating the various functional structures such as the roles and responsibility of:

- The Trust Board
- Directorate Heads
- Service Managers
- Senior Ward Sisters

The author is of the opinion that, for any model of TQM to work in the NHS, the responsibility and roles of these key functionaries must be determined and integrated within the model to create a managerial focus for TQM. The mixed model fails to

make this important provision. Hence, it lacks the comprehensiveness of a specific TQM model for the NHS, whilst the How-to-do approach has specifically delineated the functions and responsibilities of each of the key players to avoid conflicts of interest. Furthermore, the mixed model, like the orthodox model which it sought to replace, represents a piecemeal approach to TQM in the NHS. Finally, none of the Quality Managers interviewed by the author was aware of the existence of the mixed model; despite the fact that the Brunel Report was sponsored by the Department of Health.

ADVANTAGES OF THE HOW-TO-DO MODEL

If the 'How-to-do' model is applied within the context of the NHS, the author contends that it is capable of:

Dealing with the confusion that exists in the NHS as to how to integrate TQM within other, on-going quality initiatives such as the Patients' Charter. This is because the model integrates the Patients' Charter as its quality standards against which certain improvements can be measured.

Drawing managerial attention to the initial weaknesses experienced by the hospitals, the existence of service gaps, which demand attention prior to the introduction of the TQM approach.

Facilitating communication, horizontally, vertically and cross functionally, and improving coordination by stressing the importance of processes and laying the foundation for a team driven approach to problem solving and process improvement.

Leading to the development of the crucial linkages between supplier, processor and customer and emphasising prevention rather than detection through an in-depth, organisational assessment exercise prior to TQM.

Enabling the more rapid growth and development of the TQM initiative beyond the narrow confines of standard setting and monitoring which seems the central

focus of quality in the NHS. By so doing, serving the NHS better than the individualised approaches which, in effect, lock quality improvement into one area, the professional area, in which poor quality is a problem.

Providing a clear sense of corporate direction and a climate supportive of continuous quality improvement.

Ensuring constant measurement and monitoring of the TQM process in order to know whether the organisation is moving in the right direction

The How-to-do model suggests that, in the implementation of TQM, managers should concisely and properly administer the tenets of TQM. This will ensure the achievement of a quality focused culture across all strata of organisational activities.

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CHAPTER 8

CONCLUSION

Herein is an analysis to establish the development of a generic model for the implementation of TQM. As earlier established this study was embarked upon for two main reasons:

- (1) to establish why TQM programmes often fail
- (2) limited number of research in TQM in healthcare.

The research methodology chosen, which represents the use of both qualitative and quantitative data, enabled a wider and more in-depth analysis of the process of TQM implementation in the NHS. Earlier studies, for example, Joss et al¹, were based on eight NHS hospitals representing a limited sample of the TQM sites. Thus, the methodological instrument used in this study facilitated a wider coverage of TQM sites and this enabled a more systematic, reliable and valid account of:

- the mode of TQM implementation across TQM demonstration sites;
- the pitfalls to TQM;
- the critical key success factors of TQM; and
- where the NHS stands in relation to quality.

Based on the rigorous assessment of these essential characterisations of TQM, it was possible to discern and develop a generic context specific model for the implementation of TQM in the NHS.

Additionally, the methodological framework in contrast to popular belief shows that case study research is capable of statistical analysis. It is believed that this work offers the first reported empirical evidence into the evaluation of TQM in the NHS which makes use of the statistical package for social scientists (SPSS) for the analysis of data.

One reported criticism of case study research is the issue that the data collected does not give room for generalisation². However, this study does not have this problem because the use of five different but interrelated postal questionnaires and the three

main case studies enabled generalisation across hospital settings. Furthermore, the use of Yin's explanation building technique also enabled the cross case analysis of the three cases³. This unique methodological approach made certain that the study established reliable answers to the 'Why' and 'How' questions posed by the research.

RESEARCH FINDINGS

In reviewing the literature this study found a number of differing definitions of quality:

Product based	-	quality defined as precise and measurable
User based	-	quality is defined as fitness for intended use
Value based	-	quality is defined in terms of costs and prices

However, the definitions put forward by Crosby and Juran were found to be widely accepted, that is, 'quality is fitness for use'⁴ and 'quality is meeting requirements'⁵. But in the NHS the two definitions had no remarkable significance. There is in existence differing interpretations of the meaning of quality from one hospital to the other, from one employee to another. In one particular hospital, the author identified four different definitions of quality in use:

- (1) To the medical staff, 'quality is about whether the patient lives or dies'.
- (2) To the receptionists, 'quality is about how we present things'.
- (3) To the Chief Executive, 'quality is low cost'.
- (4) To the Quality Manager, 'quality is about affording the patient what is medically affordable'.

Thus, there exists a lack of common definition of quality in the NHS. This is symptomatic of the failure of NHS Quality Managers to adopt an organisationwide definition of quality at the onset of TQM; although there seems to be an implicit agreement amongst Quality Managers in the NHS that quality is meeting patient requirements. Thus, Crosby's definition of quality seems the acceptable and common

definition. However, Quality Managers in the NHS do not consider the adoption of a companywide definition of quality as axiomatic to the successful implementation of TQM. This apparent ignorance, the author notes, is one of the contributory barriers to the implementation of TQM in the NHS because the TQM initiative lacks a central focus on which to align all organisational members. Furthermore, with regard to the implementation of TQM, the literature is inundated with prescriptions in the form of step-by-step approaches or TQM as culture change. These prescriptions, in particular the "Gurus'" philosophy, are not problem specific and have not been derived from empirical evidence. They fall short of the holism required of TQM. Their apparent limitations can be summarised thus:

- the lack of attention directed to the 'people issues' within organisations
- the absence of a realistic approach to organisational politics, in particular, the politics of organisational change
- the failure to address the issue of organisational culture
- weak on 'how' to operationalise, sustain and follow through their ideas in an organisational context
- failure to furnish the specific/essential details of an action plan
- failure to contextualise their ideas within a comprehensive framework
- failure to deliver a 'statement' which both underpins and elaborates the philosophy of TQM

The author is of the opinion that these obvious limitations have led to 'Cafeteria Management' in the NHS. This is a situation whereby managers, charged with the responsibility for the maintenance and enhancement of quality in health provision, have opted for 'individualised' models based upon their personal experience. Thus, Quality Managers within the NHS are working to evaluate the benefits that TQM can bestow upon their organisations on the basis of an idiosyncratic understanding of past, intra-

organisationally determined, experience. Inevitably, this has impacted upon the process through which TQM has been introduced within the NHS, with the Quality Managers' experience of TQM directly determining the way in which the tenets of TQM are implemented. This situation has led to the adoption of different 'personalised' approaches to the implementation of TQM across the TQM demonstration sites. The study identified 15 different personalised approaches to the implementation of TQM in the NHS; although most of them adopted a central focus on standards setting and monitoring. This depicts the confusion managers were facing in determining an appropriate or 'best' implementation framework for TQM and underlines the fact that TQM sites in the NHS have not adhered to any prescribed pattern of implementation.

Whilst such 'individualised' approaches have the merit of affording recognition to those essential characteristics of any one organisation, they have the demerit that they fail to guarantee continuity of implementation which is an essential requirement for the sustainability of any TQM process. As successive Quality Managers add their own personal dimensions to what should be a systematic drive for enhanced quality, the obvious consequence is a loss of direction and momentum. Therefore, the author argues that the 'prescriptions' in the quality literature which represent the traditional paradigm of TQM is inadequate to deal with the unique organisational complexities inherent in the NHS. What is required is a holistic model for TQM which would recognise that organisations are not mere apparati but instead, a conceptualisation of human interactions working towards the achievement of overtly stated purpose. Furthermore, whilst most writers in the quality field advocate the need for an organisational infrastructure to support and sustain TQM they have failed to provide such a framework. However, this study offers such an infrastructural framework. The framework - the 'what-to-do' approach is introduced through five phases: Pre-Set up, Set up, Get up, Stay up and Move up. It is advocated that this framework would serve as the 'foundation' stone upon which the implementation of TQM in the NHS could best be based.

The very lack of adherence to a structured systematic approach to the implementation of TQM in the NHS has invariably given rise to many Trust hospitals encountering problems with their TQM programmes. Thus, in determining the potential 'pitfalls'

which have led to difficulties in implementation across the TQM demonstration sites, the study identified 'pitfalls' arising from each part of four key managerial processes:

- management systems and processes
- workforce
- senior management
- management practices and work methods

Under these key managerial processes, eighteen pitfalls were found to be valid and specific across the NHS. The factors include:

- the hierarchical structure of the NHS
- the emphasis on finance and contracts
- redundancies and streamlining of services
- hospital processes designed for staff convenience
- difficulty in establishing measures/quality indicators
- organisational segmentalism
- the 47 year old culture
- lack of coordination from the centre
- difficulty in identifying the customer
- the professional nature of the workforce
- professional resistance
- fortress mentality
- turnover/changes in key personnel
- fear and resistance to change
- lack of involvement by professional staff
- other initiatives going on at the same time as TQM
- standard setting and monitoring seen as the basis for quality
- failure by management to walk the talk

In addition, the NHS was found to be experiencing difficulties arising from the failure to address the seven quality gaps identified by Parasuraman et al⁶. The gaps have led to barriers in the implementation of TQM within the NHS. The seven quality gaps that exist in the NHS are:

- lack of management understanding of patient expectations of the service
- failure to translate patient expectations into quality specification
- failure to adhere to specifications for service delivery
- failure to communicate effectively with patients
- failure to ensure that patients' expectations equate to the patients' perception of the service provided
- failure to listen to contact staff
- staff are not empowered and trained in delivery of quality service

On the basis of the avalanche of pitfalls, particularly the existence of the seven quality gaps, the study suggests that the services provided by the NHS fall short of patient expectation. This is congruent with Zeithaml et al's view that, "the presence of the gaps in any organisation suggests that the organisation is not providing a quality service"⁷. Nevertheless, the study found that the 'main' reasons for the avalanche of pitfalls inhibiting the introduction of TQM in the NHS were two fold:

- the NHS is under-led both from the centre and from within as revealed by the four key managerial activities. It is the responsibility of management to prevent the barriers from arising.
- most of the pitfalls are symptomatic of the lack of a managerial understanding of the holistic nature of TQM due to the absence of holistic, context specific model of TQM. Hence, the NHS is stumbling in the dark with regard to quality management.

Despite the impossible difficulties the NHS is facing in the implementation of TQM, the study found through the use of the Crosby Maturity Grid, nine hospitals were making meaningful progress towards the state of continuous improvement. The nine

hospitals had scores of between 43-87 percent quality maturity; although six hospitals were potentially struggling with their TQM programme. This underlines the fact that TQM has not failed in the NHS, it is yet to be tried. The study established that what is required is a model that will facilitate progress; thereby moving the dynamics of the NHS towards the provision of a quality focused service. Against this background, it was essential to delineate the critical key success factors specific to the NHS which would enable the eradication of the identified pitfalls. Seventeen critical success factors were empirically discerned as being of specific relevance to the NHS:

- the need for an organisational structure
- demonstrable leadership, commitment and vision from the Trust Board
- a need for a holistic approach
- communication across all departments
- education and training
- a need for a corporate quality agenda between purchasers and providers
- redesign and streamline critical work processes
- optimisation of the system
- the need to involve professional staff on a continual basis
- involvement and empowerment of staff
- management should create joy in work by instituting honesty
- managers must 'walk-the-talk'
- institute robust systems for monitoring and measurement
- establish partnership with Royal Colleges
- institute a reward system
- review continually the quality process
- integrate into strategic business plan

The awareness of the critical success factors underpinning TQM in the NHS would enable Quality Managers to benchmark against the specific requirements of their individualised approaches in order to ensure that the essential factors for success are adequately represented. However, caution must be exercised to avoid the fizzling out of the programme. In order to guard against this, the study suggests a sustained commitment and knowledge of the interlinked critical success factors on the part of Quality Managers.

In the final analysis, it is in pursuit of making the TQM philosophy manifest, in making it operational, that practising managers in the NHS need help and guidance. To date there have been only a few piecemeal and non-empirical attempts made to offer an holistic implementational model of TQM that could serve as a reference point for managerial efforts and which could facilitate the 'total' eradication of the barriers to implementation presently being encountered across the TQM sites. To this end, the provision of the context specific model of the 'how-to-do' approach to TQM could serve as a guide for Quality Managers in the NHS in their attempt to introduce and sustain holistic TQM. The 'how-to-do' model requires an adherence to its four interrelated and sequential parts:

Planning	-	Leadership
Doing	-	Process redesign
Checking	-	Measurement
Action	-	Customer Focus

However, it must be noted that although the specific logistics of the model are given, it is not written in tablets of stone. The model can be adapted to fit any specific organisational characteristics.

The analysis herein appears to fit the title of the study: 'the analysis of the feasibility of developing a generic model for the implementation of TQM', albeit with modifications to the effect that a generic context specific model was provided after thorough analysis. Thus, the development of the context specific model was first determined empirically and then validated by 15 Quality Managers in the NHS.

RECOMMENDATIONS FOR FUTURE RESEARCH

The provision of a context specific model for the implementation of TQM provided by this study is consistent with Black's doctoral thesis that a scientifically derived model for the implementation of TQM is required⁸. Although the Quality Managers in the NHS have validated the 'how-to-do' model as relevant and reliable in dealing with the identified pitfalls of TQM in the NHS, any model which lays claim to providing a pathway to the implementation of TQM should have been tested under operating

conditions. This constitutes the limitation of this research. Thus, future research is required into the practical application of the 'How-to-do' approach within a hospital setting in order to determine its effectiveness as an implementation model that would enable the facilitation of TQM to take the NHS towards the desired future state; the state of continuous quality improvement. Furthermore, research is required in 3-5 years to determine 'what' becomes of total Quality Management in the 23 demonstration sites. In the author's opinion, it seems as though the Department of Health will change the organisational focus of the NHS from TQM to the implementation of the requirements of the Patient Charter. Thus, total quality management in the NHS in the very near future 'may be' discarded. Nevertheless, this study provides an opportunity for NHS managers to redesign the process of TQM as it raises their awareness of the fundamental problems which will be encountered. This would assist the progress of many quality initiatives in the NHS to attain Crosby's stage five on the Quality Maturity Grid; the stage of quality certainty⁹.

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QUESTIONNAIRE 1

PREPARATION FOR THE TQM PROGRAMME

This questionnaire seeks to determine the implementation process your organisation undertook for the TQM programme. Information pack to the questions would be appreciated.

Question 1

What preparations, if any, did you undertake at the initial stage of introducing TQM. Identify what you did exactly, and the time allocated to this initial stage?

Question 2

What progressed from the initial stage?

Question 3

What followed on from question two, i.e. Stage 3 of the process?

Question 4

What other comments can you make about your TQM programme?

QUESTIONNAIRE 2

In order to measure effectively at what level your TQM programme is at the present time, please tick the appropriate block in the grid indicating the stage at which you think your organisation is in for each of the five measurement categories. This should reflect your opinion in your capacity as the Total Quality Management Co-ordinator.

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

QUESTIONNAIRE 3

The list below are factors identified in the TQM literature as obstacles inhibiting the effective implementation of TQM in healthcare. Rate your organisation on each factor.

1. *Lack of strategic direction and executive leadership.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

2. *A tendency to deal with specific episodes that constitute bad clinical care instead of removing the underlying causes of those chronic levels that are less than perfect.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

3. *Hospital processes are designed for the convenience of staff and practitioners.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

4. *Lack of active personal involvement by upper-level managers.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

5. *Very much financial and contracts driven.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

6. *Lack of active involvement by the professional staff (Doctors, Consultants, Nurses, etc.).*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

7. *Lack of communication both horizontal and vertical.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

8. *Ineffective method of introduction of TQM.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

9. *The lack of adequate education and training in TQM methods and problem solving skills.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

10. *Limited funding for the TQM programme.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

11. *The hierarchical structure of the N.H.S.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

12. *Many other initiatives going on at the same time with TQM.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

13. *No agreed upon meaning of quality. A commonly held definition of quality.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

14. *We already practice quality; TQM is not important.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

15. *The professional nature of the workforce, i.e. independence of consultants.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

16. *No coordination and support from the centre, i.e. DOH and NHSME.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

17. *No agreed upon implementational process. Confusion on which Guru to adopt his strategy.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

18. *Difficulty in identifying who the customer of the NHS is?*

☐

Most
Significant

☐

Significant

☐

Least
Significant

☐

Not
Significant

☐

Does Not
Apply

19. *Lack of an appropriate vision.*

☐

Most
Significant

☐

Significant

☐

Least
Significant

☐

Not
Significant

☐

Does Not
Apply

20. *Difficulties in establishing measures and quality indicators that truly reflect the objectives of the organisation. Senior management tend to impose quality indicators.*

☐

Most
Significant

☐

Significant

☐

Least
Significant

☐

Not
Significant

☐

Does Not
Apply

21. *The attitude that standard setting and inspection is the basis for quality in Healthcare.*

☐

Most
Significant

☐

Significant

☐

Least
Significant

☐

Not
Significant

☐

Does Not
Apply

22. *Resistance from professional staff, particularly Doctors and Nurses.*

☐

Most
Significant

☐

Significant

☐

Least
Significant

☐

Not
Significant

☐

Does Not
Apply

23. *Turf battles between departments.*

☐

Most
Significant

☐

Significant

☐

Least
Significant

☐

Not
Significant

☐

Does Not
Apply

24. *Organisational segmentation.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

25. *Apathy/lack of commitment by all employees to the TQM process.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

26. *Turnover/changes in key personnel.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

27. *Fear and resistance to change.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

28. *Inadequate knowledge about and understanding of TQM.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

29. *Inadequate planning for TQM implementation.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

30. *Unclear definitions of TQM goals, authority, and boundaries: Lack of constancy of purpose.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

31. *Staff shortage; no spare time to attend meetings and to problem solve.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

32. *Failure to implement solutions in a timely manner.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

33. *Lack of involvement by middle managers.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

34. *Lack of confidence in the TQM program by most employees.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

35. *Approaches to TQM mechanistic.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

36. *Difficulty in overcoming an organisational culture that has been in existence for over 40 years.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

37. *General management coming late to the NHS.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

38. *The lack of market pressure: patients do not have a choice in a service that is free at the point of delivery.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

39. *Failure on the part of management to work to talk.*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

40. *Fear of losing jobs, i.e. redundancies and streamlining of services (cut backs).*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most Significant	Significant	Least Significant	Not Significant	Does Not Apply

QUESTIONNAIRE 4

This questionnaire lists 7 key elements of service quality. Rate your organisation on each item by circling the correct code. Give three points for a high ranking ("We're good at this; I'm confident of our skills here"): two for medium score ("We're spotty here; we could use improvement or more experience"); and one point for a low score ("We've had problems with this; this is new to our organisation"). Be honest. Don't trust only your own perspective; ask others in the organisation, at all levels, to rate the company too.

THE GAP	THE PROBLEM	SCORE		
Management Perceptions (Gap 1)	Do management understand correctly what patients expect of the service?	3	2	1
Service Quality Specification (Gap 2)	Do you translate knowledge of patients' expectations into quality specifications, standards or guidelines?	3	2	1
Service Delivery (Gap 3)	Are guidelines and specifications for service delivery adhered to?	3	2	1
External Communications (Gap 4)	Do you communicate effectively to patients about the service?	3	2	1
Patient Expectations - Perception Gaps (Gap 5)	Are you able to map the cycle of the patient's moments of truth; that is the patient's journey through the service, ensuring that the patient's expectations equate to his/her perception of service provided?	3	2	1
Internal Communications (Gap 6)	Does your organisation listen to contact staff about what the patients think of services delivered?	3	2	1
Contact Staff Perceptions (Gap 7)	Are staff empowered and trained in delivering quality service to patients?	3	2	1

CRITICAL SUCCESS FACTORS FOR QUALITY IN THE NHS

Please answer Yes or No to the following 8 questions and if possible kindly add to the list any other additional factor(s) you consider 'critical' for Quality to succeed in the NHS.

1. Necessary Management Behaviour: Clear leadership, commitment and vision is required of senior management. Is this significant in the NHS in your experience?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
1	2

2. A Strategy for Quality Implementation: The specific Quality objectives and requirements of the organisation must be determined. Quality must be integrated in the organisation's business plan. Is this significant in the NHS in your experience?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
1	2

3. Organising for Quality: Quality requires an organisational structure which demands and harnesses the full potential of the workforce. Is this significant in the NHS in your experience?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
1	2

4. **Communication for Quality:** Communication provides the means of raising quality awareness and involvement and reinforcing the message. Is this significant in the NHS in your experience?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
1	2

5. **Training and Education:** Education and training should cover all employees as part of an ongoing process suited to each group's needs. Is this significant in the NHS in your experience?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
1	2

6. **Employee Involvement:** Involvement in Quality process is a key determinant of a successful programme. Is this significant in the NHS in your experience?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
1	2

7. **Process Management and Systems:** Process management and systems are a key part of a successful programme. Is this significant in the NHS in your experience?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
1	2

8. **Quality Techniques:** Quality techniques such as SPC, quality costing and benchmarking are necessary to reduce variation. Are these significant in the NHS in your experience?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
1	2

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

WORTHING



SOUTHLANDS

Hospitals

Southlands Hospital Upper Shoreham Road
Shoreham-by-Sea
West Sussex BN43 6TO
Tel: (0273) 455622

Our Ref: EJ/TH

Your Ref:

14th November, 1994

Mr. Uche Nwabueze,
Policy Research Centre,
City Campus,
113 Arundel Street,
Sheffield,
S1 2NT.

Dear Uche,

Thank you very much for your letter and for sending me your framework paper which I personally found very helpful and constructive. I have no other comments to add except to say I am sure you will find that it is received very positively. I was pleased that I was able to help in some small way towards your project and if there is anything I can do in the future please do not hesitate to get in touch again.

Yours sincerely,

Ernie James,
Management Adviser,
Directorate of Trauma, Orthopaedics & Maxillo-Facial Surgery

East Somerset NHS Trust

Yeovil District Hospital
Higher Kingston, Yeovil, Somerset BA21 4AT
Telephone Yeovil (0935) 75122 Facsimile (0935) 26850



Please ask for/Ext

Our ref: EM/ELC/068

Your ref:

Direct Dial (0935) 707 ---

10 November 1994

Mr Uche Nwabueze
Policy Research Centre
Sheffield Business School
Sheffield Hallam University
113 Arundel Street
SHEFFIELD
S1 2NT

Dear Mr Nwabueze

Thank you for your framework on TQM. I think you have clearly identified the prescribed activities and the pitfalls which I certainly recognise!

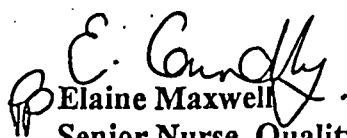
The framework itself is interesting but appears to be a vacuum without reference to external quality measures such as the Patient's Charter, purchaser specifications, EL communiques and Clinical Audit requirements.

Much of the disillusionment that health care staff in the UK experience is due to this ad hoc approach which results in both areas of omission and areas of repetition. The rest of a TQM framework is to bring everything together into an integrated system which motivates staff and produces observable change.

I am sorry if this sounds negative; and these may well be problems peculiar to the NHS and in fact these problems have been discussed by Kogan Joss et al at Brunel. (Evaluation of Total Quality Management Projects in the NHS May 1994).

I hope these comments are useful.

Yours sincerely


Elaine Maxwell

Senior Nurse, Quality and Special Projects

PUBLICATIONS

1. Nwabueze U., Morris D. and Haigh R. (1993) "TQM is not the Ultimate Medicinal Compound". A published paper presented at the 1st University of Newcastle-upon-Tyne Conference, Quality and its Applications, September.
2. Nwabueze U., Morris D. and Haigh R. (1994) "Quality: The Linkage between Definition and Doing in the British National Health Service". A published refereed conference paper presented at the 5th Annual Education, Training and Research Conference, European Foundation for Quality Management (EFQM) Barcelona, May.
3. Nwabueze U., Morris D. and Haigh R. (1994) "Does BPR have the Philosophy to Match TQM". A refereed conference paper, presented at the 2nd Academic Conference on BPR, Cranfield University, June.
4. Nwabueze U., Morris D. and Haigh R. (1994) "TQM in the NHS; Impotence to Progress". A published refereed conference paper, presented at the 10th International Conference of the Israel Society for Quality, Jerusalem, November.
5. Nwabueze U. (1995) "Organisational Diagnosis, a Healthcare's Experience of BPR". Being a published refereed paper presented at the 49th Congress of the American Society for Quality Management (ASQC) Cincinnati, Ohio, May 22nd-24th.
6. Nwabueze U., Morris D. and Haigh R. (1995) "A Model of Hope: The Integration of TQM and BPR". A paper presented at the 46th International Industrial Engineering Conference in Nashville, U.S.A., May 21st-23rd.
7. Nwabueze U. (1995) "TQM in the NHS: Rhetoric or Reality". A refereed paper presented at the 1st World Congress for TQM, 10th-12th April, Sheffield, U.K.
8. Nwabueze U., Nwankwo S. and Montanheiro L. (1995) "TQM, BPR and MARKOR: Competitive or Complementary Business Philosophies". A refereed paper presented at the 1st World Congress for TQM, 10th-12th April, Sheffield, U.K.
9. Nwabueze U., Morris D. and Haigh R. (1995) "Implementing TQM; How the Quality Gurus failed us and how to put it right". Being a refereed paper presented at the 7th Annual Meeting of the International Academy of Business Disciplines (IABD) Conference, Redondo Beach, California, April 5th-10th.