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TOTAL QUALITY MANAGEMENT

The Development, Application and Analysis

of a Total Quality Management Paradigm in

Healthcare

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ABSTRACT

The research programme focuses on Total Quality Management adoption and application. TQM which is established in a number of businesses and industries has more recently been introduced into healthcare. TQM definition and eclectic paradigm has been developed and tested for establishing quality performance and distinguishing radical change and continuous improvement approach. A number of critical elements and variables concerning implementation and application are identified which pertain to organisations which through size and bureaucracy operate with diverse missions, a wide range of systems and are characterised by degrees of rigidity from an employee mix of multiple knowledge, understanding competences skills and hence commitment.

Research was conducted in healthcare provider organisations, which involved eighty-three NHS hospitals/Trusts, wherein two pilot, twelve TQM demonstration and sixty-nine sites were involved. The main focus concerned a case study Trust, which although demonstrating keen interest in quality management had not reached the formative stages of developing TQM definition or paradigm.

The research framework is based on a number of approaches in that methods selected for evaluation were appropriate both to the situation and the context of TQM strategies being examined. Intention was to identify successes and failures of the TQM processes applied, establish similarities and distinguishable differences and determine extent to which TQM objectives were achieved and the impact of the processes on specific groups.

The investigation was undertaken using longitudinal analysis which involved in-depth interviews with top managers and clinicians and a mix of employees, customers, potential customers and purchasers in the form of managers, consultants, hospital doctors, nurses, support services personnel, patients, members of the public and GPs. TQM Awareness and Action Seminars and Workshops involving personnel from a variety of international healthcare organisations provided an additional source of data. Self-completion questionnaires were also used.

Data analysis compares and contrasts varying TQM models, processes, activities and results from degree of emphasis placed on critical elements and variables. Stage predictions and resulting outcomes are presented and quality of care improvements suggested from analysis of customer perceptions of quality and value. The findings show significant variations in approach between the hospitals/Trusts in matters which concern organisation, management and culture issues, resulting in a high proportion viewing TQM process as evolution from quality assurance to radical change, hospital process re-engineering and patient focused care. A minority only included such processes in their application of TQM.

Key conclusions result from attempt at establishing some measure of success and failure from TQM implementation and application. Findings contribute to the extant literature specifically in that beyond top management and clinician commitment to high level strategic focus is a combination of facilitator-led culture change, motivation and shared values directing attention to exceeding that of merely doing enough for reducing poor quality and customer complaints. Patient involvement in TQM is more problematic than literature suggests from both the patients and professionals perspectives of patient empowerment.

Bottom-up action focused TQM paradigm working simultaneously with top down support and commitment requires barrier breaking, culture transformation and the establishment of internal/external customer and supplier chains and seeking to establish opportunities for continuous improvement and radical change in advance of attempts at in-depth implementation and evaluation. It is not over-statement to conclude that the majority of managers and clinicians were unaware of the costs of getting things wrong.

Despite TQM being acted upon as driving force for competition most had limited knowledge of how much non-quality cost them, suggesting that they had not earlier thought it necessary to measure the costs of none or low quality. Research results, irrespective of applications definition or paradigm, question the views that TQM is long-term process. Whether these may be concluded as desire to integrate TQM with other foci or vacuum sucking in panaceas was unclear. It was clear however that although quality in healthcare is sacred total quality management is not.

ACKNOWLEDGEMENTS

Finally but by no means the least my sincere thanks to my Director of Studies, Dr B Kenny and my Supervisors Dr J Cook and Mr S Naylor, whose wisdom and council were so freely given.

CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1   BACKGROUND TO AND NEED FOR THE STUDY

The significant changes taking place in the NHS and the structures and systems of its constituent parts through which healthcare is delivered, along with the advent of Total Quality Management (TQM) offer significant research challenge. Schmele (1993), suggests that the paucity of published research on the object of TQM concerning health care organisations demonstrates need for investigation in this area. Research can provide healthcare organisations with important information regarding TQM implementation which lets them build on the experiences of others and generalise from research findings. To this end, researchers need to build a TQM knowledge base which incorporates the findings of others and replicating studies.

The rapidity of changes taking place in healthcare, Schmele points out, and the introduction of new paradigms necessitates research in order to bring about knowledge-based practice. Application of evaluation research to study TQM methodologies will increase knowledge in this area and assist healthcare organisations to expedite the implementation process.

As we move more into the 1990s and beyond it is possible to expect that the decade will be reflected upon as the decade of quality management. R L Chase (1990), suggests that organisations intent on surviving the uncertainties of the 1990s must be ready to make quality their one and only business goal.

Environmental forces are such that most organisations are now managed on BUSINESS lines, including the NHS and central to which is the need to continually improve productivity performance in terms of quality, costs and time. In 1989 for example, the Department of Health embarked upon a programme to encourage the introduction of a managed approach to quality in the NHS, and this was extended in the 1990s to the point of the Patient's Charter (1991), as a means for putting the Government's Citizen's Charter initiative into practice in the health service.

It is not uncommon to conclude from reports and published material which target TQM and the NHS, confusion and disagreement resulting from theory spread and over-generalisations, and in addition, a limited number of theoretical models to facilitate implementation. Hudson (1992), when summarising the King's Fund Institute briefing paper concerned with 'Quality Time' emphasised need for clear strategy and changes occurring in line with new policies. He went on to indicate a need for a new quality paradigm based on organisation and culture change.

Dalley (1990) reports that in most health authorities some sort of quality work is going on which he groups into three distinct areas:

Quality assurance
Quality improvement
Quality initiatives

He goes on to suggest, however, that to these areas should be added that most 'ill-defined' of topics, *total quality management*. Similarly, Dickens and Horne (1991), state that Quality is of vital concern to the NHS, and they further emphasise that TQM is ill-defined and based on system-wide projects that are less easy to define and observe. Finerty (1992), in witnessing the growth of TQM, makes the point that companies achieving quality require to make fundamental changes. Brooks (1992), whilst agreeing that TQM is both valuable and essential for the NHS, asks what barriers are to be overcome and how is the introduction of TQM compatible with other NHS initiatives?

A fundamental *a-priori assumption* is that the quality paradigm will only be achieved through the development of sound macro (common) and micro (specific) models, which require to address and accommodate a number of fundamental changes to how organisations do business. That is change in the sense that quality will feature more prominently in the corporate philosophy and permeate the whole organisation by providing people with the opportunities and support for continuous improvement.

2

In addition to this most important assumption is the writer's belief that research is required to underpin the management of quality in the broader terms of value satisfactions perceived by the customer, the elimination of waste and the practice of respect for internal and external customers and suppliers, rather than relying on the models relating to absolute standards and systems only which are considered to be constraining.

For the purposes of this research the term *customer* is defined as purchasers of care (General Practitioners, District Health Authorities, Directly Managed Units, Purchasing Authorities and other Agencies) and the users of care services, the Patient. The public at large are potential customers.

Research design and procedures are described in Chapter 5, which are built on the following framework:
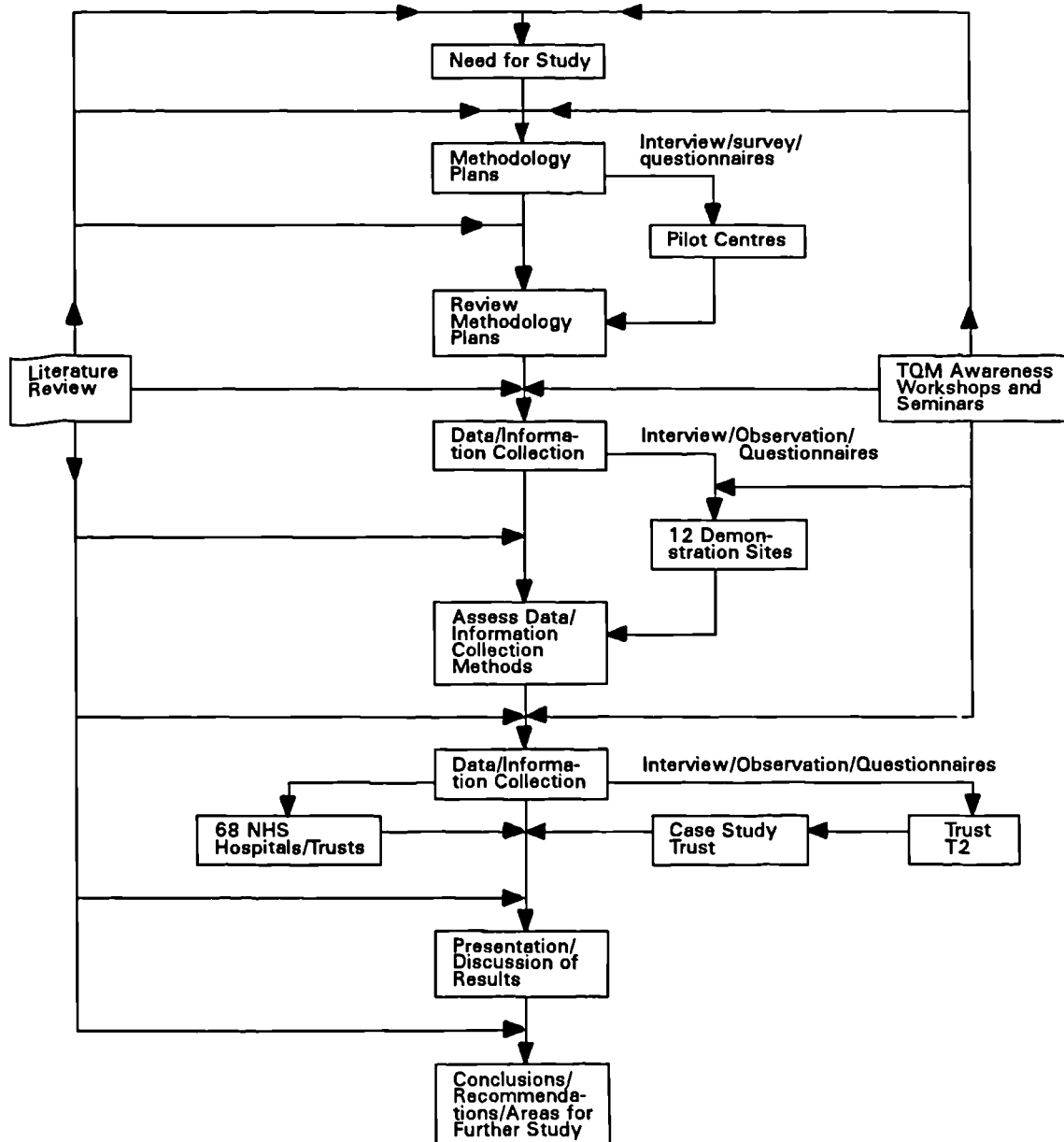
CHAPTER 2   DEVELOPMENTS IN HEALTH CARE 1920 - 1994: AN ORGANISATIONAL

AND MANAGEMENT PERSPECTIVE

2.0   Introduction

This chapter serves to provide secondary data overview of some important events in terms

of the political and directional changes in the health care services and to provide some

background of the historical, organisational, management and culture issues which have

evolved. These, as will be described later, need to be taken account of when attempting to

establish the organisational and culture changes necessary to implement and practice Total

Quality Management in health care organisations.

2.1   The Health Care System before the National Health Service (NHS)

History records the Ancient Egyptians as the first to have a health scheme in that when they

got sick they were visited by healers paid for by the Community.

Some 4,000 years later, and before the creation of the NHS, Britain's health care system

was a complex mix of private and public services. Lloyd George's National Health Insurance

Act which was placed on the statute book in 1911, had entitled insured persons to free

doctoring from a doctor of their choice, provided the doctor had agreed to participate in the

scheme (a 'panel doctor'). The scheme did not provide hospital or specialist care, however,

and failed also to provide for dependents.

The private sector consisted of voluntary hospitals and trusts, private practitioners and other

voluntary and commercial organisations, whilst the public sector was made up of municipal

hospitals and community health services run by local government.

Criticism of the British health care system began to emerge particularly after the first world

war, in that it was over fragmented into hospital, community and public services.

4

A number of reports in the 1920s to 1940s exposed the problems of the health services and chartered future paths for reform. The **Dawson Report** (1920) for example, argued for the integration of preventive and curative medicine under a single health authority which would co-ordinate a network of local hospitals and health centres.

The **Royal Commission on National Health Insurance** (NHI) (1926) urged the approved bodies who operated the NHI scheme to provide mechanisms for pooling surplus resources to fund access to specialist medical services.

The failure of the health care system to cater for the needs of those requiring specialist care was also a concern reported by the BMA (1929) who argued that NHI should be expanded to cover specialist services provided by the hospitals. It was also suggested that the scheme should be extended to cover the families of insured workers.

High rates of unemployment, particularly in the 1930s, undermined the operation of the NHI system, where people exhausted their rights to benefits of the scheme.

In the years before the second world war, the government (Conservative) actively considered the integration of existing health services. In 1936 the Minister of Health requested his Chief Medical Officer to report on the feasibility of a comprehensive health care system, from which the recommendation was made for local authorities to provide the basis of a comprehensive scheme.

The **BMA Reports** (1930, 1938), identified the need to regionalise the organisation of hospital services.

Such plans, however, were stopped by the need to address short-term emergencies, firstly the financial crisis experienced by many voluntary hospitals and second, imminent war.

During the war, the idea of a comprehensive health service became part of the wider issues concerned with reconstructing Britain, once hostilities ended. A major announcement by the Minister of Health (1941), identified the government's (Coalition) intention to create a comprehensive hospital service after the war. The broad principles of the post-war policy for health were contained in **Beveridge's Report on Social Insurance and Allied Services** (1942), in which the proposals for a national insurance rested on the assumption that there would be a comprehensive health and rehabilitation service for the prevention and cure of disease available to all.

The **BMA Draft Interim Report of the Medical Planning Commission** (1942), set out many features which were eventually incorporated in the NHS, these included organisational, administrative and financial issues, recommending regionalisation of hospital administration, remuneration of General Practitioners (GPs) mainly by capitation fee and an extension of NHI to pay for hospital and community health services.

Although a period of broad agreement on the need for a comprehensive health service, these were times of differing opinions surrounding the organisational and financial principles on which a service should be based.

The **Brown Plan** (1943), named after the then Minister of Health, sought to bring GPs and voluntary hospitals under the responsibility of local government, which pleased neither, from which a **White Paper** (1944) compromise was published. Significant proposals included a comprehensive and free at the point of delivery health service where GPs would come under the control of a Central Medical Board and the hospital service would be operated by joint local authority boards, responsible for controlling municipal hospitals and co-ordinating the activities of the area hospital network.

The doctors rejected the White Paper, fearing loss of autonomy, their lobbying was sufficiently effective to have removed major proposals including the establishment of the

Central Medical Board. Local authorities also obtained concessions to concentrate planning more at the local level.

The General Election of 1945 changed the Government from Coalition to Labour and Aneurin Bevan was charged with forming a new health service. The **National Health Service Act** (1946) was produced providing a broad plan for extending a comprehensive and free service of medical and ancillary care, advice and treatment for all, encouraging the maintenance of good health, rather than the treatment of ill health.

Bevan opted for a nationalised health service within a tripartite system of health care provision (Appendix 1). This required to accommodate varying interest groups, the medical profession who were alarmed at the principles of nationalisation, those who favoured local authority, and the numerous views on how the hospital service should be structured.

The Act came into operation on 5 July 1948 with Bevan spearheading a movement which already had force, and one which allowed him to practise his long held vision of a NHS composed of highly skilled men and women who were devoted to providing high quality care to their many patients irrespective of their ability to pay.

2.2   The NHS Formative Structure

The organisational form as earlier noted was a tripartite structure which represented a political compromise between the Government and the various provider groups.

The first part of the tripartite arrangement was for General Medical Practitioners (GPs) to remain self-employed contractors to the NHS, remunerated largely through capitation fees. The contracts of GPs along with those of General Dental Practitioners, Pharmacists and Opticians (also self-employed) were administered by Executive Councils, upon which the four professions themselves were heavily represented.

The second part of the arrangement was provided by local government - County Councils and County Borough Councils, who were responsible for preventive services, maternal and child welfare, health visiting, home nursing, ambulances and the school medical service. As a result local authorities appointed a Health Committee of Councillors, to whom the Medical Officer of Health (MOH) was responsible for these services.

The third part of the organisational form was constituted by hospital authorities. Nineteen (later twenty) regions were formed, each contained a medical school and each were controlled by a Regional Hospital Board (RHB) responsible to the Minister of Health. Hospital Management Committees (HMCs) presided over groups of hospitals in each Region. Groups of hospitals with medical undergraduate teaching functions were run by Boards of Governors, who unlike HMCs were responsible direct to the Minister of Health. The Boards and Committees employed a Chief Administrative Officer (Group Secretary), and individual hospitals were normally managed on a day-to-day basis by a triumvirate. The consultants were employed by RHBs rather than HMCs, and consultants retained their right to engage in private practice by opting for a 'part-time' NHS appointment.

The NHS had barely begun its existence before it faced financial problems. By the early 1950s concern had grown at the high costs of the NHS and the Government (Conservative) established the Guillebaud Committee in 1953, to investigate reasons why the NHS had consistently exceeded cost estimates. Their report was unexpectedly favourable concluding that rather than there being any financial crisis, estimates had failed to allow for demographic change or to take account of inflation. The report strengthened the case of those who argued for greater expenditure and made it more difficult for those seeking economies. The Committee did, however, recommend more emphasis on "over-seeing" and "supervision" of the service. Committee of Enquiry (1956):

2.3   Management and Organisational Review

At a similar time to the Guillebaud Committee the **Bradbeer Committee** was responding to

uncertainties about management relationships, reported by NHS managers from widely

differing pre-NHS backgrounds. The Committee legitimised the existing trend for HMCs to

appoint a Chief Administrator at the group level, and a triumvirate arrangement at the

hospital level. It opposed the appointment of matrons or medical officers at group level, and

argued that lay departmental heads within a hospital should be responsible to the Hospital

Secretary. Central Health Services Council (1954).

The **Noel Hall Report** (1957) and the **Lycett Green Report** (1963) subsequently provided

arrangements for recruitment, training and the promotion of NHS administrative staff and

emphasised the needs for **management training** by the introduction of a **management trainee**

grade.

The first decade of operation of the NHS had provided for the medical profession to call for

it to be reviewed. This led to the formation of the **Porritt Committee (1962)**, which

produced a wide-ranging report on behalf of the British Medical Association (BMA) and the

Royal Colleges. One particular recommendation was to seek for the integration of the three

parts of the tripartite structure, but without changing the employment status of GPs.

The Hospital Plan for England and Wales was being produced simultaneously with Porritt's

deliberations, Ministry of Health (1962), which was to result in the concept of the district

general hospital. This required an 'enhanced' management role in planning and

commissioning capital developments in particular.

The period 1964-70 evidenced a Government (Labour) emphasis on management. An

Advisory Committee (1966) paper, for example, comparing the management functions

between hospital and industrial managers, noted that, whereas the industrial manager

worked in a unified and clearer environment in terms of definable responsibilities and more

easily evaluated work, the hospital manager did not. The paper urged hospital managers, consultants and doctors in particular to make management improvement, by the scientific scrutiny of their work.

With the move towards integrating and grouping hospitals together and administering them as consolidated units, group secretaries and senior medical staff assumed effective control, leaving matrons, for example, with a reduced but more specialised area of responsibility, there being no collective voice for nursing staff at the group administration level.

Shortages of trained nurses and the decline in the status of the nursing profession prompted the government to set up the Salmon Committee to report on management structures for senior nursing staff.

The Salmon Report (1969) noted that the title 'matron' was equally applied to nursing heads of hospitals with few beds as to those with many beds and that a distinction between their differing duties was unclear. In addition, since men were increasingly joining the service the title 'matron' and 'sister' had become anachronistic.

It was further found that the role of nurses as administrators was poorly defined and that there was confusion over the relative status of general nursing, midwifery, psychiatric nursing and teaching.

The report proposed that status should be determined by the type of decisions being made and not by the number of beds controlled nor by the category of patients nursed.

Senior nurses deciding policy were designated 'top managers', those programming policy were 'middle managers' and those active in policy execution, 'first-line managers'.

The report introduced the terms; section, unit, area and division, to define a nurse's span of control and named the senior nursing posts accordingly, Table 1.

The government accepted the Salmon recommendations and sixteen pilot centres were targeted for introducing and evaluating the proposed structures.

LEVEL	GRADE	TITLE	SPHERE
Top Manager Top Manager Middle Manager Middle Manager First Line	10 9 8 7 6 5	Chief Nursing Officer Principal Nursing Officer Senior Nursing Officer Nursing Officer Charge Nurse/Ward Sister Staff Nurse	Group Division Area Unit Section

(Source: Report of the Committee on Senior Nursing Staff Structure, HMSO (1966).)

Table 1   Nurse Manager Posts

Also in 1969, the Report of the Working Party on Management Structures in the Local Authority Nursing Services, known after its chairperson as the Mayston Report, noted that the fragmented community nursing services should be co-ordinated by a designated head nursing officer. The extent to which the Salmon report's proposals were applicable to the community nursing services were considered.

Its findings commended to the local authorities by the Secretary of State, proposed that: every local authority should appoint a chief nursing officer; the senior nursing staff structure should be immediately reviewed; three management tiers, top, middle and first-line should be appointed; and management training should be provided for senior community nurses.

The result was that local authorities gradually re-organised their nursing structures. The title Director of Nursing Services was given to the head person and second level 'top managers' were appointed to the larger authorities with the title Divisional Nursing Officer. Area Nursing Officers co-ordinated groups of nursing officers to comprise the 'middle management' tier, leaving qualified field workers as first-line managers, parallel to the Charge Nurse/Ward Sister grade of the Salmon proposal.

During the same period, the medical profession had begun to explore the relationships between NHS management and hospital medicine. A Joint Committee of the Ministry of Health and the profession produced the first of three reports, the **Cogwheel Reports** (1967), which urged doctors to recognise their interdependence with each other and to set up speciality based divisions within hospitals.

The late 1960s evidenced the first applications in the NHS of **quantitative management** techniques, largely in the form of organisation and method studies to aid operational planning. These also became widespread as a means of introducing payments by results schemes for hospital manual workers. Barnard and Harrison (1986), suggested that these developments were a significant input to the increased numbers joining trade unions at that particular time.

A Green Paper (consultative document) published by the Minister of Health (1968) addressed the **administrative structure** of the medical services. It was particularly noted that greater integration of services was required, together with a recognition of political problems of health services transfer to local government.

Later in 1968 the Ministry was amalgamated into the new Department of Health and Social Security (DHSS) as a means of achieving integration of social policy.

Some two years later, a second Green Paper announced that further reorganisation of health services would involve them being administered by some ninety Area Health Authorities. DHSS (1970).

2.4   Re-organisation of the NHS

The Secretary of State for Social Services published a White Paper in 1970, setting out the government's (Conservative) reorganisation intentions. Although there were a number of differences to the earlier structure, including the regional tier, and explicit references to effective management, the proposals showed evidence of continuity.

Consideration of management roles and responsibilities was in process, from which there was evidence of only little support for the notion of a Chief Executive Officer.

A further emphasis was placed on persuading doctors to become more 'visibly' involved in the management of the service, and it was in this context that the role of community physician as 'link person' began, in order to inspire clinicians and administrators to work together, in the management of quality, costs and time.

The so-called 'Grey Book' (DHSS, 1972) was jointly produced by DHSS and NHS officers, from which a system of consensus decision making by multi-disciplinary management teams was recommended, formed from administrators, finance personnel, nurses and doctors.

Along with the reorganisation of local government authorities in 1974, the reorganised structure of the NHS was implemented, by the Government (Labour). A major thrust of the reorganisation was the introduction of Community Health Councils to represent the patients' viewpoint. This was based on evidence that patients were becoming more concerned about the quality of health services and their responsiveness to customer pressure.

The 1974 reorganisation can be reflected upon as the culmination of a long standing trend towards managerial specialisation, and its reorganisation was completed by the introduction in 1976 of a planning system to ensure that 'representative machinery' existed to enable joint planning at the resources allocation point - the operational district level.

Reorganisation was needed to accommodate the existence of the different staff structures. Nurses after Salmon for example, were represented at the district level by the District Nursing Officer, whereby GPs were under contract of service to the Family Practitioner Committees and Consultants were contracted to the Regional Health Authorities. Some hospital consultants were already grouped in the previously mentioned Cogwheel system.

The resulting District Medical Committees who acted as advisory and planning bodies included GP and Consultant representatives, from which one of each participated in the Area Medical Advisory Committee.

The period 1974 to 1979 was a particularly difficult period for the NHS, for a number of reasons. It was a period of economic restraint due to the treasury introduction of a 'cash limits' system of financial allocation to the public sector. The result being that NHS hospital and community health services were no longer automatically protected against the inflation costs of manpower and resources. The introduction of a formula for resource allocation, however, by the Resource Allocation Working Party (RAWP) was an attempt to provide an equitable geographical distribution of health care resources.

RAWP established the use of a funding formula to allocate resources based on each regions health care needs, rather than by the allocation of resources on an historical basis.

Despite these changes, many regarded RAWP as a 'blunt instrument' which in times of financial stringency had serious service delivery and service quality implications in those districts which lost out in the redistributive process, Baggott (1994).

Secondly, it was a period of increased militancy amongst trade unionists in the NHS resulting in increased industrial action. (Note the infamous 'winter of discontent' during 1979.)

Further, it was a period of growing conflict between the Government (Labour) and the medical profession. One particular bitter 'struggle' was over the attempt to remove private beds from NHS hospitals. Against this background of unrest, the Royal Commission was established to consider the best use and management of financial and manager resources in the NHS (1976).

By the time the Royal Commission published its report in 1979 a new Government (Conservative) had been elected. The government came to office with a manifesto commitment to simplify, decentralise and reduce the NHS bureaucracy.

The report indicated the Commissions' broad satisfaction with the performance of the NHS, but made a number of important observations. It noted that the NHS operated in the absence of clear objectives and sought to remedy this by setting out seven key objectives:

- to encourage and assist individuals to remain healthy;
- to provide equality of entitlement to health services;
- to provide a broad range of services to a high standard;
- to provide equality of access to the services;
- to provide a free service at the time of use;
- to satisfy the reasonable expectations of its users;
- to remain a national service responsive to local needs.

Many of the 117 recommendations made by the Commission, Baggott (1994) points out, were unsuccessful, for example, the abolition of Family Practitioner Committees and the transfer of their functions to health authorities, and the abolition of charges and direct accountability of the regional health authorities to Parliament.

The new government did, however, find some of the recommendations acceptable. The Commission's suggestion of a limited list of prescribed medicine and the abolition of a management level below the regional level, for example, were enthusiastically pursued.

The recommendations for medical audit and the extension of screening programmes were later taken up by the government.

A major part of the Government's further response to the report and its own proposals for reform was in the form of 'Patients First', a consultative document published at the end of 1979. The proposals were substantially different to those of the Royal Commission's, and included the abolition of the middle tier of the NHS - the Area Health Authorities and the establishment at the district level, of the new District Health Authorities (DHAs).

Although no major management changes were suggested at this stage, greater responsibility and accountability was proposed for those managing hospital and community services at the unit level.

The planning and professional advisory systems established following the 1974 reorganisation were simplified and the earlier DHSS practice of providing detailed guidelines for NHS authorities was reduced to providing general statements of department priorities.

These priorities were outlined in 'Care in Action' (DHSS policy document, 1981c). Some were consistent with those sought by the earlier government (Labour), for example preventive medicine, community care and priority group services. Others were not, for example the emphasis placed on the commercial and voluntary health care sectors and upon the quality and efficiency of services.

'Care in Action' continued the focus set out in 'Patients First', that management responsibility and accountability would be delegated to localities so as to reduce political interference.

2.5   Efficiency and Effectiveness

It was clear in 1981 that the government expected the NHS to make 'efficiency savings', the practice was based on the assumption that health authorities 'out-turn' expenditure would be less than their nominal budget by a specified percentage. Harrison and Gretton (1984), later observed that such arrangements provided no controls over where the savings were actually made, reporting that it was no more than a convenient assumption that they resulted from improved efficiencies.

The moves to decentralise responsibility and accountability in the NHS was short lived. Within a little time, pressure was mounting from parliament to abandon the relative 'hands-off' approach adopted by government and to improve the central monitoring processes of the NHS.

Early 1982, the Secretary of State announced arrangements to 'improve accountability' (DHSS, 1982a), which involved two particular fundamental changes - a review process and a set of performance indicators. The review process was intended to secure greater adherence to national policies and priorities. The performance indicators were to be developed in conjunction with the review process and operated on a pilot basis in the Northern Region. Due to numerous criticisms a number of Joint DHSS/NHS working groups were later established to review and revise the indicators, and a revised package was issued (DHSS, 1985).

Other initiatives announced during this time period were a need for ten year strategic plans to be set every five years by RHAs and DHAs indicating the state of the services and their perceived future needs and priorities. In addition, the experimental use of private firms of

accountants to audit the accounts of health authorities (DHSS, 1982b); an extension of 'Rayner Scrutinies' from the Civil Service to the NHS (so named after Sir Derek Rayner, Managing Director - Marks and Spencer Ltd). The scrutinies involved intensive study of particular expenditures by seconded officers (DHSS, 1982c); a review of NHS Audit arrangements; and a study of the possibilities of cash-limiting FPC budgets (DHSS, 1982d), by a firm of accountants.

In early 1983 (noted earlier) the first public suggestion was made that the Government was seriously considering restrictions on doctors' rights to prescribe (DHSS, 1983a). Late in 1983 the Minister for Health also announced proposals to place restrictions on the use of deputising services by off-duty GPs (DHSS, 1983b). During the following year the withdrawal of a range of proprietary drugs from NHS prescription occurred (DHSS, 1984).

Although this study does not attempt to address a public sector perspective, Greenwood (1988), identifies the 1980s as time where almost every part of the public sector witnessed managerialist developments by particular focus on economy, efficiency and effectiveness. The impetus in the NHS he points out, concerned Griffiths managerial changes.

Possibly the 1980s development which was to have the most important consequences for managing the NHS and to further move it from the decentralist approach came from the four-man independent management inquiry team under the chairmanship of Mr R Griffiths, (Deputy Chairman - Sainsbury's Supermarkets), later to be known as The Griffiths Report (1983).

The team's focus was on the absence of clear lines of responsibility in the NHS, blaming in particular consensus methods of decision making introduced in the 1974 reorganisation.

No member of the management team (consisting of administrative, finance, nursing and medical personnel), for example, had superior status for the operations management of health service business, each had powers of veto. Consequently decisions were made through negotiation, bargaining and agreement which delayed decisions.

They also found unclear responsibilities between the DHSS and NHS. The DHSS, they reported, had continued to intervene, in a haphazard and inconsistent way, in detailed health authority affairs, contrary to the declared decentralisation policy.

Further, the team was critical of the failure of the service to address customer (patient) needs and to achieve national policy objectives. They saw an absence of clear NHS objectives, and a failure to monitor performance.

Griffiths made a number of specific recommendations. At the national level, two new boards were suggested, within the DHSS. The Health Service Supervisory Board (HSSB), chaired by the Secretary of State, and responsible for, strategy determination and direction, performance review and the approval of overall resource allocations and the NHS Management Board. This board, which it was recommended should be responsible to the HSSB, would be chaired by a general manager from outside the NHS and Civil Service and include managers of such functions as finance, procurement, personnel, property and service planning, and take over existing DHSS responsibilities for the management of the NHS.

The system of consensus management, it was proposed should be replaced with one of general management, defined as the responsibility drawn in one person at the different organisational levels, for planning, implementation and performance control. The intention was that general managers would take overall responsibility for these at the region, district and unit levels.

The key responsibilities of the General Manager, were broadly to:

- Achieve set objectives.

- Breakdown inappropriate professional boundaries.

- Involve doctors more closely in management and make them more cost conscious.

- Improve the measurement of health outcomes.

- Ensure devolution to units.

- Improve the sensitivity of the service to the views of the customer.

The next set of recommendations concerned accountability which, it was suggested, would be further strengthened by including units within the annual review procedures. Districts would thus become directly involved in performance, monitoring the units at the service delivery level, so establishing a continuum of accountable managers from unit through the regions and districts up to the new Management Board.

Other recommendations included special roles for health authority chairpersons in relation to the introduction and operation of general management. At each level, their's was the responsibility, in the identification of the general manager, to review performance, the organisation of health authority business and the introduction of efficiency initiatives. These would include: cost improvement programmes, management budgeting at the unit level, relating clinical workload directly to budget and manpower allocations and improvements in the quality of services, by management taking steps to evaluate quality performance, particularly from the patients perspective.

On reflection the Griffiths Report has had a major influence on organisational, management and culture matters in the NHS, although Greenwood and Wilson (1988) point out that full acceptance of the spirit of Griffiths was in fact patchy, evidencing for example, the time taken (some two years) for all general managers to be appointed down to unit level, a development, which they point out, was marked by many staff movements and much uncertainty as the appointees restructured their domains.

2.6   Radical Developments

Since the Griffiths Report there have been significant and radical developments in the NHS. These have further contributed to the changing organisational and culture issues.

The NHS Training Authority Publication (1986), for example, sought to provide various values, stressing concern for the customer, concern for the quality of care and concern for getting things done.

The government's Green Paper, 'Primary Health Care: An Agenda for Discussion' (1986), contained three particular proposals: A commitment to introduce a good practice allowance (GPA) for GPs, including such criteria as GP availability to patients, amount of screening and preventive services offered and their attendance on relevant post-graduate courses and programmes. The creation of health care shops, creating an opportunity for other bodies, such as private enterprise to integrated primary care services. A proposal that prescription charges for medication should be more closely related to their costs.

The review into community nursing, 'Neighbourhood Nursing: A Focus for Care' (DHSS, 1986b), known as the Cumberledge Report (after the chairperson), explored the problems of primary care from two particular perspectives: the fragmentation of primary care, Baggott (1994) notes, and the failure to maximise the contribution of nurses in the community.

The report recommended a reorganisation of community nursing on a 'neighbourhood' basis (ie. small local areas), to enable a better planned and organised service directed on local needs. The report sought to establish well defined, clear and agreed objectives for each primary health care team, between the neighbourhood service and GP practices and urged the ending of GP subsidies for employing their own nurses. The report also called for nurses to be given wider responsibilities, including prescribing drugs.

Although at the time the government did not support many of the central recommendations of the Green Paper and Cumberlege report, both did provide useful debate for the government's policies for the future of primary care outlined in the White Paper, 'Promoting Better Health' (1987). The main proposals were concerned with customer choice, health promotion/illness prevention, remuneration of doctors, dentists, primary health care teams, family practitioner committees, charges/finance and other items (Appendix 2).

A few months after the re-election of the Conservative Government in 1987 and consistent with their manifesto statement that the NHS, while not a business, required to be run in a more business-like way, a Prime Ministers prompted review of the NHS was underway.

The review focused on two particular areas, alternative funding and ways of allocating resources. The review rejected private funding, state health insurance systems and 'earmarked' taxes accepting that the NHS would continue to be general taxation funded mainly. Growing criticism of ward closures and postponed operations as health authorities aimed to balance their budgets due mostly to the government decision not to fund NHS pay awards in full and the effects of the earlier mentioned RAWP system of redistributing funds, resulted in a 'stop gap' injection of £100m into the NHS.

The focus was on the allocation of resources into the NHS, from which there was support for fundholding schemes, which emphasised the 'gatekeeper' role of the GP, Bevan et al (1988), Culyer et al (1988), in that GP practices would receive a budget closely related to the number of patients on their lists. The budget would be used to pay directly for hospital and other health services and GPs would compete for patients in order to generate income.

The internal market was an idea whose time had come, Baggott (1994).

The governments review culminated in January 1989 with the publication of two White Papers: 'Working for Patients' and 'Caring for People'. The former outlined ways of improving patients choice, service efficiency and quality, through a number of reforms, the major ones being the introduction of a system of contractual funding, measures to manage clinical activity more effectively, proposals to strengthen management at all levels and new arrangements for allocating resources (Appendix 3). The latter White Paper addressed the funding and co-ordinating arrangements for community care services.

The major thrust of Working for Patients, which represented a marked shift and new departure, was that of an internal market for health care based on a system of separating the service into purchasers and providers, Figure 1.

Purchasers
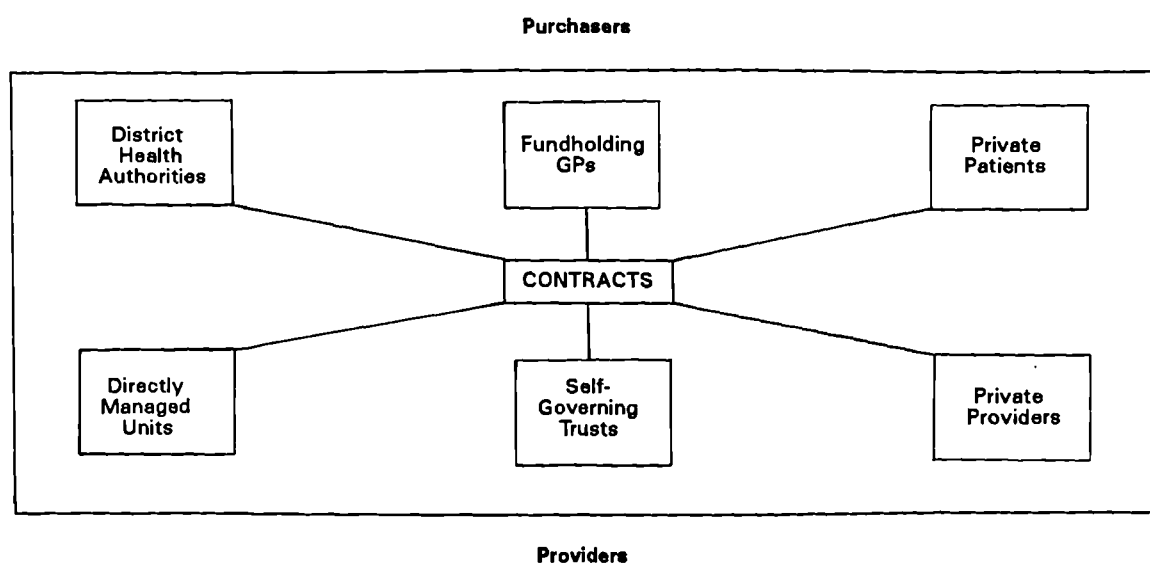
Providers

Baggott (1994). Health & Health Care in Britain. St Martins Press.

Figure 1   The Internal Market

In the market place of medical care, purchasers are those who purchase treatments for patients and providers are those responsible for providing them.

Eagle (1993), refers to the internal market concept as a method aimed at having the NHS work in a manner not dissimilar to private industry, with competitive forces keeping prices low and quality high.

The governments time-scale for implementation was two years, and despite arguments, some quite vociferous, against principle and time from the main organisations representing the health professions and workers plus the public at large, the White Papers passed into legislation in 1990 to become the NHS and Community Care Act, with only minor concessions, for example the establishment of a statutory Clinical Standards Advisory Group to establish the impact of the reforms on standards of care.

It is of particular interest for the writer to note (in context of this research), that although quality had featured from the early life of the NHS, it was some forty or more years later that NHS managers and clinicians were being directed towards providing an increased service, delivered with a business management vigour in terms of cost effectiveness, efficiency and with an emphasis on quality. The focus on internal market competition was being introduced as a major facilitating process, Waddington (1991), from which the 'slimming down' of Health Authorities resulted (Appendix 4) as hospitals took charge of their management operations. The Health Authorities maintained a broad responsibility for ensuring that hospitals in their district could provide the range of care needed by their population, but this apart, their main role was to make annual contracts with hospitals, agreeing in advance the services the hospital(s) would provide and the price to be paid for them. Hospitals were encouraged to become independent of their district health authority by becoming 'NHS Trusts'.

Family health services authorities (previously the family practitioner committees) were the purchasers who made contracts with the providers of non-hospital care: general practitioners, dentists, pharmacists and opticians.

GPs working in larger practices were offered the opportunity of becoming purchasers as well as providers. If the practice had in excess of 11,000 patients (later 7,000), they could apply to become 'fundholders'. They were given their own budget to purchase drugs and

hospital care for their patients. Like DHAs fundholding GPs could make their own contracts with hospitals and decide where to have their patients treated.

It was clear by the late 1980s and the early 1990s that the reforms of the NHS had resulted in quality becoming an explicit issue in health service management. The contracting environment was intended to provide the incentive for purchasers to demand high quality services from the providers of healthcare, terms such as quality management, clinical indicators, protocols and audit began to emerge as explicit issues in the management of the internal market.

At the beginning of 1990, the Department of Health embarked on a programme to introduce a managed approach to quality in twenty three demonstration sites, ranging from departments within units to entire districts. These pilots were part-funded to introduce total quality management. The point was made that although quality had always been the essential basis of professional health care standards, total quality was needed to switch the focus from quality practised within the professions to the whole of the organisation.

It was clear from the emphasis placed on it that total quality management was to be a strategy to get the organisations, within the health care systems working to maximum effectiveness and efficiency.

Clinical indicators and protocols were encouraged as a means to ensure that best practice would be consistently practised, whilst process audit aimed to target activities which led to expected outcomes. Outcome audits were similarly encouraged as a means of identifying shortfalls against expected/agreed outcomes.

As the quality movement gathered momentum in the 1990s numerous perspectives of quality in health care began to emerge resulting in many quality definitions and paradigms being suggested to ensure the most effective implementation and management of quality.

A Patient's Charter, outlining what people can expect of the health service, was drawn up by the Department of Health (1991). This was extended in 1993 to spell out that what people are entitled to expect from their GPs, and modified again in 1995 to introduce additional and more stringent quality criteria.

The Charter was intended to make the NHS more customer orientated in that it required to outline the minimum standards which the customer had the right to expect. In addition to the already established rights to receive health care on the basis of clinical need, regardless of ability to pay and to be registered with a GP, three rights in particular came into effect. These covered issues concerned with access to information, waiting time for treatment and complaints procedures. Although not legal rights, they are presented as major and specific standards which the Government expects the NHS to achieve. In addition, the Government expected Health Authorities to develop local charter standards, which applied to local hospitals and other services, given the individual needs of the local community and available resources.

In 1990, the Government (Conservative), drew up new contracts for GPs and dentists, which were intended to encourage them to undertake more preventative medicine. GPs were expected to provide health checks for patients and received 'special payments' for immunising and screening and for operating health promotion clinics. Rather than being extra income for GPs, the special payments were found by reducing other fees and allowances which they had been earlier entitled to.

Dentists, instead of being paid for each treatment, were paid a single annual fee for each patient on their list. Additionally there were incentives for the quality, rather than the quantity of treatment, in the form of penalties, - undertaking remedial work free of charge within set time periods.

A further change in the 1990s was that of the 'Care in the Community Primary Health Care' programme placing, for example, the purchasing of residential care of old and disabled people into the control of local authorities.

From April 1993, the Department of Social Security (DHSS) was no longer expected to pay whatever residential homes decided to charge. Instead fixed sums or grants went to councils who were required to work with the local health authorities to establish those requiring residential home care, medical support and decisions concerning who should be cared for at home by their family (or other carers) and the amount to be paid for these services. A greater focus was also placed on the individual and/or family paying for care provision.

In order to secure public accountability of Trusts and aid the functioning of the internal market, the Audit Commission's publication of hospital league tables (1994) aimed to further improve NHS performance. Hospitals (initially) were ranked according to such performance criteria as patient waiting times, ambulance response times, ... etc.

Rigge (1993) refers to the publishing of league tables as a valuable means of empowering patients in the operation of the internal market, and as a 'spur' to managers to improve performance through the competitive process. Assuming that patients wish to be empowered, the empowering process was to some extent at the discretion of a patient's GP, as expressed in the Patient's Charter. The information it was suggested, might be influential in the awarding of contracts between purchasers and providers.

1993 evidenced yet another review of the NHS in the form of the Langlands Review (named after Alan Langland - NHS deputy chief executive). The aim was to review tasks in addi-tion to organisational structures, through a wide ranging scrutiny of the shape of the NHS.

The brief was to take particular account of balance between the benefits of de-centralisation and the essential requirements of public accountability. The structures of the DoH, NHS management executive, RHAs and outposts were examined in terms of their inter-relationships and their relationships with ministers. Purchasing development was also scrutinised including HA mergers, liaisons between HAs and family health services authorities and the development of GP fundholding.

The need to regulate the market effectively was addressed, as was probity in corporate management. For some in the NHS this aspect of review was particularly welcome, claiming that at the top, it was as though the NHS had never been reformed, Lilley (1993). There was, Hunt (1993) claimed, a top heavy bureaucracy overhanging the NHS, emphasising the need to carry on devolving power.

A number of the outcomes of the review were radical, for example, the option of reconstituting the management executive along the lines of a health authority for England, with a chairperson heading a board of non-executive and executive directors, under which regions and outposts would be disbanded and turning the management executive into a 'next steps' agency.

But, as experienced on a number of occasions by Griffiths, reported in interview, May (1993), politicians tend to look at the next election and favourably consider short term options. As such RHAs were to bear the brunt of government proposals to slim down the upper tiers of the NHS management, while the DoH and management executive escaped largely unchanged. Health Secretary Virginia Bottomley announced the reduction in RHAs from 14 to 8, which would ultimately be abolished and replaced by regional offices monitoring both purchasers and providers.

Legislation, it was also announced, would be introduced to enable mergers between health authorities and family health services authorities.

The report did not specifically address potential job losses, or the level of cash savings as a result of the changes.

There was widespread agreement among managers that scrutiny of the role and responsibilities of the DoH and the management executive, which had been delayed, should not fall by the wayside.

Other national policy developments announced during the 1990s have included 'The Health of the Nation', 'Opportunity 2000' and 'R&D initiatives' each of which have had organisational and management effectiveness and efficiency focus in terms of quality, costs, time, and culture balance towards caring for staff, customers and a balance of values. The time for radical change and innovation had come, by a Total Quality Management Process which would focus on hospital process re-engineering and patient focussed care, Waddington (1994).

2.7   Change, Praise and Criticism

There has been more reported changes and upheaval, Eagle (1993) to the NHS during the 1990s than at any time since it began. Conferences, published papers, journal articles and media coverage abound, both criticising and praising the changes.

A major criticism is directed at the emphasis placed on competition, in that competition does not necessarily guarantee high quality. Instead there is a temptation for providers to 'cut corners' to minimise costs, and/or reduce or eliminate the service(s) if high standards oblige them to charge higher prices. Price may take precedence over value for money (Waddington, 1992).

The two-tier system likely to develop, from well-funded purchasers securing better services for their patients is a further criticism.

Eagle (1993), suggests evidence of growing mistrust of NHS Trusts who are perceived to pay more attention to business mattes than to public service provision.

Fundholding equally arouses suspicion, since it was predicted that some GPs would be tempted to base treatment decisions on costs rather than needs.

The residential care changes, it is claimed are being undertaken by ill-prepared local authorities, in terms of their new roles and responsibilities. Indeed there are strong views that haste has taken precedence to planning.

Other criticisms relate to:

■   Difficulties in obtaining NHS dental services in some parts of the UK, due to an apparent growing number of dentists refusing to accept new NHS patients, British Dental Association Survey Report (1992), as resentment to the DoHs reduction of the amount it paid them. This has resulted in many dentists now working exclusively on private patients.

■   NHS prescription charges which have risen to a level which makes some commonly prescribed medication cheaper to purchase over the counter from the pharmacist.

■   Charging the patient/elderly person for residential care or taking a 'charge' on their property.

- The withdrawal, by some Health Authorities, of non-medically urgent treatments, which may be of importance to people's 'well-being'. Or running out of funds resulting in the inability to use available and needed capacity.

- 'Re-cycled' waiting lists, which reduce 'official' figures but which emerge elsewhere.

- Mental health patients, who still receive 'over-hospitalisation', because of lack of resources in the community, or are turned out to an ill-prepared 'hostel' for care in the community.

- The generation of more bureaucracy and paperwork.

Criticisms apart, the Audit Commission (1993), in its review of purchasing authorities recognised benefits to fundholding in addition to problems, the least not being shorter waiting times and a more responsive service.

It is clear that more and more hospitals and GP practices are opting for the independence which trust and fund-holding status arrangements confer. Independence in terms of self-management, autonomous budgeting and budget flexibility in the transfer of monies from savings achieved, and the treatment of more patients in spite of real term cuts in income.

Finally, the value of league tables in assessing the effectiveness and efficiency of hospital services is currently being questioned in that they fail to take account of a number of funda-mental criteria. For example, a failure to account for the quality of clinical care and factors which are described as, the individual circumstances faced by hospitals, Rigge (1993).

The major thrust for generating league tables however, is claimed by the Government to be one of an 'incentive' to make improvements - 'what gets measured gets done'. Care will need to be taken to avoid the internal market encouraging a different affect. If efficiency is

such as to fulfil the quota of patients before the year end, for example, will there be financial support to treat more patients which the spare capacity could accommodate?

2.8   Summary and Key Findings

This chapter has provided an overview of seventy-five years of on-going organisation, management and culture change in the provision of health care, whether it be viewed as a capacity or an asset to be possessed, or emphasised as the absence of specific illnesses, diseases or disorders.

The British system of health care is state dominated, the majority of which since 1948 has been provided by the NHS. When the NHS was founded, with its budget of £275.5m, politicians naively predicted that once everyone had been made well, demand for the services would fall. In fact, demand proved alarmingly infinite while resources proved distressingly finite, Rogers (1993).

Health care debates before and throughout the existence of the NHS have involved complex ethical and controversial economic and resource issues, many of which have been politically driven.

It is clear that the direction and implementation of change and reform in health care provision has been affected, sometimes significantly by government changes and indeed in changes in political office and that practical as well as political difficulties have played a part in constraining reforms.

The creation of the NHS provided for the first time a comprehensive system of care for all, which was not based upon the ability of individuals to pay. The aims of the national system were to provide an organisationally coherent, planned and integrated system based on a funding mechanism (taxation and national insurance funds) which was Treasury focussed.

Although a significant achievement, and one which is envied in many parts of the world, the NHS has been bedevilled by crisis.

Some of the early difficulties originated from political compromises, others related to changing demands and the expectations placed on it, and a combination of failed or faint-hearted attempts to reorganise it, plus the wider political and economic issues.

Beyond the first decade of operating the original and 'fine-tuned tripartite structure, NHS reviews reported problems concerning organisation and management issues, particularly in terms of co-ordination between the three parts and high costs and waste in the form of duplication and over-lap.

Following a succession of organisation, management and to some extent culture changes the structure came under increasing pressure for a fundamental reorganisation and change.

The new structure created three tiers of management below the DHSS, at regional, area and district levels where emphasis was placed on professional management of the services. New health authorities were established at the regional and area levels with responsibilities for the planning and development of services.

The reorganisation, however, failed to solve some of the problems of segregation. The family practitioner services, supplied by GPs, dentists, opticians and pharmacists, for example, remained separate under the new FPCs which replaced the former executive councils.

Although the NHS became responsible for community health services, from local government responsibility, local government continued to be responsible for environmental health and social care services. Thus there remained a tripartite organisation of three separate agencies responsible for the provision of national health care.

Not putting too fine a point on it, the 'power' over service developments was concentrated at the local level in the medical profession who had an effective veto over policy implementation, and health authorities (made up from local government and health professions) could not be relied upon to impose central government policy.

The new NHS structure was also criticised for being over-bureaucratic, with too many management levels and requiring too many administrators. New management, planning and control systems which accompanied the changes were seen to be slow in response to decision making and lacking in accountability.

Despite numerous attempts at structural reform the medical profession continued a dominant position exerting a powerful influence within health care.

The Griffiths inquiry in the 1980s, however, was central in reforming the management process in the NHS. The main aim was not only organisational, to provide a more coherent service, but cultural to make it more business effective and efficient by the introduction of performance indicators, accountability reviews, resource management, medical audit, quality management and so on. The idea that health care should be the best available changed into the phrase, 'health care services should be quality services'.

Baggott (1994), suggests that many of the changes ushered in by Griffiths will likely be even more significant in the future in light of the Government's White Paper 'Working for Patients'.

The White Paper 'Working for Patients' identified as a key objective the improvement in the quality and quantity of care available to NHS patients. This, the Government argued, was to be achieved by introducing within the NHS a market economy.

The organisational, management and culture focus necessary to achieve these, was to be more private-sector orientated than public sector focussed. Since the intention was for the NHS and its hospitals to compete with private care organisations and for NHS hospitals to compete with each other, **competitive advantage** was an appropriate term. Clearly, the emerging political philosophy was one of favouring more business freedom, more choice for individuals, the removal of market impediments, a larger role for markets generally and less state intervention.

A common theme also at this time and one which was consistent with the political perception, was that public sector management was underperforming and that concepts, paradigms and personnel needed to be imported more into health care organisations from the private sector. Greenwood and Wilson (1988), draws attention to the increasingly blurred distinction between public administration and private management by the widespread adoption of management tools which were originally meant for private sector analysis.

In this respect, however, it is important to note that since its inception NHS performance has been under constant parliamentary scrutiny, requiring ministers to frequently respond to criticism and defend the record of health authorities. Additionally a system of management had resulted which was more likely to be concerned with bureaucratic control than with dynamic management and radical change.

The 1990s has evidenced the most major changes in the NHS since its inception. For example there is clear intention in Working for Patients, the Patient's Charter, the Health of the Nation and Healthcare 2000 initiatives, for a more responsive and continually improving health service tailored to the needs of patients and one in which **quality of service, value for money and business effectiveness and efficiency** are central issues.

The importance of performance achievement through sharper organisational and culture focus and realising the potential of women in addition to men within the NHS, were also explicit intentions to meet the quality health care needs of the population and minimise the conflicts between efficiency and the health gain of individual care and population health.

Seedhouse (1994), makes the important point (particularly relevant to this research), that it is absolutely necessary to be clear of what quality performance in health care is. At the very least, he suggests, a philosophically sound distinction is required between quality health care and none quality health care, for which, a proper analysis of quality per se, is essential. In the absence of a lucid and practical definition the word quality is obviously open to wide interpretation and hence manipulation by any group which lays claim to it. No one yet in the NHS, Seedhouse suggests, has developed a convincing account of quality.

Langlands (1993) has focussed attention on the need for radical change in the NHS beginning at the top and permeating the whole organisation, and although many options have been asserted rather than implemented through political expediency, radical issues have now been made explicit, for consideration and debate.

Although medical advances, longer life expectancy, and greater expectation in level of service have added significantly to NHS costs, by far the greatest increase is still the growth of health service bureaucracy and the increased numbers of managers and administrators. Rogers (1993) estimated that 60% of hospital staff budgets are spent on non-medical activities and the NHS is now the largest employer in the world other than the Indian state railway.

The chapter has outlined some important events in a state dominated health care system in the form of on-going organisational, management and culture change, which in 1995 remains a service with a supply and demand imbalance which if left unchanged, is likely to continue to demand more for less.

The writer believes that Total Quality Management, if correctly understood and applied is a means of addressing imbalance so as to achieve more equilibrium between business effectiveness and efficiency in terms of quality, costs and time.

It is therefore considered a fundamental requirement to identify a suitable definition (or definitions) for quality performance in health care and to seek a Total Quality Management paradigm (or set of paradigms) which take account of the organisational, management and culture issues resulting from years of continuous change and redirection and which provide for radical change, innovation and patient focused care. This is considered important if not essential, in order to update the current body of TQM knowledge which has come under some confusion due to the paucity of published research in healthcare organisations.

CHAPTER 3   QUALITY AND TOTAL QUALITY MANAGEMENT (TQM):   DEFINITIONS AND

PARADIGMS

3.0   Introduction

Evidence from the writer's previous research involvement with quality management

programmes in a diverse spread of manufacturing and service organisations, including health

care organisations, suggests a disparity of understanding and hence applications of both

quality management and TQM. A major symptom of both, is a lack of clear theoretical

models concerned with integrating the distinctions.

This chapter seeks to explore the emergence of TQM as an approach to organising,

sustaining and improving the quality of products and services offered by business

organisations.

3.1   Quality - Definitions and Emphasis

As we approach the mid-1990s it is likely that the decade will be reflected upon as the

decade of managing quality. Chase (1990) predicted that to survive the 1990s

organisations must make quality management their business goal.

Since his prediction, an increasing number of organisations are evidenced as being more

managed as a business, particularly those in the service sector, central to which is the need

for continuous improvement in quality, costs and time.

Tenner (1993), makes the point that quality and productivity improvements combined with

cost reductions, should always be joint organisational objectives.

What then is the quality objective? Schonberger (1986), suggests that quality is like art,

everyone is for it, everyone recognises it, but each define it differently.

BS 4778 part 1 (1987) refers to quality as the features and characteristics of a product or service that bear on its ability to satisfy a stated or implied need.

The Oxford English Dictionary, amongst its numerous definitions, states that quality is concerned with value and degrees of excellence.

ISO 8402 (1986), defines it as all the features and characteristics of a product or service that bear on its ability to satisfy stated or implied needs, and quality management as that aspect of the overall management function which determines and implements the quality policy, and as such is the responsibility of top management.

BS 4778 part 2 (1991) emphasises the totality of cost effective quality management as a management philosophy embracing all the activities through which the needs and expectations of the customer and community are met. And the objectives of the organisation are satisfied in the most efficient and cost effective way by maximising the potential of employees in striving for improvement.

BS 5750/ISO 9000/EN 29000 (1987), places emphasis on quality management systems and certification schemes. It requires organisations to establish, document and maintain effective and economic management systems and provides opportunity for the providing organisation to demonstrate commitment to supplying goods and services which meet the quality needs of customers and clients.

The government's Citizen's Charter announced in July 1991, seeks to set standards, ensure greater competition and accountability and provide redress for customers who are victims of poor service. The charters, with their performance criteria and non-performance penalties, are supported by legislation. In other words the legislature has decided to support the customer against the executive (Civil Servants or quasi-government employees and others) in the provision of quality services.

Garvin (1987) identifies five alternative perspectives of quality as:

- **The Transcendent View**, synonymous with innate excellence, a mark of uncompromising standards and high achievement, believing that people recognise quality through the experience of repeated exposure.

  A suggestion that internal and external customers will know quality when they see it, may offer little practical guidance.

- **The Product Approach**, sees quality as a precise and measurable variable. Totally objective views may fail to account for taste, needs and preferences.

- **User Based**, the premise that quality lies in the eye of the beholder, equating quality with maximum satisfaction.

  This subjective, demand-oriented perspective recognises that different customers have different wants and needs.

- **The Manufacturing-Based Orientation**, is supply oriented and significantly concerned with engineering and manufacturing practice. It focuses on conformance to specifications which are often productivity improvement and cost containment driven.

- **Value-Based**, definitions focus quality in terms of value and price. By risking a trade-off between performance and price, quality may be relegated to affordable excellence.

Garvin suggests that differing views of quality help to explain some of the conflicts which arise between different functional managers. Despite these, he suggests, organisations can benefit from multiple perspectives, as reliance on a single definition is a frequent source of problem. Since each approach has predictable blind spots, he points out, organisations are likely to suffer fewer problems if they employ multiple perspectives, actively changing the various approaches as products move from design to market.

To incorporate the different perspectives, Garvin developed eight categories of quality to act as a useful framework for quality analysis and strategic planning:

1.   Performance - primary operating characteristics.

2.   Features.

3.   Reliability.

4.   Conformance - to specifications.

5.   Durability.

6.   Serviceability.

7.   Aesthetics.

8.   Perceived quality.

These, he suggests, translate into lower prices and create a receptive environment for further improvements.

However McConnell (1992) questions quality as a watchword for the 1990s or, perhaps, the same 'old song' being sung differently. In contrast Crosby (1984) points out that quality and competitiveness are directly inter-related, for by ensuring and promoting conformance to requirements, costs are reduced and through it, price competitiveness increased. Thompson (1990) suggests that the best opportunity available to business organisations for competitive advantage is to provide differentiation between their products and services and the best way of doing it is through quality variation.

Bank (1992) also emphasises quality and competitiveness, and cites numerous business organisations who have used quality improvement as a short cut to improved profits (demonstrated in Figure 2).
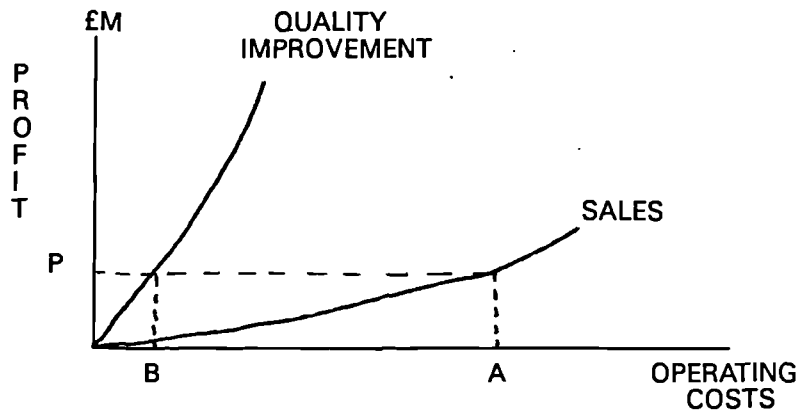
■   To gain an increase in profit P through increased sales would require a *significant* increase A in operating costs (sales personnel, promotion/advertising, inventories, etc.).

■   To make the same increase in profit P through quality improvement would require *only a fraction* of those operating costs B, which in any case diminish through time.

Figure 2   Quality pays for itself in cost reduction (Bank, 1992)

The Essence of Total Quality Management (Prentice Hall).

He goes on to suggest that the actual quality improvement also increases sales by generating customer demand which has its own momentum as shown in Figure 3.

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                                QUALITY IMPROVEMENT
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■   The more quality improves, the faster sales will increase because customer satisfaction carries its own acceleration.

■   As a 'quality reputation' grows, marketing can emphasise increasing customer satisfaction as a major element in advertising and other promotions.

■   The longer term effect will be to reduce the spend required on advertising to maintain competitive lead.

Figure 3   Quality pays for itself in sales growth (Bank, 1992)

The Essence of Total Quality Management (Prentice Hall)

Whilst endorsing the point that quality is defined differently in that it can be viewed from different perspective, Ribourdoville (1989) and Brant (1992) place emphasis on meeting customer expectations and value satisfactions. Barry et al (1988) and Cannon (1993) similarly focus on conformance to customer expectations in their definitions. Cannon suggests a 'systematic process' by which statistical data may be collected in order to establish explicit customer value criteria against which organisational performance might be measured.

Pall (1992) suggests that customer requirements have three fundamental components, firstly a statement of recognised need, secondly the expected manner by which these should be met and finally some measure of the benefits which will come from meeting the need.

The above perspectives however fall short of a completely satisfactory explanation of the fundamental "customer-supplier" relationship. Expanding this perspective there is a need for a quality paradigm which focuses on customer issues in the forms of 'exchange value' - price and cost of ownership and 'use value' as fitness for purpose and needs conformity (Waddington, 1993). A customer value extending beyond these is concerned with pleasure and regard which ownership bestows 'esteem value'. The paradigm also needs to focus on the organisation in terms of internal performance and cost of provision - 'cost value' incorporating and measuring the effects of quality control - achieving and maintaining the quality of product, process, and service and quality assurance and the prevention of quality problems.

Bank (1992) suggests there are problems in defining quality as fully meeting agreed customer requirements when the awareness of customer service in UK is so low. People, he suggests, are simply not conditioned to expect a high level of customer care in their private dealings and hence do not have models or paradigms which easily transfer to the context of work. It may be he says, that serving the customer in the UK gets confused with servitude and class barriers. This is possibly reason enough for the Citizen's Charter to make customer rights the central theme of public life for the 1990s showing that the goals of quality, at least, have surfaced in government!

Kane (1993) shows quality to be a relatively early development, and outlines a 'quality development timescale' from the early part of the century to the 1990s, which radicates the varying emphasis placed on it, (see Figure 4).

1990s	Federalism Peters - Quality differentiated, Radical change, re-invention and re-engineering
1980s	Organisations strive towards Total Quality Quality messages reach western world due to Japanese threat
1970s	Crosby zero defect movement began Feigenbaum/Juran make significant contributions
1960s	Mid 1960s - change of attitude, importance of quality control department grew Quality important dimension of management both inside and outside the firm
1950s	1956 - Feigenbaum introduces TQC 1951 - Deming Quality Award established 1950 - Year when quality movement began Demings 14 point plan spearheads Japanese economic recovery
1940s	US army developed acceptance sampling AQL - Average Quality Limit
1930s	Early process control methods in Bell's Telephone Co Sheward - developed production process control methods
1920s	Dodge Roming - developed acceptance sampling plans
1910s	R Fisher - applies statistics to agricultural research

Figure 4   Quality Development Timescale (Kane, 1993)

To this list might be added the 'Right First Time' campaign of the British Productivity

Council in the early 1960s, the 'Quality and Reliability Year', 1966-67, the 'National

Strategy for Quality' 1978 and the various DTI 'National Quality' campaigns, etc. Finally,

the much earlier claim that Jean-Baptiste Colbert, Louis XIVs finance minister and founder of

the Sevres and Gobelins state factories, wrote to the Emperor in 1664 advising that 'if the

factories through careful work assure the product's quality, foreigners will seek supplies

from them and their money will flow into the Kingdom' (Holbert, 1991).

3.2   The Development of Quality as a Concept

Kane (1993) makes strong reference to the Gurus, suggesting that through them confusion

has arisen both in the terms quality and total quality.

Bendell (1992) points out that quality and TQM, although emphasising an organisation-wide

approach to the provision of quality, means different things to different people. It is likely,

he suggests, that this has resulted from three distinct Guru groups covering the post-war

World War II period.

Deming (1964), (1968), (1986), one of the early Americans stated his fundamental

definition of quality being that of satisfying the customer beyond expectations.

His early work which reflected his statistical background broadened the manufacturing

emphasis to include non-manufacturing and human variation. He suggested that

management by focus on variability should more understand the differences between special

causes and common causes. The special causes of product, service or process variation

were the assignable causes which prevented constant statistical performance, and could

often be solved by those undertaking the work itself.

Common causes however are those remaining once the special causes have been resolved.

They require higher authority (management) to eliminate them. His work went on to

considerably extend beyond statistical methods, focusing on senior management becoming

actively involved in quality improvement, estimating that management were accountable for

90% or more of potential improvement. He also targeted the need to adopt a more

systematic approach to problem solving.

To achieve these, he referred to the need to totally transform Western management style to halt the decline of business organisations. He produced 14 Points for Management (Appendix 5) to help the understanding and implementation of the management transformation, which he propounds apply to small and large organisations alike and to both manufacturing and service organisations.

Despite their inherent sense, a number are quite controversial and as will be seen later, contradict other Guru views. This apart, with careful consideration in the context of individual organisations, the 14 points should be viewed as points and not tools.

Deming's paradigm for change (his 7 point action plan), begins with management struggling over the 14 points and their obstacles and ends with the construction of organisation for quality, which he regards as requiring the participation of knowledgeable statisticians:

1. Management struggles over the 14 Points and their obstacles and agree meaning and plan direction.

2. Management takes pride and develops courage for the new direction.

3. Management explains to the people in the company why change is necessary.

4. Every company activity is divided into stages, identifying the customer of each stage as the next stage. Continual improvement of methods should take place at each stage, and stages should work together towards quality.

5. Start as soon and as quickly as possible to construct an organisation to guide continual quality improvement.

6. Everyone can take part in a team to improve the input and output of any stage.

7. Embark on construction of organisation for quality.

In addition an interesting model for quality improvement activity is the - plan, do, check, act cycle or the 'Deming Wheel', Figure 5,
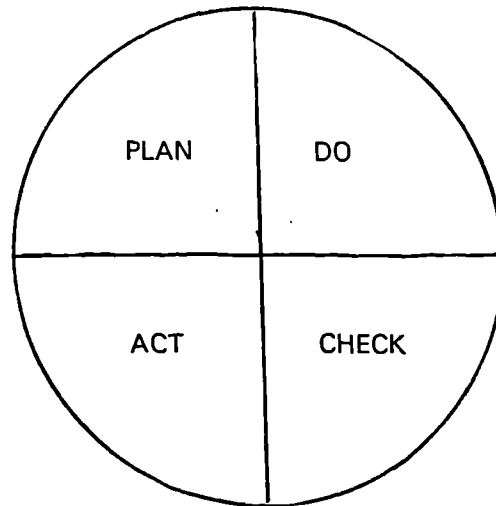
Figure 5   The Deming Wheel (Deming, 1988)

Out of Crisis. University Press.

which suggests the following of a sequence of events to improve the end result of the process and then to ensure continued improvements. The plan phase begins with a study of the current situation, during which facts are gathered to be used in formulating a suitable set of actions for quality improvements. In the do phase the planned actions are implemented. During the check phase results are compared with those specified in the plan stage and techniques and procedures used to identify the extent to which they are really solving the identified problems. Finally the act phase is used to standardise successful methods so that new techniques introduced are put into continuous action.

Before his death in 1993, Deming summarised his life work into four inter-related areas:

System Appreciation, emphasising the need for managers to understand and practise relationships between function and activity. A visibility of long term objectives, which involves everyone gaining through success - the employees, stockholders, customers, suppliers and the environment.

Knowledge and Statistical Theory, effective management, leadership and teamwork through knowledge and the understanding of variation, process capability, control charts, interactions and function loss.

Theory of Knowledge, visibility and understanding of past performance and success through understanding the theory.

Knowledge of psychology, understanding human interactions, intrinsic and extrinsic motivators.

Feigenbaum (1951), (1983), (1990). His definition of quality was for a systematic or total approach requiring the involvement of all functions in the provision of it - total quality management. His early work concentrated on building in quality in place of checking and controlling quality after the fact, his idea of quality control was as a business method rather than a technical activity.

Supporting the use of statistical quality control methods, which he saw as having a profound effect on Quality Control at the concept level, he propounds such methods as a part of the overall administrative system, not the system itself.

Feigenbaum sought to generate gradual commitment to quality control through complete support by top management and employee involvement and responsibility, through open-communication channels for product/service quality information and procedures for participation in quality programmes.

His later work further emphasised quality as an essential element of managing business operations, against which Total Quality Control,was seen by him, as the process of placing continuous emphasis throughout the organisation on quality leadership, investment in technology and commitment to quality and productivity improvement.

He defined 10 crucial benchmarks for total quality success as:

1. Quality as a company-wide process.

2. Quality as what the customer says it is.

3. Quality and cost as a sum, not a difference.

4. Quality requiring both individual and team zealotry.

5. Quality as a way of managing.

6. Quality and innovation as mutually dependent.

7. Quality as an ethic.

8. Quality requiring continuous improvement.

9. Quality as the most cost-effective, least capital-intensive route to productivity.

10. Quality as implemented with a total system connected with customers and suppliers.

The aim was to make quality a way of focusing on the internal and external customers and suppliers, and to provide a base for 'world-class' quality leadership.

Feigenbaum identified three key fundamentals for achieving the leadership which he suggests are crucial to the global markets of the 1990s they are concerned with an understanding of global markets, a thorough grasp of total quality strategy towards satisfying the customer in these markets and applications management acumen for creating the organisations quality environment and the targets for quality leadership.

At the heart of the TQM philosophy, he points out, is a simple but far reaching message. Britain's business organisations at the very highest levels must challenge the traditional ways of working and encourage the adoption of more innovative practices throughout the total organisation. Hence TQM is an on-going long term philosophy and process to achieve, his extended quality definition, namely to achieve customer satisfactions by continuously improving the quality of their goods and services.

The new doctrine of the 1990s, he states, is to make products and services faster and cheaper by managing people in such a way as to draw on their skills and competences.

Juran (1951), (1974), (1980), (1988) defined quality as fitness for purpose. Consistent with other early writers and an engineering background, he formerly placed an emphasis on the technical aspects of quality control, in terms of statistical analysis, engineering methods and the economics of quality.

His work also had a strong managerial emphasis on goal setting, planning, organisational procedures and change, in that quality does not just happen, but requires to be planned. He saw planning as part of the 'quality trilogy' of quality planning, quality control and quality improvements.

The strategic thrust he emphasised requires the identification of customer needs, establishing optimal quality goals and quality performance measures, meeting the goals through process planning and achieving continuing results through larger market share, value for money and reduced error rates.

Jurans 'Quality Planning Road Map' is concerned with:

1. Identifying external and internal customers.

2. Determining their needs and expectations.

3. Translating their needs.

4. Developing a product or service which satisfies the needs.

5. Optimised product/service features to meet organisational (in addition to customer) needs.

6. Developing a product/service process capability.

7. Optimising the process.

8. Checking the process capability under operating conditions.

9. Transferring the process capability to operations.

The mission of Jurans' later work targets the failure of raising quality awareness from the 'quality crisis' of the 1980s in terms of the failure to change behaviour despite campaigns or drives based on slogans and exhortations. The raised aware-ness he noted failed to change behaviour in the sense of 'right first time' activities.

His regard for campaign failures he put down to poor planning and a lack of substance. The action requirement suggested is based on 90% substance and 10% exhortation, rather than the reverse.

Jurans distinctive contribution to quality has been to emphasise the primary importance of understanding customer needs as opposed to wants or requirements. The emphasis applies equally to those involved in design, marketing, manufacturing and services. Whilst wants only reflect surface features, he states, identifying customer needs requires a more rigorous analysis and understanding to ensure the product meets the needs and is fit for the intended purpose.

His approach further places emphasis on pragmatism rather than perfectionism, eg. zero defects. The attraction of a quality approach to many top management he suggests, is to reduce the costs of quality. With Johnson et al (1992) quoting failure costs to account for 50-80% of the costs of quality, it is little wonder that management are driven to reducing them to the point where any additional expenditure on appraisal and prevention could exceed savings from reduced failure or defect, also suggesting the impracticality of zero defects. Juran further claims that the zero defects approach is mistakenly based on the assumption that most quality problems are due to poorly motivated and undisciplined workers, rather than poorly trained and unaware top management. His belief being that many quality problems result from poor management rather than inept workers.

Ishikawa (1971), (1985), one of the Japanese gurus defines quality as company-wide, in that quality does not only mean the quality of product, but also after sales service, quality of management, the company itself and the human being.

He pioneered the 'Japanese Quality Circle Movement', in the early 1960s as a means of involving 'grassroots' employees in the practise of quality control.

Although the role and nature of the Quality Circles varied between organisations, they were typically volunteer groups of five to ten people from the same department or place of work who regularly met to deploy their collective skills and infinite potential towards continuous work development and improvement and to practise respect for each others points of view.

To assist with the difficult task of educating everyone towards quality control, Ishikawa produced a 'Quality Analysis Workbook' (later to become 'The Guide to Quality Control). He paid particular attention to the development of practical statistical techniques and procedures, included in these were 'Pareto Diagrams', to prioritise quality improvements and

'Ishikawa Charts' to identify cause and effect. Using such techniques he emphasised open team communications as being critical in their construction.

Even though many Quality Circles have been discontinued in Japan particularly through over-control or lack of interest from management, many still work. It is claimed, Bendell (1990), that there is in excess of 10 million circle members there and, although benefits are typically seen as minor from any one improvement, added together they are substantial. More importantly, it is pointed out, greater worker involvement and motivation is created.

Taguchi (1978), (1986). In contrast to some western approaches at the time, his early quality focus was on the effects of quality loss, placing particular emphasis on statistical method, primarily developed and largely used by engineers.

His quality definition was concerned with prevention, (the routine optimisation of product and process prior to manufacture) rather than cure (through checking and inspection processes), thus emphasising quality and reliability as the province of design in providing product tests prior to manufacture. Additionally, he suggested, if required, the resulting methodology may be used also for troubleshooting purposes to resolve actual manufacturing problems.

Taguchi developed the 'Quality Loss Function' concept in place of quality control which he defines as quality loss to society at large, the internal organisation through rework, scrap, downtime and warranty costs and the external environment in costs to the customer and from it, further costs to the provider as market share falls.

Taking an objective or target value for the quality characteristic under consideration as the best possible value of the characteristic, he associates a simple quadratic loss function with variances from the target. This loss function indicates that a variability reduction around the target leads to lower losses through quality improvement. The loss function can be further

used for a comparative analysis of financial design decisions to establish the benefits of additional operational costs in terms of the market.

Bendell (1989), concludes a large UK and world-wide potential for these methods in that normally design and line calibrations are far from optimal. He identifies manufacturing 'folklore' as based on the need to 'twiddle' important parameters or settings, typically not understanding the correct settings.

The Taguchi method on the other hand enables the identification of the optimal settings necessary to consistently supply the fitness for purpose required by the customer.

Shigeo Shingo (1986), (1988), although not so much a definition but an idea, advocated **stopping the process whenever a defect occurred, defining the cause and preventing the recurring source of the defect.** Shigeo Shingo based his improvement principles on industrial engineering practice, plant improvement training and process investigation methods, placing greater emphasis on production than on management.

Although an advocate of statistical quality control, he extended the ideas of quality control to develop the 'Poka-Yoke' (mistake proofing or zero defects concepts) and 'Source Inspection' systems, realising that statistical quality control methods alone are not able to reduce defects to zero. The fundamental idea was to provide people the means to operate 'line-stop', when-ever a fault occurred, define the cause, and action the prevention of re-occurrence. A key feature was the use of source inspection in monitoring potential error sources in order to identify errors before they became defects.

As part of the Just-In-Time focus of the 1970s aimed to increase productivity performance and reduce both defects and stock levels, Shingo originated the 'SME' (Single Minded Exchange) system and was influential in the development of non-stock production methods.

55

His industrial engineering and plant improvement principles complimented Poka-Yoka, SME and Non-Stock systems by the introduction into manufacturing of mistake-proofing devices and simplified set-up programmes and procedures. In combination, they constituted zero quality control and just-in-time operations, which he argued could achieve far more than using statistical quality control methods alone and the traditional methods of relying on the skill levels of workers for set ups.

Oakland (1989), (1993), (1994), identifying need for newer Western approaches to TQM, suggests an approach for improving the effectiveness and flexibility of business as a whole. It is eventually a way of organising and involving the whole organisation at every department, every activity and every single person level.

Oakland explains that quality is the most important of the competitive weapons which any business possesses. He identifies a paradigm of which the sensitive core is the customer-supplier interface. The core needs to be surrounded by high commitment to, and the communication of the quality message with a recognition of the need to address organisation culture issues to create total quality, Figure 6.

CULTURE   COMMUNICATION

Customer-Supplier   COMMITMENT
Interface
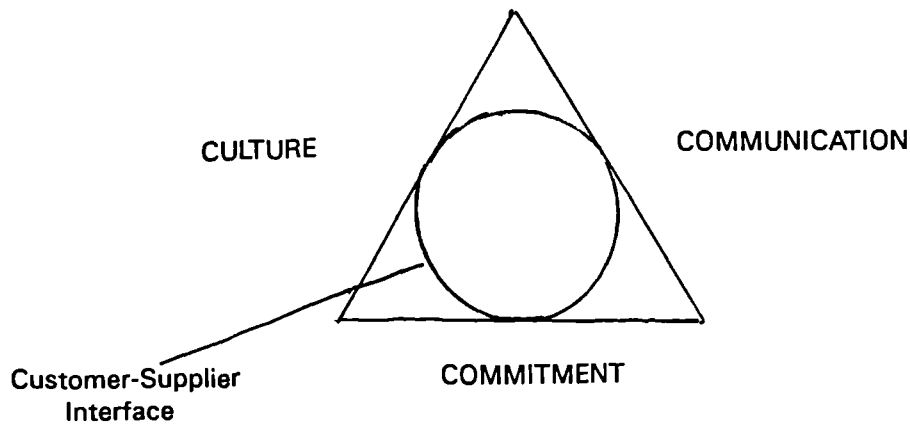
The Soft Foundations of TQM, Oakland (1993)
Total Quality Management - The Route to Improving Performance
(Butterworth-Heinemann)

Figure 6

His classification of these are, 'the soft-foundations', to which, he says, needs to be added

the hard management necessities of, systems, procedures and teams, and the process of

change.

The importance which Oakland places on this is well expressed in his view that in today's

business environment managers need to plan strategically just to maintain a hold on market

share. TQM is an approach to improving business effectiveness and flexibility as a whole.

He sees it as basically a new way of organising every part of the business, every activity

and every person in such a way of working together and understanding that each person

and each process affects, and in turn is affected by each other.

He suggests fourteen steps to quality improvement (Appendix 6), explaining that each step is a natural progression, and as such, any attempt to short-cut the steps will result in the entire model failing.

Crosby (1979), (1984), (1988), (1989) defined quality as conformance to requirements and is probably best known for "Right First Time" quality management leading to 'Zero Defects'. Zero defects he defined as not meaning that people never make mistakes but that the organisation does not begin from a position of expecting that mistakes are inevitable.

He emphasised customer needs and expectations believing that most organisations have cultures, procedures and systems which allow deviations from what is actually required. The costs which result from repeated activities, can, he predicts, be as high as forty percent of operating costs for service organisations.

His further emphasis is quality management, in that management drive quality and employees follow their example. This, he notes, is in contrast to many quality approaches where the workers take prime responsibility for poor quality results.

As indicated earlier, not everyone agrees with Crosby's approach to quality, but he does point out that his are ideas 'who's time has come'.

Central to many of his ideas is the need for a core of quality specialists within organisations, thus further emphasising his top-down approach where top management are entirely responsible for quality.

His goal is to provide management and employees the training and means for quality improvement so as to ensure the application of prevention management everywhere,

viewing work as a process or a series of actions conducted to produce a desired result. A process model should be developed he emphasises to ensure that quality requirements are clearly understood between supplier and customer.

Words are important, he states, with regards to 'process model' and not programme. Programme he believes implies nothing more than a temporary situation.

Crosby's 'Quality Improvement Process' is based on his 'Four Attributes of Quality Management':

- Conformance to requirements (not goodness or elegance).
- Prevention (not appraisal).
- Zero Defects (not a 'that's close enough' approach).
- Quality measurement (not indices) as the price of non-conformance.

The management tool he evolves out of his conviction that the absolutes should be defined, are contained in his fourteen steps to quality improvement (Appendix 7). These he advocates should be defined, understood and pragmatically communicated to every member of the organisation.

In some of Crosby's later works he identifies additional quality building tools, including the 'Quality Management Maturity Grid' to enable organisations to establish their quality position. A 'Quality Vaccine', which he develops, consists of twenty-one ingredients for executives to use to support the implementation process.

In his broadening approach to quality improvement he defines the following characteristics as being necessary to achieve external success:

- People routinely do things right the first time.

- Change is anticipated and used to advantage.

- Growth is consistent and profitable.

- New products and services appear as needed.

- Everyone is happy to work there.

Moller (1988) sees personal quality as the basis of all other types of quality.

Moller, in the development and running of Time Management and Putting People First Programmes, became convinced of the value of administrative process focus over operations process focus offering more opportunities for quality and productivity improvements. The objective being that improvements in work organisation, inter-personal skills and human relations provided the 'bed-rock' for job satisfaction, and from it team identity.

He suggested that improvements in customer service came from inspiring employees to aspire to continually perform their best. To these ends Moller believes that large scale and long term culture change is fundamental to improving the personal quality of the employee in the areas of Productivity, Relationships and Quality. In placing Personal Quality as the fundamental foundation of quality management, he identifies it as the 'Ideal Performance Level' and the 'Actual Performance Level'.

His description of the ideal performance level concerns the personal quality goals of individuals, a quality value influenced by experiences during their formative years. Thus it fluctuates in the early years and stabilises as maturity is reached, to be then influenced by strong emotional experiences only. The ideal performance level therefore has a decisive effect on both the future development of individuals and their attitudes towards it.

The actual performance level on the other hand, he suggests, is influenced by individual self-values when the two performance levels actually match or mis-match. Then the actual performance level is strongly influenced by the visibility and understanding of the organisational goals, the work expectations and the rewards or reprimands which result. Environment factors, the nature of work, time available, resources and competence levels are also influential.

Moller also advocates twelve 'Golden Rules' to facilitate the Actual Performance Level and recommends seventeen 'Hallmarks of a Quality Company' (Appendix 8). In addition he suggests two procedures for raising personal quality:

- The 'do/check' system - continuous self checking.
- The 'quality business card' - a personal guarantee of work quality.

Peters (1982), (1985), (1988), (1992), (1994) concept of quality heavily focuses on what the customer perceives as quality and the degree by which expectations are fulfilled. His philosophies of the Quality Improvement Process is by continuous change through 'Revolution' and 'Reinvention'.

His early works identified the importance of leadership as being central to the quality improvement process, preferring the word leader to manager. The leader should be an enabler in the process of empowering the employees to take responsibility for continuous change and improvement. To these ends he styles the leader as a facilitator, mentor, coach and supporter, managing by wandering around (MBWA), enabling the leader to remain in constant contact with innovation and the internal/external customers and suppliers.

In later works he portrays other additional central issues to leadership, namely customers, innovation and people, covering each of them in terms of 'prescriptions', describing tools, key strategies and tactics for the implementation of excellence.

In relation to customer orientation and responsiveness he describes twelve attributes or traits for a quality revolution (Appendix 9) based on his perceived characteristics of successful quality improvement programmes in top American organisation.

Peters latest work predicts corporate failures unless organisations (any type of organisation) go beyond change to embrace revolution. He suggests sixteen major issues which need to be addressed and accommodated if organisations are to survive.

- Hierarchies - maximising on four layer organisations which operate as two layers.

- Federal Structures - subordinate independent and autonomous units with decision making powers to the corporate centre.

- Accountability - the demand of performance accountability from top management, in addition to elsewhere in the organisation.

- Large-scale Change - transformational leadership towards an inexorable change process.

- Shamrock Organisations (citing Handy) - small core organisations of permanent professionals with significant amounts of work networked and the employment of numerous part-time staff.

- Total Quality Management - emphasising front line worker responsibility.

- Information Technology - facilitating the networked organisation.

- Teams - moving from control oriented hierarchical management to self-controlled team based management.

- Re-engineering - re-inventing business processes and integrating warring functional areas.

- Customer Awareness - customer focus in all aspects of the business.

- Globalism - referring to the transnational corporation concept which amounts to locating business sector leadership at the focus point rather than wholly at corporate headquarters.

- Going Green - translating Draconian environment standards into export success.

- Core Competences - concentration on essentials and the regular reinvention of competences to match rapidly changing markets.

- Trust - valuing employees worth and the demonstration of mutual respect and trust.

- Learning Organisations - developing learning networks and learning from each others cultures as the essence of its strategy.

- Government - the public policy drift away from protectionism and towards privatisation to provide the business organisation culture and through it competition.

Recognising that Peters suggested revolution is not solely focused on the management of quality, the writer feels that a number of his issues are consistent with TQM, particularly those which are concerned with flexibility and responsiveness, and which are particularly apt to large, bureaucratic and 'top heavy' organisations, which has earlier been suggested of the NHS.

The writer agrees with Bendell (1990) that the Guru's have been strong in defining what is broadly needed in terms of the management of quality.

The early Americans were significant in putting Japan at the centre of quality leadership. They adopted, developed, adapted and applied distinctive approaches, brought to them in the 1950s, which matched their culture.

Much of the increased awareness of the importance of quality in the West has resulted from the work of the newer Western Guru's and indeed Bendell himself, who have diligently published and debated many of the quality issues.

Macdonald (1993), draws attention to an 'intriguing' aspect of the quality movement in the 1990s, in the relative demise of the quality guru's. Throughout the 1980s he says, Crosby, Deming and Juran dominated on the subject of quality. Now there is a reaction to

evangelism, profound wisdom and engineering theory he says. The new theme, he states, is a broader based realism, suggesting that the decade of the gurus was initially invigorating, but later became suffocating.

He does conclude, however, that they each have provided wisdom and powerful drivers for thought, but none have provided a complete and final answer.

The writer recognises that whilst each of the guru's have their own distinctive approaches, there is considerable commonality between them:

1. The importance of controlling the process not the product.

2. The need in focussing on process control, to emphasise the human process.

3. Top management responsibility for quality, (not the work force) - by providing commitment, leadership, understanding of process and appropriate support to technical and human processes.

4. Management providing a climate and framework in the organisation fostering work force participation and involvement of others such as vendors and stakeholder's in quality improvement, developing a culture and changing perception of and attitudes towards quality.

5. An emphasis on the prevention of defects not inspection or cure, and through it the reduction of costs to improve competitiveness.

6. Quality improvement emphasised, producing benefits over time, whether developed continuously or on a project by project basis.

7. Broad agreement that all aspects of processes should be considered for quality improvement, as these contribute towards quality.

Although historically much focus and emphasis was associated with the manufacturing sector in particular, the need for similar focus and emphasis in the service sector was

identified during the 1980s. Garvin (1987) for example, in assertive terms, states that at least a similar focus is a crucial factor for service differentiation.

Waddington (1994) reviewing the guru quality and total quality management definitions and paradigms, warns against viewing quality as three separate activities, namely: standards/ specifications; systems/procedures; and total quality. He asks organisations to ensure that the three are (and are seen to be), fully integrated into a total quality culture.

3.3   Total Quality Management - Approaches and Thrusts

From the late 1980s to the present literature abounds emphasising and stating the importance of TQM as a competitive weapon. In simplistic terms most agree that TQM has organisation wide implications in that every aspect of the organisation is involved and every person in it striving for excellence. Every customer and supplier both inside and outside the organisation are also involved. A total commitment is required, beginning at the top and cascading the whole organisation.

The earlier mentioned involvement of the writer with TQM programmes and processes suggests two distinct applications levels:

■   The radical change approach (less favoured).

■   The continuous improvement approach (most favoured).

It is important to this research to identify definitions and paradigms which distinguish these.

Radical review is emphasised, in that TQM is concerned with the radical workings of the organisation as a whole, as a means for improving effectiveness through goal attainment and efficiency in the utilisation of its resources.

More specifically and recently a similarity has been suggested between **Business Process Re-Engineering** (BPR) and TQM. Oliver (1993) defines BPR as a fundamental re-think and a re-design of business processes to achieve dramatic improvements in critical contemporary measures of performance such as costs, quality, service and speed.

Hammer and Champy (1993) describe re-engineering as a radical way to re-think the way organisations work. Dismissing as fads, zero based budgeting, quality circles, decentralisation, portfolio management and value chain analysis, they suggest the re-invention of the six or so critical processes which drive the organisation.

The problems facing many organisations, they state, do not result from organisational structures, but their process structures. Overlaying a new organisation on top of an old process, they suggest, is not dissimilar to 'pouring soured wine into new bottles'.

Hospital Process Re-Engineering (HPR), Lister (1994) asserts, challenges hospitals to question their ways of working from the patients perspective. It seeks to achieve radical change, he points out, not a continuation of the incremental improvements in costs, quality and time which traditional cost reduction, value for money and quality improvement initiatives have offered in the past. It calls for a transformation of all aspects of the organisation.

In terms of the TQM perspective, he identifies similarities between HPR and Patient Focused Care (PFC), which is described as individual holistic care dictated by the needs and wishes of the patient, rather than by the values or conveniences of the providers.

Lister suggests a 'Five Golden Rules' paradigm for achieving HPR and PFC.

1.   Develop a clear vision for the potential for change.
2. . Ensure visible commitment and support for the programme/vision.

3.   Combine a broad view of all the necessary factors to achieve change with a narrow

       focus on action.

4.   Build on success and learning from it.

5.   Communicate at every stage with everyone.

Smith (1994) states, that in addition to re-design of processes and applications paradigms

around the patient, is the necessity to inform, educate and empower the patient.

Talwar (1993), identifies two main approaches to re-engineering, Process Re-engineering

offering the opportunity to rethink and streamline individual processes and Business Re-

engineering, re-thinking and re-designing the entire business behind a more focused

competence based competitive strategy. The central challenge, he suggests, (and one

which the writer feels is not dissimilar to both the radical change and continuous

improvement approaches of TQM), is to understand where and how value is created for

both customers and shareholders and then to ask, what is done, how it is done and what is

necessary to improve it.

He suggests an approach (paradigm) to re-think and streamline the business processes and

supporting architecture through which business organisations create and deliver value,

Figure 7.

BPR in the Public Sector (1994), CCTA Guide, suggests that organisations could consider

BPR as a response to the new Public Management initiatives requiring public sector

organisations to improve the quality of services to the public and to reduce costs.

It identifies quality, cost and time benefits from a 'BPR Exercise' in responding to customer

orientation (Citizen's Charter), opening the internal market to the private sector and

expecting more from less.

Shareholder Value

↓

Customer Service and Retention

↓

Efficient Operations

↓

Cross-Functional Processes and Cross-Organizational Activities

↓

First Principles Review and Redesign of Business/Key Processes

Strategic
Alignment

Capability,
Performance, Ambition

Value Creation
Drives Activity

External
Benchmarks

Optimized
Architecture
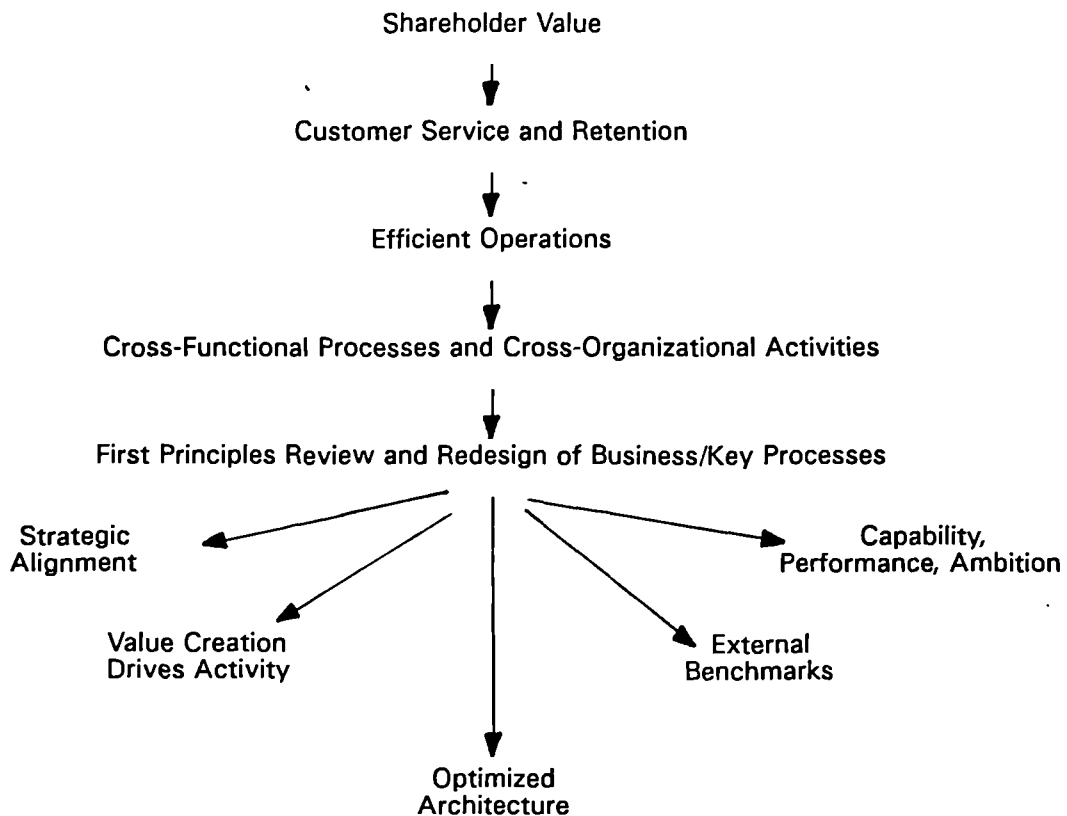
Figure 7   The re-engineering approach to corporate transformation. Talwar (1993).

Business Re-engineering - a Strategy-driven approach. (Long Range Planning, Vol 26, No 6.)

Suggesting a BPR team approach it identifies the essential requirement to target the total

process with the end customer in mind. The implementation of TQM, it suggests,

encourages personnel to think of the next step in a process as 'internal customers'.

Hutchins (1992), presents TQM as an 'umbrella term', in that it includes everything which

an organisation does to ensure that customers both recommend and return to them. His

paradigm emphasises competition as defined by strengths, weaknesses and internal

effectiveness. Customer perceptions are fundamental and TQM requires to be policy driven

to these ends. He relates to business organisations who have achieved 'market power'

through re-structuring so as to emphasise value satisfactions both competitively and

profitably.

Andersson (1992), defines Quality Function Deployment (QFD), as a systematic process for translating customer expectations into different levels of customer requirements. The cross-functional team procedure, involving those from the functions which are heavily involved in creating new products, he suggests, can help an organisation become more customer oriented and fits well into the TQM concept.

He goes on to emphasise the QFD steps originally formalised by Dr Yoji Akao in Japan during the late 1960s, to assist the organisation to achieve both improved quality and profitability. These he lists as:

- Identifying customer expectations.

- Ranking the importance of each expectation.

- Benchmarking, with the most important competition.

- Translating customer expectations into objectives and measurable product characteristics.

- Establishing which characteristics are correlated to one another.

- Noting relationships between customer expectations and product characteristics.

- Using the information to establish target values for the product characteristics.

Zairi (1993), asks the question of a positive link between TQM and QFD. He advocates a focus on the Japanese understanding of QFD and the ways they relate it to total quality, in order to answer the question. He goes on to style Japanese TQM in terms of a company wide emphasis in the form of company wide quality control (CWQC). This he says consists of the application of company wide commitment to continuous improvement and multi-disciplinary action through prioritizing technological and business acumen.

Zairi suggests, this reflects the fundamental use of QFD as a necessary part of the TQM philosophy.

Added to these however is the achievement of quality management through a **continuous and consistent effort to solve problems, deal with customer complaints and comply with requirements.** A positive contribution made, least of which is not in connection with definition and paradigm, is to refrain from limitation. To introduce QFD as merely a TQM tool, limits its potential, instead it has greater potential in changing organisation and work culture.

Zairi's paradigm is thus concerned with focus on the total organisational goal which begins with the customer. To these ends the emphasis is on **teamworking, multi-functional contribution, prevention and right first time philosophy, based on the development of a culture for superior competitiveness and visibility.** Technical capability and competences in meeting customer requirements and market competitiveness are assessment driven.

Al-Assaf and Schmele (1993), point out the need for a re-definition of TQM for such organisations as health service organisations. Their definition calls for a continuous effort by all members of the organisation to meet the needs and expectations of patients and other customers. Although the definition is basically a substitution of the words patients and customers to other non-health service definitions, the reference to continuous effort, emphasises the value of striving to exceed prevailing standards, rather than an acceptance of them, as limits on performance. The fundamental shift in health care, offered by the definition, is from **structure standards to process standards to outcome standards.**

The term, all members of the organisation, serves to suggest the need to be fully aware of and integrated with the organisational processes by which health care is produced and provided.

The reference to expectations, recognises that patients reports of their experiences and their assessments of results are valid indicators of quality, including some of its technical aspects.

Fundamental to this expanded definition is their 'contemporary leadership' paradigm which focuses on three health care cornerstones, **quality, access and costs**. Although they are independent, they do impact one another. Quality is the 'driver' of access and costs they say. It is clear, from this, that their leadership paradigm focus is the achievement of quality through providing accessible services in an efficient, cost effective and acceptable manner. They point out that the achievement of quality occurs when the needs and expectations of patients and other customers are met.

This is consistent with Waddington's (1993) view, that in health care, TQM aims to ensure both the quality of services and the quality of outcomes produced by those services.

Foster and Whittle (1990) responding to the question - which quality management approach is best for a business organisation? - state that comparing quality management is difficult **due to the number and variety of the terms employed.** Too often, they say, TQM strategies are control strategies. By comparing TQM with other generic categories - quality assurance, quality control and total quality control, the emphasis of their definition is concerned with a fundamental shift from the past. Systematic analysis, pre-planning and blue-printing operations, they point out are essential, but there needs to be a focus shift by business organisations, from processes driven by external controls through procedure compliance and enhancement to a process grown out of habitual improvement, where control is embedded within and driven by the organisations culture.

They suggest a paradigm which focuses on business objectives and business strategies as a 'best' approach to quality management, based on a consistent and detailed analysis of the

organisations market position. They direct attention to 'competitive benchmarking' as a means of comparing the quality of products, services and practices with those of the market leaders. This is not inconsistent with Zairi's (1992) point, regarding the accelerating quality movement. He draws attention to an increasing interest by business organisations of many types, in using benchmarking as a continuous rather than isolated procedure. The manner in which quality has evolved, from inspection to control to assurance and to management, he says, was inevitably moving towards the need to benchmark.

It is evident to the writer, from Foster and Whittle's research, that management need to be clear of their business objectives and strategies in order to provide the purpose, direction and vision for a successful TQM programme, which should be simultaneously aligned to the strategies concerned with quality culture. To these ends, their paradigm is facilitated through organisational and work re-structuring, customer and supplier strategies, leadership strategies and human resource analysis.

Webster (1992), rather than suggesting a definition prefers to view quality as continually satisfying the customer (patient/purchaser). The TQM objective, for him is achieving quality at lowest costs by harnessing everyone's commitment towards the elimination of waste. His suggested paradigm is to relate low costs and waste elimination to matters of accessibility, relevance, equity, efficiency, acceptability and effectiveness.

Lascelles and Dale (1992) suggest the meaning of quality should be no more complicated than customer delight, to which end quality management is a dynamic set of activities to achieving this goal. Quality Management they say, becomes TQM once there is an integrative framework which encompasses three particular strategic parameters - customer perceptions, competition and business efficiency. To these they add a fourth parameter in the form of organisational truth as a quality concept. Organisational truth is described as collective purpose and the involvement of everyone with visions, pride of achievement and the practice of respect for and commitment to each other.

Their enabling paradigm, referred to as Total Quality Improvement (TQI), they say, is necessary to achieve the TQM vision. It is based on continuous improvements and the incorporation of strategic 'drivers', concerned with customer care, competition, suppliers, leadership, people and money. TQI they recommend requires carefully planned organisational change from the top management team, with a cascading procedure for implementation.

Long term effectiveness it is suggested, is through a culture development, possibly over a five to ten year period, which develops enabling leadership, teamwork and commitment to never-ending improvements aimed at delighting the customer.

Fundamental to the Baldridge approach to quality, Evans and Lindsay (1993) point out, was his firm belief that quality is defined by the customer, in that the customer has defined the requirements and transmitted them to the supplying organisation.

In order to provide the customer expectation, Baldridge stated that senior leadership needs to create clear values and goals in such a way that employees know what is expected of them and they are trained to be able to provide them. His choice of leadership, rather than management, indicates his belief that empowering and facilitating staff in place of commanding and controlling them, has beneficial affects on the quality of their output.

In addition, he emphasises the need for well designed and executed operations systems and procedures with an emphasis on continuous improvement through which the business remains competitive.

Figure 8 outlines his quality award criteria.

```
                              SYSTEM                    ┌─────────────┐      GOAL:
                                                        │Customer Focus│
                                                        │and Satisfaction│    ■ Customers Satisfaction
                         ┌──────────────┐               └─────────────┘
                         │ Management   │                      ▲            ■ Customer Satisfaction
              DRIVER     │ of Process   │                      │              Relative to Competition
                         │ Quality      │                      │
                         └──────────────┘                      │            ■ Customer Retention
                                                               ▼
         ┌──────────┐    ┌──────────────┐               ┌─────────────┐      ■ Market Share Gain
         │ Senior   │    │Human Resource│               │ Quality and │
         │Executive │    │Development and│              │ Operational │      MEASURE OF PROGRESS
         │Leadership│    │ Management   │               │ Results     │
         └──────────┘    └──────────────┘               └─────────────┘      ■ Product and Service
              ▲                                               ▲                Quality
              │          ┌──────────────┐                     │
              │          │ Strategic    │                     │            ■ Productivity Improvement
              │          │ Quality      │                     │
              │          │ Planning     │                     │            ■ Waste Reduction/
              │          └──────────────┘                     │              Elimination
              │                                                │
              │          ┌──────────────┐                     │            ■ Supplier Quality
              │          │ Information  │
              │          │ and          │
              │          │ Analysis     │
              │          └──────────────┘
```

Figure 8   Malcolm Baldridge National Quality Award Criteria

Evans and Lindsay (1993). The Management and Control of Quality (West Publishing Co).

Not dissimilar to Crosby (Zero defects) Baldridge refers to 'Error Prevention' and is a keen
advocate of the 'Quality Chain', emphasising the need to integrate supplier quality into the
organisations quality chain.

Consistent with the popularity of the Deming Prize in Japan, the Baldridge Award was
established in the late 1980s for those manufacturing and service organisations with a high
quality profile against explicit criteria.

The writer is mindful of recent media criticisms of the award, particularly in the message
which has emerged that winning the award does not guarantee business success and of the
resource hungry aspects required to win. But agrees with Garvin (1991), that understanding
the award criteria provides an audit framework, informing organisations where and how they
may demonstrate proficiency rather than how to proceed.

Roth (1993), insists that TQM encompasses statistical process control, employee
empowerment and team driven project management, integrating the customer-supplier chain

to achieve consistent quality improvements, higher productivity and employee satisfaction. They note with interest the growing number of 'world class' organisations now openly talking of delighting the customers and of winning customers.

Bank (1992) focuses TQM on the requirements of customer demands which grow stronger and get better organised. He warns, however that TQM is not only about customer awareness, it also demands a delivery process system. It is essential, he suggests, that the process system should ensure everyone (total), working on activities which are important for the success of the business by fulfilling work group missions, internal customer/supplier focus, the elimination of work which prevent 'right first time' results and harnessing the total and combined skills and competences of group members to continuously improve business and satisfy the external customers. He suggests ten steps to the quality delivery process (Appendix 10) around which he develops the quality delivery model, Figure 9.
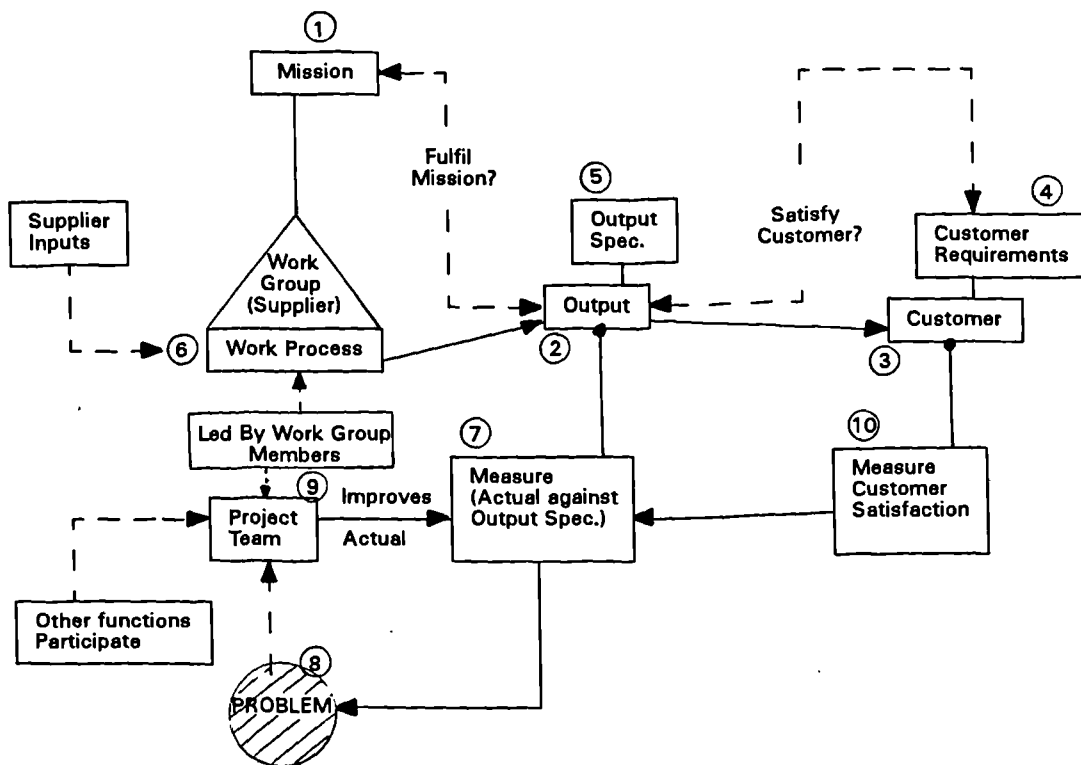
Figure 9   The Quality Delivery Model. Bank (1992).
The Essence of Total Quality Management (Prentice Hall).

Atkinson (1991) is concerned that whilst the basic theory and methodologies behind TQM are easily understood too many assumptions are made of their applications into practice, suggesting that were TQM that simple, many organisations would have done it years before.

Wilkinson and Witcher (1991) suggest a focus on People, Methods and Internal Markets, Figure 10.
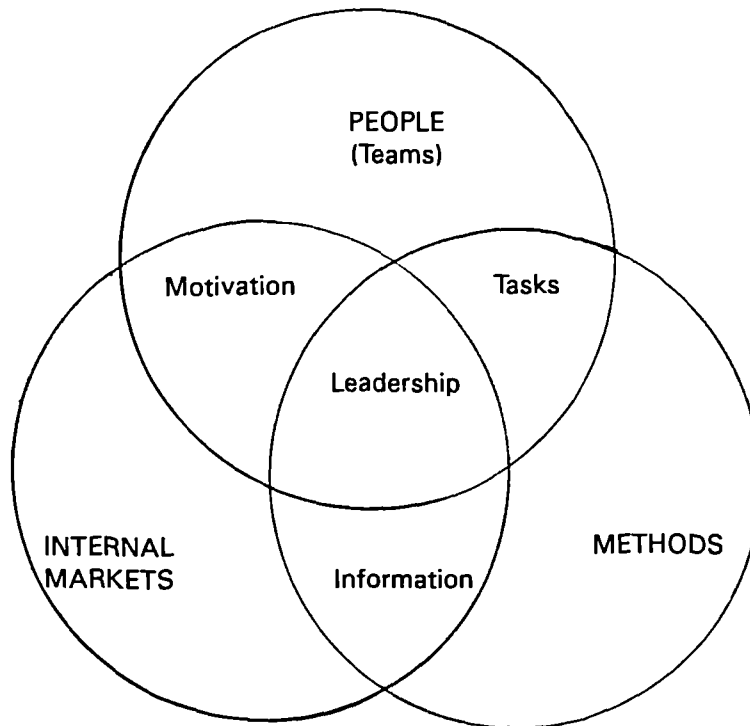
Figure 10   People, Methods and Internal Markets. Wilkinson and Witcher (1991).

TQM in the UK - Fitness for Use? (Occasional Paper Series - Durham University).

METHODS, refer to business systems, for example ISO 9000. PEOPLE, are involved in teams and through the teams they learn who their customers are, so raising the INTERNAL MARKETS. These are supported by good leadership, which in turn facilitates motivation and information, resulting in the effective and efficient undertaking of tasks.

Madu and Kuei (1993), introduce Strategic Total Quality Management (STQM) as an extension of TQM. Accepting that if TQM is achieved, the organisation is able to improve productivity, competitiveness and market share. They make the point, however, that it fails to instil new thoughts on how to further improve quality, other than by recycling that which

is already known. STQM, on the other hand, they suggest, is a philosophy based on developing a total systems view of quality, viewing quality as the driving force to survivability and competitiveness.

Rather than viewing quality just from the standpoint of products and services to the customer, it is seen as a reflection of the overall performance of the organisation in its immediate and extended environment in matters that may be unrelated directly to the product/service performance.

Thus STQM is a philosophy that considers socially responsible and environmental sensitive decisions and integrates them into TQM in order to improve global competitiveness. Quality, they point out, is seen as holistic, whereas STQM proposes that quality is customer and environmental driven and both must be considered in order to develop an effective quality programme. The transformation process they suggest, Figure 11, operationalises the 'Deming Wheel' by specifically detailing the process of achieving continuous quality improvement and also identifies when the necessary quality tools should be used.
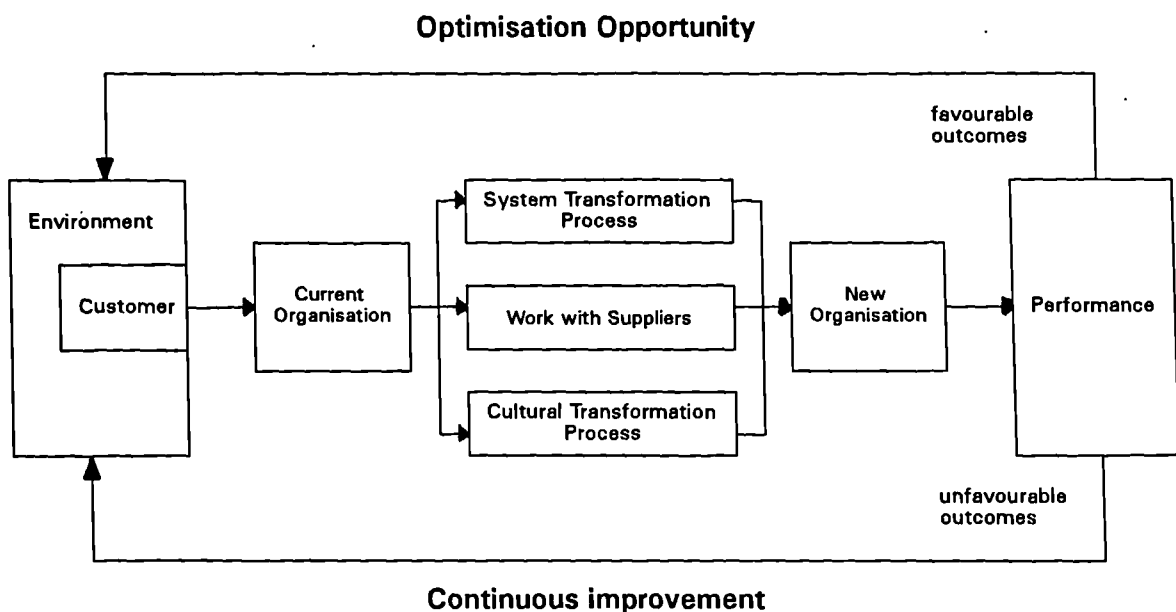
Figure 11   Strategic total quality management process. Madu and Kuei (1993). Introducing Strategic Quality Management. (Long Range Planning, Vol 26, No 6).

The transformation process views the plan - do - check -act cycle from a strategic viewpoint, where plan represents strategic planning and formulation, the do represents strategy implementation on a smaller scale, the check represents evaluation and control and the act, strategy implementation on a full scale, resulting in a 'Strategic Cycle or Wheel'.

As Figure 11 illustrates, the strategic cycle is continuous, analogous to the loop found in the PDCA cycle ('Deming Wheel', Figure 5), indicating the need to continuously strive for the best, acquiring new information and using it to improve the strategic framework. The approach is seen as a customer and environment driven analysis of both the internal and external performance of an organisation to drive defects to zero and to maximise customer satisfaction.

The transformation of today's organisations, they suggest, is through system transformation process, working with suppliers and that the organisational transformation process is mandatory to survival. Chang, Labovitz and Rosansky (1993) state that to actually achieve the process of TQM, you balance your emphasis on departments and functions with an even greater understanding of, and focus on, the key work processes which cut across functions, simply, they state, because no one function can satisfy the customer. Any paradigm can work, they suggest, providing the 'magic ingredient' of facilitating and mentoring leadership is present to make quality work.

The TQM Leader develops vision and defines the right things to do, to these ends they suggest a self-check leadership audit, Figure 12 and a self discipline based on Allow, Support, Manage and Lead steps, Figure 13.

Right Things Wrong	Right Things Right
STRESS IMPROVED · EXECUTION	STRESS CONTINUOUS IMPROVEMENT
Wrong Things Right	Wrong Things Right
ZERO - BASE	CLARIFY GOALS

What You Do
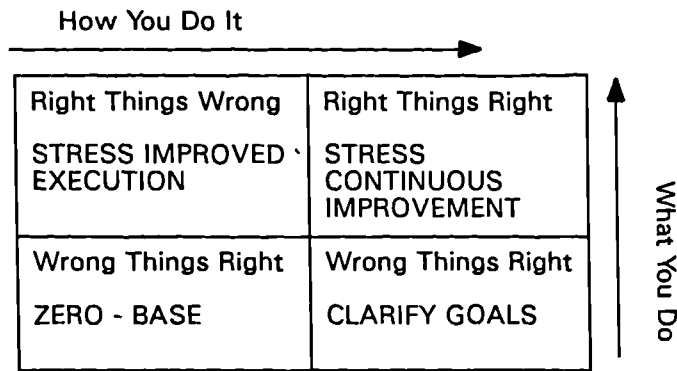
Figure 12   Self-Check Leadership Audit. Chang, Labovitz and Rosansky (1993).

Making Quality Work (Harper Business).

Followed by a self-discipline based on Allow, Support, Manage and Lead steps, Figure 13.

STEP 1   ALLOW

- Allow people in your organization to attend TQM training.
- Attend TQM training yourself.
- Create a TQM coordinator position that reports to senior management.
- Fund limited TQM training without becoming directly involved.
- Fund an exploratory TQM pilot effort.

STEP 2   SUPPORT

- Delegate the responsibility for TQM initiatives.
- Create senior management TQM initiatives.
- Kick off TQM training sessions for your people.
- Endorse TQM as a priority for the organization.
- Include TQM topics in presentations.

STEP 3   MANAGE

- Chair a quality council, head a quality improvement team, and remove barriers.
- Establish TQM measures to track your organization's success.
- Implement an innovative rewards and recognition system for TQM efforts.
- Model doing Right Things Right.

STEP 4   LEAD

- Commit yourself to becoming a champion of TQM.
- Insist on the use of TQM to achieve organizational goals.
- Hold people accountable for supporting quality goals.
- Never compromise quality for schedule, volume, or cost.
- Ensure that TQM is part of decision making in all organizational and clinical processes.

Figure 13   Allow, Support, Manage, Lead Steps. Change, Labovitz and Rosansky (1993).

Making Quality Work (Harper Business).

Flood (1993), similarly looks how management functions are organised for the successful implementation of quality, in the form of viable systems thinking/method (VSM). It shows how management functions are organised together and introduces recursion. This, he states, represents an exciting new image of organisations. The process of management in a viable system replaces the systematic use of mechanical parts in organisations, and organisations through recursion replaces the traditional hierarchical tree. Thus VSM replaces a mechanical-coercive representation of organisations with a viable one, where work activities are brought together in a logical and effective manner, thus leaving the way open for participation, autonomy and responsibility to become a central part of management.

Goodman and Adamson (1993), identify eight ways of improving customer loyalty and hence profitability, by meeting customer expectations better. They are: quantify where you are, set improvement targets linked to rewards, train and empower staff, solicit complaints, automate service and quality systems to get a clearer sight of root causes of problems, create a focal point for customer satisfaction and problem prevention, invest in customer education and track satisfaction by transaction.

On the point of training and empowering staff, they point out, whilst 50% of customers with problems never complain, only 5% actually take their complaint to top management. The remaining 45% complain to the customer contact employee. Citing their experiment with Xerox field staff who were trained and empowered to do what was necessary to satisfy the customer, they noted an increase in customer and employee satisfaction without a corresponding increase in costs.

Gilbert (1992), suggests that there are three basic types of quality model, Process Analysis, Integrated and Charismatic. Although each focus on the customer, as to determine the actions required by the organisation to improve itself, the structure and organisation of the TQM processes used to achieve the actions do differ quite significantly.

Many aspects of the three processes, he suggests, are similar and actually merge into one, when excellence has been achieved, Figure 14.

```
                        ┌─────────────────────┐
                        │  TQM Process Models │
                        └─────────────────────┘

   ┌──────────────┐       ┌──────────────┐       ┌──────────────┐
   │   Process    │       │  Charismatic │       │  Integrated  │
   │   Analysis   │       │              │       │              │
   └──────────────┘       └──────────────┘       └──────────────┘
          │                      │                      │
          ▼                      ▼                      ▼
   ┌──────────────┐       ┌──────────────┐       ┌──────────────┐
→  │ Flowcharting │       │   A leader   │       │  Teach the   │
   │ of activities│       │     of       │       │   rhetoric   │
   ├──────────────┤       │ great stature│       └──────────────┘
   │ Core         │       └──────────────┘              │
   │ Processes    │              │                      ▼
   ├──────────────┤              ▼               ┌──────────────┐
   │ Supporting   │       ┌──────────────┐       │  Everybody   │←┐
   │ Processes    │       │   Process    │       │  into teams  │ │
   └──────────────┘       │    Steps     │       └──────────────┘ │
          │               └──────────────┘              │         │
          ▼                                              ▼         │
   ┌──────────────┐                              ┌──────────────┐  │
   │ Measurement  │                              │    Start     │  │
   │     and      │                              │   Projects   │  │
   │ Improvement  │                              └──────────────┘  │
   ├──────────────┤                              │  │  │           │
   │  Eg. Cost    │                              ▼  ▼  ▼           │
   │  of quality  │                              ┌──────────────┐  │
   └──────────────┘                              │   Measure    │  │
          │                                      │  successes   │  │
          │                                      └──────────────┘  │
          │                                             │          │
          │                                             ▼          │
          │                                      ┌──────────────┐  │
          │                                      │   Disband    │──┘
          │                                      │   Project    │
          │                                      └──────────────┘
          │              ┌──────────────┐                │
          └─────────────→│  Excellence  │←───────────────┘
                         └──────────────┘
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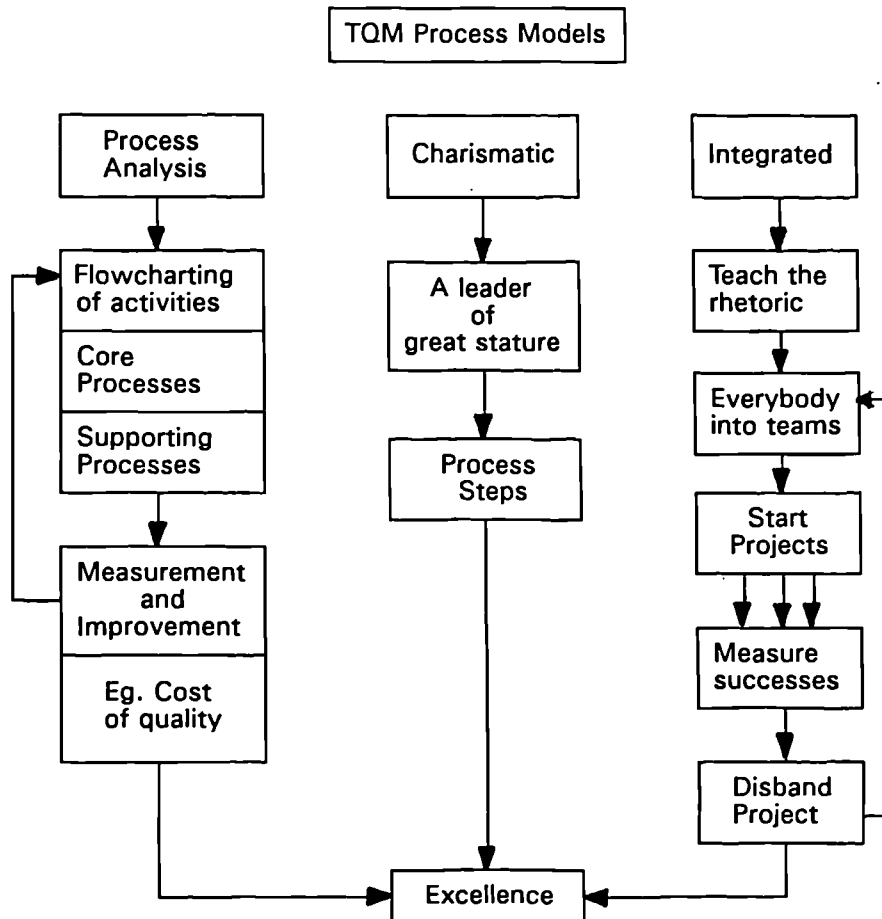
Figure 14   Three Types of Quality Model. Gilbert (1992).
A Slice by Slice Guide to Total Quality Management (Tudor).

It can be seen that process analysis is essentially a top down process of improvement with bottom-up review activities. Charismatic TQM is typified by small organisations with visionary leaders who infuse quality, commitment and passion for excellence into all those working there. The Integrated TQM process model is concerned with customer focus through teams, where everyone in the organisation is a member of at least one team - steering teams, continuous improvement teams, facilitator networks, project teams, etc.

Gilbert subscribes to the careful selection of processes to achieve perfect control over technical and business processes, and through it achieve TQM, for which his definition is - a process designed to focus on customer expectations, problem prevention, building workforce commitment to quality and the promotion of open decision-making.

Dale and Boaden (1994) from their research into TQM decided that what was lacking in many organisations attempting TQM, was a framework for introducing and developing the process of continuous improvement. Not unlike Gilbert, the foundation of the framework they suggested, is organising and the two main essentials are systems and techniques, and measurement and feedback. Changing culture is improvement, they state, but culture change will naturally occur as an operating experience of TQM is developed.

Central to the process of improvement are people, both as individuals and team members, Figure 15.

A clear long-term strategy for the process of quality improvement is essential, they recommend, which must be formulated and integrated with other key strategies. The framework should be used as part of a six-stage process:

1.   · Review the organisation's TQM state to date.

2.   Customise the features of each section of the framework.

3.   Assess using self-audit and internal-external indicators to establish which features are already in evidence.

4.   Prioritise the features not in place in accord with the overall business strategy.

5.   Develop implementation plans.

6.   Identify potential implementation problems.

Suppliers

```
                          Suppliers
                            │ ▲
                            ▼ │
        ┌───────────────────────────────────────┐
        │           Culture Change               │
        │        Individuals/Teamwork            │
 ◄──────┤────────────────────┬──────────────────┤──────────────►
 Contractual │ Systems and   │ Measurement      │  Benchmarking
 Requirements│ Techniques    │ and Feedback     │
 ──────────►─┤───────────────┴──────────────────┤◄──────────────
        │              Organising                │
        └───────────────────────────────────────┘
                            ▲ │
                            │ ▼
                          Customers
```
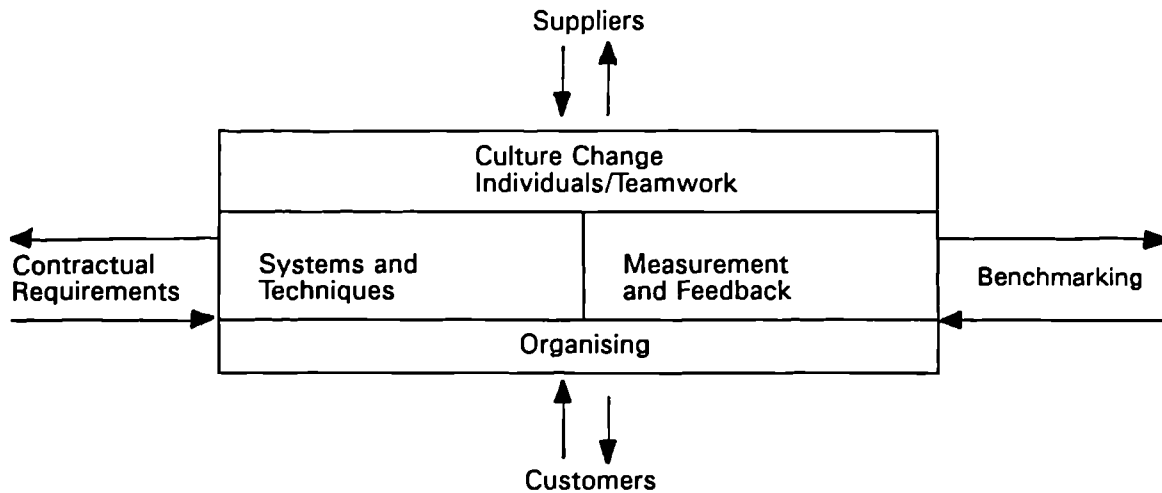
Figure 15   The Quality Improvement Framework. Dale and Boaden (1994).

Managing Quality (Prentice Hall).

Davies (1991), suggests that having a TQM process underway is no longer a competitive

advantage, but that ensuring you strive to understand and reach the later states of the TQM

evolution is. He subscribes to three distinct phases of development with the evolution;

survival, prevention and continuous improvement.

Most who begin TQM, commence at the survival stage focusing on key problems and the

elimination of them. The biggest challenge he suggests, is planning the transition to the

second stage and their passage through it. This stage is where the organisation is really

brought under control, where existing roles and methods are challenged and a clear vision of

future improvements act as a development focus. Quality is really 'designed in' to the

organisation, he suggests and its processes, and the workforce developed and re-developed

at all levels.

The third continuous improvement stage, he reports, is a type of activity observed by him in

but a handful of organisations, where the organisation is truly an integrated process with

individuals and teams fully understanding their roles and means of improving further. Total

customer orientation, at this stage actively exists throughout the organisation.

The TQM cycle he proposes to achieve the later stages and to avoid journeys down 'blind-alleys' is shown in Figure 16. His recommendation being a well structured review profile to establish the current stage status followed by rigorously routing the cycle.
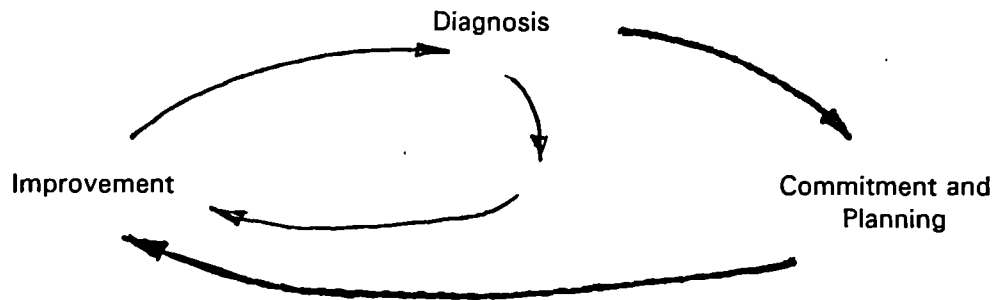
Figure 16   The TQM Cycle. Davies (1991).

What Does the Future Hold? (Total Quality Management Magazine, June 1991).

Pace (1989), suggests that employee involvement (EI), a process for empowering members of organisations to make decisions and solve problems appropriate to their levels in the organisation, is seen by most TQM authorities as a necessary ingredient for overall organisational effectiveness. Typically, he states the goals of EI are increased productivity and improved employee satisfaction.

Whereas EI is an individual process, TQM is a company approach intended to bring under control all the processes and systems of the organisation.

Although TQM is traditionally defined in terms of zero defects and the attainment of customer satisfaction, he prefers to view the goal of TQM as continuously increasing user value simultaneous with continuously decreasing user sacrifice. The potential conflict between TQM and EI, and hence the need to concentrate on integration, he points out, is clear, for EI is philosophically oriented towards higher commitment by means of reduced managerial control and TQM either explicitly or implicitly is oriented towards more management control.

84

He goes on to say that EI means living with creative solutions and the resultant variety of approaches, whilst TQM will strive to achieve work process and work output standardisation. He warns organisations not to implement both processes simultaneously without integrating them, since this is likely to send mixed signals to the workforce of the organisations true intentions. Conceptually his model for integrating TQM and EI is quite straightforward, Figure 17. In it TQM is the vehicle for deciding what is important to work on, whilst EI is a procedure for deciding how to go about working on it.

Controlling .... Planning

Total Quality Management
(top down)

Motivation
(Integrated state)

Employee Involvement
(bottom up)

Leading .... Organising
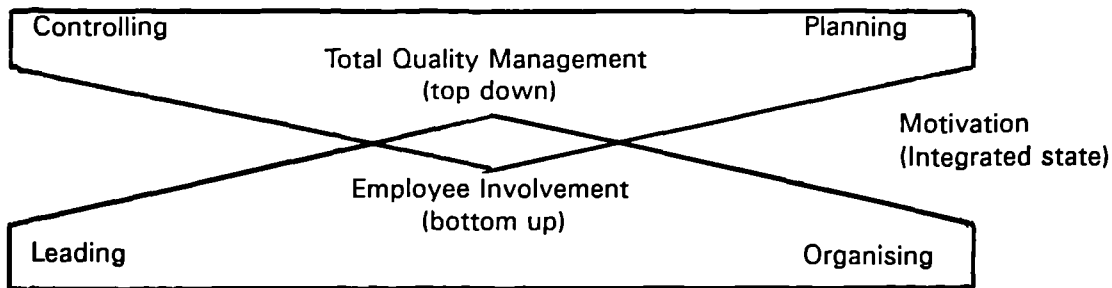
Figure 17
Integrating Total Quality Management and Employee Involvement. Pace (1989).

Moving Towards Systems Integration. (Survey of Business, Centre for Businees and Economic Research).

By providing direction in selecting the right thing to do (planning), and doing things right (control), management may allow employees discretion in how to do things (leading or self-management), and how to do things together (organising). The cooperation results in a top-down concentration on planning for continuous improvement of user value, and a reduction in user sacrifice, whilst the bottom-up focuses on getting results by working together.

Also in terms of integrating TQM with other practice, Baraldi (1994) recommends consideration be given to integrating it with **Management By Objectives (MBO)** systems. He asks, is MBO a managerial tool in decline or, is it in a period of re-thinking? He points out

that since TQM is based on a set of strategic objectives shared inside the organisation, MBO could be an effective way of spreading the knowledge of strategic priorities and the awareness of how individual behaviour helps reach the priorities. As a consequence, the objectives assigned to the different organisational units involved in the MBO process have to be able to evaluate not only executive performance, but also strategic performance. This contributes to shift the focus of the MBO system from short to longer term.

In addition, Baraldi states, it is necessary to extend the MBO process to staff areas to measure the effect of their contributions and participation in the development of cross-functional processes to generate customer value, thus a higher horizontal spreading of MBO systems.

Furthermore, since TQM emphasises competitive excellence, the MBO system needs to consider both the internal and external business objectives and be capable of evaluating competitive positioning in terms of competitors, customers and suppliers, Porter (1985), thus defining this characteristic of MBO as outward orientation.

Since the word 'total' in TQM normally aims to involve everyone in the organisation, the MBO system could develop the inclination to personalise the organisations objectives, exploiting informal mechanisms, such as that of the clan Ouchi (1981).

3.4   Some Views on the Adoption of TQM Approaches and Thrusts

Reflecting on TQM adoption and application, Dean and Evans (1994), suggest caution, pointing out that despite the rhetoric, most European and American organisations have not come near fully adopting TQM. Adoption, they make clear, requires substantial organisational change, particularly in such areas as design, work processes and culture.

There are a significant number of approaches, they observe, some through the use of quality tools, others through problem solving procedures, there are those who emphasise error

prevention and quality 'build-in', and there are those who focus on continuous improvement coupled with innovations in work processes and organisation strategy.

Although many have realised limited improvements they point out, the full potential of TQM is lost due to such reasons as lack of understanding by the entire organisation, lack of managerial support, limited culture change, lost opportunities for continuous on-going improvements and stop-go, over time, policies, reducing enthusiasm and support. TQM they recommend, requires a visible and comprehensive effort which encompasses all of the approaches. A total change in thinking, rather than a new collection of tools. Unfortunately it is all too easy to focus on tools and techniques but much harder to achieve the necessary attitude and behaviour changes, they conclude.

An Economic Intelligence Unit Study conducted by the Ashridge Management College (1993), 'Making Quality Work - Lessons from Europe's Leading Companies', investigates the experiences of over 40 companies each with long term total quality involvement.

A major finding reported by George Binney, the study leader was the failure of total quality to deliver the anticipated results by those who had initiated the programmes. For the most part he found many of the programmes to be internally focused and lacking in a clear link to either customers or business results. At best, he stated, total quality programmes as company wide, training led, add-ons to existing jobs are ineffective. At worst he found them to inoculate organisations against real change.

There was a positive note to the study in that those who had educated the entire workforce from top management to shop floor to view total quality as a philosophy and a set of operating principles required for continuous improvement, had successful programmes.

For others to emulate successful implementation he recommends, a holistic approach to change is required, focusing on customers, practising fact-based management and creating an environment in which people bring to work the same drive and commitment levels they often display outside of work. For most organisations he concludes, radical change in operating approaches and culture is essential.

Although a most interesting study in the context of the writers focus, the writer is unclear about such issues as, sample appropriateness, the definition(s) of total quality used, proof/consistency of information provided, (particularly, sensitive information) and the type of success/failure indicators used.

A management Centre Study, conducted by the University of Bradford and reported by those responsible, Zairi et al (1994) aimed to establish whether similar patterns of behaviour were emerging within European companies pioneering TQM in trying to enhance competitiveness and in those reported in 1990 by the US General Accounts Office Study (USGAO), the first known reported attempt to link TQM practice and bottom line results.

Twenty-nine companies, not representing any particular industry were selected, the analysis concentrating on their performance over five years, a reasonable period, the writers suggested, to expect benefits, providing TQM had been introduced with a clear mission, tangible goals and a sound action plan. In this context, their chosen definition for TQM was:

> A positive attempt by the organizations concerned to improve structural, infrastructural, attitudinal, behavioural and methodological ways of delivering to the end customer, with emphasis on: consistency, improvements in quality, competitive enhancements all with the aim of satisfying or delighting the end customer.

Rather than relying on information collected directly from the organisations, which were subject to a wide diversity of measures and confidentiality issues, the study targeted externally reported information, which was subject to company law and standard accounting practice.

Zairi et al's findings suggested a high proportion of companies exhibiting above average performance using their eight carefully chosen financial indicators in combination which are concerned particularly with turnover, profitability and the use of assets, to reflect short and long term business performance.

They were satisfied that the patterns suggested a positive association between the introduction of TQM and tangible benefits and a strong association with the USGAO study (and Japanese studies), providing strong evidence that TQM has a direct impact on financial results. The proviso was in context of the definition, providing there is a strong commitment presence, in sustaining continuous improvements which focus on customer benefits. However the authors were careful to point out that TQM offers organisations the opportunities to action improvements and focus on closeness to the customer. Which is not to suggest that TQM in itself, leads directly to improved bottom-line results, as they point out.

Consistent with that which has been reported earlier in this section, organisations must have the correct strategies in place, the right products and services, sound commitment and proper investment strategies in order to succeed, they conclude.

3.5 Quality and TQM - Service Sector Focus

Albrecht (1993) suggests a Total Quality Service (TQS) model for service organisations intent on providing customers with services which are different from and better than the competition. He emphasises that the only hope of achieving market differentiation and competitive advantage based on service quality is through a constant and concerted effort to make the whole organisation customer driven, service orientated and profit minded. This

means that strategy, people and systems must work together to provide the customer with an experience at the moment of truth, he says, which is truly different and better than that provided by the competition.

Referring to the importance of implementation, he contends that culture-based approaches, of which the TQS process is understood, offer the best promise for achieving service quality as a competitive weapon. The focus is on the social context of the workplace, with the anticipation of establishing an ethic of commitment and enthusiasm for service quality which leads to self-motivated effort and ownership of the values behind service excellence.

This is consistent with the ways in which many service organisations operate, more by culture than coercion, more by motivation than by mandate and more by shared values than by standards.

To these ends Albrecht references 'discretionary effort' beyond 'mandatory effort'. Figure 18 illustrates a methodology for TQS implementation as a family of interrelated methods for defining, assessing and improving service quality.

The five major components work together to build service quality, but it should be noted that it is not intended that there is any one starting point for all programmes or indeed organisations. The starting point, it is pointed out, is determined by the particular organisations strengths and weaknesses at any particular time.

It can be seen that the model is a relatively simple one - perhaps too simple if not used carefully. The essence of it is in the choice of programme strategy which is the unique way of putting together the elements of methodology, resource, timing and the sequencing of actions which go together to create a successful programme.
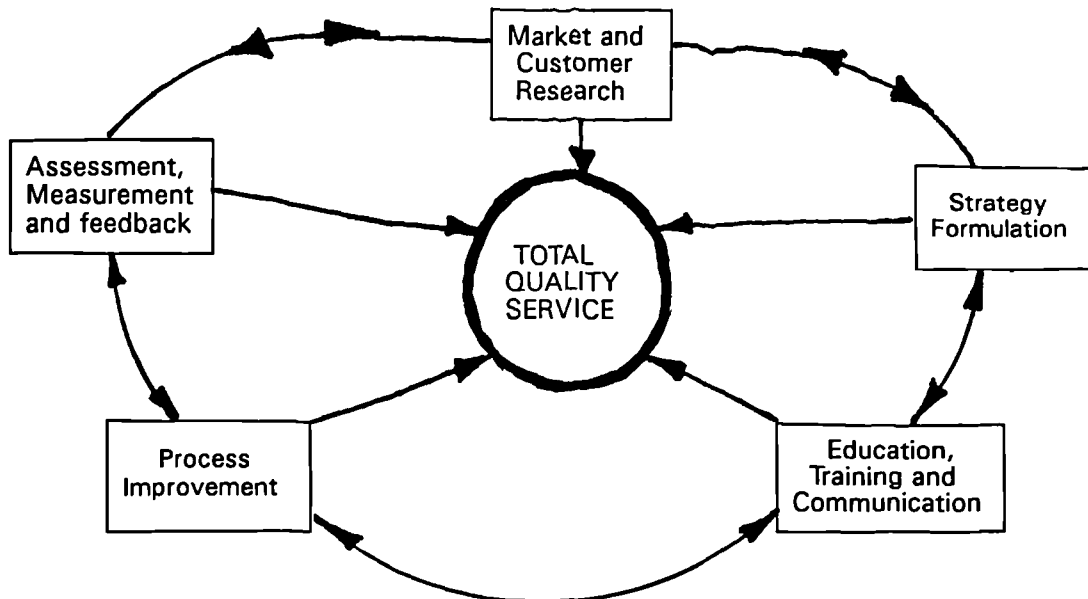
Figure 18   The TQS model for Total Quality Service. Albrecht (1993).

Total Quality Service. (TQS Group Incorporated paper - Chicago, USA).

The very existence of a service labelled total quality model implies there is a difference between service and manufacturing organisations. Protagonists for TQM have argued that the principles of quality management apply to both manufacturing and service organisations. They have pointed out that since manufacturing industry has proven the TQM principles in their own operations, administration and service functions, the same applies to the service sector. The definitions, paradigms and concepts of Juran, Deming, Oakland and Peters, for example, as mentioned earlier, would appear to be especially relevant to service quality, particularly in terms of fitness for purpose, the need to delight the customer and culture issues.

Indeed, a close examination of much of that written in this section would question the repeated claim that service organisations are different, as a false premise. The writer feels this would be too simplistic a view.

Service operations are theoretically distinguished from manufacturing operations and manufactured goods in that they do not produce or create physical end products, Lewis (1990), provides a useful definition in describing a service as an activity or benefit which

can be offered by one party to another that is essentially tangible but doesn't result in the ownership of anything.

Levitt (1981), distinguishes services and manufacturing by suggesting that a tangible product, manufactured under close supervision in a factory and delivered through an orderly and planned network of processes is much more likely than an intangible product, to fulfil the promised expectation.

Macdonald (1994), suggests that service organisations are different, even though product quality and service quality are the same in as much as they equally apply to the results of different operations. The fundamental differences he points out, are not only in the organisation of providing operations, but intrinsic differences as well. These are noted in Table 2.

Product	Service
The customer receives a tangible product in the form of goods which can be seen and touched	The customer receives an intangible service which may or may not satisfy
The goods remain with the customer	Services are consumed at the moment of delivery
The production and delivery of goods are usually separated	Production, delivery and consumption of services are often at the same time
Few producers deal with customers	Most producers deal with customers
The customer is rarely involved with production	The customer is often closely involved with production
Goods can be serviced	Services have already been consumed and cannot be serviced
Goods are subject to liability but the producer has more opportunity to ameliorate the effect on the customer and thus the financial penalty	Services which do not meet the requirements are difficult to replace - the financial impact is usually total
Goods can be purchased to store in inventory to satisfy the customer's needs	Services cannot be stored but must still be available on customer demand
Goods can be transported to the point of sale	Some services are transportable (eg. information through communication lines) but most require the transportation of the service provider
The quality of goods is relatively easy for customers to evaluate	The quality of services is more dependent on subjective perception and expectation
Goods are often technically complex - the customer therefore feels more reliant on the producer	Services appear less complex - the customer therefore feels qualified to hassle the producer

Table 2   Differences between Products and Services. Macdonald (1994).

Service Is Different. (The TQM Magazine, Vol 6, No 1).

The differences are such, he recommends, that for a successful implementation of TQM, they need to be fully understood.

Parasuraman et al (1985), Strozier (1988), Smith (1990), Lewis (1991) and Tinkham et al (1992) isolate the characteristics of service industries that distinguish them from manufacturing industries as:

■   Intangible - services are performances rather than physical objects.

■   Inseparable to production and consumption - they are perishable and cannot be stored or inventoried, nor can they be transported. The customer is brought into the service delivery system, or the system to the customer. Generally, production in consumption is almost simultaneous.

■   Heterogeneous - there is a high potential for variability, especially in labour intensive services.

■   Perishable - services cannot be stored, for example hotel rooms or seats on planes cannot be saved if they are not purchased.

Macdonald having listed differences between products and services (Table 1), based primarily on an external perspective, also considers the internal contrasts between manufacturing and service as being sufficient evidence to show that executives in manufacturing and service organisations each face different issues, Table 3.

Manufacturing	Service
Production is capital- or equipment-oriented	Production is people-oriented
Technical skills dominate	Interpersonal skills dominate
Training will dominate	Education will dominate
Production results are variable	Service results are subject to more variation

Table 3   Internal Contrasts between Manufacturing and Service. Macdonald (1994).

Service Is Different. (The TQM Magazine, Vol 6, No 1).

There are a number of important implications here for the writer, least of which is not that differences create different perceptions, real or unreal, in the minds of the customers and the employees.

The people oriented service sector tends to have a greater proportion of knowledge workers, for example consultants and actuaries, who in numerous cases, act as though their work is their own, independent of the organisation. This tends to lead to remote layers in the organisation, exaggerating divisions between the 'thinkers' and the 'doers'. Decision makers may become remote from the customer and become slow to respond to customer perceptions and needs. The traditional command, control and compliance approach to management tends to dominate.

One area which is particularly apt is the reported difficulties in the service sector in confusions between process quality and outcome quality.

Macdonald, appropriately cites outcome quality as being often wholly dependent on the hospital specialist or consultant - the ability of the actuary or surgeon. Calls for quality improvement, he suggests, meet resistance from such personnel who may interpret it as an

94

attack on their professionalism. Irrespective of whether or not their performance or outcome should be measured, they find it difficult to accept that they do not stand alone but are dependent on support processes. Most certainly, it is suggested, the patient (their client or customer), will be evaluating the process quality as part of their overall experience.

He typifies an example to illustrate the division of the two aspects of quality as:

Process Quality - the responsiveness, professionalism and friendliness of the admissions processes. The ward's patient orientation, cleanliness and the availability of good equipment and facilities. Sufficiency of good food and visitor relations well-handled.

Outcome Quality - patient recovery, limited after-effects, speediness of healing.

Ross (1993), states that although quality is not easy to define, it is necessary if strategic and business plans for service industry are to be operationalised. When asked what differentiates their service the banker will state responsiveness, the hospital will reply quality health care, the restaurant will respond customer satisfaction, and the manufacturer will simply state the quality product. When pressed to be more specific on a definition which can be measured, he says, few can be so.

Mattsson (1994), points out that research shows that services are processes, often involving customers as co-producers. Thus, he emphasises, the customer forming part of the service production system. Since the degree and style of the participation varies so much, he suggests, the control of service quality is more difficult than that of goods quality.

Lapierre (1994), refers to three waves of research concerned with service quality. The first wave focuses on the conceptual works of Grönroos (1984), who suggests that the perceived quality of a service is the result of an evaluation process in which customers compare their perceptions of service delivery and outcomes with those which they

expected. In the first wave, he also targets Parasuraman, Zeithaml and Berry (1985), whose focus group research identify ten criteria commonly used by customers in evaluating service quality. They are credibility, security, access, communication, understanding the customer, tangibles, reliability, responsiveness, competence and courtesy.

In subsequent research they found a substantial correlation between several of the criteria, consolidating them into the following five bands:

Tangibles - visibility of physical elements.

Reliability - dependable and accurate performance.

Responsiveness - readiness, promptness and eagerness to serve.

Assurance - courtesy, competence, credibility and assurance.

Empathy - a commitment to customers and their needs.

To measure customer satisfaction with the various aspects of service quality they went on to develop the **SERVQUAL** method.

The second wave of research draws mainly on the work of Grönroos, testing the importance of two generic dimensions, the technical and functional aspects of quality. Lapierre points out that some, including himself for his doctoral dissertation concerned with Value Relationship in the Process for Evaluating Professional Services (1993), have used both technical and functional quality and *the service* quality *dimensions. The specific purpose of* the second wave research he suggests, was replication in the context of different general and professional services. The nature being specifically at the **substantive level.**

The purpose of the third wave he sees is to specifically test the real value of operationalising service quality in terms of expectations and perceptions, ie. evaluating the gap model of Parasuraman, Zeithaml and Berry (1994, 1988, 1986, 1985) and Parasuraman, Berry,

Zeithaml (1993, 1991) in comparison with other frameworks, for example, Teas (1994);

Brown, Churchill and Peter (1993); Cronin and Taylor (1994); and Boulding, Staelin, Kalra

and Zeithaml (1993).

He concludes, that an important part of the research into service quality, has been the

recognition of two schools of thought, which have stimulated two streams of research, the

conceptual domain and the methodological domain. Later in his work he provides a

comparison of service quality dimensions in terms of Technical Quality and Functional

Quality.

Øvretveit (1993), suggests that service quality is not the same thing as customer

satisfaction, or that success even mostly depends upon it. The fundamental point he makes

is that in order for a service to be deemed a high quality service it must satisfy a variety of

requirements. In order to stay in business, he states, low cost high professional quality

must also be provided. He goes on to suggest three aspects of service quality which needs

to be part of a comprehensive quality measurement system. **Customer (client) quality, the**

service giving users what they want. Caution is recommended here, in that a service may

provide the customer with what they want but be harmful to them in terms of what they

need. Some services therefore include a professional or technical assessment of customer

needs defined as **professional quality.**

Although a service may provide the customer with their wants and needs, it may still be a

poor quality service in that it is provided inefficiently. Thus his third aspect of service

quality, **management quality,** is defined in terms of error rates and quality costs.

Drawing on a growing body of evidence that service-quality is a major contributor to an

organisation's performance, he says, much of his work is concerned with **measurement,**

making the difference between 'superficial' customer-relations programmes and continuous

quality improvements. To these ends he attempts to put measurement into the context of

the organisations customers, stakeholders, history and culture and in the context of where it has reached with a quality programme, pointing out that service quality measures need to be integrated into the overall performance measurement system.

3.6   Modelling, Measurement and Audit

Mattsson (1994) argues that modelling the service process is an essential first step towards improving service quality, favouring such techniques as blueprinting, Shostack (1984), (1987), George and Gibson (1991) and service mapping, Kingman-Brundage (1989), which illustrate service processes as flowcharts of interrelated activities from the point of view of the customer. These make it possible to identify fail points within the process where quality is perceived as inferior, and to use them to make improvements by making the customer process visible.

The more usual approach to measuring service quality, he suggests, has been to use (the earlier mentioned) gap models of Grönroos (1984) and Parasuraman et al (1985), which he says measure only the stated variables in the service process.

Referencing in depth personal interviews, Silvestro, Johnson, Fitzgerald and Voss (1990), PDS Studies, Lindquist (1987 and 1988), critical incidence techniques, Bitner, Booms and Stanfield Tetreault (1990), Bitner (1990) and Olsen (1992) and focus group interviews, Zeithaml, Parasuraman and Berry (1990), which are able to capture certain process variables, they have, he concludes, limited ability to reflect some of the key characteristics of the service process.

Assessment, Hillman (1994) points out, is the practice of evaluating an organisation against a model for continuous improvement, so as to identify achievements and highlight what needs improving. He advocates self-assessment as an important part of the assessment process, indicating three essential elements to it:

Self Assessment = Model + Measurement + Management

Recognising the availability of several models, he targets the EFQM Model (1994), as a basis

for identifying what to benchmark in terms of *facilitating comparisons both internally and*

externally, Figure 19.
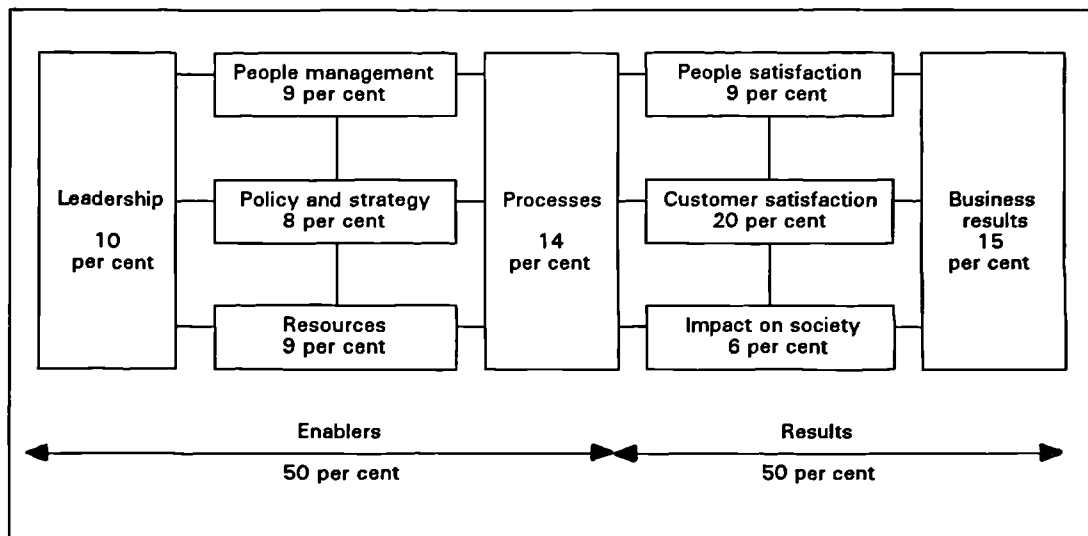
Figure 19   European Foundation for Quality Management Model.

Brussels Conference (1994).

This he suggests, provides a means of measuring how well the organisation is performing

against the elements of the model,providing tangible output to assist the evaluation of

results and the identification of priorities for future improvement.

Top management commitment to self-assessment is paramount, he states, followed by a

process to make assessment successful, which he suggests involves eight steps, Figure 20.

Hutt (1994), relates to the need for staff creativity, enthusiasm and motivation for providing high quality goods and services and the advantages of aligning individuals goals and aspirations with those of the organisation.

1	Develop commitment	Emphasises the need for commitment and how it can be developed
2	Plan self-assessment cycle	Covers planning of the process
3	Establish model and reporting system	Agrees the model to be used Designs forms for recording strengths and areas for improvement
4	Communicate plans	Ensures that everyone understands what the process is for, and how they will be involved
5	Educate self	Ensures all assessors and others are trained
6	Conduct self-assessment	Gathers and collates evidence Creates consensus view on strengths and areas for improvement
7	Establish action plan	Establishes the plan of action resulting from the assessment
8	Implement action plan	Creates improved actions Provides resources

Review

Figure 20   The Eight Step Approach. Hillman (1994).

Making Self-Assessment Successful. (The TQM Magazine, Vol 6, No 3).

He emphasises the deployment of the 'three Rs' of performance management, namely, identifying clear requirements for each staff member providing review of their performance and equitably rewarding those who achieve measured requirements. The process he recommends for achieving these is the generation of a personal performance guide for each individual, created as an iterative process between them, their team and the manager/leader, Figure 21. Creelman (1993), believes that too many organisations focus too heavily on the tangible measures of performance and performance management which are written into

standards form (BS 5750/ISO 9000 for example), suggesting that it may be equally useful to consider the intangible qualities which separate world-class organisations from the rest.
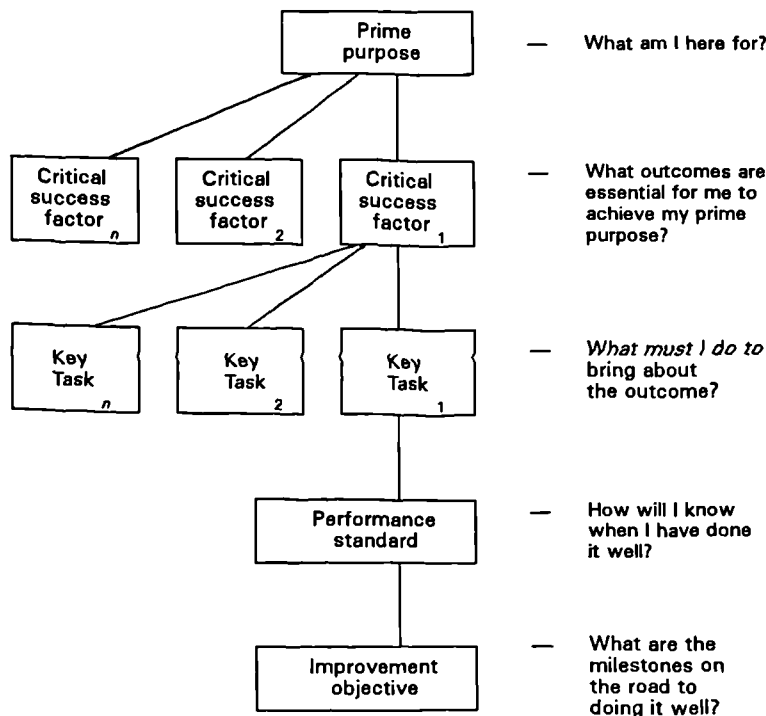
Figure 21   Structure of Personal Performance Guide. Hutt (1994).

Incorporating Quality Performance Objectives Into Performance Appraisal Systems.
(The TQM Magazine. Vol 6, No 1).

Ashton (1993), states that although corporate failure and success are immensely complex, edges do exist - unique talents or qualities - which assist pacesetting organisations to become more competitive faster and enable them to sustain their various advantages. He refers to talents and qualities found within inspirational leadership and people and the responsiveness of the organisation to changes in the environments in which they operate. No standard ever devised, he suggests, can measure these factors satisfactorily, although they are there in most exemplar organisations.

A number of informative points in the context of competitiveness through change are made by Barthelemy and Zairi (1994), in connection with auditing quality systems.

They draw attention to using auditing as an organisational development process in terms of continuous improvement, innovation and problem solving beyond ensuring compliance with set standards and procedures in the organisation and operations processes.

Table 4, they suggest, identifies comparisons and contrasts between static auditing, for certification (eg. ISO 9000) and approval and dynamic auditing which focuses on the pursuance of the necessary improvements to meet the competitive aspirations of the organisation.

Static auditing	Dynamic auditing
Reduces the scope of audits	Enhances acceptance of audits and reduces fear
Enhances cost effectiveness	Informs management and staff more adequately
Simplifies auditing and auditor qualification	Identifies opportunities for quality improvement
Allows for employing less qualified staff	Disseminates new knowledge and experience in quality assurance
Confirms meeting standards	Induces innovation
Recognises adequate performances	Enhances "cultural change" in the company
Suffices for quality programme registration	Encourages delegated decision making, integration, and co-operation
	Reviews all procedures and standards
	Provides greater challenge and recognition for auditors and auditees
	Enhances the role and status of quality assurance

Table 4   A Comparison of Static and Dynamic Auditing. Barthelemy and Zairi (1994).
    Making ISO 9000 Work: The Role of Auditing. (The TQM Magazine, Vol 6, No 3).

The total audit, they state, is intended to encourage openness and the acceptance of auditing as a means of developing team spirit and co-operation.

3.7 Quality Costing - A Criterion of Quality Performance

Payne (1994), advises that quality costing can, if used effectively, be a vital tool in the quality management process.

Three contradictory views were expressed against the costs of quality at the European Organisation for Quality 1993 Conference, Balme expressed quality costs rising towards infinity as quality asymptotes to perfection, whilst Smith Jr stated that each time a quality improvement takes place the cost of quality is diminished. Millar suggested that a point is arrived at when the effort required to improve operations performance or efficiency fails to deliver an adequate return.

Duffin (1993), suggests that the implications of these contradictory views is that if checking and fix are emphasised, costs rise sharply as the amount of errors approach zero. Figure 22 illustrates Balme's suggestion.
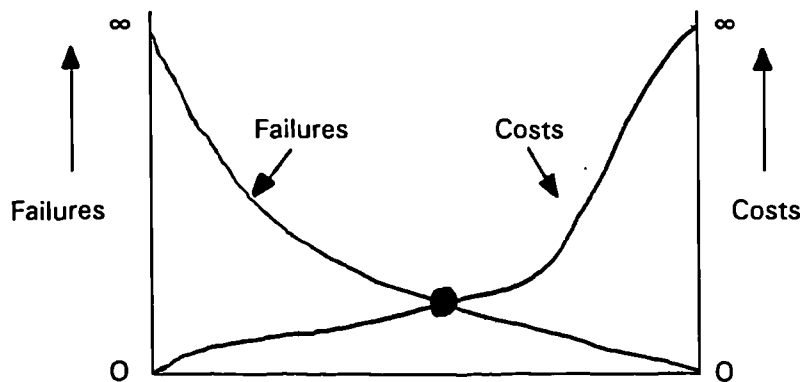
Figure 22   The old belief stated that costs rise sharply as zero defects is approached.
Balme (1993).

The SGS Total Quality Management Window Concept: An Innovative Decision Aid Tool for Managers. (Abstract from paper presented at the European Organisation for Quality Conference, Brussels 1993).

Further implications are that if process capability is improved, costs near to zero defects actually begin to diminish Figure 23, which supports Smith and Millar's points.
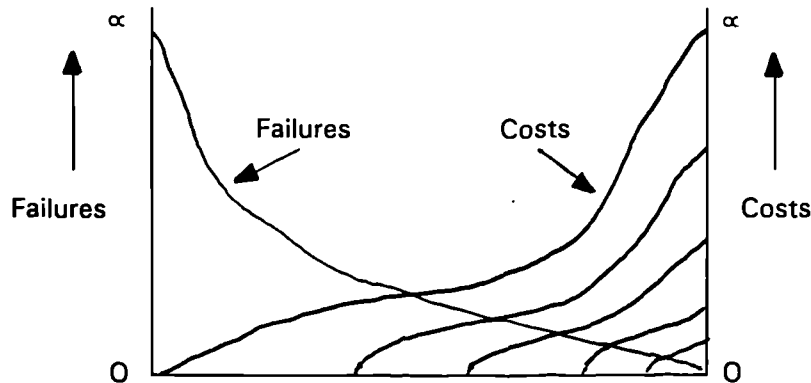
Figure 23   The new belief states that costs diminish as you approach zero defects.
Smith (1993).

Total Customer Satisfaction. Millar (1993). Breakpoint Business Process Engineering.
(Abstracts of two Papers presented at the European Organisation for Quality Conference,
Brussels 1993).

The fundamental and pragmatic questions to ask are, is perfection realisable in the real world of business?, do costs rise to infinity as zero defects are approach? and does it really matter?

Duffin, categorises products and services within a range of needed parameters of, form, fit, function, reliability, durability, ruggedness and aesthetics, and one which fully meets these he considers to have zero non-quality. At the other extreme, he points out, organisations may asymptotically approach a condition of zero yield and zero correct transactions at which the cost of non-quality is infinite, or more likely, undefined.

In between the two extremes, he identifies three ranges of quality which are relative to competitive success in 'real-world conditions', Figure 24.

Relative to the acceptable quality level within the zone of indifference, he focuses positive

variation of quality (attractive quality) and negative variation of quality (rejective quality).
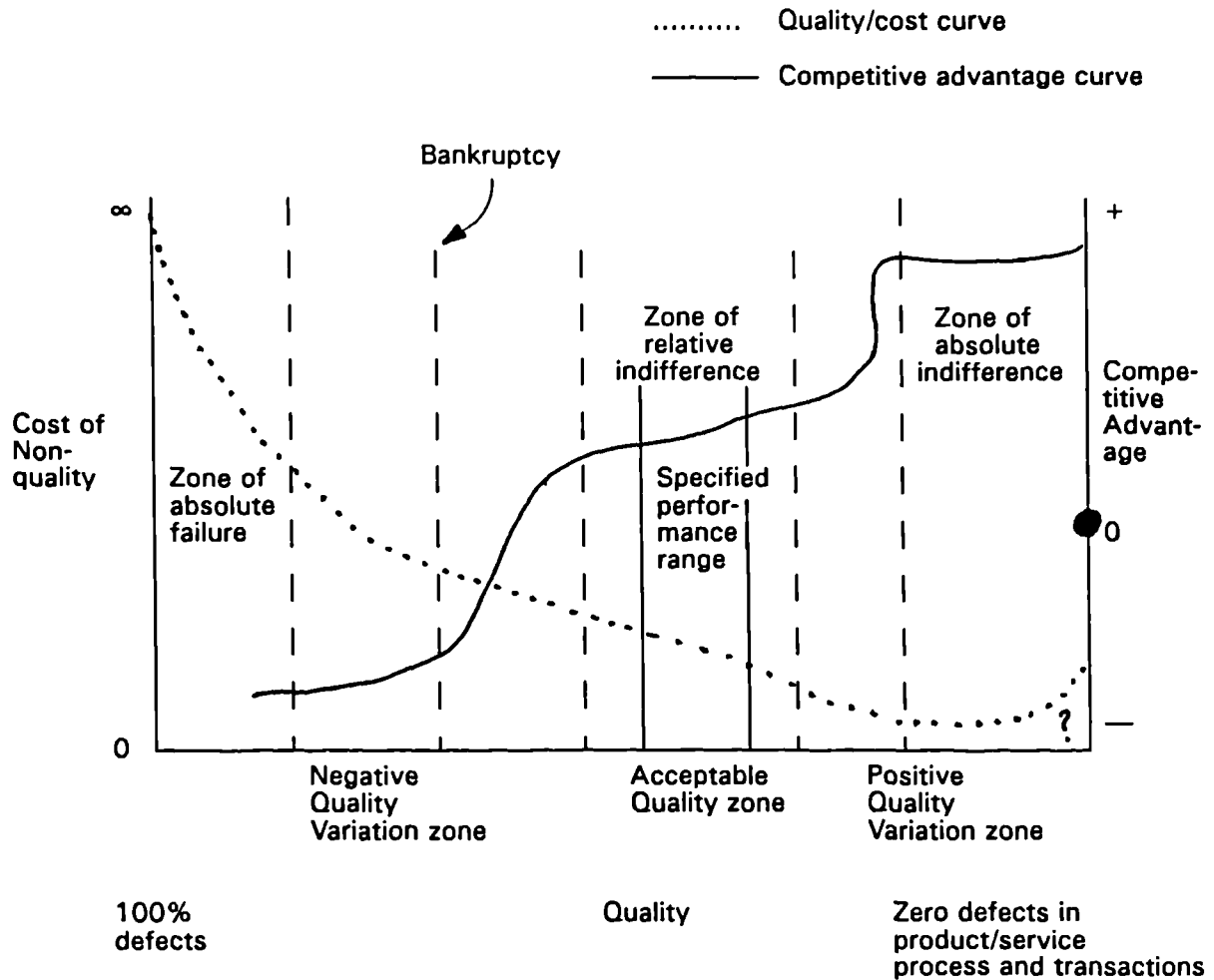
Figure 24   Costs of non-quality in real world conditions. Duffin (1993).

The Cost of Indifference. (The TQM Magazine, Vol 5, No 6).

Competitive advantage (or disadvantage), he recommends, can be realised by providing (or

eliminating) services, capabilities or features which are not specified or required. Although

these will add or reduce costs, he states, the costs should be regarded as costs of perceived

value and not costs of quality. Consequently, if the added costs are less than the perceived

added value, they are worth incurring.

From this, he suggests, there may be a zone near to zero defects, where the cost of achieving additional positive quality variance begins to rise sharply, but it is envisaged that before reaching this region the customer cannot meaningfully experience (perceive) defects. Thus a zone of **absolute indifference** (as opposed to relative indifference) would exist and there would be no reason to operate in such a region.

Quality costs may be regarded as a criterion of quality performance. The analysis of quality costs provides opportunities to assess the management of quality, identify problem areas and action priorities, providing that valid comparisons can be made between different sets of cost data. Views and ideas of what constitutes quality costs now focus more on costs incurred in developing, implementing and maintaining the quality management process, than the costs only, of running the quality function.

Dale and Plunkett (1990), suggest that the comparability of data sets depend on the definitions placed on cost categories and the elements which are used in compiling them, questioning the value of much published data on quality related costs because of the absence of precise definitions and qualification.

Detailed guidance of definitions is given in ASQC (1974), AS 2561 (1982) and Hagan (1986), recommending that matters are judged as quality related, providing they satisfy criteria set by the definitions of **prevention, appraisal and failure.**

Using the same definitions, BS 6143 (1990) attempts to depict quality costs over time, Figure 25, taking as its premise that investment in prevention and appraisal can substantially reduce internal and external failure costs.

A criticism of BS 6143 is that its model in diagrammatical form fails to differentiate between internal and external failure. Numerous authors have pointed out that it is not uncommon

for the first effect of a quality improvement programme to aim to reduce external failures by a greater emphasis on checking, only to see a corresponding increase in internal failures.
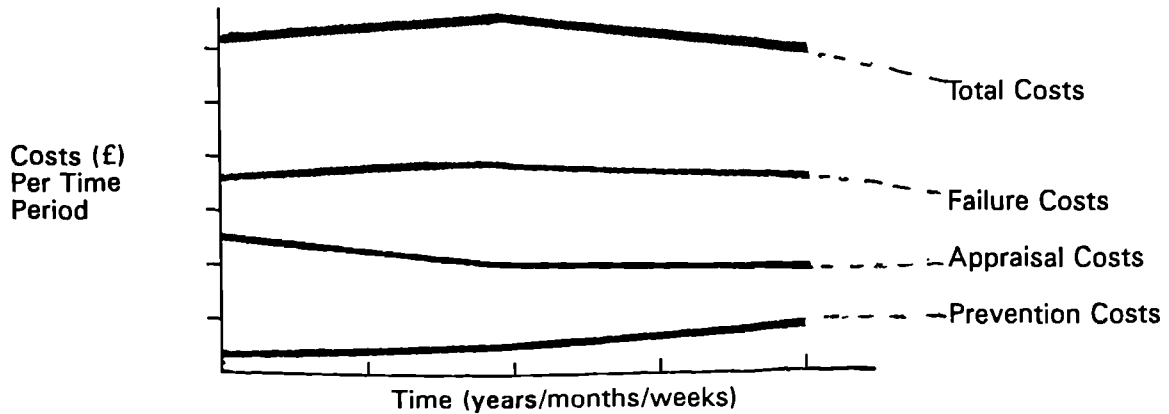
Figure 25   Quality Costs Over Time. British Standard 6143 (1990).

A significant advantage of the 1990 standard (compared to the 1981 standard), is its focus on constant improvement which is illustrated in its portrayal of probable trends in total quality related costs. This is in marked contrast to the notion of an economic balance between failure costs and prevention/appraisal costs.

Dale and Plunkett invite analysis of the definitions, questioning their potential for provoking action, except by facilitating comparisons with earlier data which in itself may lack validity. These apart, they do recognise a number of advantages to be gained from categorisation, in terms of their universal acceptance, conferral of varying types of expenditure and providing keyword criteria to establish whether costs are quality related or not.

Furthermore it is their view that as quality management has moved towards TQM, the need has arisen to identify and measure quality costs across a wider spectrum of organisational activities, making the traditional prevention, appraisal and failure approaches less suitable. Amongst the limitations, they believe, are that quality elements may not match cost information commonly available from accounting systems, quality activities may fall into

unclear areas in terms of the categories they best fit, categorisation as practised may include post-collection activities undertaken in deference to the received wisdom, and categorisation appears to relate more to the interests of quality department personnel restricting a potentially wider use of quality related cost information.

In such circumstances, the broader categorisation suggested by Crosby (1979), of measuring the costs of conformance and non-conformance may be more appropriate. He favours the broader approach in that it offers organisation wide application and attention is focused on the costs of doing things correctly in addition to the costs of doing things incorrectly, encouraging both productivity and quality improvements.

Musgrove and Fox (1991), similarly recommend two major categories for quality costs, those deliberately incurred in efforts to maintain and improve quality - the costs of conformance and costs suffered as a result of bad quality - the costs of non-conformance. Figure 26 indicates the former to be a combination of appraisal and prevention costs and the latter, internal and external failure costs.
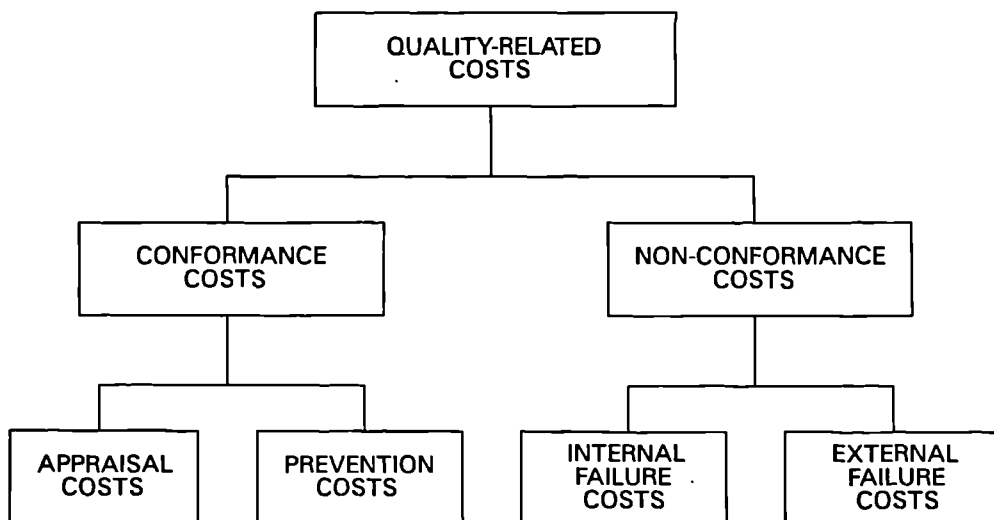
Figure 26   Categories of Quality Costs. Musgrove and Fox (1991).

Quality Costs: Their Impact on Company Strategy and Profitability. (Technical Communications - Pub Ltd).

Schmidt and Jackson (1982), define the costs of quality as the costs of producing, finding, correcting and preventing quality problems. To know the level of quality costs they state, and to act in accordance is crucial.

Juran (1974), expresses the cost of quality in terms of 'lost gold in the mine', implying that quality costs require to be subtracted from the overall product or service cost.

Oakland (1989), suggests that a balance needs to be sought between quality and cost factors, as depicted by Figure 27.
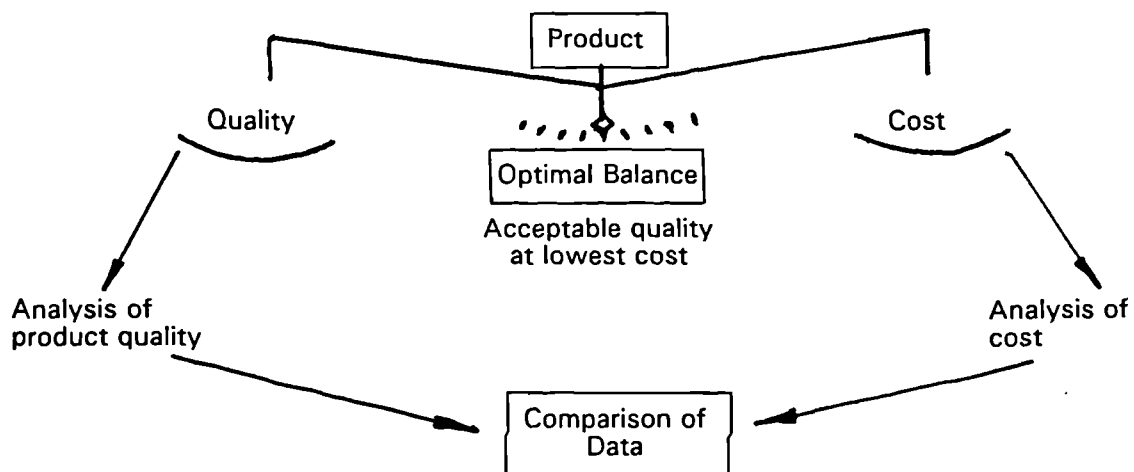
Figure 27   Balance of Quality Costs. Oakland (1989).

Total Quality Management (Butterworth/Heinemann).

The analysis of quality costs, he suggests, provides a means for assessing the overall effectiveness of quality management and of determining problem areas and action priorities.

He states that the key to successful quality cost systems are: real management commitment to establishing the true costs of quality throughout the organisation, the implementation of a system which identifies, reports and analyses quality costs, the

formation of a facilitating quality cost management team, the inclusion of quality costing as an integral part of all training activities, quality costs promotion and quality costs participation.

Jeeves (1993), exploring the theory and practice of quality costing to consider whether it warrants a place in management accounting, suggests that as a regular ongoing addition to existing management accounting practice, quality costing has a major role in monitoring and controlling the drive towards quality improvements.

Davies (1993), states that the financial costs of poor quality are well understood, but establishing the means of managing the interface between quality improvement and financial accounting is more difficult. He asks, how do organisations reconcile the absolute and precise way in which they choose to account for the organisations finances with the somewhat longer term and less precise benefits which may emerge from sustained quality improvement processes? Is it, he further asks, simply a question of keeping faith?

Hewins and Pike (1992), point out that the best way of drawing attention to quality is to focus on costs, stating that costs are the most effective way of drawing attention to any situation. Attention, they suggest, was the foundation of Deming's reputation as an improver of profit and loss accounts. The role of accountants in quality improvement teams, they recommend, is to provide services to the team, particularly to help build the quality cost and rationalise the mismatch between quality costs and management accounts.

Accounting processes should ensure that Total Quality Facilitators adopt definitions of conformity and non-conformity costs which are clear and unambiguous. Once ambiguity is avoided, they say, the impact on the profit and loss account can be measured using conventional accounting processes. Timely warnings of financial inconsistencies can be given and hidden quality costs translated into language more meaningful to chief executive officers and staff.

3.8   Summary and Key Findings

The first stage has identified quality definitions and different perspectives which are representative of the genre, where the terms: productivity improvement, cost reduction, customer value satisfactions, degrees of excellence, competitiveness, standards setting, conformance with specifications and standards are noted. Quality is seen neither as a technical function nor a department, but rather a systematic process extending the whole organisation.

The contributions of three guru groups with their distinctions have been noted in the form of early American's emphasis on method, planning and management focus, the Japanese, targeting statistical tools as a unified system, minimum prototyping in design; trouble-shooting in operations and prevention before cure methods and the 'Westerns' concentrating on organisation, culture change, continuous improvement and fundamental change through people.

Although commonality between the guru's is noted (3.2), the writer believes that more explicit theoretical models are needed to integrate their distinctions. In the context of the NHS, the point is well made by Hudson (1992), who in summarising the Kings Fund Institute briefing paper concerned with Quality Time, emphasised the need for a new quality paradigm based on four headings:

- A rational model for planning and analysis.
- A focus on environments and individuals.
- Qualitative and quantitative value based approaches.
- Performance measures based on user-defined outcomes.

The writer would add that the four headings would need to be (and seen to be) integrated into a total quality culture, and not viewed as separate or segregated activities.

TQM with its organisation-wide implications is a quality integrating process with three major aspects, satisfying customers, improving organisation effectiveness and enabling organisations to respond to market pressures. TQM as a corporate, and strategic business management philosophy recognises that customers needs and expectations are integrated with business performance goals to the point of inseparability.

Quality is seen as holistic, TQM proposes that quality is customer driven and both must be considered in order to develop an effective and efficient total quality process.

TQM is concerned with the continuous process of best practice, whether it be in the form of radical change and, or continuous improvement to ensure competitiveness. To these ends, according to conventional 'wisdom', successful execution demands management commitment, education and training, management systems and employee involvement.

The term TQM conjures up different things to different people and similarities have been noted between it and Business Process Re-Engineering, Quality Function Deployment, Company-Wide Quality Control, Total Quality Improvement, Total Quality Service, Strategic Quality Management System ... and others.

Much time and energy could be spent debating their similarities and differences, a debate which the writer feels would be fruitless, as labels may change (management consultants and academics have probably done more than most to add to the false mystique of such nomenclature) but the underlying aims are not dissimilar. According to some definitions and paradigms the customer is regarded as the key stake holder in the organisation. From this perspective, customer perceived quality and customer satisfaction are the key aspects of contemporary thinking. The prevailing paradigms result from comparisons between customer perceptions and expectations.

In context of the NHS, it is important to establish who the customer is. In addition, it was suggested in chapter 2, that to have a policy to produce quality health care, it is necessary to be clear about what quality health care is and to establish the appropriateness of the definitions and paradigms available to provide it. If quality is taken as being customer driven then it depends largely on customer tolerance, meeting market requirements and fitness for purpose, from which Seedhouse (1994) points out, that it is then defined relatively, and as such will vary according to task - a phenomenon redolent of the 'general relativity' of health care purpose.

Other definitions and paradigms broaden the concept of total quality towards examining quality and satisfaction from other stakeholders' view points, least of which are not the organisation's personnel and its suppliers. TQM, it is suggested, evolves as a major philosophy by increasing employee awareness of quality and taking steps to change attitudes towards the goals of creating a fully integrated management system.

Management commitment and good leadership, which in turn facilitate motivation, empowerment and information are central issues suggested in the effective and efficient undertaking of tasks.

TQM is portrayed essentially as a continual management approach intended to improve flexibility, responsiveness and competitiveness as a whole, ie. an overall management strategy aimed at improving the quality of all areas of the organisation, including suppliers. An organisation-wide philosophy rather than an operations quality only focus.

In the NHS, as earlier noted with customers, it is equally important to establish who the suppliers are and then establish their role and integration into the organisations quality chain, the internal market and the delivery process from which health care is produced and provided.

Other aspects of quality it has been suggested are not the same as customer perceived quality and satisfaction, in that they require to satisfy a number of requirements, for example professional quality - professional and technical assessment of customer needs and management quality - error rates and costs.

Despite the rhetoric evidence is such as to suggest that many organisations who have begun a TQM process have not fully adopted it. Two recent studies are noted (3.4), which together cover 69 organisations, and although they follow different approaches and methodologies, both identify the need for strong management and employee commitment with operating principles and policies which sustain continuous improvements and which focus on the customer.

Neither claim that TQM in itself leads directly to improved tangible results (although one does report a high proportion of organisations which exhibit above average performance), but both warn against the detrimental effects likely of not having correct strategies in place, particularly those aimed at operations and culture change.

It is intended that this research will similarly target NHS demonstration sites, earlier noted (2.6), which in 1990 introduced TQM, to seek to establish their level of adoption and their resulting outcomes in terms of continuous improvement, business re-engineering and patient focused care.

Service quality is seen as an important factor which distinguishes service organisations that are more successful than others. As customer sensitivity and competition intensify, service providers are increasingly concerned with quality provision. Gummesson (1990), reports that successful organisations have worked with service quality, but draws attention to the lack of widespread focus on services. Commenting that there has been little research and no training centres.

Research in service industries he states, has only gained widespread acceptance in the past ten years. Service industries have worked with their specific services for many years: hospitals, hotels, insurance and others. The novelty being the enquiry into generic features of service management, production, delivery and marketing, ie. the search for general service theory. In all this work, Gummesson concluded, quality stands out as the most important issue.

His conclusion was supported by Larréch et al (1990), who reported that executives of 128 major European organisations selected quality of products and services as the number one priority for the 1990s out of 18 key strategic marketing issues.

In service, quality happens the moment the service is provided to the customer, there is not normally the opportunity to test it or try it again to the extent which is possible in manufacturing. Despite this, protagonists for TQM believe that the definitions and paradigms are appropriate for manufacturing and service organisations, whereby others suggest that service organisations are different and offer their views, definitions and paradigms for total service quality.

What is important to the writer is that issues of service can be defined and measured by providers and evaluated by customers and that the nature and extent of customer interaction with the service provider is critical. The important aspect of a TQM process then, is a capability to understand customer needs and expectations and the form by which customers perceive and evaluate service quality. In addition, and with equal emphasis, the intent should provide for culture, motivation and shared values which aim for a positive strategic management approach (from vision to results), from one which aims merely to do enough to reduce poor quality and customer annoyance. To these ends, the differences between process quality and outcome quality need to be explicit.

Three particular waves of research have been targeted concerning service quality. The first wave identifies perceived quality as the result of evaluation process whereby customers compare delivery and outcomes with expectation. The second wave tests the importance of technical and functional aspects of quality, whilst the third wave seeks to establish the real value of operationalising service quality in terms of expectations and perceptions, drawing together numerous points made in the first two waves.

The writer recognises and appreciates the contributions to knowledge and understanding made by research in service organisations, particularly over the last decade, but feels there is a growing need to research TQM in service organisations, which through size and bureaucracy operate with diverse missions, changing systems and procedures and which are characterised by degrees of rigidity through an employee mix consisting of varying knowledge, understanding, interests, competences, skills and hence commitment and where quality interpretation is either unclear or where interpretations afflict the rest of the genus.

Organisations which constitute the NHS are just such organisations.

In context of improving business organisations, management style, culture, responsiveness to customers and the processes for continuous improvement and radical change 'things' have to be done better.

The terms modelling, measurement and audit have been used as a means of establishing how 'best' is done.

A number of methods have been identified and emphasis placed on those which may be used to account for quality improvement from the customer and organisation perspectives and which provide for management and non-management self-assessment.

Benchmarking which aims to make comparisons against 'best' or 'better' practice has been noted along with procedures which focus on tangible measures and intangible qualities and dynamic auditing which is more consistent with the aspirations of TQM, than static auditing which tends to underpin quality systems certification.

Re-visiting Hudson's (1992) earlier noted outline for a new paradigm, the interpretations made of the terms modelling, measurement and audit could well fit his headings concerned with, qualitative and quantitative value based approaches and performance measures based on user-defined outcomes, expanded as:

- Qualitative and Quantitative Value Based Approaches:

  TQM in terms of service availability and use. Value evaluations of services offered and received.

- Performance Measures Based on User Defined Outcomes:

  Output measures related to outcomes. Success and failure in terms of the product - the service users needs and aspirations. Establishment of positive outcomes and the development of user-focused models.

Additionally they account for a number of the service quality points earlier made, providing health care quality is defined.

Numerous definitions and paradigms have been associated with zero defects, reaching perfection, continuous improvement and radical change, but how is perfection realisable, particularly in economic terms? The ultimate measure of systems are their ability to produce results. Whether quality is viewed as a cost or an investment, it is necessary to ensure, as earlier noted, that quality, costs and time relations are kept in equilibrium.

In this context, the final stage of the chapter concerns quality costing.

Contradictory views of costs and quality improvements are expressed, namely the views that quality improvement increases costs: quality improvement decreases costs and there are diminishing returns from quality improvement. The implications of these views, it is suggested, are that checking and fix (cure) increases costs sharply as the amount of error approaches zero, whilst process capability improvement (prevention) costs near to zero defects begin to diminish.

Points are raised of costs of non-quality in 'real world' conditions, from which the pragmatic view is that where perceived value is greater than added costs, the costs are worth incurring.

In terms of TQM and particularly important to continuous improvement and radical change is the need to make valid comparisons between cost data sets across a wide spectrum of organisational activities, whereby emphasis is placed on costs incurred in developing, implementing and maintaining the quality management process, than merely the costs of running the quality function only. There is common agreement for detailed guidance of quality costs definition, but varying views whether they should relate to two or three cost categories. Some recommend prevention, appraisal and failure categories whilst others relate to costs of conformance and non-conformance.

Closer examination of the cost categories suggest a close similarity, whereupon emphasis needs to lie in the means for assessing the overall effectiveness of quality management and determining problem areas and action priorities.

What is important for this research, is to establish the level of management commitment for determining the true costs of quality and whether an interface exists or is likely between quality improvement and financial accounting in organisations as diverse as those which form the NHS, and their willingness to provide a reliable system which identifies, reports and analyses quality costs as an essential part of a TQM process.

The chapter has outlined some important definitions, paradigms and aspects of quality and total quality management, but although no single definition or paradigm for TQM exists, there are a number of common and important essentials identified in relation to it:

- a long term management and employee commitment for developing a culture and action plan to achieve continuous quality improvement;

- a measurement capability which identifies organisational strengths for achieving service and product quality and service levels and the organisational weaknesses which prevent it;

- an internal and external customer supplier focus involving everyone in problem prevention, continuous improvement and radical change;

- an enabling management support culture which provides for team and individual ownership of the problem prevention, continuous improvement and radical change processes.

Recognising that TQM plans need to reflect particular business needs and that it is unlikely that no one quality programme would give successful results in any one instance, the writer believes that a major symptom of the applications gap is a lack of understanding theoretical models.

A fundamental a-priori assumption is that quality paradigm will only be achieved through the development of sound macro (common) and micro (specific) models, which address and accommodate fundamental changes to how organisations do business. To these ends, chapter 4 will identify definition and paradigm to be used as a foundation of this research.

CHAPTER 4   DEVELOPING TQM DEFINITION AND ECLECTIC PARADIGM FOR THE

RESEARCH PROGRAMME AND WITH RESPECT TO HEALTH CARE

ORGANISATIONS

4.0   Introduction

This chapter reflects important points and issues covered in Chapters 2 and 3, in order to

suggest a suitable definition for TQM in health care and facilitate the development of a TQM

process model to operationalise implementation and enable continuous improvement, radical

change and patient focussed care, in the provision and delivery of quality services.

4.1   TQM - Implications for, and Issues Relating to Health Care

An overview of a changing seventy five years of health care has been earlier provided, in

terms of organisation, management and culture change. Forty seven years has been in the

form of the NHS during which four substantive overhauls of the service were particularly

noted, the:

■   1974 reorganisation, which aimed to rationalise structure and create coherence.

■   1979 Royal Commission which resulted in further restructuring and changing much

of the earlier administrative structure.

■   1983 Griffiths Report, placing emphasis on new management arrangements.

■   1989 publication of 'Working for Patients', underpinning the current market based

reforms.

The later reforms brought with them change of philosophy resulting in greater emphasis on

private ownership and self-reliance and a reduction in real terms of public spending.

Quality in the NHS cannot be viewed in isolation from potentially diminishing resources and

needs to be linked with economic efficiency.

Political expediency influences NHS quality management, which is hardly surprising given the high political profile the NHS has always maintained.

Ever since the government announced its intentions to reform the NHS in the late 1980s, the health service has shown unrivalled capacity to grab the headlines and cause political rows. Such is the public affection and regard for the traditional values of the NHS.

Those who defend the reforms, pretend not that there ever was a 'golden age'. To them, the NHS, along with the rest of the public services, moved from crisis to crisis. There was at the time of the reforms a very real sense that public services as an instrument for delivering effective, efficient and accessible services had failed and what the reforms aimed to achieve was better ways of using public money, which hitherto was not being effectively used in the best interests of patients.

Given the continuing political emphasis on the NHS, and anxiety to prove the effectiveness of the reforms, politics is expected to remain an important influence on the quality agenda.

The chapter outlined a NHS, which although historically changing, as one which through size and bureaucracy remains segmented and heavily driven by health care professionals often with diverse missions.

It is noted that the complex undertaking of health care delivery is divided across many specialist staff levels characterised by degrees of rigidity through varying knowledge, understanding, interests, competences, skills and hence commitment and where quality interpretation is either unclear or afflicts the rest of the genus. The problem for the NHS as a whole is to co-ordinate tasks into coherent packages of quality care.

Reflecting on the changing structures of the NHS, it is helpful to draw on Mintzberg's (1983) observation of the two important dimensions of organisational structure, namely machine bureaucracy and professional bureaucracy, (see 4.2).

The quality dimension of public sector services has gained momentum over the last decade. The government shows ever increasing interest in the way services provide high quality to their customers through well managed systems, processes and workforce, and in how quality is best monitored and improved.

During the 1980s the NHS started to take an interest in how quality management models could be adapted and used within a health care environment, TQM was an example, with DoH funding pilot sites. These initiatives reinforced the concept of a customer centred environment which not only targeted the external customer but the internal customer (Directorates) also, towards addressing their needs and expectations.

Chapter 3 identified quality definitions and different perspectives which are representative of the genre. TQM was emphasised as an innovative management philosophy and a different way of managing business. It was seen as an amalgam of numerous management philosophies presented with a list of principles which are customer/supplier and process driven and which aim for continuous improvement, radical change, employee participation, teamwork and individual responsibility, which may be applied across a spectrum of service and manufacturing organisations. It is a culture transformation and an education experience which cascades the organisation.

Services were identified as processes which often involve customers as co-producers. It was noted that **Providers** in the NHS are the suppliers of quality care services and the **Users** and **Purchasers** their customers. Other members of the **Public** are their potential customers. Quality, it was said, is concerned with increasing user value and decreasing user sacrifice.

To professionals working in the NHS, it may seem that quality of care has always been an issue of importance. It is not uncommon however, when decisions are made about health care resources, for the issue of quality to be more implicit than explicit. The more recent reforms aim to make quality more explicit in health service management, the least of which is not, it is suggested, in keeping providers on their toes.

Contracting requires agreement between purchasers and providers of health care about the quality of care to be delivered and the costs of that care. Distinctions between process quality and outcome quality has been made. These link to the three noted business corner stones; quality, costs and time, which although interdependent and impacting one another, should, it was suggested, be quality led. In health care it may be more appropriate to substitute the word access for time.

Perceived quality of service was noted to be the result of an evaluation process whereby customers compare their perceptions of service delivery and outcomes with what they expect.

Suggestions for evaluating the services have been made using qualitative and quantitative based approaches. Quantative method may be used to satisfy the internal evaluation process and focus primarily on the 'right first time' process. The qualitative approach may best evaluate external processes, which determine the extent of customer satisfaction.

One of Oakland's (1989) noted quality management points was to utilise price and quality as measures of effectiveness and efficiency.

Quality has an impact on the cost of health care services. Quality of services becomes an important factor when providers can only survive by being fit and lean. Providers who survive fierce competition will be those who deliver quality health care services in a cost-

conscious environment. There is, however, a limit to the amount of cost reduction which can be achieved without affecting the quality of care provided. The challenge of TQM is to reorient personnel to think about the high costs of non-adding value activities.

4.2   Aspects of Machine Bureaucracy and Professional Bureaucracy

The NHS overview presented in Chapter 2 sought to establish aspects of organisation, management and culture change with Quality Management and TQM in mind. As such, the writer finds it helpful to view change as moves towards or away from bureaucracy.

The stereotype bureaucratic organisation is a form which is inflexible and slow to respond, bound by rules, intrinsically ineffective and inefficient and obstructive to innovation and creativity.

Elements of machine bureaucracy can be recognised in the NHS in the form of sharp divisions of labour, highly standardised work processes and strong reliance on control. Regulations are part of the fabric of control, formal communications are favoured at all levels and a strong sense of hierarchy is deeply rooted in the culture.

But there are features in the NHS which clearly set it apart from machine bureaucracy and make the tasks of division of labour and co-ordination more difficult. It is not difficult to recognise elements of professional bureaucracy either. The key co-ordinating mechanism for professional bureaucracy is standardisation of skills. Like machine bureaucracy, professional bureaucracy achieves co-ordination through pre-determined standards, but whereas in the machine model these standards tend to be generated internally and enforced by line managers, in the professional mode the standards are set by self-governing associations and enforced by self-regulation at a range of levels.

Oakley and Greaves (1995), ask the questions, why are hospitals bureaucratic? and are they too bureaucratic? They suggest that the answer to the first question is, that contrary

to popular belief, bureaucracies are fundamentally efficient, but only where the organisations products can be standardised. This concept is not difficult to relate to the more mechanical functions of a hospital.

Oakley and Greaves have unravelled something of the nature of standardisation in other parts of the hospital's work, they claim, in the tasks of professionals. Although the authors acknowledge that these are very complex, the way in which the process works efficiently is through assigning various tasks to individuals who all work within clearly set and uniform standards. In this way some uncertainty is removed from a highly complex process.

Turning to the second question, it is suggested that hospitals are often too bureaucratic. Problems occur when the process of 'pigeonholing', that is professionals classifying their clients' condition in terms of a standard programme and applying/executing that programme, and standardisation are taken too far. This springs from a fundamental flaw in professional bureaucracy. Although it may work as an operating framework for groups of highly motivated, independent experts, it is difficult to inculcate common goal or strategic purpose for the organisation as a whole.

Without a strong and unifying bond of common corporate purpose, the risk is that the professionals become the central concern and the pigeonholing process takes over.

One way through this, the writer believes, is to focus NHS processes on the customer. Cost effective TQM it is suggested, provides a process to achieve this, providing it demands a serious appraisal of how services are structured, centralised and directed, and it is accepted that there are better ways of doing things which are customer sensitive.

A key to continuous improvement and radical change is to dissolve the traditional thinking which has locked professionals into rigid compartments and customers into narrow

pigeonholes. When bureaucracy becomes too dominant, the risk is that the customer becomes too much the standardised product and is the casualty rather than the beneficiary of the process.

In addition to being a reaction to some powerful forces of bureaucracy within the NHS, TQM reflects two particular aspects of the current reforms. First the internal market which has driven significant parts of the NHS into competition, of which, TQM it is suggested might be a way for those parts to gain competitive advantage. Second, the reforms introduced a new strand of consumerism into the NHS, whereby change and re-shaping is taking place from the former organisational frameworks where professionals work, into the environment of quality expectation.

4.3 Definition for Quality Performance in Health Care

It was earlier noted that by the late 1980s the Department of Health was encouraging a managed approach to quality in the NHS. Such terms as quality assurance, total quality management and quality circles had become currency in the health service. There was however disparity of understanding and applications of quality management and TQM.

Dalley (1990) reported that in most health authorities some sort of quality work was going on in the form of quality assurance, quality improvement and quality initiatives to which, he suggested, should be added the ill-defined topic TQM.

Dickens and Horne (1991) recommended quality as of vital concern to the NHS, but suggested that TQM is ill-defined and based on system wide projects that are less easy to define and observe.

Brooks (1992) whilst agreeing that TQM was both valuable and essential for the NHS asked what barriers needed to be overcome and to what extent TQM was compatible with the NHS?

Chapter 3 looked beyond the boundaries of the NHS at Quality Management and TQM, where commercial organisations have addressed such quality issues for longer.

Whilst there are lessons to be learned therein, it is important to recognise that health care is both varied in its products and services and involves more diverse interests than many commercial enterprises.

White (1993), suggests a cautious and flexible approach in applying imported concepts to a health care environment, and reminds that:

- organisation change takes time;
- quality 'ownership' comes from understanding core values held by the organisation and individuals, which require to be reflected in the business/quality strategies;
- the average NHS provider organisation is a hugely complex organisation with many different 'core functions', each reflecting different needs and cultures;
- over-emphasis on commercial models may alienate and threaten and need to be adapted to the NHS culture in a subtle and sensitive way.

In order to have a policy to provide quality health care and operate quality management processes, it is necessary for there to be clarity about what quality health care is.

1992 evidenced The Patient's Charter introducing a series of targets which services should aim to provide and a number of rights and standards throughout the NHS. The emphasis being that customers will be more informed about what to expect from their health care and thereby be more likely to judge the standards of service delivered.

The message seems to be clear - focus on customer needs and expectations is a key issue for providers of quality care.

Numerous quality definitions have suggested that it be defined as continuous effort by all members of an organisation to meet the demands and expectations of the customer, for health care purposes, this definition may be modified to substitute patient's and other customers, for the word customer.

The advantage of such a definition for providers of quality health care are several. The reference to continuous effort emphasises the value of striving to exceed prevailing standards rather than accepting them, even temporarily as *limits on performance*. The term, *all members of an organisation*, suggests an imperative to focus the organisational process, by which health care is produced and provided. The reference to expectations recognises that customer reports of their expectations and their assessment of results are valid indicators of quality, including some of its technical aspects.

By singling out the patient from other customers, the definition acknowledges the ethical primacy of the individual patient needs and expectations.

One particular advantage of acknowledging the existence of other customers is the likelihood of encouraging open and frank discussion within health care organisations of the reality that they are constantly engaged in complex efforts to satisfy many parties.

Further to quality being defined as continuous effort, other definitions targeted quality improvement and radical change. The basic understandings to be sought, in health care organisation wide quality improvement and radical change, are understanding the customer and a knowledge of the work health care professionals undertake as a process.

Understanding health care customers, both internal to the organisation and external, involves active dialogue and information pervading the barriers of segmentalism aiming for a more homogeneous integrated organisation in practice.

Knowledge of work as a process across the barriers enables health care professionals to improve and change that process.

Gurus have earlier suggested that a basic means of gaining such understandings and knowledge is through study and application of statistical thinking. Deming (1986) referred to this as 'profound knowledge'.

Applying statistical thinking to on-going work processes invites the use of analytical statistics rather than enumerative statistics. The focus of such statistical thinking is the future performance of on-going processes and systems, not describing or comparing fixed populations of the past. Understanding process then, facilitates performance predictions and the potential for future improvements and change.

The application of knowledge using the scientific method is what the Deming Wheel (Figure 5) is about.

Quality has been described as holistic and TQM as an organisation wide integrating process involving all the functions in providing quality. The basic elements come together, it is proposed, when TQM processes are coupled with the creation of an organisational environment that fosters the effective functioning of people when working together.

Service TQM, as a philosophy, also seeks to integrate socially responsible and environmental sensitive issues. There is compatibility in this and Quality Loss function in connection with quality loss to society, the organisation and the external environment.

To these ends, clear mission statements, concise statements of vision, explicit definition of quality and visible organisational expectation of management and culture, it was suggested, are essential. TQM needs to instil new thoughts and re-direction, other than recycling that which is already known and done. To continuous improvement, then, it was noted, was added the term radical change.

Definitions which recommend communication and integration up, down and across the organisation have also been identified.

Donabedian (1980) targeting quality of care in medicine, defines it as that which seeks to maximise an inclusive measure of patient welfare, after account has been taken of the balance between expected gains and losses that attend the process of care in all parts.

High quality health care, from a medical perspective, is said to consist of both a scientific (technical) component and an interpersonal component which together enable the patient to attain the highest possible functional state and psychosocial result.

Cognizant of such definitions, quality programmes and processes have earlier been seen to have three important foci: measuring performance, identifying performance gaps compared with standards and improving performance when standards are not met.

These are consistent with the development of contracting for health services and the formal introduction of audit, whether organisational or clinical.

Such approaches to quality have a number of important limitations, although rightly emphasising the extent to which health care providers improve the physical and psychological health of individual patients, they require to target more the needs of other

individuals and groups, such as patient's relatives, referring GPs, health authorities and the public. Such a static approach to quality with its emphasis on conformance to standards, can be distinguished from the professional ethic of medical personnel, for example, to continuously improve existing practice.

The approach implicitly assumes that some rate of poor outcomes is acceptable and that little information can be obtained from the analysis of cases in which the prevailing standards are met. Furthermore, should standards be set too low, quality programmes and processes could contribute to complacency and thereby contribute to poor quality. Should they be set unrealistically high they could alienate or frustrate providers.

A further limitation is its focus on individual performance segmentally, under-emphasising the need for integration of organisation, management and culture.

The point was earlier made of need to understand where and how value is created for customers and indeed stakeholders, and the means to continuously improve it.

Some quality definitions have emphasised matters of surveillance and rectification, which might lead those who espouse them to search for tools which have excellence in their measuring ability, high sensitivity and specifity. They may search for statistics far enough removed from the average, it is suggested, that chance alone is unlikely to excuse. Such theorists might direct quality effort in health care, to publishing mortality data for example, and invest in systems of case mix adjustment and the funding of vigilant regulators!

On the other hand, performance outcomes could provide useful benchmarks for setting quality improvement and measuring progress.

Numerous references have been made to customer satisfaction and delight. TQM is concerned with seeking to continuously increase value satisfactions, it was recommended,

whilst continuously decreasing user sacrifice. Means of translating customer expectations into objectives and measurable service characteristics have been suggested.

Providers of health care services have been identified as the suppliers, and the Users and Purchasers their customers. The public at large, it was noted, are potential customers.

Differences between process quality and outcome quality it was earlier suggested needs to be explicit as a means of moving away from an attitude and practice of doing enough only to reduce poor quality and customer annoyance. The real value is to operationalise service quality in terms of perceptions and expectations.

It is important to recognise, it was earlier pointed out, that the quality perspectives of the providers in the NHS quality chain are likely to be influenced by their professional outlook on the provision of health care. In addition to concerns about issues of importance to patients and relatives are matters concerned with process quality of professional standards and integrity in the provision of care. These are likely to include staffing levels, working practices, patient confidentiality, accuracy of diagnosis and availability of support services. Fundamental to the users - patients and their relatives, are likely to be matters which concern quality outcomes of treatments, staff attitudes, time and responsiveness, and the nature of the environment.

Purchasers of care (GPs, fundholding GPs, DHAs, Directly Managed Units, Purchasing Authorities and other Agencies), in addition to sharing the concerns of users regarding effectiveness and equity of health care being provided, are likely to require to establish process quality in the form of access to services, costs, and the quality standards which will be provided. They will seek to ensure that patients (their customers), will have access to the services they require. Purchasers are also expected to be concerned with relative quality levels of provision between competing providers.

The publics' perspective of quality of care provided will likely be concerned with both process and outcome quality which are likely to be influenced by media reports, hearsay and their expectations as potential users.

Distinctions were made between service and manufacturing processes in terms of culture based approaches and the customer forming a part of the service operations system. Research, Garvin (1987), identified criteria commonly used by customers in their evaluation of service quality. These it was claimed, enable customers to make comparisons between their perceptions of process and outcome qualities. Multiple perceptions it was suggested, can be beneficial to an organisation.

The need to understand where and how value is created for customers, is essential, the writer suggested, as is the means to establish what is done, how it is done and thereby determine what is necessary to improve it.

TQM has been described as an umbrella term in that it includes everything which an organisation does, yet too many definitions result in quality being viewed as separate activities concerning standards, specifications, systems, procedures, quality control, quality assurance and indeed, TQM itself. Definition and paradigm should ensure integration and totality not separation and segregation.

Although there are process differences between TQM and Business Process Re-Engineering, Quality Function Deployment, Company Wide Quality Control, Total Quality Improvement, Total Quality Service, Strategic Quality Management System ... there is commonality of focus on customers, continuous improvement and organisation transformation. Long term organisation, management and culture change, is, it is suggested, fundamental to inspiring everyone to continually perform their best, and improve organisation quality through improved personal quality.

It has been suggested that without strong and unifying bonds of common corporate purpose

there are risks of professionals taking 'centre stage', and the pigeonholing process taking

over. NHS process focus on customers (users and purchasers), it was recommended, is one

way of reducing the risk.

The need for serious appraisal of how services are structured, centralised and directed, has

been made, with particular reference to internal customers and suppliers, providing there are

means of reducing traditional thinking which lock providers into rigid compartments and

customers into narrow pigeonholes.

The following broad definition is suggested, which takes account of points and issues made

and inculcates common goal and strategic purpose for health care organisations targeting

TQM for continuous improvement, radical change and customer focussed care:

> Total Quality Management is continuous involvement and effort by all
> concerned with health care to continually seek and apply quality
> improvement and radical change to achieve the elimination of waste, the
> practice of respect for people and the provision of value satisfactions
> perceived by the external, internal and potential customers and suppliers.

4.4 Total Quality Management Paradigm

The NHS quality agenda presents a difficult challenge. Providers of health care are required

to deliver ever-increasing care, against a background of economic constraint, demographic

change and political intervention.

The quality focus since 'Working for Patients', the writer suggests, has not involved many

of the fundamental changes which it has been earlier suggested TQM has to offer.

The new emphasis on consumerism requires organisation, management and culture change (often radical) from former frameworks where professionals work, into an environment of quality and expectation.

The tremendous scope of TQM and the reason it has so many manifestations lies in the fact that it has become in effect an all-purpose vehicle for change which embraces a host of evolving activities, all with common theme. This common, although often unstated, theme is the implementation in practice of two major paradigm shifts in management thinking, namely towards people and towards customers.

The key to this transition lies in the development of organisation culture into one which is dedicated to the delivery of quality service to the customer, not only in terms of the end user, but also the internal customer.

To bring about continuous improvement and radical change, TQM needs to improve that already known and challenge fundamental values upon which the organisation rests.

Total quality needs to be seen and acted upon as the driving force to survival and competitiveness, being viewed as reflection of total organisation performance in its immediate (micro) and extended (macro) environment.

There is need for an explicit, understandable, acceptable and user friendly paradigm for introducing, developing and maintaining the TQM processes, by those directly or indirectly concerned with the NHS, which is based on process, organisation, management, people and culture.

The paradigm needs to address fundamental business change and facilitate demands placed on health care organisations, the least of which is not, flexibility and responsiveness and avoid:

- over focus on 'professional quality' standards which focus less on customer outcome perceptions;

- an over-concentration on explicit quality systems (for example ISO 9000 systems), which tend to over-target process quality in the form of process design and operation, relying more on efficient use of resources and less on effectiveness in the form of customer and supplier value;

- over-emphasis on cost reduction, in preference to quality improvement, which risks mediocracy from reducing resource levels and massaging costs, causing service to suffer;

- models which are more reactive than proactive in their attempts to check/audit quality into service in preference to building it in;

- those processes which threaten the needs and perceptions of interest groups and others;

- over-cautious focus on changing that already known reducing innovation, inventiveness and radical change.

To take advantage of the broad definition proposed, a flexible and responsive participative approach is required to plan, analyse, implement and evaluate TQM practice.

Demands from conventional 'wisdom' for successful execution have been made, and the need for long term commitment, measurement capability, internal and external customer focus, and an enabling management recommended as common and important TQM essentials.

Based on earlier observation, the key to successful implementation is in establishing a quality culture which encompasses good leadership, a customer centred philosophy and a strategy which values and respects people.

Reflecting these points and earlier models presented, the writer has developed an eclectic

TQM paradigm which incorporates a number of their features, Figure 28.

USERS - PURCHASERS - PUBLIC

EVALUATION STAGE

Expected Service — Perceived Quality → Perceived Health Care Service

Judge TQM

Action TQM

PROCESS AND IMPLEMENTATION STAGE

Translating requirements into action. Determines and measures performance. Implements solutions.

Plan/Organise TQM

IDENTIFICATION STAGE

Internal/External customer needs and expectations. Professional and management quality. Opportunities for continuous improvement and radical change.

RESULTS

Customer Supplier Chains

TO

Culture

DECONSTRAINING STAGE

Culture transformation deconstraining barriers.

VISION

Top Management Support/ responsive

COMMITMENT STAGE

Corporate and strategic

Information

Figure 28   Eclectic TQM Paradigm for Health Care Organisations

137

Any paradigm must be carefully framed in terms and metaphors which are supportive of, rather than threatening to those who work in the organisation. If people are to be part of the solution rather than part of the problem they need to be able to see how they can be active participants in the TQM process. They need to establish how they can be empowered to gain greater certainty over economic stability, maintain sufficient freedom to deal with the uncertainties of patient care, gain a sense of participation and proactive influence in institutional development for the future, and maintain and enhance their value. To these ends those who speak for health care organisations must establish rational policy and hold shared vision of a health care system undergoing continuous improvement and radical change.

The commitment stage - top management making it unmistakably evident that they are responsible for, and supportive of TQM initiation and operation.

The first stage of the proposed TQM process model will involve all top and senior managers, consultants, nurses, support services staff and professionals attending one-day awareness 'work-shops', followed by individual and/or group interviews with the writer, who will co-ordinate, facilitate and report progress.

It is intended that the workshops will target basic essentials which need to be understood and accepted before a strategic plan for TQM can be established. These will be concerned with long-term commitment, seeking clear support objectives of quality, costs and time, establishing TQM opportunities and threats in terms of quality of service (macro-external environment) and internal organisation (micro) strengths, weaknesses and aspirations, and enabling leadership which is supportive of and responsive to continuous improvement and radical change programmes and issues concerned with work team ownership. Corporate objectives and strategies will be agreed as will views and directions on the critical processes needed to make it happen.

The proposed TQM definition and paradigm for health care organisations will be established, as will opportunities to personalise and implement process. Means of identifying top management support of vision and culture goals will be identified as the formation seeds for transforming organisational mind set.

Individual and/or group interviews will seek to establish detailed and explicit stage plans which follow and to seek statement based on the following ten points:

- commitment to effective leadership and quality;
- a formal budget for TQM;
- internal relationships;
- commitment to people involvement whatever the work pressures;
- conscious effort and availability to mentor people;
- commitment to responsiveness in providing information and action;
- relationships with customers, suppliers and co-workers;
- recognition that small improvements are as important as large-scale radical change;
- visibility of target sectors, customer, market and service position;
- monitoring performance against customer needs and expectations.

The deconstraining stage-transforming culture involving open communications, breaking down barriers, and empowering employees.

It is not sufficient that management espouse TQM values, but that they are seen to believe in them and manage from them.

The second stage will involve everyone meeting with management in vertically 'sliced' groups to hear first hand their commitment to TQM and details of the agreed stage plans which require support and participation from everyone.

TQM processes and procedures will be explained and definition, values, and mission made explicit. Environment and organisation focus, it will be pointed out, will provide for understanding the needs of individuals to their environment.

TQM was earlier seen to be concerned with changing attitudes, skills and competences so that the culture of the organisation is one of doing the right things to achieve the TQM definition.

To these ends, an important strategy will be to seek team ownership of TQM, in the form of staff empowered departmental, cross-functional and multi-disciplinary work teams, whereupon those aspects of the ten-point statement concerned with leadership, internal relations, people involvement, mentoring and commitment to responsiveness in particular, will be put into practice.

Culture, it is recognised develops over long time periods from daily interactions of groups and individuals with each other and the processes, language and values which bind them as an organisation.

This apart, the starting point will be to ask people to identify the constraining barriers of organisation, management and culture which affect service quality and to invite them as individuals or team members to do something about them.

The identification stage - planning TQM encompasses identifying internal/external customer needs and expectations also professional and management quality. It provides for opportunities to improve continuous improvement and radical change.

During this stage teams become the focal point in guiding the TQM process. Emphasis on getting close to work team members will be placed on training, facilitating the removal of constraining barriers, opening channels of communication, provision of information, and targeting 'fortress' mentality.

Although all team members will receive a formal training 'workshop' in team dynamics and processes, the bulk of the training will be within the teams themselves led by a team facilitator, who will provide stage development against real and 'live' continuous improvement and radical change projects.

Emphasis will be placed on establishing means for detailing internal customer-provider quality needs and external user, purchaser and public quality expectations in terms, it is envisaged, not dissimilar to those earlier suggested, but with more detail.

Targeting and resolving constraining barriers are, it is expected, likely to be first stage projects for teams to address.

Teams will be encouraged to identify and address the 'fortress' mentality which reduces communication and information flow and prevents Directorates, Wards, Departments and people from inter-relating to ensure total provision of quality and the practice of respect. The movement away from a unidisciplinary focus to an interdisciplinary focus, the writer believes, is extremely important in achieving good TQM process.

There is little (if anything) in caring for patients that requires the contribution of one discipline only. Further the processes are seldom within the control of a single discipline. The team focus therefore will be to integrate disciplines to facilitate TQM process, recognising it will be an evolutionary process.

New ideas require a support plan, teams will need to establish where and how to target information, funding, backing and support, and who will run the data.

The process and implementation stage - translates service requirements and availability into practice, identifies and uses criteria for evaluation and performance measurement and implements solutions.

Enabling management and team members will be responsible for translating customer, professional and manager quality requirements into action. The aim will be to provide people with the opportunities to create their own environment in which they have belief in themselves to continuously improve and constantly re-invent quality performance.

Means of personalising services, replacing constraining rules and convention with judgement, addressing performance before procedure issues will be targeted, and 'ideas campaigns' used to involve people in solving who or what prevents the regular and consistent achievement of the TQM definition.

Team members will be developed in the practice and application of such techniques and procedures as brainstorming, cause and effect analysis, six-word problem solving, critical and regular criteria decision making, audit, paretoanalysis, benchmarking and user based outcome measures as means of problem solving, evaluating performance and implementing solutions.

The use of fast response technology will be targeted to provide information on a need to act basis.

Teams will be encouraged to establish with their customers that what delights them and as such customer data collection competences will be developed.

As teams develop their understanding and skills to a point of self-management, the role of team facilitator will diminish to the point where team members will consult with them only when support is required.

Team members will be required to determine their own recognitions and rewards for contributions to continuous improvements, radical change and new ideas which save

money, increase quality, and improve competition which are congruent with TQM. As such it will be necessary to determine structure (resources), process (activities) and outcomes (results) as key elements of evaluation. The TQM process deals with structure and process whilst the ultimate improvement will be reflected in the outcome. Two key questions will need to be answered when evaluating the process - How did this improve organisation performance? How did it improve quality of care?

The evaluation stage - concerns evaluating results of implemented improvements and change and of team effectiveness.

Three important foci were earlier noted with reference to measurement and evaluation: measuring performance, identifying performance gaps and improving performance when gaps occur. Three approaches concerning quality evaluation were also identified in the form of structure, process and outcome. Emphasis will be placed on teams evaluating the results of their actions and implemented solutions.

Evaluation will form an important part of team training to enable team members to select and agree with facilitating management the most appropriate means of measuring and evaluating structure, process and outcome quality.

What is important at the evaluation stage, is to establish the levels of management commitment for evaluating the true costs of structure, process and outcome quality and to determine the extent of interface between quality improvement, radical change and financial accounting in health care organisations and the willingness to provide reliable system which identifies, reports and analyses quality cost evaluation as an essential part of TQM process.

In addition to cost evaluation, performance indicators will be established which evaluate qualitative and quantitative aspects of structure, process and outcome.

The means of using clinical audit and organisational audit as part of the evaluation stage will also be established. Clinical audit in the form of systematic and critical analysis of the quality of clinical care, including procedures used for diagnosis, treatment and care, the associated use of resources and the resulting outcome and quality of life for the patient. Organisational audit will be used as a means of monitoring and evaluating the organisations ability to deliver quality services.

Once evaluation processes are established, means will be decided on how information gained will be shared with others while at the same time continuously planning and organising on-going TQM.

Whichever means team members choose and agree for evaluation, the need is that issues of service quality can be defined, and measured by providers and evaluated by users, purchasers and the public. The important aspect of the evaluation stage is the capability to understand needs and expectations and the form by which customers perceive and evaluate quality of service.

4.5   Summary and Key Findings

Health care has been described as varied in its products and services, but although involving many diverse interests the need for focus on internal/external customers and suppliers, it has been suggested, is paramount. The scope for TQM and the reason it has so many manifestations lies in the fact that it has become an all-purpose vehicle for change embracing a host of evolving activities with common theme. This common, although often unstated, theme is the implementation in practice of two major paradigm shifts in management thinking, towards people and towards customers.

Contracting requires agreement between customers (users and purchasers) and suppliers (providers of health care services) concerning quality of care and for both the purchaser and tax payer, the costs of that care. Distinctions between process quality and outcome quality

144

was suggested, linking three important business cornerstones - quality, costs and time (access), which it was recommended, should be quality led.

TQM reflects two particular aspects of the current reforms, the internal market which has driven parts of the NHS into competition and the emphasis on consumerism, whereby change and reshaping is taking place from former organisation frameworks where professionals work into an environment of quality expectation.

Understanding health care customers and suppliers, both internal and external requires active dialogue and information pervading barriers of segmentalism, seeking a more homogeneous and integrated organisation in practice. Knowledge of work as process across the barriers enables health professionals to improve and change that process.

TQM definition and eclectic paradigm has been developed, seeking to inculcate common goal and strategic purpose by ensuring organisation wide integration through communication and participation up, down and across the organisation. Furthermore, they seek to foster better understanding of where and how value is added and created for customers, encourage improvement and challenge fundamental values, in the forms of continuous improvement and radical change.

The five-stage paradigm, which seeks to change vision into results, begins by top management and clinicians making it unmistakably clear that they are responsible for and supportive of TQM. The deconstraining stage, requires open communication culture, barrier breaking and employee empowerment, so to provide for the third stage, where internal/ external customer needs and expectations are identified, along with those of professional and management quality, and thus opportunity for the continuous improvement and radical change processes to be established. The final stages concern translating customer, professional and management quality requirements into action and evaluating both the results of those actions and the effectiveness of the processes used to achieve them.

145

Before implementation and monitoring can be considered further, suitable methodology requires to be established by which to evaluate definition and the actions and inter-actions which result from applying the eclectic paradigm.

CHAPTER 5   METHODOLOGY: RESEARCH DESIGN AND PROCEDURES

5.0   Introduction

It was earlier reported that health care organisations which form the NHS are under

increasing pressure to evaluate and improve their performance in terms of effectiveness,

efficiency and outcomes, and to assess degree of satisfaction amongst the customers

(users, purchasers and the public) of their services. Evaluation, it was noted, has

importance in the suggested TQM eclectic paradigm, emphasising that the intended

beneficiary is central.

The intention to provide best possible care has always been of main concern, but for many

years the over-riding aim was to improve efficiency, now it is also to improve effectiveness.

In this context the fundamental organisation questions are, do we do right things? and do

we do things right? (Drucker, 1968).

The major focus of earlier chapters was to define TQM and develop a process model which

aims to improve effectiveness, efficiency and outcomes in health care organisations through

continuous improvement, radical change and focus on the customer.

> Methodology then is central for evaluating the definition and the processes
> (actions and interactions) in using and applying the definition and paradigm.

5.1   Measuring Performance

A major part of methodology focused individual, team and group attention on identifying,

developing and using performance measures which identified performance gaps as a means

of targeting improvement when standards were not met. Schein (1969), recommends group

processes being evaluated by group members themselves with the aid of a facilitator. He

suggests methodology concerning clear goals, leadership, participation, diagnosis, decision

making, creativity and growth, which should be seen as scale or dimension he suggests.

Emphasis was placed on self-assessment and process assessment in the identification of critical success factors and the key tasks which focus performance standards and the continuous improvement and radical change objectives.

Auditing, consistent with points made by Barthelemy and Zairi (1994), sought to identify opportunities for quality improvement and radical change, culture improvement, encouraging innovation, providing for empowerment, broadening decision making, stronger integration and co-operation and seeking also to inform customers and suppliers more effectively.

Effectiveness was used to regard the extent to which TQM objectives were achieved in terms of desired outcomes from the TQM process and from the process itself. Government policy for mixed economy of care and control of public expenditure, it was earlier suggested, has created business culture in the NHS. Policy demands independence and wider user-purchaser choice of health services.

Consumerism places emphasis on outcomes to include a number of areas which impact upon quality of care. Outcome as end result of process, protocol or procedure delivered, is customer oriented. To be useful to health care organisations, outcomes require to target improving user-purchaser status. Such is the reason for Lohr (1987) to propose outcome research as an important part of developing paradigms for clinical process, in which is built patient empowerment.

Although outcomes are end results they require analysis as part of the total process. Focus then required collaborative effort in the collection, analysis, evaluation and dissemination of results from the TQM process, for improving the outcomes of health care. The main objective of measurement aimed to establish relative value satisfactions. Outcome evaluation involved measuring the impact which particular outputs had on customers and suppliers.

Consistent with recommendations of Phillips, Palfrey and Thomas (1994), outcomes were monitored by targeting users, purchasers and members of the public to establish the extent to which TQM process had improved sense of well being, self-confidence and extent also to which other criteria are perceived to have been achieved.

The proposed TQM definition served to provide for the development of detailed mission statements concerning patient charter matters which relate to such effectiveness issues as access to services, personal consideration and respect, information provision, waiting time and value satisfactions of care as precondition for assessing TQM effectiveness and the resulting effectiveness of quality care outcomes.

To formulate mission statements which provide for internal/external customers and suppliers within the TQM process, Palfrey et al (1992) suggest method requiring them to be explicit, specific, measurable, scheduled, prioritised, owned and communicated.

Clinical and organisational audit in the form of The National Audit Commission's programmes of review, provide performance information appropriate to Directorates and other parts of health care, which were appropriate to this investigation.

In addition to evaluating quality standards of care and service levels, the TQM process concerns efficiency in the control of resource. Efficiency is the ratio of outcome benefits to the costs of providing them. Attention has been drawn to perceived value costs in preference to costs of quality where added costs are less than perceived value satisfactions.

Contained in the proposed TQM definition is the recommendation for continuously making quality improvements and radical change by the elimination of waste - anything which fails to add value. The rationale for evaluating efficiency as part of methodology lies in team and

group attention drawn to application accountability, in that benefits and costs were regarded as criterion of TQM performance.

Comparing efficiency involved health service resource management methodology in the establishment of activity arrangement to describe TQM process, activity inputs, the conditions for them to take place, resulting outcomes and the resources required to achieve them. Activity costing was used to underpin analysis of activities, and the level of interface between TQM and financial accounting ascertained.

5.2   Research Design and Procedures

The preference was for a framework which combined a number of approaches to enable methodology to best fit the major foci.

Social science research, the application of scientific research procedures to solve problems of a social nature, offers a range of methodologies. Miller (1991) identifies three different foci: basic, applied and evaluation research, each of which require inclusion of guiding theory. Schmele (1993), recommends evaluation research as a means of providing health care organisations with step-by-step methodology for assessing the appropriateness of various TQM models and the effectiveness of their application.

A major part of the methodology concerned evaluation in the context of judging merit. Data was collected, analysed and interpreted against objectives and hypotheses and the process by which they are achieved.

Phillips, Palfrey and Thomas (1994), point out that evaluation is normally an attempt to measure the extent to which certain outcomes can be validly correlated with inputs and/or outputs. The aim, they recommend, is to establish whether cause and effect relationship exists.

Not all evaluation is concerned with outcomes, attention also needs to be directed to service inputs, throughputs and outputs. Some of these are quantifiable performance indicators which evidence the extent by which specific targets are met.

Formal evaluation involves elements of comparison. Comparisons were made at different time points between the macro external environment and the micro internal organisation, different health care organisations and between groups, teams and individuals which constitute the internal/external customers and suppliers exposed to the varying aspects and applications of the TQM stages.

A number of pre-checks, mid-checks and post-checks were made at time intervals during the introduction and application of the stages. Fitz-Gibbon and Morris (1987) recommend this as a particularly appropriate approach when making comparisons at different time points.

Some experimental design was used from the outset, particularly in the form of providing different interventions. This enabled evaluation of intervention levels and the assessment of their impact. The use of experimental groups and control groups, reduced risk of misinterpretation of reason for a number of outcomes.

A case-study approach in the form of a participating NHS Trust provided a major opportunity to provide for in-depth action research, whereby the writer was closely connected with preparation, implementation, monitoring, testing, fine-tuning and maintaining the stages of the TQM paradigm. Close connection provided for high level participation and a means of regular feedback.

The approach therefore was exploratory, in that it aimed to determine feasibility of TQM in an NHS Trust, descriptive, in that it provided for thorough description of its application and explanatory in its aims to explain cause-effect relationships.

Yin (1989) classifies case-study approach as an empirical enquiry which investigates a contemporary phenomenon with real life content, addresses situation in which the boundaries between phenomenon and content are not clearly evident and uses multiple sources of evidence.

Case study also served to counteract possible assumptions that the only valid, and therefore useful data, was that which is founded on large sample numbers and which turns out to be generalisable across other service users and agencies.

Individual outcome or process evaluation was an important means of establishing whether health care services were able to create care programmes sufficiently individualised to be seen as valuable and beneficial to those whom they intend to provide for.

A weakness of the case study approach as a procedure for primary research is that of rigid structure, with the researcher over-duly influencing findings and conclusion and the lengthy time commitment necessary to achieve depth. It is the writer's view, however, that such weaknesses are more than compensated for when account is taken of case study providing for strong inter-personal relationships between researcher and case organisation and the likelihood of being able to target information and data which may hitherto be difficult to access.

5.3   Planning Primary Data Collection

Decisions needed to be made in connection with the sort of data required, method of collection, validity, reliability and the means by which it was to be analysed. Choices and decisions were planned before evaluation took place.

Quality of information in evaluation is largely dependent on the quality of data collected.

Formative evaluation was used in the form of continuous feedback during the course of the investigation. Summative evaluation was used where parts of the investigation were seen to be finished or ready for moving on to the next paradigm stage.

Qualitative evaluation took precedence when targeting such external processes as relationships between customers and suppliers and when seeking to understand interpretation of TQM definition, intention and motivation towards TQM application and perceptions of resulting quality of service.

Quantitative evaluation in the form of applying statistical thinking to the on-going application of TQM work processes and paradigm stages invited the use of analytical and summary statistics rather than enumerative statistics. Audit and cost analysis targeted efficiency matters and performance outcomes were used to provide benchmarks for making comparisons, setting quality improvements and measuring progress against 'best' and 'better' practice (see 5.5).

The case organisation selected was an NHS Trust, which although demonstrating a keen interest in quality management, had not yet reached the formative stage of developing definition or paradigm for total quality management. It was supportive of the suggested TQM definition and paradigm and the researching and facilitating role of the researcher, and equally responsive and supportive of collaboration in experimentation and application over a time period of two years, which the writer believes (from previous TQM experience in other business organisations) to be a minimum, but adequate time to evaluate the suggested stages.

The population from which the sample of other NHS Trusts was selected was determined by the possible value of the findings. The nature of data and detail required for this investigation imposed restrictions on the number of DoH funded pilot sites and other NHS Trusts to be included. Since the investigation was conducted by the researcher only, it was

considered necessary to limit the sample size. At the same time it was necessary to obtain a sample which would be representative of the NHS and provide for rigorous analysis.

The National Health Service Management Executive was contacted to seek assistance in providing a list of Health Authorities/NHS Trusts in England who had a quality management or TQM focus. Once satisfied that the research was of a highly confidential nature, detail was provided in the form of regional breakdown by name, address, telephone/ fax numbers and the name of the Chief Executive.

The Health Authorities/NHS Trusts included in this investigation were drawn from these lists using random number tables. Twelve were chosen from the DoH funded sites and sixty-eight from other sites representing some fifty-two percentage of those provided.

In addition to that earlier stated in connection with the case organisation, the success of investigation to compare and contrast points and issues concerning TQM was dependent upon the co-operation and participation of the other selected Health Authorities/NHS Trusts. To obtain this, two particular obstacles were anticipated, to convince that the nature of the research would be of real value to them and to guarantee absolute confidentiality. In addition daily work pressures, sensitivity to sharing information and resistance to observation were also correctly envisaged.

These apart, it was also correctly anticipated that because diverse and inconsistent interpretation of TQM exists and since relatively little research has been undertaken and reported in health care organisations to determine value and appropriateness in terms of continuous improvement and radical change, any up-to-date factual information and opportunity to participate in development, implementation and application would be readily appreciated.

Before consideration of methodology for primary data collection, it was necessary to define research aim, objectives and hypotheses under test.

5.4   Aim, Objectives and Hypotheses Under Test

The major research aim was to test acceptance and application of the TQM definition and paradigm in health care and to establish its appropriateness for providing continuous improvement, radical change and patient focussed care.

From literature search and subsequent discussion the basic objectives were to seek answers to a number of researchable questions which called for investigation and enhancement of knowledge base in the application of TQM. The evolving paradigm suggested called for research based practice to substantiate knowledge and understanding and test issues concerning: organisation, management and culture; customers and suppliers; competitive advantage and challenge to improve user and purchaser care through the improvement of provider performance.

- Organisation, management and culture - To what extent can TQM:

  re-shape organisational framework into an environment of quality expectation?

  inculcate common goal and strategic purpose for the organisation as a whole?

  facilitate customer/supplier empowerment into solution rather than problem?

  improve multi-directional communications and integration?

  co-ordinate tasks into coherent packages of care?

  integrate socially responsible and environmental sensitive issues?

  provide for management commitment, support and sound leadership in targeting continuous improvement and radical change?

- Customers and suppliers - To what extent can TQM:

  facilitate understanding of customer/supplier needs and expectations and more clearly establish how service quality is perceived and evaluated?

155

strengthen their role and integration in the quality chain, internal market and delivery process by which quality health care is produced and provided?

improve contracting agreement between purchaser and provider in the quality and costs of care delivered?

provide clearer knowledge and understanding of work undertaken by health care professionals in terms of professional standards and integrity in the provision of care, as a means of determining necessity and improving it?

■   Competitive advantage - To what extent -

is TQM part of overall strategy for enhancing organisation quality, including suppliers and through it improving flexibility, responsiveness and competition?

is TQM acted upon as the driving force for survival and competitiveness?

does TQM facilitate the NHS and its hospitals to compete with private providers and with each other?

■   Challenge - To what extent does TQM:

link economic efficiency?

reorient people into targeting high cost non-adding value activities?

make quality more explicit in health care provision?

Earlier a fundamental a-priori assumption was that the quality paradigm would only be achieved through the development of sound macro and micro models which accommodate fundamental changes to how organisations do business. From this a number of common and important TQM essentials were identified.

The data and information required to achieve the major aim and objectives of this research provided for the following broad hypotheses to be tested.

- TQM enables organisational integration in organisations which through size and bureaucracy operate with diverse missions, a growing range of systems and procedures and are characterised by degrees of rigidity from an employee mix of multiple knowledge, understanding, competences, skills and commitment.

- TQM improves attitude and practice towards internal, external and potential customers and suppliers and seeks to establish what quality performance in health care is, and directs attention towards improving input, process, output and outcome performance.

- TQM application through a planned and preparatory approach with clear missions, and tangible goals, facilitates the fundamental changes necessary to achieve competitive advantage through continuous improvement, radical change and patient focused care.

- TQM challenges costly inefficiencies by making non-adding value activities more explicit.

5.5   Data Collection Methods

Individual and group interviewing formed an important part of data collection. A total of three hundred and eighty three case Trust personnel, detailed in Chapter 7, and fourteen GPs participated in in-depth structured and semi-structured interviews and one hundred and eighty four patients and thirty two family members were involved in indirect interviews, a major aim being to establish what the interviewee thought about the TQM definition and paradigm and their views as stage application evolved. Kotler (1988) proposes interviewing as a most versatile research method, permitting explanation by interviewer and interviewee and probing to seek full response.

Case research provided opportunity for interviews to be undertaken on an on-going basis, since the researcher was able to devote lengthy time blocks to the case organisation, establish good relationships and accommodate interviewees time availability.

Tull and Hawkins (1993), point out that in-depth interviews are particularly appropriate when: detailed probing of individual's behaviour, attitude or need is required; subject matter is likely to be confidential; there might be emotional implications; strong socially acceptable norms exist and the need to conform in group discussion could influence response; highly detailed understanding of complicated behaviour or decision making patterns are required and the interviews are with professional people or with people on the subject of their job. Most of these points were particularly relevant to this investigation and consistent with NHS organisation, management and culture.

Krueger (1988), identifies focus groups as a form of group interview, where useful data can be collected from dialogue and general discussion among participants.

On-going awareness, action and feedback workshops, steering group meetings, continuous improvement and radical change teams involving some one thousand, four hundred and thirty three Trust personnel, facilitated the application and maintenance of the TQM paradigm, whereupon a range of views and attitudes within the case organisation provided opportunity to observe the processes by which people interact and thus infer something of organisation, management and culture, as well as providing views and opinions of the issues.

Another important data collection procedure involved TQM Awareness and Action Seminars and workshops external to the case organisation, targeting some seventy personnel from a variety of health care organisations, in which time and procedure was available for collecting individual and group data. A minor weakness with focus groups is that some control is lost over the sequence of questions dealt with, compared to individual in-depth interviews and that data may be more difficult to analyse.

A limited amount of telephone interviewing was used as a method of gathering data and information quickly from personnel in the other Hospitals/Trusts as a means of providing greater flexibility and sample control than mail questionnaires, but not so compared with face-to-face interviewing. This involved a total of eighty-three named persons responsible for quality management.

Nachmias et al (1976), suggest the disadvantages of this procedure outweigh the benefits, targeting particularly time restrictions, less chance of interaction, loss of non-verbal communication and loss on the part of the interviewee, to experience confidentiality. Telephone interviewing can also be considerably expensive.

The majority of interviews were 'direct interviews', in that interviewees, through their participation in the TQM process stages, were aware of the purpose of the questioning. Some 'indirect interviewing' concerned those less involved, which in part was in the form of conversation directed to definite purpose.

An important decision which pertains to interviews concerns structure. **Unstructured interviews** which provide for open questioning and wider discussion were used as exploratory method in the early stages of the investigation in particular, concerning understanding and interpretation of definition and paradigm and comparing definition and paradigm with those of DoH demonstration sites. Unstructured interviews were also undertaken with participants attending TQM Awareness and Action Workshops where views and attitudes regarding TQM were recorded.

Structured interviews which aim to ask more closed and similar questions in a consistent manner and sequence assisting analysis and providing like-with-like comparisons, were used at later stages, targeting those concerned with process and those with evaluation of outcomes.

Semi-structured interviews, wherein a combination of set questions are asked and the interviewee encouraged to deviate were on-going throughout each stage of the paradigm as events took shape. These involved users, purchasers and members of the public, in addition to participating and Trust personnel, as earlier noted.

An advantage of this investigation was in the procedure of all interviews being undertaken by one person, which provided consistency of approach in terms of questioning style, probing and, Patton (1982), in accessing the perspectives of interviewees.

Durgee (1989), recommends three questioning techniques; 'laddering' which requires interviews to identify and describe attributes, 'symbolic questioning' requiring description of the opposite of a subject, be it activity, service or produce and 'hidden issue questioning focusing on feelings about sensitive issues. Laddering and hidden issue questioning were particularly relevant to this investigation.

Questionnaires were also used to elicit qualitative data. These were in the form of self-completion questionnaires undertaken by personnel (individuals, teams and groups), users and user family and friends within the case organisation and mail questionnaires which targeted a named person responsible for quality management in the other participating Hospitals/Trusts. A total of eight hundred and seventy self-completion questionnaires were distributed in the case Trust and three hundred and twenty four mail questionnaires sent to the other participating Hospitals/Trusts, Chapter 7. Eight hundred and three (92%) and two hundred and eighty one (87%) were returned respectively.

Although comparatively inflexible, the questionnaire does have a number of benefits. It can be precisely designed to extract particular kinds of data and provide precise answers to precise questions, Walters (1990). In addition, respondents may express opinions more willingly than in the possible unease of face-to-face or telephone interviews and/or they are

persuaded of anonymity. Mail questionnaires facilitate large and scattered population, as in the case of NHS Trusts and other health care organisations.

As noted earlier, the quality and appropriateness of the questions cannot be over-emphasised, as is the need for good questionnaire design. These not only determine quality of response, but quantity of response also. Jobber (1989), warns that despite the advantages of questionnaires (mailed or handed out), they suffer in terms of response rates which are usually low and slow. Oppenheim (1986) puts them at around 20-40 percent. Issues of non-response, may pose particular problems in the interpretation of findings because of potential bias arising from an incomplete set of respondents. To these ends, questionnaires were tested prior to their use in the investigation, in that pilot study focused people with similar characteristics as the sample group used in the main investigation.

As a research procedure, observation can be more, or less structured, depending on what is appropriate in the particular circumstance. Where it is clear of what is being sought a more structured approach is likely to be appropriate. Observation may be used alone or in conjunction with other methods, such as interviewing to seek to uncover, for example, what is done compared with that claimed to be done. This, the writer believes, provided valuable insight on matters which related to the elimination of waste and the practice of respect, in particular.

Observation may be participative, non-participative, covert or overt. Participative observation occurs when the researcher becomes part of a group or team being observed, for example a steering group, continuous improvement team or radical change team, so as to provide deeper insights and opportunity for rigorous data collection.

Non-participative observation, was particularly appropriate as spectator to quality activities concerning provider, user and purchaser interface and the value satisfactions which resulted.

161

Although most observations were overt, there were occasions when it was necessary to resort to covert observation. These concerned some observations of patients in clinical care. Gill and Johnson (1991) identify two general occasions where using such observation could be appropriate, these are concerned with reducing risk of people behaving differently (Hawthorne effect) during observation and where refusal of access is a risk. It is necessary to recognise ethical implication when using covert methods in evaluation, particularly with matters of confidentiality.

It was earlier noted that formal evaluation involved comparisons and that performance measures in TQM terms concerned competitive standard. Data collected for this investigation provided ample opportunity to apply benchmarking towards achieving and continuously improving upon best practice.

Shaw (1994), perceives benchmarking as having significant potential in the NHS, keeping pace with and improving innovation; patient care; getting providers to face up to 'hard' quality criterion and in helping to provide value for money service. It concerns information sharing and becoming a learning organisation, he suggests, in order to continuously improve.

There were three main areas by which best practice was sought in this investigation, they concerned internal benchmarking in comparing site-to-site, directorate to directorate and department to department within the organisation, functional benchmarking in the form of comparisons against best organisations in health care and competitor benchmarking for making comparisons with direct competitors, particularly private care providers.

It is less appropriate to attempt generic benchmarking in the form of making comparisons against the best from all industry groups.

The suggested TQM paradigm identifies a bottom-up focus on customer-supplier involvement in continuous improvement and radical change, but benchmarking, Zairi (1992) suggests, is top down performance management effect, wherein the effect requires to clearly communicate objectives and reliance on employees to perform in meeting them. It is, he points out, only by taking the two effects that organisations begin to aspire to best class position.

His links between TQM and benchmarking well match the suggested paradigm for this investigation, Figure 29.
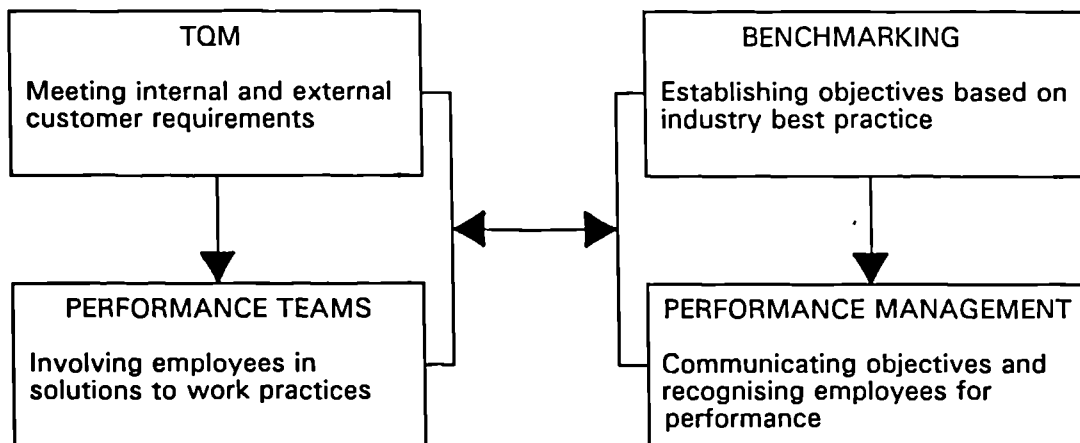
Figure 29   The link between TQM and benchmarking (Zairi, 1992).

Competitive Benchmarking: An Executive Guide.
(Technical Communications Publishing Ltd).

5.6   Pilot Study

It was felt necessary before commencing the investigation to conduct a pilot survey to confirm procedure, test reactions and provide the writer with additional research experience. Two NHS Trusts agreed to act as 'test organisations', providing access to interviewing a range and mix of managers, consultants, hospital doctors, nurses, support services staff, patients (users) and GPs (purchasers).

A total of 27 Trust personnel and 9 GPs participated in in-depth structured and semi-structured interviews and 23 patients and 8 family members were involved in indirect interviews to establish views concerning quality of service, quality management and TQM matters (Appendix 11).

Fifty self-completion questionnaires were also distributed to Trust and Health Authority personnel seeking response to TQM definition and paradigm (Appendix 12) of which 37 were returned, a better than expected result. In addition, four, half-day, TQM Workshops were presented, involving 57 participants in discussing definition, paradigm and implementation issues.

Participative and non-participative observation of executive meetings, a resource management project team, quality circles and a seminar concerning benchmarking, provided insight into a number of diverse views, attitudes and activities helpful to the proposed investigation.

The results of the pilot survey were in some ways encouraging yet in other ways disappointing. Both Trusts demonstrated noticeable commitment to service quality and a keen interest in quality management. One was preparing to move from quality assurance focus to TQM process and requested that they be permitted to use the proposed TQM definition and paradigm, which later proved to be a most beneficial arrangement for comparing and contrasting stage application results.

Both pilot survey results suggested that the proposed definition and paradigm provided ample scope for continuous improvement, radical change and patient focused care. There were no suggestions to change them in any way. Most participants (73%) felt that the suggested two year target time for all stages application was achievable, others felt a longer time period (of up to three years) would be beneficial.

One Trust had developed and displayed a mission statement which was consistent with their quality management focus: "The Trust's principal aim is to produce high quality cost effective services to meet the needs of clients and their carers in a dignified and sensitive manner". This apart, quality issues, as earlier suggested, were more implicit than explicit.

There were noticeable references to customer (patient) focus, but fewer reference to internal customers and suppliers. Some (64%) were concerned with need to strengthen interface between provider and purchaser of health care services.

A number of GPs had attended TQM workshops and were practising forms of quality management, mainly quality circles. A number claimed to subscribe to 'Practice TQM', a University of Hull, Department of Public Health Medicine publication.

One Trust was exploring the use of benchmarking for making service quality comparisons as a means of improving patient focused care.

Hospital Process Re-Engineering and BPR were terms mentioned by a number of senior managers as *a means for creating a more flexible and responsive health service,* and questioned the need for both TQM and BPR focus.

Procedures for audit, appraisal and the use of performance indicators found commonplace with the quality, cost and access cornerstones mentioned earlier, but were less well co-ordinated than would be expected with TQM process. Most (83%) expressed support of the proposal that group and team members might develop and agree situational performance measures, providing they are compatible with mandatory requirement.

One Trust, involving Finance, Resource Management and The Regional Directorate of Nursing and Quality were developing an initiative to put cost to quality problems and establishing procedure guidelines for resolving them through quality improvement.

It was particularly encouraging to note appropriateness of the suggested data collection methods and the helpful recommendations to add questions concerning, recognition, rewards, government reforms and economic constraints.

Patient and family member interviews indicated a particular willingness to share satisfactions and dissatisfactions of service needs, expectations, perceptions and views concerning patient empowerment.

It was disappointing that despite operating through the Personnel Directorates/Departments, who the writer had made aware of the pilot survey intentions, there was misunderstanding of reason for the survey, particularly in the experimental aspects of data collection method. This resulted in more suspicion on the part of participants than was originally envisaged.

It was most obvious that matters of confidentiality was of major concern to all levels of Trust personnel, there was a distinct reluctance to voice concern, almost to a point of conspiracy of silence, about problems, until absolute confidentiality was guaranteed. Threats to "whistle blowers", was referred to on a number of occasions.

There was a less than satisfactory response from senior consultants to interview, questionnaires and attendance at workshops. Reasons given were their unavailability at the requested times, misplaced questionnaires and a reluctance (division of labour), to partici- pate in multi-disciplinary activities which involved personnel from a number of status levels.

There was stronger evidence of machine and professional bureaucracy than was envisaged, which although a disappointment was an encouragement also, in expectation of TQM providing a strong and unifying bond of common corporate purpose.

Interview and questionnaire completion times took almost double the expected time and there was some suspicion of rehearsing answers in part.

Financial information in the form of quality costing was extremely limited and there appeared to be poor interface between financial accounting and quality management. There was strong intention for cost reduction, but little focus on high cost non-adding value activities. There was general acceptance that reduced service levels were an inevitability.

Very few patients or their family were aware of Patient's Charter targets, rights and standards. There was a lack of confidence in complaint procedures, being described by some as an "exercise in futility" and "not a patient friendly procedure".

Numerous and diverse opinions were expressed towards value and procedure for patient focussed care.

With such a small sample size of respondents, the intention was not to evaluate quality management process or attempt detailed analysis of the researchable questions listed in 5.4. The value was in confirming and fine-tuning procedure, experiencing reaction and response and providing research experience in health care organisations.

It was clear for investigation which followed, that matters of confidentiality had to be guaranteed by avoiding organisation and individual identity, a simple code was used to indicate organisation roles and status level.

Meeting the time availability of senior consultants and others was paramount and attempts needed to be made, particularly with senior consultants, to maximise the number of in-depth interviews and minimise the number asked to complete self-completion questionnaires. Over-emphasis on multi-disciplinary TQM Seminars and Workshops was avoided.

Better scheduling and planning of interviews and self-completion questionnaires was successful in reducing time taken.

Less emphasis was placed on standard forms of quality costing and more focus placed on means for putting costs to quality problems and the establishment of guidelines for solving them through continuous improvement and radical change.

Co-ordinating investigation through the cross section and mix of Directorates was successful in ensuring understanding of aims and objectives which resulted in fewer misunderstandings of intent.

A most important outcome from the Pilot Survey was in the appropriateness of the suggested research design, procedures and method of data collection, although subsequent refinements were implemented in the form of questionnaire refinement, the specifics of which are noted in subsequent chapters.

CHAPTER 6   ANALYSIS: TQM DEMONSTRATION SITES

6.0   Introduction

The previous chapter concerned methodology, research design and procedure for primary data collection. This chapter presents results from primary research findings from NHS Trust Demonstration Sites.

Twelve sites were selected at random from the twenty-three sites (52%), using random number tables. The purpose of demonstration site analysis was to:

■   compare and contrast their TQM definitions and paradigms used and seek views concerning their appropriateness in application;

■   ascertain the Trusts' perceptions concerning adoption and applications of TQM;

■   establish views and attitudes concerning the appropriateness of TQM for achieving continuous improvement, radical change and patient focused outcomes;

■   record opinion of the proposed definition and eclectic paradigm to be used in the case Trust.

Six of the twelve selected Trusts were invited to participate in direct interviews, observation and the use of self-completion questionnaires, four agreed. Forty-seven Trust personnel, active participants in TQM process, were involved in direct interviews (Appendix 13 and 15), 12 managers, 2 consultants, 4 hospital doctors, 15 nurses and 14 'support services' staff. Four hundred self-completion questionnaires (Appendix 14) were distributed to a random number of Trust personnel in proportion representative of number and mix of organisation role and status levels. One hundred and eighty three were returned, of which (17%) were managers, (6%) consultants and hospital doctors, (35%) nurses and (42%) support services staff.

The participating Trusts preferred not to involve patients or family members in data collection, although three provided details of surveys previously undertaken by them concerning quality matters and complaints.

Participative and non-participative observation - involving four quality circle meetings, two quality policy action teams, a hospital management steering group review of quality improvement suggestions and a 'TQM Awareness Seminar' - provided the opportunity to gauge style, process and progress and also provide forum for conversation directed to definite purpose.

The remaining six Trusts of the selected twelve, were invited to participate in telephone interviews and the use of self-completion mail questionnaires, and five agreed. Seventeen Trust personnel, active participants in TQM process, 5 managers, 1 hospital doctor, 5 nurses and 6 'support services' staff agreed to structured interviews (Appendix 13), as did forty-four non-active participants, 10 managers, 1 consultant, 3 hospital doctors, 14 nurses and 16 support services staff. Subsequently five hundred self-completion questionnaires (Appendix 14) were posted to Personnel Directorates/ Departments to be distributed to a random number of Trust personnel in proportion representative of number and mix of organisation role and status levels. One hundred and ninety-one were returned, of which (19%) were managers, (9%) consultants and hospital doctors, (38%) nurses and (34%) support services staff.

The 482 respondents from the participating Trusts involved 94 (20%) managers, 39 (8%) consultants and doctors, 171 (35%) nurses and 178 (37%) support services staff.

Again the Trusts preferred not to involve patients or family members in data collection, one provided survey results undertaken by them pertaining to the Patient's Charter.

Each of the three Trusts who declined to participate provided written and/or audio-cassette material concerning their TQM activities, processes, progress, outcomes and successes.

Total confidentiality of identity, material and response was guaranteed in that no Trust or individual was referenced by name. A simple code was used to indicate organisation and status level, for example M - manager, C - consultant, D - hospital doctor, N - nurse, CO - clerical officer, P - porter ... and so on.

6.1 TQM Definitions and Paradigms

Each participating Trust was able to provide explicit detail of TQM (or quality) definition in the form of quality policy or mission statement. There was no evidence of attempt between the pilot sites to co-ordinate or agree definition, each had styled their own.

Although definition length and wording was different, there was some consistency of focus. There was emphasis on customers and suppliers in targeting customer driven service; seeking to understand patient/client needs; aiming to delight patients, purchasers and colleagues in terms of continuous improvement and intention to promote better health in the most effective and efficient ways.

Some definitions concerned organisation, management and culture by reference to assisting staff fulfil their potential in releasing creativity; top management commitment support and accessibility; open channels of communication; total organisation involvement; breaking down barriers to change and innovation; removing fortress mentality; building mutual trust and focus on client and public expectation.

There were some references to competitive advantage through provision of high quality services and satisfied patients making excellent ambassadors.

Challenge was occasionally included in definition in the form of high quality cost effective services, standard setting and the need to monitor success in achieving them.

An arithmetic mean of (68%) of active participants and (63%) of those not actively participating in TQM activities (interview and questionnaire results), indicated importance of definition to precede TQM process, Figure 30, in so far as it provides explicit strategic direction and intention for quality improvement and patient focused care.
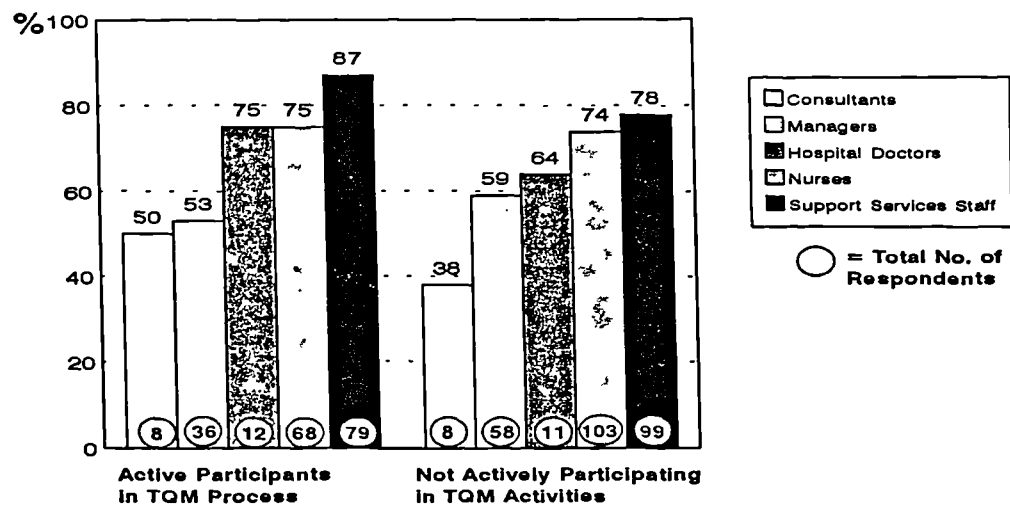
Figure 30   Breakdown of Respondents in Favour of Definition to
Precede TQM Process

A total of (24%) claimed no knowledge of existence of Quality or TQM definition, (47%) could not recall focus or content.

It is clear from the investigation that no site had used an 'off the shelf' approach or process model, preferencing instead to develop their own. There was strong evidence of links to guru and other theoretical models, many of which are referenced in Chapter 3. Unlike the suggested paradigm with parity of emphasis at each stage, from vision to results, most emphasised particular stage or state focus. For example, developing customer focussed service; project management culture; improving the ways of work; breaking down segregation; liberating potential; demonstrating commitment; unlocking information; opening communication channels; standard setting, monitoring, analysis and action.

This is not to suggest absence of paradigm but to report perceptive response to request for participants to describe their TQM process.

An arithmetic mean of (61%) of active participants and (53%) of those not actively participating in TQM activities (interview and questionnaire results) favoured staged process, Figure 31, to provide for a planned approach to TQM implementation, which is conducive to individual organisation, management and culture issues.

Most (70%) however, in their description of TQM application placed emphasis on particular stage or state.
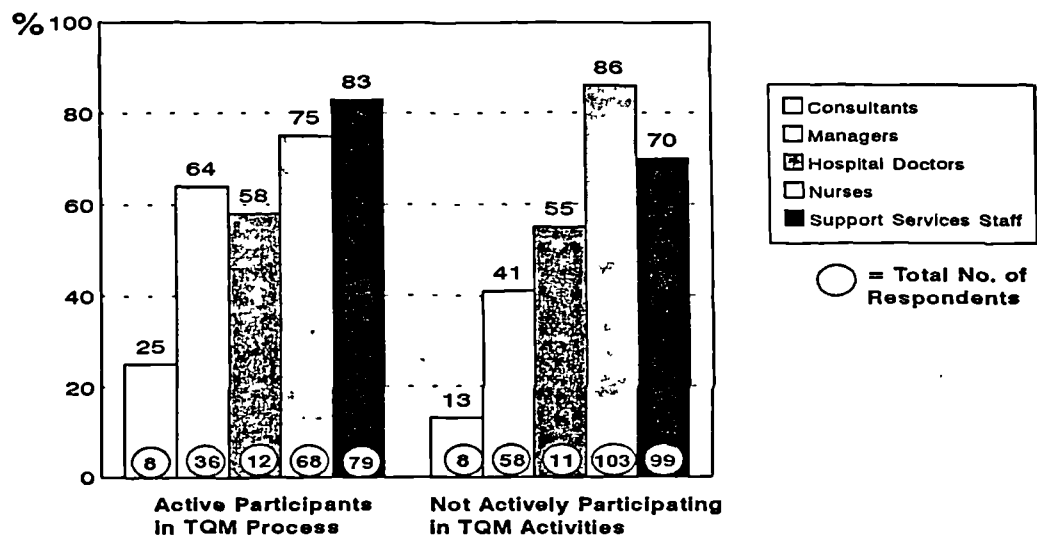
Figure 31   Breakdown of Respondents in Favour of Staged TQM Process

A total of (48%) claimed no knowledge of existence of TQM paradigm.

6.2   Adoption of TQM and Application

In addition to comparing and contrasting TQM definitions and paradigms and seeking to determine their importance, demonstration site investigation sought to establish detail of adoption and application.

One Trust had introduced TQM process in phases and was seventeen months into application, at phase 3 stage. Emphasis was placed on organisation integration and staff empowerment, recognising those best placed to identify problem areas are staff members undertaking the work.

From commencement, team leaders had figured prominently in the TQM initiative, extensively supported by training. Quality improvement programmes had been developed detailing means to establish and undertake quality improvement projects along with techniques and procedures.

Phase 1 had focussed environment issues, claiming twenty-six achievements in the first ten months, from improved patients information to better access to premises.

Phase 2 encouraged cross disciplinary and cross unit working, targeting larger scale quality issues between hospital and community care, for example.

Phase 3 intends TQM as means for establishing quality culture and practice for whole site projects.

As one of the DoH Demonstration Sites, they had benefited from additional funds to help develop quality improvement programmes, essentially the money had been used for 'pump priming'. One leader claimed to have received £6,000 to get a project started.

It was stressed, however, that many projects had actually cost little or nothing to implement, whilst others had aimed to re-channel wasted resources.

Particularly helpful material for comparing and contrasting TQM process, adoption, results and outcomes, was provided by a second Trust, who pointed out that before TQM focus, managers were demonstrating commitment to quality improvement through a mix and spread (in excess of 120) of quality initiatives at different stages.

The first stage had involved establishing a small (five person) Total Quality Support Unit, who, through their Co-ordinator, reported directly to the Unit General Manager. Their initial aim was to co-ordinate scattered initiatives into a coherent framework. Establishing the Unit, it was suggested, had conveyed top management concern and support for quality improvement.

Some 2,000 staff had attended Quality Awareness Seminars, which were personally led by top management, the total quality co-ordinator and a member of the team of management consultants assisting implementation. The seminars had provided good response from staff to discuss the mission statement intended to underpin TQM and opportunity to hear, first hand, top management determination to bring about quality improvements.

Key elements of their process involved diagnostic stage, whereby customer surveys were undertaken to establish how their services were viewed by patients, staff, GP's, HA's and others. Quality improvements, they stated, were firmly based on the data provided.

The second stage, emphasised problem prevention in preference to problem solving. To these ends, they established service levels offered to customers, by setting standards for all services and monitoring the extent to which they were met.

Effort had gone into determining scale of problems in the form of waiting times, rearranged admissions, and cancelled operations, for example, in order to make effective improvements.

The Quality Support Unit, facilitated the formation of measurable standards for each service and their publication in the form of a standards manual. Standards which are monitored over two to five quality audit days annually, involve peer assessment.

An important outcome from quality audit, they suggested, was that peoples views of problems are often impressionistic and impressions may not be supported by facts.

Standards setting, they described, was large scale bottom up process wherein staff reflected work which would benefit (effectiveness and efficiency) from close monitoring.

Each Trust manager nominated a staff representative to liaise with the quality support group in the standards setting/monitoring process, whereupon 80 had attended 'Quality Standards Workshops'. They worked closely with colleagues to identify, set and monitor standards in key work areas and forwarded results to the support unit for publication, so enabling inter-organisation and earlier performance comparisons.

The third stage is involving senior managers and everyone taking seriously the view that staff are also internal customers and suppliers, with needs for good working conditions, training, support, recognition, trust, open and effective communications.

Top managers and the total quality co-ordinators are beginning to regularly attend staff briefings, quality action teams and joint consultative meetings to keep staff abreast of developments and outcomes in the total quality programme and to emphasise high quality profile, celebrate success and establish culture which is conducive to quality improvement.

Success and outcomes reported included a better understanding of quality issues, 'softer' inter-directorate/department/unit barriers, a more accessible management, a stronger awareness of patient and staff needs in the form of reduced waiting times, improvements in booking protocols, a co-ordinated commitment to achieving patient charter standards, focus on performance improvement and a means for rewards and recognition.

Appreciative of the TQM process detail provided by two of the Trusts not participating directly, primary data collection sought to focus TQM adoption and application which was particularly relevant to the five process stages contained in the proposed TQM paradigm.

There was strong opinion (89%) that commitment to quality management leadership was essential in ensuring high quality profile. Ninety-two per cent of top managers said that they gave it, (32%) of Trust personnel said that they received it. Figure 32 provides breakdown of those (68%) claiming not to receive it.
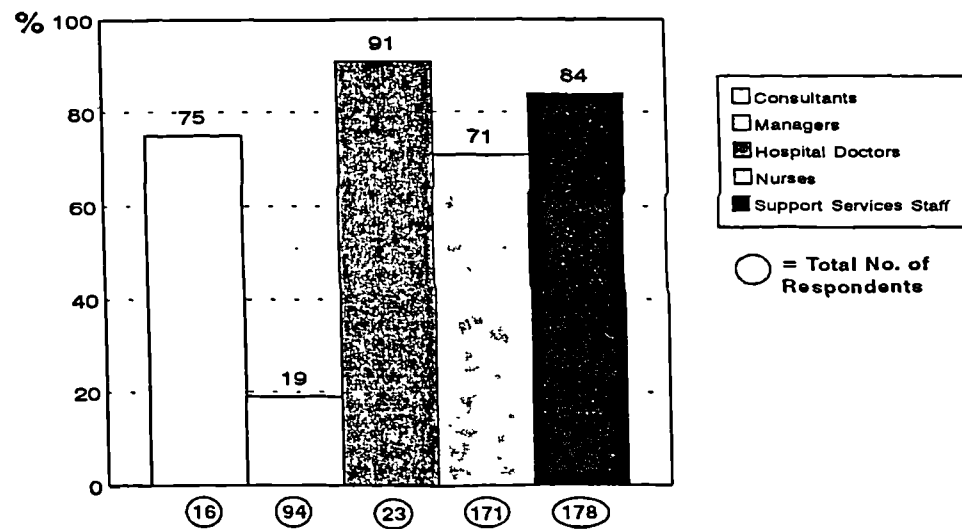
Figure 32   Breakdown of Respondents Claiming Not to Receive Commitment to Quality Management Leadership

Five Trusts provided top management 'Quality Councils' or 'Quality Steering Groups' to ensure leadership and support, four reported to the Management Board and one direct to the Chief Executive. One Trust styled collaborative approach at the top in both the community

and acute units in the Director of Personnel co-ordinating TQM in the former and the Director of Human Resources in the latter. The Director of Quality at the Health Authority liaises with both.

One Chief Executive interviewed fashioned his commitment to quality by presence on "the front line", in his undertaking of menial tasks at ward, clinic and administrative levels, when time permitted.

Trust personnel not experiencing management commitment claimed disbelief of quality as high priority or quality programmes as serious issue. It was equally clear from discussion and responses, that if managers, clinicians and other staff were expected to show their commitment to TQM they needed first to see top management commitment. Expressions such as "commitment has to be explicit, you can't just expect it" were not uncommon.

Of the sixty-four active participants in TQM process, all with the exception of five (92%) had attended TQM Training Programmes ('Awareness Seminars', 'Action Workshops' or 'Appreciation Courses'), which varied from five days to one day in duration. Of the forty-four non-active participants, twenty-three (52%) had attended training programmes.

Most programmes had expressed TQM in terms of organisation-wide quality initiative with main purpose to exceed quality control, quality assurance and quality systems practice. All emphasised need to involve external/internal customers and suppliers in the improvement of quality services.

The majority of respondents (61%) were critical of the training programmes in their failure to emphasise continuous quality improvement, radical change and patient focused care methods. A number of active participants (34%) detailed application experience of continuous quality improvement focus in their TQM process of which (14%) exampled radical change and patient focused care in this context.

It was clear from examples detailed that most concerned incremental improvement rather than challenge to organisational beliefs and structural constraints. There was little reference for need to rethink the business (re-invention and revolution).

Training programme material included need to focus work on the customer, but little emphasis was placed on rethinking why they did what is done.

Although staff and patient empowerment issues were evident in four of the training courses material (31%), a large majority (91%), of those interviewed, who had attended training courses, failed to communicate understanding of methodology to practice it.

Statistical method was detailed in one course (7%) and benchmarking practice in three (23%). Two of those interviewed (3%) provided evidence of using statistical method to monitor complaints whilst seven (11%) provided evidence of using internal benchmarking involving personnel department protocols and the use of performance measures concerning the Patient's Charter.

Internal relations were also expressed as major issue, in that 92% of all respondents indicated that TQM process should seek to breakdown barriers between staff in the same Directorate, different Directorates, at different levels and in different units, in order to unlock valuable information about procedures and problems which otherwise remain untapped. A majority of all respondents (68%), felt that TQM had not gone far enough in achieving this, pointing out that most people have views concerning quality matters. There were numerous references to "breaking down barriers as a means of sharing views".

The majority of respondents (71%) thought the use of multi-disciplinary teams, quality circles and/or project based approaches were a major means of minimising attitude of 'own territories', although only (27%) professed to participate in either.

Two Trusts claimed to focus barrier breaking by encouraging their personnel, at all levels, to identify internal customers and suppliers and to collectively explore means for improving quality of work and quality of working. Most of those interviewed (73%) supported this, but were critical of the lack of co-ordination and support in application.

Detail provided by one Trust, sought 'Total Quality Communications' application for reducing barriers caused by seniority and status. This was beginning, they claimed, to encourage more direct exchange of information, active listening and a willingness to openly acknowledge problems, which it is intended, "will emphasise action".

Three Trusts provided detail of employee surveys to establish response to TQM process as a means of co-ordinating quality work already being undertaken, opportunity for change and improvement and for bringing purchaser and provider cycles closer together. Each claimed a response in excess of (50%) with the majority (varying between 52% and 60%) favouring TQM process with definite purpose.

As a means of improving internal relations one Trust had established a 'Quality Network Group' as a fundamental part of its TQM adoption and application. This involved one member from each care group and patient care department facilitating and supporting quality improvement action. A briefing report is forwarded from it, to every manager, following group meetings to provide means for keeping staff abreast of change in quality matters. Explicit evidence was provided of feedback from reported TQM activities and outcomes in the form of memorandum, broadsheets, newsletters and items in the house journal.

There was high level of support (71%) for TQM process establishing effective methods for consulting and involving users, purchasers and the public more in focus shift from provision of health services designed by 'experts' only, Figure 33.
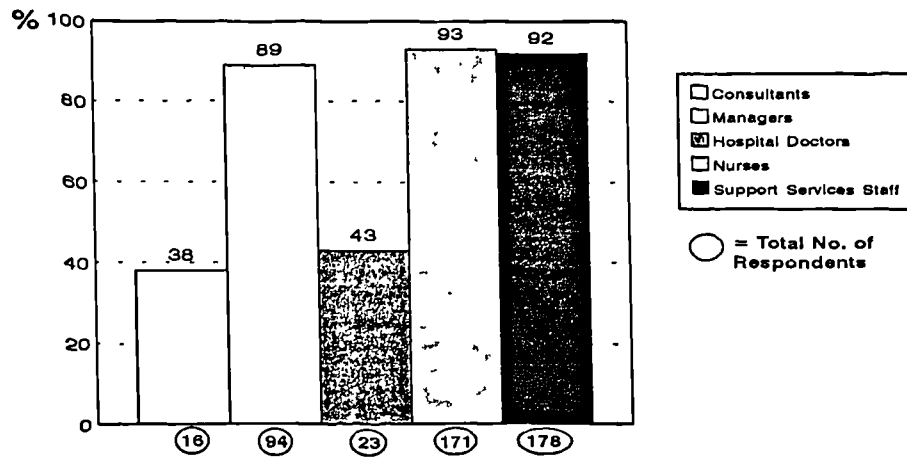
Figure 33   Breakdown of Respondents in Favour of Involving Customers in
Design of Health Services

Some consultants and doctors were scornful of the notion that patients can constructively

comment on clinical aspects of care.

Most Trusts (83%) had undertaken patient surveys and to a lesser extent (58%) GP

surveys, (mostly in the form of self-completion questionnaires), in attempt to involve them

more in design of quality care services, and to provide information to 'tailor' services

towards their needs and expectations.

Although the researcher had only limited access to survey results, detail was provided of

TQM process method for achieving this.

One Trust involved local community in developing health priorities of action. A consultation

leaflet discussing local health concerns and requesting feedback went to every household.

Some five hundred responded (3%), many (not stated), offering to become further involved

should opportunity provide. A second Trust claimed quality achievements in meeting

patients needs through the involvement of patients in treatment plans and advisory clinics,

resulting from 'quality request' leaflets handed out at clinics.

Another Trust described a feature of their drive for quality as "management's determination to listen to what people have to say, and giving them the power to put their views across by as many means as possible". In order to receive feedback from internal/external customers and suppliers, the Chief Executive and other Board Directors, hold monthly evening surgeries where patients, their relatives, staff members and the public, can discuss matters of concern. In addition, special regular surgeries with interpreting facilities are held for people from ethnic minorities.

Allied to this is an effective complaints procedure. Eye-catching posters in hospitals and clinics invite people to complain and leaflets tell them how to go about it. The Director of Quality, stated that his unit aims to say what they perceive of the hospital and its services. This he pointed out, is a most valuable source of first hand information on the care they provide.

Two Trusts detailed survey method used in their TQM process for establishing that what in terms of quality performance is important to their personnel. Team formation and 'brainstorming' methods were described centering on quality expectation, improvement and recognition. Ideas were grouped into topics which formed the basis of questionnaires for all staff. The results, it was claimed, provided vital information of what motivates staff towards quality improvement in different parts, and at different levels, and the form of support and recognition they would respond to.

Four Trusts made particular reference to the Patient's Charter, detailing a number of initiatives to implement the standards. Local Charters have been put in place to bring together national and agreed local standards and leaflets made available detailing them, in a number of languages. The Trust Boards receive reports on quality concerns and complaints, which provide a basis for monitoring how they are performing against charter standards.

One 'Complaints Manager', stated that all complaints were acknowledged within twenty-four hours of receipt and that it was her job to ensure that they are investigated and a full response, endorsed by the Chief Executive, provided to the complainant within the target time of one month.

Quarterly reports, analysing complaints by cause, go to Senior Managers and Purchasers, making it less difficult to monitor quality trends and highlight areas for improvements.

It was evident from outcome examples detailed, that some restructuring of services had begun in the form of grouping patients and tasks to seek to minimise cross-scheduling between departments, and the introduction of clinical protocols to pre-plan sequence during events of care. It was also clear that because of job loss risk and need for change in responsibility and skill level, there was indifference to staff training aimed at task mix across the professions.

One Trust provided detail of large-scale structural change which had begun, by involving a multi-disciplinary total quality team in reorganising acute and community services into care groups to reflect patients needs. Each group, it was pointed out, is supported by a Primary Health Care Manager who ensures close working with GP's. Another had involved TQM process towards major review of Accident and Emergency services and to provide for public consultation, closer liaison with external agencies and stronger internal communications.

Observation at a quality policy meeting, provided detail of discussion of need for a radical re-examination of beginning to end care delivery process, scrutiny of the process and realignment of delivery, wherein patient quality is paramount. Observation, left the researcher with little choice but to conclude greater resistance, by those present, to the suggestion, than support for it.

It is clear from interview and participative and non-participative observation in particular, that their is emphasis and preference for incremental and small scale activities within TQM process, which involve few or single directorates and departments. Some are contained within particular professions.

Quality has earlier been described as achieving clinical outcomes, meeting agreed standards and providing a number of features and dimensions of service.

A majority of respondents (53%) referenced the importance of and need for reliable data and "hard facts" to convince managers and clinicians where quality of service is not provided. There were numerous suggestions that, "when people are provided with actual and reliable facts, they generally seek to solve and prevent problems".

Seven of the Trusts provided evidence of standard setting, which a majority (66%) of their managers believed led to better team working, improved staff moral and trust, effective communications, improved consistency and stronger customer relations. More than half of their non-manager respondents (51%) claimed they were unclear how standards were used to improve quality performance and quality outcomes.

A majority of all respondents (57%) saw need to measure the success of TQM process in terms of customers, suppliers, outcomes and costs, Figure 34, less than one quarter of the active participants (21%) were able to provide detail of measured improvements.
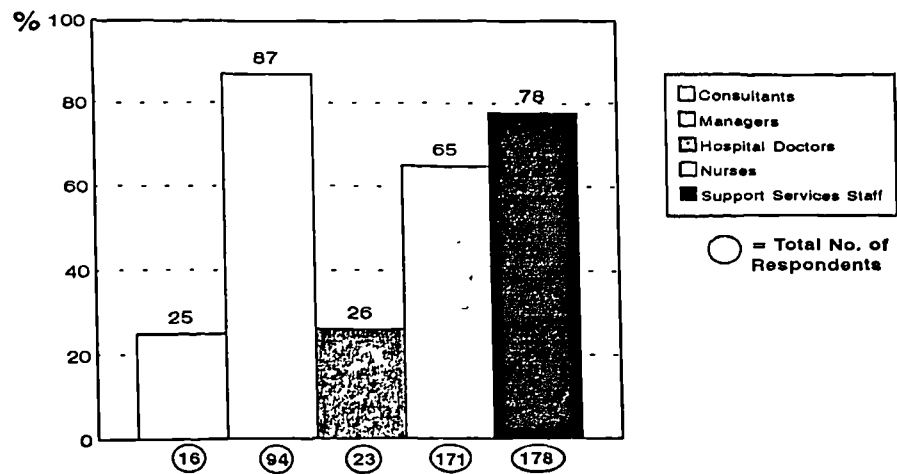
Figure 34   Breakdown of Respondents in Favour of Measuring TQM Success
in Terms of Customers, Suppliers, Outcomes and Costs

Although no attempt was made to target patient or family members direct, to seek opinion of quality of service provided, instead relying on information from the Trust's survey results, their was clear evidence to suggest a pattern of complaints concerning quality matters. These concerned levels of care, staff attitudes, availability of services, poor information, lack of participation, poor facilities, hygiene and cleanliness matters.

A significant number of active participants (83%), indicated that TQM goals need to target and prevent complaints, to these ends (56%) suggested use of Patient Charter standards and expectation.

A number of references were made to shortage of time for setting and auditing standards over and above "mandatory requirement".

One Trust in particular provided a framework of measurable standards to demonstrate fulfilment of quality and business objectives. The first step in setting the framework, they suggested, is comparatively simple. Each department was asked to spell out existing standards and objectives for their service and methods for monitoring and reporting them.

185

The standards were agreed with senior management and produced in 'Quality Manuals' for each Directorate. "Examining the extent by which standards were achieved, helped determine areas for quality improvement", they pointed out.

By setting standards and producing the manuals for each department, they believe, has brought scattered initiatives into a coherent quality framework and an overview of the quality of service as a whole.

Standard setting and audit method selection by staff who perform the work, which aims to identify strengths and weaknesses, in preference to top down imposition of standards, was supported by the majority of respondents (69%), providing that management veto "safeguards" existed to ensure degree and consistency.

6.3   Views and Attitudes Concerning Appropriateness of TQM for Achieving Continuous Improvement, Radical Change and Patient Focused Outcomes

The majority of respondents claiming awareness and understanding of TQM (77%), by attendance on courses, or from texts, journal articles and media items, viewed it as a means of involving management, clinicians, nurses and support personnel in multi-disciplinary and cross-functional team effort, to improve the quality of services. A minority (37%) however, said that given the chance, they would be voluntary participants in the process, Figure 35. The majority (63%), of those who were unwilling to be voluntary participants, gave reason of, little interest, work/time pressures, likely to lead to job insecurity, unwillingness to share information, inappropriate for health care organisations, poor management support, own interests and territories and 'flavour of the month' expectation.

% 100

80

60

103 respondents
(37%) of 279
respondents

40

40

31
27

71

31
27

20

13
9

1 58 1 103 99   8 58 11 103 99

0

8   11   1 41 1 32 28

Active Participants   Not Actively Participating
In TQM Process   In TQM Activities

☐ Consultants
☐ Managers
☑ Hospital Doctors
☐ Nurses
■ Support Services Staff

○ = Total No. of Respondents

☐ = No. of respondents willing to be voluntary participants
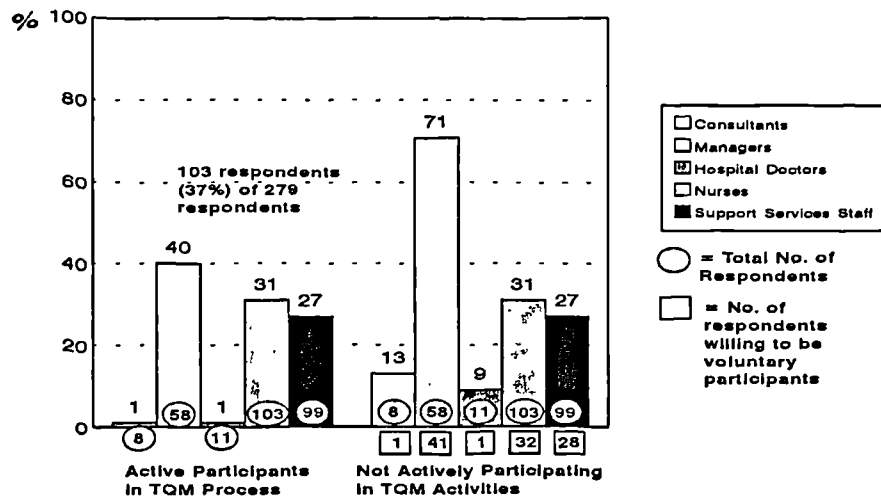
Figure 35   Breakdown of Respondents Willing to be Voluntary Participants in
TQM Process

It is clear from Figure 35, that by far the least willing group were hospital consultants and doctors (2%). Apart from time and work demands, a major reason given was preference for procedures aimed to discard and replace poor quality processes, in place of merely improving existing ones. Recognising limitation in attempting conclusion from a sample of but seven consultants and hospital doctors (interviewed), it was difficult not to conclude that discarding and replacing processes were directed at those other than their own.

Two Trusts provided evidence of consultants and doctors leading quality 'trials' and presenting results at quality training seminars for clinicians. One Unit General Manager saw these as important steps in influencing their Peers.

One Chief Executive advised recognition from the outset that not many consultants or doctors would be persuaded to participate or even support TQM process. She identified two major factors which had helped gain some support - the Trusts Clinical Manager (medicine) had been an enthusiastic member of the formative TQM strategy team, giving it credibility, and secondly, it was expressed from the outset that TQM would not impinge clinical judgement and procedures.

Material provided from one of the non-participating Trusts, referenced need for flexibility and responsiveness, when "mixing professionals with other staff", advising not to be "too rigid about it".

It is not unexpected, from data collected in the Trust Demonstration Sites and from pilot study earlier noted, that consultants and doctors, with their historic (Chapter 2) quasi independence of structure and accountability, traditionalism and sensitivity to power and control within the health care systems, may prove a particular challenge in the application of the proposed TQM paradigm.

The majority of active participants (92%) expressed opinion that TQM provided opportunity for shared understanding between policy makers, patients, purchasers, managers, clinicians and staff, of what quality in health care meant. Many non-participants (65%) claimed that TQM had missed this important opportunity.

A number of managers interviewed (59%) expressed disappointment that intangible results outweighed tangible expectation.

It was not uncommon for respondents to ask (both during interview and through returned questionnaires), the extent to which the Trust had provided budget to support TQM process. The researcher was unable to obtain detail regarding this question, other than DoH funding.

A number expressed concern of switch from emphasis on professional quality to emphasis on customer quality in strategies which support less professional expectation, than the needs of those they are aiming to service. An external customer-focused culture that lets the voice of the customer be heard poses new problems, it asks not only whether it is doing things right, but whether it is doing the right things for its customers.

Two interviewees, who were responsible for leading TQM in their respective Trusts, expressed opinion that for TQM to have real impact, it is essential for it to bring about fundamental change in basic culture, exampling in particular, the need to move beyond superficial and cosmetic activities to a detailed re-think of policy.

There were strong views from a number of senior management respondents for opportunity within TQM process to establish, in explicit terms, that what the Trust is trying to be and of the future it wishes to create.

A number of respondents (31%) felt their Trust was attempting to move too quickly with TQM, without first persuading staff of its merits, (53%) preferred a bottom-up approach in that it recognised need for energy and commitment from below, and were less vulnerable to changes at the top. Others (38%) preferred top-down models, which provided evidence of top management commitment, stronger focus and less risk of multiple directions in approach. There were accusations of "lip-service", in participants claiming they were doing something radical and revolutionary, when in fact they were doing something much the same as before (referencing quality control and quality assurance activities in particular).

Some expressed difficulty and some disbelief in the merits of seeking quantitative measures for qualitative experiences. Others questioned ability to cost specific activities characterised by complexity of the service performed and the environment in which it is provided.

A minimum (37%) thought of TQM as a driving force to survival and competitiveness. A much larger number (69%) believed that low costs took precedence in practice.

6.4   Opinion Concerning the Proposed Definition and Paradigm

The proposed definition and paradigm, Chapter 4 - 4.3, 4.4, was presented to each of the 47 Trust personnel who participated in in-depth interviews, to provide opportunity for explanation of questions (Appendix 15) and detailed probing to seek full response.

Opinion regarding the extent to which the definition and paradigm would likely facilitate organisation integration and totality instead of separation and segregation, and ability to inculcate common goal and strategic purpose were particularly sought, as was focus on identifying performance gaps in order to continuously strive to exceed prevailing standards.

The writer was encouraged by the majority (81%) who preferred the proposed TQM definition to their own and their reasons given. There was strong favour for its clarity of vision, organisational expectation, customer centred philosophy and strategic implication which values and respects people. There was strong opinion that the definition was supportive, rather than threatening to those who work in the Trust and it defined well the need for effective customer supplier relationships in the achievement of value satisfactions, quality perceptions and expectation.

Those less in favour of the definition (19%) claimed it to be ambiguous and poorly defined in terms of the quality of health care being offered and failure to prevent notion that some rate of poor outcomes are acceptable. There was criticism of failure to recognise and understand the many different core functions and values, each of which reflect needs and cultures. There was comment by four respondents (9%) of the definitions failure to recognise the Patient's Charter.

Although minority responses, it is clear that emphasis must be placed on intention for broad definition to provide for the development of mission statements which concern micro and macro matters of importance.

A majority (85%) supported the suggested stage by stage paradigm which they saw as a user friendly process for introducing, developing and maintaining TQM in the NHS, providing that explicit time targets were set and met for each stage, otherwise, the majority (77%)

warned, it would lose support and/or be overtaken by events. No-one thought that it placed overemphasis on professional standards, particularly quality systems, cost reduction or changing that which is already known rather than challenge to fundamental values. Opinion was that it would be regarded by users as proactive process.

Most (68%) felt strength of the paradigm in its potential for translating customer expectations into objectives and measurable service characteristics and to facilitate clarity between process and outcome quality. On the other hand, (23%) claimed it failed to sufficiently accommodate the needs of patient's relatives, referring GP's, health authorities and the public, and as such they would fail to become active participants in the TQM process. Others (28%) said that more emphasis should be placed on it as an organisation-wide integrating process requiring to involve all the directorates and departments in working together.

6.5   Summary and Key Findings

Although each Trust Demonstration Site had an explicit TQM definition, there was no evidence to suggest collaboration, each had styled their own. This apart there was consistency of focus concerning customers, suppliers, enabling staff, top management support, barrier breaking and building mutual trust. There were some which referenced challenge and competitiveness. There was strong support for the proposed TQM definition and reasons given, by those interviewed (direct interviews), for its clarity of purpose, vision, expectation, customer focus, and strategic implication of value and respect for people.

Although viewed as supportive of personnel and focussing need for sound customer supplier relationships in order to provide value satisfactions, quality perceptions and expectation, it is clear that further emphasis needs to be placed on intention to provide for mission statement(s) development which address micro in addition to macro aims and intentions.

No particular process model had been used, each had developed their own, most however showed strong links to guru and other theoretical models. Strong emphasis, in explanation,

was placed on particular stage or state which matched particular aspects of their definition. This apart there was strong support for the suggested staged paradigm, provided that explicit time targets were set and adhered to, for each of the stages. It was felt that it avoided over-emphasis on any one particular aspect of quality and would be seen as a pro-active process, by users.

Although viewed as a paradigm with potential for translating customer expectations into objectives and measurable service characteristics and facilitating clarity between process and outcome quality, it needs to emphasise more the needs of patients relatives, referring GP's, health authorities and the public at large. Equally, it was suggested, more emphasis needs to be placed on it as an organisation-wide integrating process.

Need for commitment to quality management leadership figured prominently, which top managers claimed to be providing, and significantly fewer personnel claimed to be receiving. There was evidence of Quality Councils and Quality Steering Groups as means of providing top management leadership and support. Where top management support was not visibly provided, personnel failed to see quality as high priority or quality programmes as serious issue.

Training was regarded as important, although training programmes varied from one day awareness seminars to five day awareness and action (methodology) workshops. Emphasis was placed on organisation-wide quality issues, exceeding quality control and quality assurance activities, with emphasis on external and internal customer supplier relationships and performance measurement. There was criticism of training programmes in their lack of direction to re-think health care provision in terms of continuous improvement, radical change and patient focussed care, a consequence of which, it was suggested, was limited activity concerning beginning to end care delivery process scrutiny, preferring instead incremental improvement. There was little focus on developing statistical method or

benchmarking procedure, some direction was provided concerning patient empowerment, but with little guidance for establishing methodology for application however.

Internal relations were expressed as major issue, but many respondents claimed that TQM had failed to break down barriers between directorates, departments and professionals. Team working was expressed both as major means for practising TQM and improving internal relations, but relatively few participated in them, or would wish to, they claimed, should they be provided the opportunity. Identifying and improving internal customer supplier relationships was seen as important means for improving work quality and quality of working, but many were critical of the lack of co-ordination and support in its application.

There was strong support for moving from health care services designed by experts to involving customers and suppliers, there was noticeable resistance however from consultants and hospital doctors. Concern was expressed in connection with emphasis switch from professional quality to customer quality, which supports less professional expectation and more those who they aim to service. Customer surveys were commonplace, which sought to establish views and complaints concerning services provided. Although there was reluctance to provide detailed findings from patient surveys, (despite guaranteed confidentiality), there was sufficient detail to suggest a pattern of complaints concerning quality of service, with respect to levels of care, staff attitudes, service availability, poor information, lack of participation, poor facilities and matters of hygiene and cleanliness. The Patient's Charter had prominence, some suggested, when setting TQM goals.

Need for reliable data was emphasised, to establish in a well defined and unambiguous way where quality of service was not provided. Standard setting and measurement was seen as an important TQM activity, but there was uncertainty of the way standards were used to improve quality performance and quality outcomes. A large majority were unable to provide information of measured improvement, resulting from TQM application. The adequacy of

quantitative measures for qualitative experiences were questioned as was NHS Trust ability to cost specific activities characterised by the complexity of the service performed and the environment in which it is provided. Most suggested that cost reduction took precedence to quality improvement in practice.

Consistent with Chapter 5, 5.1, pilot survey findings, the least willing participants in TQM process were consultants and doctors with some consistency of reasons given. Investigation in the TQM Demonstration Sites,however, noted their opinions for TQM to exceed the aim of improving existing services. There was also mention of need for clarity in TQM not intending to impinge clinical judgement and for flexibility and responsiveness to need when mixing professionals with other staff.

A large proportion of active participants expressed opinion that TQM provided opportunity for shared understanding between policy makers and interested parties concerning what quality in health care meant, but a majority of non-participants claimed that TQM had failed to achieve it. There was some expression that TQM is achieved when fundamental culture change has occurred moving from superficial activities to detailed re-think of policy in the establishment of Trust intention and the future it seeks to create.

Other than DoH funding there was no evidence of budget provision in support of TQM process, Joss, Kogan and Henkel (1994), suggested that inadequacy of funding is one reason for a lack of TQM success in the NHS. References were made to fewer tangible returns than intangible results following application.

There were references to TQM being introduced too quickly, in advance of persuading staff of its merits. There were mixed views concerning top-down or bottom-up introduction and application, most favoured the latter.

Drawing on the experiences of the demonstration sites investigated, it is clear that various approaches to TQM are taking place with varied amounts of support and success. No one particular definition has been agreed or process model applied. Importance lies in top management support and competency in providing quality management leadership and the availability of reliable information, responsive culture, effective and efficient planning and organisation, action and judgement. These are central to the suggested TQM paradigm. Consistency lies in recognition of internal/external customers and suppliers and value satisfaction attainment. The NHS reforms along with the Patient's Charter initiative noted in Chapter 2, target the requirements of users and purchasers in a way which suggests TQM is less a possibility than a requirement.

Training is important in providing a balance of knowledge and understanding and applications skills and competences. Failures and setbacks need to be a part of the development process, to further advance the processes of continuous improvement, radical change and patient focused care.

Although definitions and paradigms suggest total involvement in quality improvement and change, each Trust showed focus in particular areas where successes have been achieved. Contrary to views expounded by Crosby (1979), quality was not always free in that commitment to resources and money was essential for the processes to succeed. DoH funding had been used to support and finance those quality initiatives which had shown prospects of success, but it was clear that more emphasis needed to be placed on quality costing and performance measurement method to establish costs and returns.

CHAPTER 7   ANALYSIS: TQM DEFINITION AND PARADIGM IN PRACTICE

7.0   Introduction

Definition for quality performance developed and TQM paradigm proposed, Chapter 4, recognised that customer needs and business goals are inseparable. With post-Griffiths development of general management and total service delivery concepts, an environment was established in which TQM thinking became both relevant and attractive in helping to deliver health care services more effectively in terms of equity, access, efficiency, appropriateness and responsiveness.

The definition identifies quality vision as concern for providing value satisfactions perceived by the customer and the elimination of all aspects of waste in so doing. Quality, it is suggested, involves the practice of respect for people. Not inconsistent with message contained in the presidential address concerning the Institute for Health Services Management Annual Conference (1992), entitled 'Better Quality Better Health', organisations it was recommended, should move from doing things to people to a service which does things for people. Quality, it was pointed out, whether in the promotion of good health, or in primary, secondary or community care, can only be achieved through people. Managers have major responsibility, it was stated, for ensuring emphasis on people and meeting their aspirations as patients, carers and professionals in health care.

The bottom-up paradigm which it was suggested required top-down commitment and support is consistent with Tribus (1992) recommendation for winning the commitment of knowledge enthusiasts, rather than going through the formal power structures, focusing results in the form of services to the customer and the processes required to provide and sustain them. It could be argued that in a public funded NHS, the government is customer, through the agencies of health authorities, not the patient, and government focus on quality may differ from that of the customer. Consistent with earlier mentioned government reforms, with their patient focus, the customer has been identified for this research as external user (patient), purchaser (GP and others) and the public at large.

Primary data, Chapter 5 - 5.6, pilot study and Chapter 6, TQM Demonstration Sites, suggested support for the quality definition providing that ambiguity was avoided regarding quality health care and provided there was not risk of acceptance of some rate of poor outcomes. More emphasis, it was recommended, needed to be placed on definition as means for providing mission statement to account for different core functions, values, needs, cultures and charter intentions.

In support of the paradigm, which most felt was achievable within the planned research period, recommendation was for explicit time targets for each planned stage. Stronger emphasis on the integrative nature of the paradigm was also suggested to communicate it as a for all paradigm, aiming to involve all those associated (or potentially associated) with health care.

Brooks (1992), suggested that in contemplating TQM introduction and having identified the challenges to implementation in the NHS, the first issue was that of natural unit of implementation. It is clear that in order to achieve maximum impact, the NHS Management Executive should be seen to lead an NHS-wide initiative. The priorities of the Executive however, and their occasional conflicting political and managerial agendas, make such involvement unrealistic. Nor, it can be argued, is the development of managerial and organisational culture in the NHS (Chapter 2), sufficiently advanced to make an NHS-wide commitment to TQM practical. The proper unit for implementation then, might be the region, district or, more probable, the provider unit. Indeed, it is prerequisite for successful implementation, that the TQM unit is both discrete and self-sufficient.

The major thrust of investigation method described in Chapter 5, concerned evaluation research as means of providing a case Trust unit with step-by-step methodology for assessing appropriateness of the TQM definition and paradigm, by effectiveness of application.

The case Trust selected employed two thousand, three hundred and twenty personnel to serve a population of some one hundred and sixty five thousand residents and consisted of five hospitals. They shared a keen interest in TQM development, but had not reached any particular application stage. They were supportive of the proposed definition and paradigm and agreed collaboration in experimentation and implementation, beginning September 1992. One of the two earlier mentioned pilot study Trusts, who also undertook TQM application using the proposed definition and paradigm, commenced implementation during October 1992. They employed some two thousand seven hundred personnel to serve two hundred and eight thousand residents and consisted of four hospitals. Although not directly involving the researcher in application, they proved an invaluable means for comparisons. Comparison and summative evaluation was undertaken at different stage times, these were commitment stage, one month after commencement; deconstraining stage, a further three months; identification stage, four months; process and implementation stage, eleven months and evaluation stage, six months, involving those exposed to the various aspects and applications of the stages.

Experimental design in the form of providing different interventions with teams and groups established impact concerning mentor and facilitator support, whilst experimental and control teams and groups reduced risk concerning misinterpretation of reason for a number of outcomes.

Formative evaluation by on-going in-depth action research in the case Trust,involved the researcher in preparation, implementation, monitoring, testing, fine-tuning and maintenance activities, proving opportunity for thorough description of application and explanation, by seeking in particular, cause and effect relationships. Regular feedback from the Trust undertaking similar application was by means of telephone interview and stage reports. Feedback from the sixty-eight participating Hospitals/Trusts was by telephone interview and returned questionnaires, to compare and contrast detail concerning adoption and application and to establish views and attitudes concerning TQM appropriateness for achieving

continuous improvement, radical change and patient focused care. TQM training involving personnel from other hospitals/NHS Trusts provided detail concerning TQM expectation and implementation.

7.1   Commitment Stage

A number of recommendations concerning need for support leadership and clear direction for introducing TQM were noted in Chapter 3, placing strong emphasis on need for top-management to clearly communicate their commitment to quality by the way that they managed. To these was also added top clinicians. There was strong opinion in the demonstration sites that commitment to quality leadership was essential for ensuring quality profile and although (92%) of top managers said they gave it, some (68%) of those they manage, said that they didn't receive it. With the traditional hierarchical structures of the professions they manage, and the pressures of cost containment, difficulties were not unexpected regarding visible commitment necessary to lead and sustain TQM process. It was clear to the researcher that particular effort was needed at the formative stage to ensure explicit top, senior management and clinician support and that bottom-up process would influence the practice of TQM.

Crosby's quality management maturity grid, Chapter 3 - 3.2, concerns 'awakening' and 'enlightenment', whereby management become committed to quality. Evans (1992), suggests that any health authority can use the grid to evaluate its position. She views most Hospitals and other NHS organisations, as at the awakening stage, wherein management recognise that TQM may be of value, but are nevertheless only prepared to invest limited time and money. Her implication is that until recently (the 1990s), few have had a quality function and they have tended to fight particular problems as they arose. The costs of poor quality has rarely been used to draw attention to the scale of the problem.

The commitment stage began by holding a full-day TQM workshop away from Trust premises, involving fifteen Trust Board Executives and six Trust Management Team members. There were two absentees, the Director of Mental Health (on holiday) and the Director of children and Women Services (no reason given). This provided awareness training and explanation of proposed definition and paradigm, and forum for corporate consideration in the form of envisaged opportunities and threats resulting from TQM application. Strategic planning implications were identified concerning implementation and plans for personnel training established. A number of organisational strengths were also identified to facilitate TQM introduction and the organisational weaknesses which were likely to constrain it. A formal budget was considered, but majority view was that the means of NHS funding on a financial year basis could lead to an over-emphasis on short-term success and over-caution in taking on radical change commitments.

Both the Chairman and Chief Executive voiced intention for visible commitment and support, along with the Medical Director, Executive Director (Nursing) and Director of Operational Management. There were no apparent dissenters, although most gave the impression of reserving judgement.

It was agreed that TQM opportunities outweighed the threats, and the responsibility was theirs to set and share vision with their employees for bottom-up paradigm to succeed. Some Directorates-Personnel, Business Development, Clinical Support, Nursing and Community Services, had particular strengths concerning teamworking, quality control/assurance and quality circle activities.

It was decided that ten one-day TQM awareness workshops spread over a two-and-a-half working week period would provide opportunity for senior to middle managers, consultants, doctors, nurses (Senior Nursing Officer and above) and status equivalent support services staff to attend in vertical (organisation) sliced groups, to hear first-hand top managements' commitment to TQM definition expressed in terms of intention to seek excellence through

continuous improvement and radical change, and as means for encouraging mission statement or protocol development, which specify quality of health care values and seek to account for needs, culture and patient charter issues. The bottom-up paradigm was explained by the researcher, emphasising value of commitment from each of them in reflecting top managements support and intended responsiveness to their staff and others who focus quality care on internal/external customers and suppliers, the least of which is not patient focused care. A total of nine workshops were run involving four hundred and twenty employees in mixed groups, plus a workshop attended by twenty three consultants and doctors. Each workshop was led by two members of the Trust Board/Management Team and the researcher, on eight occasions one was a clinician.

In addition to providing understanding of TQM and explanation of the definition and paradigm to be used, intention also was to share the strategic implementation plan for the short, medium and long term. The participative aspects of the workshops provided ample opportunity for group questioning, discussion and debate concerning matters fundamental to TQM application. Information collected from these and that collected from in-depth individual interviews (Appendix 16), involving all Trust Board/Management Team members and forty five (10%) Trust personnel who had attended the workshops, in proportion representative of mix, provided invaluable data concerning statement based on ten points, Chapter 4 - 4.4, the commitment stage. A group meeting with the Personnel Manager, Project Development Manager, Clerical Support Administrator, Nursing and Community Services Managers provided a cross-section of views concerning practice of bottom-up approaches.

There was majority view (58%) that long term commitment was questionable in an NHS which suffers 'holy grail syndrome', believing that new ideas as they come along would be panacea for all its problems. There was certainly evidence of this as the research programme progressed from a number of the participating hospitals/NHS Trusts who sought

to move from TQM, to hospital process re-engineering, patient focussed care, risk management and managed care, as separate programmes and processes. Others believed that quality improvement would yield to cost reduction. There was reference to the Chief Executive as driving force behind the initiative and question of *likely effect should he leave* the Trust. (It is of importance to note, that it is later reported that he accepted early retirement some fourteen months into TQM application.)

Most (87%), claimed existence of organisation, management and culture barriers to continuous improvement and radical change, which they said were not conducive to TQM. Self-interests, own territories, bureaucracy and organisation politics were particularly mentioned, with strong reference to groups and individuals who with divergent interests created tension and conflict. The definition and paradigm when explained was seen as potentially helpful to the organisation environment in that they would provide for concise statements of mission to answer questions of who and what we are, statements of vision answering questions of who and what we seek to become and providing understanding of quality meaning in the context of the Trust organisation. The explicit paradigm stages were accepted as guidelines for management, making clear the process expectation. The paradigm goal was projected, not merely as paper statement but as means for seeking to connect understanding of it with the daily tasks of each Trust employee.

There was strong suggestion that the 'Deconstraining Stage' must closely diagnose and improve the Trust organisation in this context, before any attempts were made at large scale TQM introduction.

Although intent was to make TQM high profile, only a minority (28%) could envisage commitment to people involvement whatever their work pressures. This apart, there was strong suggestion of on-going commitment in the form of time set aside for regular team meetings, fact finding and reporting, for example.

A focal-point leader for the TQM initiative was seen as a fundamental necessity. Some suggested the appointment of a Director of Quality, others a Director of Nursing/Quality. Costs, likely limitation concerning availability of applicants with a combination of TQM and health care experience at the level required, difficulties of organisational fit in terms of reporting lines of communications and responsibilities, conflict of interests between emphasis placed on nursing and quality matters ... resulted in the Director of Operational Management taking focal point responsibility.

Mentoring and facilitating groups, teams and individuals was seen by most (79%) as essential, particularly in the formative stages, suggestion was that TQM facilitators be sought and trained, (which is not dissimilar to the earlier reported demonstration site Trust, who during their first application stage had formed a small support unit). It was agreed that one full-time facilitator would be seconded from operational management and five part-time facilitators (available for one day each week) from management, doctors, nursing and two from support services personnel. This involved a Human Resource Manager, Junior Hospital Doctor, Senior Nursing Officer, Complaints Officer and a Portering Services Superintendent. The agreed trial period was for six months with an envisaged extension for a further six months should demand require it, (this proved to be invaluable, and with the exception of the junior doctor who was replaced by a Medical Registrar, time was extended to cover the whole investigation period).

Training, involving the researcher, was undertaken by Personnel Department and Operational Management staff. Their roles were to note, record and draw attention to poor quality of service through observation and liaison with patients, family members, Trust personnel and GP/Health authority purchasers and to mentor and facilitate towards prevention of reoccurrence. They were also instrumental in developing, maintaining and facilitating continuous improvement and radical change teams and in co-ordinating the formation of steering groups for team presentations and feedback. Additionally they were much

appreciated by the researcher, in their attempts to provide him with understanding of internal and external Trust 'politics'!

Protocols for managing information were discussed in each workshop with emphasis placed on information availability and sharing, on a need to act basis to underpin TQM process. It was not the intention for the investigation to explore the merits of, or route choices for, complete hospital information support systems (HISS), nor The Information Management and Technology Strategy (1992) which set a target of the year 2000 for all acute hospitals to have integrated systems. Focus was however directed towards the availability and use of information which reflected and supported the TQM approach and identified the *benefits* of quality service which derived from it.

A little more than half (52%) felt they were not well informed about what was happening in their Trust, more (65%) said that stronger information channels were needed if the public were to influence quality of service in the form of empowerment rather than merely consultation. Need for more information focus concerning the effectiveness and efficiency of clinical treatments, developing ideas about effectiveness and sharing them was *recommended.*

Standards of information within the Trust were discussed as Key Trust objective, pointing out need for valid, appropriate, available, acceptable, accurate, up-to-date and timely information. There were mixed views by those interviewed concerning information standards, (47%) thought they were less than satisfactory to paradigm expectation. A major thrust of TQM process it was agreed, was to establish means to get information across consultants, doctors, nurses and others and to get them to use it.

One Executive Director expressed the view that, what was special about care was the quality of it,the value for money achieved when delivered, the accountability for it, and the ability to monitor and accredit the services.

A considerable number (43%) said they were resentful to feeling unable to voice concern, believing that the principles which gave employees the right to speak out were being eroded by new contracts restricting freedom of speech in the name of commercial confidentiality. Throughout the investigation period, the researcher observed this resentfulness which, it is pointed out, did not decline following introduction of the NHS Management Executive publication 'Guidance For Staff On Relations With The Public and The Media' (1993), which provided assurances that under no circumstances would employees be penalised for expressing views concerning health service issues in accordance with its guidelines.

More than half (56%) regarded relationships with customers, suppliers and co-workers in terms no less monolithic than competition between hospitals and purchasers, (76%) compared with (37%) in demonstration site investigations, favoured TQM as a driving force for survival and competitiveness. This was particularly expressed in terms of process for establishing effective methods for consulting and involving users, purchasers, suppliers, co-workers and the public more in matters which relate to design and delivery of service. There was also a *more positive response and level of realism from consultants and doctors* in this respect than that recorded in any of the demonstration sites.

A majority (62%) believed there were benefits to be gained by the Trust providing care through a mixed economy of services, some public and some private, by going out and winning business elsewhere. Possibilities were expressed of using TQM in developing quality of care models which the population should be exposed to, even though traditional style and structure may be challenged. A fundholding GP, later interviewed during the Identification Stage, made reference to the Trusts' inability to provide a number of quality services and their unwillingness to negotiate price. In order to reduce waiting lists, it was claimed, and to receive high quality care, he had negotiated a contract with another Trust which met his needs.

It will be noted later however, that although voiced support for competition and fuller involvement of others was strong, intention to practice them were weak.

Others expressed concern that pressures created by the internal market had begun to undermine the ethos, and challenge the values that put care before costs, which had, they claimed, made the NHS special.

A number of consultants and doctors also raised concern that competition with others could make them cautious with regard to the kind of patients they took on. The consequences on results from taking on difficult surgery, they pointed out, would not be good compared with less complicated work. Judging on quality of success alone, they warned, might result in them being more selective. Competition was voiced as an important issue from which competitive forces, value for money and increased throughput well fit Figure 29, the link between TQM and benchmarking. Whether favouring competition or not, care in the NHS is the integrated care of other people, TQM was favourably viewed in these terms.

A number of those interviewed (23%) drew attention to TQM potential for developing customer-led audit, in preference to customer satisfaction surveys. Customer-led audit, they pointed out, involved method for placing equal weight on customer's and local people's views in terms of value satisfactions, with those of the professionals and their co-workers, in assisting purchasers to detail future contracts and enabling providers to be more responsive to user needs and expectations.

Without suggesting customer-led audit as an alternative, a majority (55%) were critical of customer satisfaction surveys as means for assessing service quality, in that actual satisfaction remained blurred, quality was assumed to be high and improvements were rarely considered, let alone implemented.

There was significant (71%) reference to the use of Charters for improving services, particularly through value in the form of public statements of rights and the means available for strengthening relationships with customers, suppliers and co-workers.

User-inspired charters were referred to as means for promoting empowerment and partnership. The 'Identification Stage' of the TQM paradigm was suggested as opportunity for bringing people together to collectively share experience of services, in belief that experiences would be improved for the benefit of others. A number of group discussions, during TQM awareness workshops recommended caution with staff empowerment, exampling employment uncertainty. Reference was made to a number of Trusts, where it was stated, (supported by media and journal articles), that empowerment had cost people their jobs. This apart, a majority (59%), expressed TQM process as requiring conditions which enable and encourage staff to achieve TQM definition, mission, values and quality health care.

The Scottish Office, Framework for Action (1991) for the NHS in Scotland, was introduced for awareness workshop discussions, in which staff empowerment was identified as 'core value'. Note was taken of definition for empowerment as:

> "enabling those who work in the service to achieve its purpose, share its values and feel valued themselves".

Although the health service has been deluged with messages of consumerism since the NHS and Community Care Act (1990) noted earlier, in which there is duty to consult users and carers, and despite existence of policy document concerning quality assurance and customer relations and a Regional Officer with responsibilities in this area, evidence was such to suggest customer involvement in the Trust was little more than notional. Group discussion and individual interview provided numerous suggestions for need and means for empowering users and purchasers in place of consulting them only, but policy was absent for practising

it, which most thought would result in difficulties for both managers and professionals. This is not to suggest rejection of empowerment as part of TQM process, but recognition that for it to become part of service provision, the onus was on organisation, management and culture change rather than preparing users and purchasers only, to accommodate it. Consistent with these points, Rodgers (1994) later suggested that advocacy and empowerment influence services from the bottom up and should not be regarded as one-off exercises. Recommendation, was from those referencing empowerment, that the identification stage should take cognizance of requirements necessary for patients (users) and purchaser empowerment.

The importance of small improvements and large scale radical change were discussed at the TQM awareness workshops and in group discussions and interviews which followed. The majority (73%) said that both should be seen as of equal importance, (64%) conditioned this by emphasising that small scale improvements must concern continuous quality improvement and patient focus, whilst large scale radical change should concern process, sequence, and the combination of activities which delivers value to users and purchasers. Process focus is not inconsistent with earlier noted description of BPR, Hammer and Champy (1993), concerning one or more inputs into one or more value adding activities leading to one or more outputs.

Consistent with findings from Demonstration Site investigations, a number of consultants, doctors and top managers were attracted to paradigm which extended beyond continuous and incremental change. Some expressed expectation of early tangible returns to justify costs and time spent preparing for and implementing TQM process.

Most (78%) felt that expectation for detail of target sectors, customer, market and service position was on-going Trust expectation and involved activities concerning Strategic Planning Teams, Resource Management and Information Technology Departments.

Although it was recommended that TQM process would benefit from a strong liaison with these teams and departments a minority only (8%) expressed need for TQM to take responsibility for ensuring regularity of information for informing Trust employees and their users/purchasers, of the corporate and strategic thrust, and direction.

Issue concerning competitiveness, customer-led audit, user inspired charters, patient and user empowerment have been earlier noted, and references made in Chapter 3 - 3.5, for operationalising service quality in terms of expectation and perception. Difficulties were noted concerning confusion between process quality and outcome quality. It was not surprising therefore that by far the most contentious part of group discussion during awareness training and the interviews which followed, concerned performance monitoring against customer needs and expectations.

Three earlier noted approaches were considered for quality measurement concerning structure, process and outcome (ie. Donabedian, 1988), and the extent to which they were both complementary and appropriate for measuring the quality of care. Considerable concern was voiced with respect to performance monitoring, the least of which were not reliability of data, appropriate levels at which personnel should participate, extent to which non-clinicians were competent to draw conclusions concerning medical care and issues of high quality service needing to satisfy a variety of requirements, later supported by Øvretveit (1993), and noted in Chapter 3 - 3.5. After considerable discussion and debate, assisted by reference to literature, there was agreement in part for method which targeted the end result of process, p or procedure delivered in the form of improving medical status, of the patient as indicator of quality of care rendered during the time that the patient was involved with the Trust. A study of end result (outcome), it was suggested, would provide information concerning where problems occurred, and identify the means for preventing their reoccurrence. Outcome measures were seen as systematic and closely related to process quality, hence attempts to improve structure and process were needed to have a positive effect on outcome and vice versa.

In addition to direct care outcomes, there was suggestion for focus on behavioural, physiological and psychosocial outcome measures (Jennings, 1991), concerning rehabilitation potential, functional status and quality of life issues, so as to provide fuller understanding of value satisfactions perceived, particularly by the user, and by the purchasers and public at large. A number expressed preference for Department of Health, health service indicators (HSI's) whilst others were critical of their lack of quality detail and relevance. Attention was drawn to patient focus by using medical audit procedure, but a number claimed difficulty in using this in relation to strategic planning, resource management and operational decisionmaking. Not inconsistent with demonstration site results, there was support (51%) for performance monitoring procedure being recommended by those directly concerned with continuous improvement, radical change and performance focussed care activities, providing that it fell within an agreed framework and was supported by top management. In accordance with recommendation made by Coles (1990) need was expressed for managers and clinicians bringing together outcome measures and information concerning both process and input, in order to address overall issues of effectiveness.

Implicit in this, was need to reduce the large quantity of data to that which is manageable and interpretable. To these ends, it was agreed that the facilitators would seek to facilitate clinicians and managers in sharing common perspective to achieve common interest, namely, better quality service for the user and purchaser. Ellwood (1988) suggested common perspective in terms of:

- patients worried about the sensitivity of quality care to the levels of resource available;

- purchasers concerned about variations in practice and performance between providers;

- information systems which increasingly record the cost of that done to patients, but not why it is done or the outcome;

■ difficulties concerning accuracy of prognosis as medical complexity increases and consultants/doctors become more concerned with recognising broader issues of patient needs.

Following Ellwood's analysis of these points, a framework was produced for outcome management, Table 5, which the case Trust Board Executive and Management Team Members agreed should form a basis for collaborative action.

(i) Outcome management to provide widely accepted guidelines and standards which consultants and doctors can use in determining appropriate interventions in the process of delivering medical care.

(ii) Over routine and periodic time intervals, outcome management to provide the skills and tools required to measure the status and well being of patients, both clinically and functionally.

(iii) Information on pooled clinical and outcome data to be available on large data base.

(iv) Wide dissemination of information, customised as appropriate for decision makers and updated and modified to reflect changes in technologies, philosophies and expectation.

Table 5   Framework for and Benefits of Outcome Management (Ellwood, 1988)

Feedback was provided for all four hundred and sixty four workshop participants and those who had participated in direct interview but who had yet to attend workshop training, that the proposed framework was for guidance purposes and that outcome indicators developed required to concern effectiveness, appropriateness and efficiency of health care provision.

Rowland and Rowland (1992) recommended application of outcome measures as total measures in that they required to measure end result of process delivered, and resources involved (the elimination of waste). Recommendation was for outcome measures to improve the health status of the patient and through it provide value satisfaction of quality service for both them and the purchaser. Rowland and Rowland's recommendations were

211

detailed to assist those later involved with continuous improvement, radical change and patient focused care, at the Process and Implementation and Evaluation stages, in seeking the desired outcome of patients' encounters in the form of improved health status relative to their health status before their encounter. The degree of this desired improvement, it was pointed out, is dependent on patient expectations and perceptions, (value satisfactions), together with the efforts of the health care team in meeting them.

Herein, it was further pointed out, lies the difference between measuring the outcome of process and managing total patient outcome. The process of outcome measurement seeks to target patient episodes as process in continuum, wherein outcome management requires to view outcomes as total process seeking to establish the extent to which the continuous improvement of patient care is established from health promotion, patient education, clinical intervention and follow-up through to rehabilitation.

TQM awareness seminars which followed and preparation for the subsequent stages, required that the framework, Table 5, be revisited to establish procedure for monitoring performance. It was illogical to assume that the type of performance measurement system which is appropriate one day may be on the next! In addition and during the early part of the process and implementation stage, data collection concerning four hundred and seventy English hospitals/Trusts and ambulance service league tables became prominent. These were later published by the DoH in June 1994, detailing performance results against twenty three standard measures. They also provided detail of ambulance arrival times within the Orcon standards of fourteen minutes for urban services and nineteen minutes in rural areas. The writer believes that Garvin's (1987) suggestion that multiple perception can be organisationally beneficial, is put to the test somewhat, in context of NHS performance measurement and evaluation.

It was clear from pilot study and analysis of demonstration sites that consultants and doctors failed to respond well to TQM process. Traditional NHS quality review seems to have largely developed from implied expectation that clinicians are largely sole determinants of quality health care. Merry (1990), suggests that in place of retrospective review of individual patients, analysis of statistical data is primary focus for review. There is not suggestion that case review is unimportant, but rather that focus is now more epidemiologic, towards common denominator, than individual case.

Identification stage, later provided methodology to augment subjective review of cases by clinicians, in the form of brainstorming, 'fish-bone' diagrams, six-word analysis, pareto charts and others.

A principle we sought at the 'Commitment Stage' was to avoid TQM implementation without clinician participation, recognising their potential impact as decision makers and problem solvers on, and preferably within, the total process. The challenge was to convince them of that, and the potential benefits to be gained from their participation.

The first paradigm stage involved thirty five Trust consultants and doctors in TQM awareness training, discussion group activity and ten in direct interview. Twenty three (66%) supported moving to the next stage, providing the names of staff for TQM training. Five (14%) said they were likely to support it, whilst seven (20%), stated they were unlikely to support it, giving reason of, marked departure from practice, incompatibility with clinical function, disbelief of longer term support, time pressures and attempt to impose industrial practice into service culture.

Excluding Trust Board Executive and Management Team Members, whose support had been earlier noted, by far the majority (76%) of those this far involved, were in favour of proceeding to the 'Deconstraining Stage', Figure 36.

% 100

	62	74	70	89	85

Legend:
- ☐ Consultants
- ☐ Managers
- ☒ Hospital Doctors
- ☐ Nurses
- ■ Support Services Staff
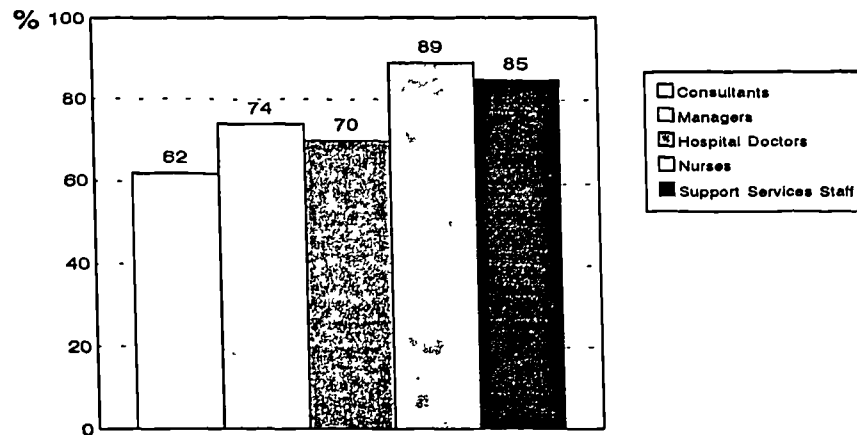
Figure 36   Breakdown of Respondents by Category (other than Trust Board Executive and Management Team Members) in favour of Proceeding to Next TQM Process Stage

Telephone interview with a named person responsible for quality management at sixty eight hospitals/NHS Trusts, suggested that eighteen had implemented TQM, twenty-one were about to implement it, sixteen were 'positively' thinking about it and thirteen were undecided whether or not to continue with quality assurance focus. Each agreed to the researcher making further contact with them over the planned research programme period. Postal questionnaires (Appendix 17) were sent to those about to begin TQM or at the point of giving it consideration and (Appendix 18) to those undertaking it.

Table 6 indicates reason for TQM application from those claiming involvement. Responses relate to 3 and 4 scores, question 1 (Appendices 17 and 18).

A total of sixteen TQM definitions, quality policy or mission statements were received. Although all were different, there was commonality of focus concerning total involvement of people, customers and need for improvements in quality performance. Some (25%) were general (non-detailed) statements, and were, to the researcher, somewhat confusing in terms of intent. Others (38%) communicated a distinct mismatch between intention for TQM and reasons given for undertaking it, (Appendix 18, question 1), by the named respondent, responsible for quality management.

214

REASON FOR UNDERTAKING TQM: TO-	PERCENTAGE RESPONSES		
	Score 3	Score 4	Total
Achieve ISO 9000/BS 5750	22	11	33
Assist with standards setting	5	0	5
Ensure conformity to standards	28	22	40
Reduce costs	28	17	45
Provide reason for everyone striving for excellence	50	44	94
Get a more effective complaints procedure	11	11	22
Save time	5	33	38
Involve more people in quality matters	55	45	100
Link with audit procedures	11	28	39
Better satisfy: Patients	22	78	100
Purchasers	22	72	94
The Public	17	17	34
Suppliers	22	11	33
Build on teamworking/ quality circle activities	0	17	17·
Improve productivity performance Added to the list by some respondents	0	5	5
Motivate staff	5	28	33
Breakdown barriers	11	33	44

Table 6

Analysis of Postal Questionnaire Results Returned from Eighteen
Hospitals/NHS Trusts Involved with TQM Application
(September/October 1992)

Table 7 indicates likely reason for application from those about to begin and those

contemplating TQM.

REASON FOR CONSIDERING TQM APPLICATION: TO-	PERCENTAGE RESPONSES		
	Score 3	Score 4	Total
Achieve ISO 9000/BS 5750	14	11	25
Assist with standards setting	8	5	13
Ensure conformity to standards	8	14	22
Reduce costs	24	27	51
Provide reason for everyone striving for excellence	54	41	95
Get a more effective complaints procedure	16	11	37
Save time	24	30	54
Involve more people in quality matters	32	39	71
Better satisfy: Patients	38	62	100
Purchasers	16	77	93
The Public	22	19	41
Suppliers	38	14	52
Motivate and recognise staff*	8	11	19
Breakdown barriers*	0	43	43
* added to the list by some respondents			

Table 7

Analysis of Postal Questionnaire Results Returned from Thirty-Seven
Hospitals/NHS Trusts, Possibly Going to Commence TQM Application
(September/October 1992)

A total of seven TQM definitions, quality policy or mission statements were received from those who claimed intention to commence TQM. One was identical in wording to a TQM mission statement received earlier from one of the NHS Trust Demonstration Sites. Two were lengthy (198 and 221 words in length) and poorly detailed in terms of intent. Three closely matched intention for TQM with emphasis placed on possible reasons for undertaking it (Appendix 17, question 1), by the named respondent, responsible for quality management.

Interesting that it may be to note closeness of response with those reported from NHS Demonstration Sites, Chapter 6, and points taken from literature, Chapter 3, concerning customers, suppliers, teamworking, people involvement, and barrier breaking, to name but a few, main concern was to establish data which identified reason for TQM application against which process stage activities could be compared and successes noted. In addition, the data also provided useful comparison with the TQM stage applications undertaken in the case Trust.

Five hospitals/Trusts (28%) claimed to be at first stage TQM application, seven (39%) indicated they were at the second stage, four (22%) the third stage and two (11%) at stage four. Table 8 indicates the views of those with stage 1 <u>experience</u> and views also concerning stage 1 <u>expectation</u>, from those not practising TQM.

TQM Process Activity	% claiming application	% expecting application	TQM Process Activity	% claiming application	% expecting application
Strategic focus:	94	100	TQM training:	100	100
Preparing the organisation:	22	24	Brainstorming:	22	26
Preparing management:	67	76	Seeking top management commitment:	89	100
Preparing others:	44	51	Focus on: internal politics:	33	11
Preparing culture:	17	35			
Teamworking:	72	76	external politics:	22	5
Standards setting:	56	54	Communication Systems - Internal	72	86
ISO 9000/BS 5750:	27	19	- External	50	70

Table 8

Stage 1 TQM Process Activities.
Analysis of Questionnaire Results Returned from Eighteen Hospitals/NHS Trusts Involved
with TQM Application, and Thirty Seven Hospitals/NHS Trusts Possibly
Going to Commence TQM Application
(September/October 1992)

There were similarities between those applying TQM and those likely to implement it, with regard to stage one process activities, exception being in 'preparing culture', where more emphasis was expected than practised, and concern for 'politics', where there was more applications emphasis than expected. One of the major concerns expressed by those interviewed was the extent to which TQM might be constrained by political policy making.

A number of first stage activities undertaken well matched reasons provided for TQM application noted in Tables 6 and 7, and inparticular those concerning ISO 9000/BS 5750, the involvement of people in quality matters and striving for excellence and in addition the emphasis placed on internal/external customers and suppliers. There was, on the other hand, more concern with standard setting practice than reason had implied, and little activity concerning quality costing as means for establishing TQM success in reducing costs through quality improvement.

Seven reported lack of success in preparing management for TQM, reporting problems which concerned senior management response who, most suggested, could have been more persuasive in gaining middle management support. Four who had reported internal politics as part of TQM process activities implied they had spent too much time in fractious discussion with individuals who failed to support TQM at a time cost spent with those who volunteered support. Most respondents (72%) said that, with hindsight, they had attempted too many activities during first stage application, particularly in terms of time scale suggested (Appendix 18, question 2).

Table 9 indicates the views of those with stage 2 experience and from those not practising it. Teamworking; ISO 9000/BS 5750; TQM Training; Brainstorming; Internal/External Politics and Internal/External Communication Systems were reported as "on-going", by those involved with stage 2 application.

TQM Process Activity	% claiming application	% expecting application	TQM Process Activity	% claiming application	% expecting application
Preparing the organisation:	69	74	Audit:	15	17
Preparing management:	31	24	Information/data collection:	85	100
Preparing others:	54	48	Statistical method:	8	10
Preparing culture:	77	33	Cause/effect analysis:	62	45
Continuous quality improvement:	100	95	Benchmarking:	15	7
			Pareto analysis:	69	38
Leadership development:	46	52	Method for voicing concern:	77	74
Staff empowerment:	38	24	Focus on:		
Facilitator/Mentor development:	31	21	- Internal politics	-	45
Problem solving procedure:	92	81	- External politics	-	52
Problem prevention procedure:	85	74			
Standards setting:	38	45			

Table 9

Stage 2 TQM Process Activities.
Analysis of Questionnaire Results Returned from Thirteen Hospitals/NHS Trusts
Involved with TQM Application, and Forty-Two Hospitals/NHS Trusts Possibly
Going to Commence TQM Application or at Stage 1 with Application
(September/October 1992)

There was a distinct similarity between the Trusts' applying Stage 2 TQM with those who had not exceeded Stage 1 and those possibly going to implement it, with regard to Stage 2 process activities, with exception, as earlier reported, to 'preparing culture', which most targeted during Stage 2 application. There were some differences between application and expectation concerning staff empowerment, benchmarking and pareto analysis, suggesting that knowledge, understanding and competences gained from application, changed views concerning that which was expected. There was little practical or expected application of audit, statistical method or benchmarking during the first stages and none recorded concerning radical change, patient focussed care, patient empowerment, handling complaints, patient charter focus, performance measurement, quality costing or reference to rewards and recognition.

Three complained that top management support was more concerned with reaction to market forces, by customer imposed quality than issue concerning internal customers and suppliers. One exampled poor support for employees to attend quality circle meetings and reluctance to release people to attend "action training" whilst another was concerned with too much emphasis on quality system (ISO 9000/BS 5750), being "market driven". One wrote on the returned questionnaire, that her opinion was that "too many managers viewed quality and TQM as 'necessary evil', and a user of valuable resources".

Two claimed that much of the original commitment had gone and were questioning the "process model", which they were following (both 'models' were named, and are known to the researcher). One claimed that TQM was losing impetus and that they may be better to concern themselves more with Hospital Process Re-Engineering or "something else". Six respondents made no reference to problems experienced in connection with Stage 2 application.

Analysis of findings from the fifty-five Hospitals/NHS Trusts with regard to Stage 1 TQM application suggested similarities and differences, compared with the 'Commitment Stage' of the TQM paradigm undertaken in the Case Trust. There was customer and supplier focus, emphasis on top management commitment, training and recognition of need for communication (information) systems. But despite a large number (94%) claiming strategic focus, subsequent telephone interviews suggested more were concerned with tactical activities than strategic orientation.

First stage paradigm application in the case Trust avoided preoccupation with standard setting (normally quality control/quality assurance activity) and ISO 9000/BS 5750 systems, both of which, the writers previous experience has shown, diminish attention to TQM strategy and commitment. ISO 9000/BS 5750 prompt conformance to requirements rather

than continuous improvement. Most traditional approaches to quality, Coulson-Thomas (1992) suggest, especially those which use these standards, tend to become bureaucratic, and in themselves are unlikely to differentiate an organisation in the marketplace. They can, they point out, be achieved by organisations which fall short of benchmark status and world class experience.

Teamworking a most important part of TQM was not considered until later stages wherein emphasis was placed on identifying barriers and problems which if left unsolved would limit application and integration of definition and paradigm. These concerned audit, patient charter, performance measurement matters, staff, user, purchaser empowerment and intent concerning continuous improvement and radical change. The strength of the commitment stage was in top/senior personnel focus on TQM strategy and in bringing barriers and problems out into the open, which if left unsolved would likely constrain TQM implementation. Recognition was that TQM facilitator role would prove to be invaluable with those contrariant to solutions.

7.2   Deconstraining Stage

Feigenbaum (1951), Chapter 3 - 3.2, sought total approach to quality requiring the involvement of all functions, perceiving the need to interconnect activities which impinge the provision of quality for the customer. Essential to this is attention to human direction and culture in the delivery process. Barriers between departments, it was noted earlier, have their own different agendas and priorities. The workforce in a hospital, it was suggested, Chapter 2, consists of many professional groups with relatively high levels of autonomy in their actions. There is no clearly defined protocol or algorithm which describes their work, which flows horizontally, more than vertically, in that customers move between departments. Communication then is key to integrating them and ensuring that the process ensures and provides quality of service. Purchasing and providing health care have been presented as processes. A number of references were earlier made, Chapter 3, to employee responsibility in determining and ensuring work processes which meet the needs of the

customer. A fundamental part of the TQM paradigm, it is suggested, is that decisions concerning quality of care need to be made at the lowest possible point in the organisation, unless it can be demonstrated that they need to be made elsewhere. Employee development is means for ensuring that quality is seen as individual responsibility.

Direct interview with senior management and clinicians towards the end of the commitment stage (Appendix 16, question 3), sought to establish views concerning organisation and culture issue, an essential part of the deconstraining stage, in that when an organisation seeks continuous improvement and radical change it requires to take an objective view of its current stage, so as to seek to determine scope for change. We sought also to establish support for the bottom-up approach and scope for application of internal customer/supplier chains aiming to improve quality throughout the Trust. Intention was to establish the extent of culture change likely to emerge from the mechanistic and structured organisation. Concern was to avoid need to deliver short-term payoffs amongst a plethora of restructuring which could have obscured the long term sustained change necessary for supporting continuous improvement and radical change.

Most (72%) supported the notion for employee development in providing opportunity to attend TQM training voluntarily providing that work quality was maintained during their absence. A minority (19%) voiced likely support and intention to encourage staff volunteers, (9%) said they did not support it, mainly stating as reason, work pressures outweighing likely advantages and questioning long-term commitment, noted earlier. Consistent with that found during demonstration site survey, most (87%) favoured the notion of vertical (organisation) attendance, which aimed to reduce barriers caused by seniority and status, providing that we were not too insistent about it.

Training programmes involving eight hundred and forty three Trust employees, nine GPs, four Health Authority staff, three Community Health Council members, one non-Executive

Trust Board Member and six patients who had expressed interest, were run over seventeen half-days, in group sizes of approximately fifty people. Each department was represented with the exception of the Library, Chiropody and the Alcoholic Clinic. One further programme involved eleven consultants and doctors from twenty two specialism, one for twenty seven middle managers and a further programme for fifteen trade union and health and safety representatives. Each were led by a top manager and/or clinician and a senior manager and/or clinician. Also in attendance was a TQM facilitator, and on fourteen occasions the researcher. From the 5th September to the 23rd October 1992, a total of one thousand, three hundred and sixty (59%) Trust personnel had attended TQM awareness training of a half or full day duration. A further seventy three employees attended subsequent training programmes during the application stages and fifty one employees claimed they had attended training courses elsewhere.

Direct interview with senior management and clinicians showed support (93%) for top management and clinicians openly committing the Trust to TQM and everyone being provided with copies of definition and paradigm which required explanation in strategic and tactical terms, at the awareness training workshops. In addition, definition and paradigm, with accompanying letter (Appendix 19), were sent to all non-participants, GP, HA and other purchasers and displayed at various points in the Trust organisation.

Each training programme concerned education in explanation of why TQM was being applied and training in the form of what to do and how to do it. Macdonald (1992) recommends that education should create the environment in which employees are motivated to implement improvement in practice, illustrating the educational element in TQM courses needed before implementation should begin, Figure 37.

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┌─────────────────────────────────────────────────────────────────────┐
│  ┌──────────────┐        ┌──────────────┐        ┌──────────────────┐ │
│  │  EDUCATION   │   +    │  TRAINING    │   =    │   IMPROVEMENTS    │ │
│  └──────────────┘        └──────────────┘        └──────────────────┘ │
│   ■ Awareness             ■ Appropriate skills    ■ Continuous quality │
│   ■ Need                  ■ Managing change         improvement        │
│   ■ Common culture                                ■ Change             │
└─────────────────────────────────────────────────────────────────────┘
```
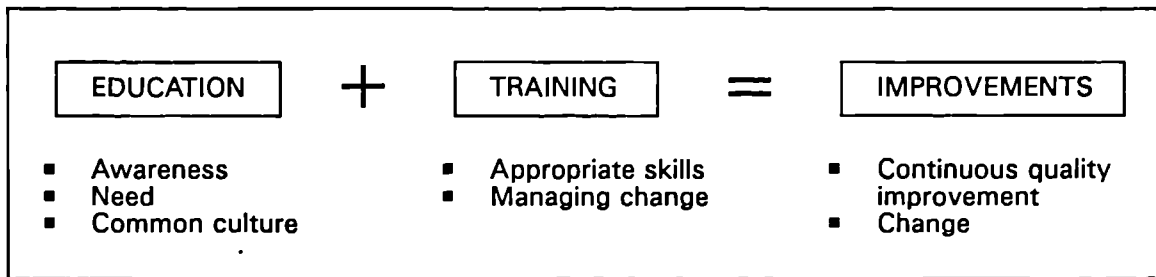
Figure 37

Education Creating Environment To Implement Improvements (Macdonald (1992))
TQM - Does It Always Work? Harper

The education element aims to develop individual's awareness towards taking ownership of the need to change and taking part in common culture. The awareness, Macdonald suggests, seeks to induce individuals to learn the skills of using communications and problem solving tools. Some 'selected people', he points out, will additionally need to know how to manage change and thereby require additional training. A most important issue noted for the TQM awareness training workshops was recognition that education and training, though distinct, were not separate in that each programme included both elements. Education and training was led by the TQM facilitator, supported by the researcher.

The future culture of organisations' who have as objective continuous improvement and radical change, it was noted, Chapter 3, requires to be shared culture between manager and employee seeking for every individual sharing the values of the organisation and the knowledge and skills of how to put improvement and change into practice. In contrast to content noted in the majority of 'TQM Awareness Seminars'; 'Action Workshops' and 'Appreciation Courses' collected and observed, Chapter 6 - 6.2, which had tendency to target a large and wide spread of concepts and tools it was decided to break TQM into a number of small bites and practice them at the awareness stage and the stages which followed and in particular with team development.

To begin to develop meaningful communications one and a half hours were set aside for group discussion and ideas sharing in each of the half-day training programmes. The shared values sought to encompass the purpose of TQM in connection with the Trusts' strategic focus and couple the supporting principles which aimed to define behaviour patterns expected to achieve common purpose. The shared knowledge and understanding aimed to provide common language to maximise the power of individuals and the use of improvement tools to communicate objectively about problems and opportunities. Recognising that we could not commit any employee to TQM, intention was to make it easier for employees to commit themselves. To these ends, we sought commitment through motivation and confidence, by displaying at the early paradigm stage, little more than expectation of them.

An important part of the deconstraining stage concerned team ownership of TQM in the form of staff empowered department/functional, cross-functional, professional and inter-organisational teams, whereupon the aspects of the ten-point statement concerning leadership, internal relations, people involvement, mentoring and commitment to responsiveness were to be practised. Direct interview with senior management and clinicians suggested strong support (89%) for everyone being provided with a copy of the ten-point statement, (82%) recommended this should, as a means of displaying openness, include analysis of top management/clinicians responses to the points and provide further evidence by which to gauge their commitment to TQM and indication of expectation. Expression was for the paradigm to be viewed in terms of partnership, collaboration and interdependence.

Empowerment, it has been noted, is an essential part of successful TQM, whilst TQM culture seeks to provide an environment for empowerment. Since quality service is achieved through people, the training emphasis concerned empowering people in the form of encouraging freedom to set agendas and seeking management response to continuous improvement, radical change and patient focussed care. Although empowerment can mean almost anything one wishes it to mean, our agreed interpretation concerned enabling people to feel they can make a difference to the delivery of quality health care, intention being to provide confidence, support and the skills necessary so to do.

In seeking to foster a trusting environment where people felt free to be innovative in the implementation of continuous improvement and change, we encouraged participants to consider joining self-managed teams which we had earlier agreed with management and clinicians to mean departmental, functional, professional, cross-functional and inter-organisational teams, central to which team members were empowered to make TQM decisions. To some this was a sea-change from tradition to others an experience of déjà-vu. Training programmes which followed, 'Identification Stage', were influenced by Coulson-Thomas (1992) research results concerning teamwork priorities, relating to success and continuity, Table 10.

Making sure teams focus on things which add value for customers	61%
Ensuring all teams understand the vision, goals and values of the organisation	45%
Building an open, sharing and trusting corporate culture	38%
Allocating clear roles and responsibilities	33%
Ensuring people are equipped with teamworking skills	33%
Empowering teams with the authority to act	26%
Providing people with the technology and support to effectively work in teams	19%
Provide reward and recognition for effective teamwork	15%

Table 10

Teamwork Priorities Ranked In Order of 'Very Important' Replies.
Coulson-Thomas (1992), 'Transforming the Company', (Kogan Page).

Culture, it was earlier noted develops over longer time periods through the daily interactions of groups and individuals with each other and with the processes, language and values which bind them as an organisation. All those interviewed agreed that participants should be asked to identify the barriers which effect the provision of service quality and suggest means for eliminating them. A marginal majority (51%) favoured participants going further in them taking direct action to eliminate them.

A first principle of TQM recommended in Chapter 3 concerns the establishment of an environment which permits change to happen. From earlier TQM Awareness Workshops and interviews which followed, there was evidence to suggest that not all the facets of an ideal TQM environment were in place, and this is discussed further in 5.3. Group discussions, visioning and ideas sharing, during the TQM training programmes, which formed an important part of the deconstraining stage, provided participants opportunity to specifically identify and focus their internal/external customers and suppliers. With the aid of a questionnaire (Appendix 20), consideration was given to barrier breaking processes presented, through joint discussion of Trust business and organisation viewed from different perspectives. Since this was a beginning process, everyone was encouraged to take it to their place of work and identify with others both the means for building on organisation, management and culture strengths and the steps necessary to eliminate weaknesses.

Culture audit (Appendix 21), was assisted by Kanter's (1989) notion of organisation segmentalism, whereby participants were asked to identify, record and report back to the TQM facilitators, their perceived culture barriers which constrained them from examining and improving the Trusts' business in terms of organisation-wide continuous improvement and radical change (see Figure 38).

Emphasis was placed on avoiding an over-focus on immediate results, which in themselves constrain reflection, assessment, analysis and planning, and in addition, avoidance of obsession with functions, status and hierarchies which obscure the real purpose of the business process.
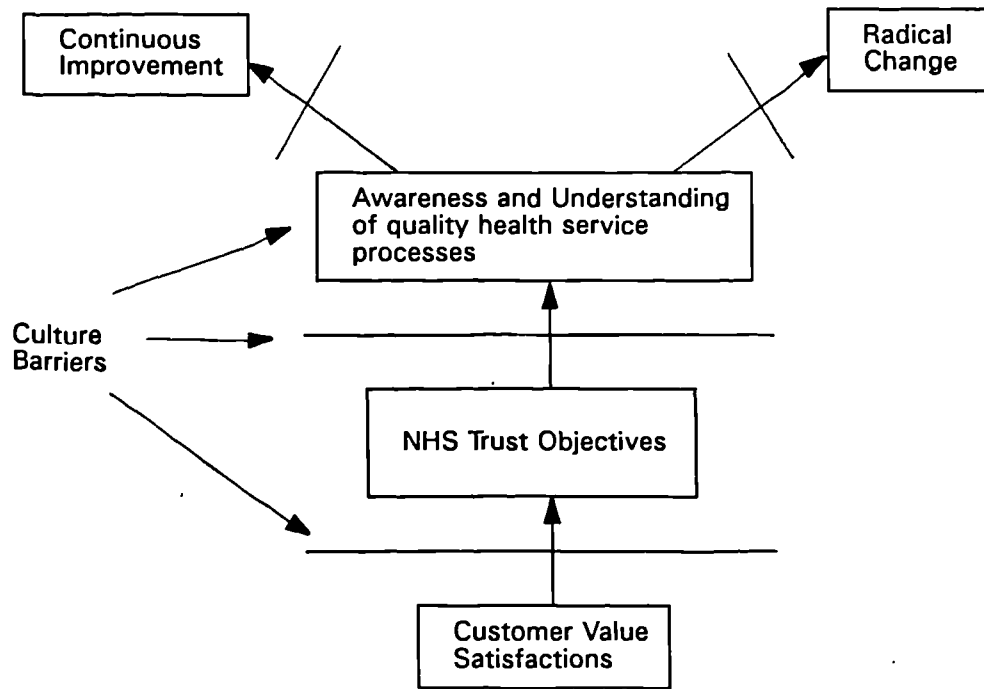
Figure 38

Barriers Constraining the Business of the Trust

These approaches proved an invaluable part of the Deconstraining Stage, in the creation of mindset which sought to personalise service, change rules and convention with judgement, address performance isues, and Peters (1992), think the unthinkable. It was clear from both group discussions and conversation directed to definite purpose that the Trusts' many hierarchy levels significantly constrained the motivation of Trust personnel to suggest and share ideas for continuous improvement, radical change and patient focussed care. It was not uncommon to note complaints of ideas being 'lost' in the hierarchy, taking too much time to reach the point where decisions were made or being consumed by others on route to that point.

It was agreed by the Chief Executive, the Director of Operational Management and others to operate a two-hierarchy communication and action system for TQM, providing any individual or team seeking to suggest means for continuous improvement, radical change and patient focused care with direct access to those in the Trust who they believed had acumen and status to judge and act on the merits of proposals. This was also to mean involving the collective wisdom of a 'TQM Steering Group', led by the Chief Executive and consisting of top and senior Trust personnel as appropriate.

Care was taken in explaining the expected merits of the procedure to middle managers and others, emphasising that the process was equally available to all Trust personnel. There was little support for applying these principles to patients, family members or the purchasers of health care services at this stage, preferring instead to continue with procedures which already existed.

By January 1993, four hundred and thirty seven Trust personnel had joined self-managed teams, of which twenty-one were department/functional teams, three professional teams (mostly clinicians), eighteen cross-funtional, across most of the Trusts' Directorates and four described as inter-organisational involving also, Health Authority personnel, GPs, Community Health Council Members and members of the public. During the full (five stage) paradigm implementation period, some five hundred and eighty (25%) Trust personnel had participated in teamworking, 102 Managers/Administrators, 9 consultants, 19 hospital doctors, 218 nurses and 232 support services staff. In addition 9 GPs, 3 Health Authority staff, 2 Community Health Council Members and 17 members of the public had been active participants in a total of 57 teams not disproportionate to those noted above. Furthermore, it was claimed by the TQM facilitators that at least as many others had contributed in ways which were supportive of TQM, but without becoming team members themselves.

Postal questionnaires (Appendix 18), were returned to the named person in the eighteen Hospitals/NHS Trusts involved with TQM application requesting that they consider question 2 in terms of **stage 3**, and re-visit questions 3 and 4, all were returned. Table 11 indicates the views of those with stage 3 experience and those yet to apply it.

TQM Process Activity	% claiming application	% expecting application	TQM Process Activity	% claiming application	% expecting application
Continuous quality improvement	69	60	Problem prevention procedures	69	100
Radical change	31	40	Audit	85	80
Patient focussed care	38	60	ISO 9000/BS 5750	15	0
Staff empowerment	69	80	Statistical Method/ Procedure	15	20
Patient empowerment	31	20	Benchmarking	15	0
Facilitator/Mentor development	38	40	Quality costing	54	20
Handling complaints	54	20	Rewards & Recognition	77	20
Patient's Charter focus	100	100	Method for voicing concern	100	80
Problem solving procedures	100	100			

Table 11

Stage 3 TQM Process Activities
Analysis of Questionnaire Results Returned from Eighteen Hospitals/NHS Trusts
Involved with TQM Application and with Stage 3 Experience or Expecting Stage 3 Application
(January 1993)

Although there were similarities between the hospitals/Trusts claiming application of stage three and those expecting to apply it, there were also notable differences. More, for example, expected patient focused care application during the stage than those who practiced it and there was less expectation for patient empowerment. Significantly more concerned stage three with handling complaints than those expecting application, as also with quality costing activities and rewards and recognition focus. Benchmarking concerned a few (three) with TQM process activity, but was not expected to be used by any of the hospitals/Trusts not yet applying the stage.

Continuous quality improvement, which all participants had earlier claimed as stage two activity and all with the exception of one had expected application during stage three, featured less than predicted. Leadership development was not identified as process activity, although Facilitator/Mentor development continued. Patient's Charter focus, problem solving and prevention, audit and method for voicing concern were reported as important activities and quality costing, which hitherto had not been recorded, also featured strongly. Similarities remained between process activities and reasons given, Table 6, for undertaking TQM.

Although there were consistencies between the recorded activities and intention for stage three application in the case Trust, using the eclectic paradigm, there were also fundamental differences in that intention for Identification Stage concerned teams as focal point guiding TQM process, by removing constraining organisation, management and culture barriers, opening communication channels, seeking information provision and targeting 'fortress' mentality.

Postal questionnaire (Appendix 22) was also sent to the eighteen hospitals/Trusts applying TQM from the outset, thirteen were returned. Table 12 indicates their responses.

Further analysis of data contained in Table 12, and compared with case Trust data and data collected from the second Trust (T2), undertaking TQM application with the same definition and eclectic paradigm, suggested that an arithmetic mean of (12%) of the hospital/NHS Trust employees were involved in teamworking as part of TQM process. This compared with (19%) and (17%) respectively for the case Trust and Trust T2, rising to (25%) and (23%) by September/October 1994, and with a mean of (27%) who had professed team participation in the demonstration sites.

Those exceeding the arithmetic mean, hospitals/Trusts D; F; H and I, for example, had earlier reported high top management commitment and had in their first stages targeted

Matters Concerning Teamworking		Hospitals/Trusts												
		A	B	C	D	E	F	G	H	I	J	K	L	M
Number of teamworking participants														
- approximate %age of all employees		12	7	9	23	11	15	3	26	17	2	10	8	11
approximate %age	managers/administrators	21	19	28	31	17	20	9	12	15	10	25	6	18
	consultants	3	0	0	5	2	4	0	7	3	0	1	0	3
	hospital doctors	1	1	0	5	0	3	1	6	3	0	0	0	2
	nurses	30	41	36	19	46	25	44	22	40	37	43	50	29
	support services	45	39	36	40	35	48	46	53	39	53	31	44	48
Team type %age	dept/functional	68	50	54	39	45	51	44	48	38	38	39	52	47
	professional	5	-	11	8	-	7	-	11	8	-	13	-	-
	quality circle	18	25	-	24	36	-	34	-	16	37	-	-	42
	cross functional	9	25	31	19	19	30	22	25	38	25	44	38	11
	inter-organisational	-	-	4	10	-	12	-	16	-	-	4	10	-
	total number of teams	22	8	28	49	11	43	9	61	13	8	23	21	19
Formal Training -	before commencement	■	■	■	■		■	■		■	■	■	■	
	during teamworking					■	■			■				■
Team size -	number of employees (average)	15	8	12	14	10	10	8	12	15	10	12	9	12
Frequency of meetings (weeks)		2	3	2	4	1	2	1	3	2	2	2	3	2
Average time taken (hours)		2	1	2	4	1	1.5	1	1.5	2	2	2	2	1.5
Major objectives -	work quality problem solving quality of working	■	■	■	■	■	■	■	■	■	■	■	■	■
	problem solving work quality	■	■	■	■	■	■	■	■	■	■	■	■	■
	problem prevention quality of working	■		■	■		■		■	■	■	■	■	
	problem prevention			■	■		■		■	■	■			
	continuous improvement	■		■	■		■		■	■		■	■	■
	radical change				■		■		■					
	patient focussed care				■		■		■	■				
Teams led by -	formal leader	■			■							■	■	
	quality function person		■	■				■	■					
	natural (situational) leader						■					■		■
	no-one					■					■		■	■
Quality Steering Group/Council formed			■		■		■		■				■	■
On a scale 1 to 4 guage level of success (1 = not successful; 4 = very successful)		3	2	3	4	2	3	1	4	3	1	3	3	3

Table 12

Analysis of Postal Questionnaire Results
Returned from Thirteen Hospitals/NHS Trusts
Claiming the Use of Teamworking as part of their TQM Application
(December 1992/January 1993)

culture barriers which they expected would, if left unchanged, constrain TQM implementation. The converse was reported by those with significantly fewer teamworking participants, B; C; G; J and L in particular. Consistent with that reported by Pilot and Demonstration Site participants, Table 12 also indicates low response from consultants and hospital doctors.

Cross-functional and inter-organisational teams which are more likely to concern end-to-end and larger scale process issues constituted (31%) of team activities compared with (48%) in the case Trust and 45% in Trust T2. Little emphasis however, (12%), is suggested in Table 12, concerning team focus on radical change and patient focused care, whereby later stages showed these to concern (34%) of case Trust team activities. The majority of teamwork training (69%) took place in the hospitals/Trusts before teamworking began, whereas most of the training took place within the teams themselves in the case Trust and Trust T2, facilitated in the former by TQM Facilitators, providing stage development against 'live' problem solving/prevention, continuous improvement and radical change projects. There was arithmetic mean consistency between both Trusts and the hospitals/Trusts concerning team size of ten to twelve, frequency of meetings, twice monthly and meeting time duration of two hours.

Second stage paradigm application in the case Trust had avoided pre-occupation with quality and TQM detail, or with in-depth TQM and team training, preferring instead to place attention on the development of meaningful communications concerning definition and paradigm and seeking to establish common language for taking objective views of the barriers which if left unsolved would likely reduce scope for TQM application. Success was sought and achieved in establishing formative stage TQM ownership by the formation of staff empowered teams.

7.3   Identification Stage

Earlier stages noted top management and clinician commitment as crucial to the success of TQM. In addition education and training, Figure 37, it was suggested, was the key to everyone understanding the relevance of TQM process. Training and executive level commitment were the beginning seeds for transforming the organisational mindset to continuous quality improvement, radical change and patient focussed care. Strong employee motivation was essential for cultural transformation to occur. Baired et al (1993), suggest, that as empowerment is experienced within individual units, pride and morale are boosted, barriers and turfs are broken down, and fear is driven out as individuals begin to take ownership of their daily work. Central to identification stage, was transformation of culture, involving open communications amongst the various levels within the case Trust, breaking down barriers and territories, eliminating fear and empowering employees. In addition, intent was for the Chief Executive to remain pivotal in implementing organisation-wide change. To build on this positive momentum, we sought to focus process rather than hierarchy alone, which it had been earlier suggested, Chapter 3, leads to stronger customer focus, more effective communications and ultimately to a flatter, more responsive organisation, facilitating the interdependent processes where everyone is a customer and supplier of each other.

During this stage self-managing teams became focal point for guiding the TQM process whereby employees were empowered as a team to make decisions on how they controlled their working environment concerning the removal of constraining barriers, opening channels of communications, provision of information and targeting 'fortress' mentality. In so doing a higher degree of correlation was sought between aspiration and action in seeking synergy between what the Trust stated it was about and what it actually did.

Formal training concerning team dynamics and processes were kept low-key to avoid being over-prescriptive, instead teams were encouraged to address their own training needs, establish personal development plans and challenge and support each other on real work

234

issues, to enable the team members to identify with the concepts and tools as needed. The TQM facilitator sought to establish ground rules at the first meeting, particularly in terms of acceptable behaviour, purpose, goals, skills, approach and accountability where references were made to Juran's 'Quality Planning Road Map' for guidance, Chapter 3 - 3.2.

Cognizant also of West and Anderson's (1993) findings concerning management teams in British hospitals, emphasis was placed on establishing clear and agreed objectives (mission or protocol statements), facilitated by the TQM definition provided. These were supported by high levels of information sharing, involvement of all team members in decision making, strong interaction between members enabling information inter-change, high level of decisionmaking through a constructive controversy and critical self-appraisal, clear verbal support for innovation, and active support for innovation within the team by providing co-operation, time and resources for new ideas. Their research findings indicated that the quality of innovation (concerning how 'novel' and radical the team innovations were), was best predicted by the personality factor of propensity to innovate among team members. Specifically, the greater the propensity to innovate at the individual level, the more radical did experts rate the innovations of the team and the more of a change did they represent to the status quo. To these ends, the TQM facilitators, chosen for their enthusiasm towards continuous improvement and radical change with knowledge of the TQM process and consistency of purpose were essential in effecting teamworking and culture change at the formative part or the identification stage.

Although time was taken for team members to accept and understand new and better ways of working together, it was not uncommon to note by the fourth meeting teams taking sufficient ownership of the TQM paradigm for them to be well concerned with problem solving/prevention, radical change and patient focused care issues. There was also clear evidence by then of more open communications, expectations more understood and teamworking activities drawing on the collective power of the team members.

Some teams after the third or fourth meeting chose not facilitation from the TQM facilitators, others used them substantially in helping them cope with the increasing levels of team responsibility and their varying stages of personal development and maturity. Equally when teams showed signs of loosing their initial impetus, the facilitators' driving force was such to refocus attention towards Trust excellence and benchmark status. There was also tendency by some teams to focus more the introspective activities of internal team effectiveness than the visions, goals and Trust values concerning competitive advantage and customer adding value activities, wherein facilitator role was prominent in redirecting attention. Facilitators were, throughout the stages of TQM implementation and application, particularly adept at re-building open, sharing and trusting corporate culture,promoting the better use of information, technology and software, providing encouragement through recognition of success and seeking holistic approach rather than attempt at single solutions only.

A major thrust of the TQM definition and eclectic paradigm sought to further enhance Trust purpose and provide means by which its employees would widely share its values and thereby integrate them around the tasks of continuous improvement, radical change and patient focussed care. TQM training and discussion which followed had encouraged participants to diagnose and analyse organisation, management and culture barriers before TQM was introduced and to follow this by taking steps to resolve them as first project for teams to address. Although many were laudable with their concern for improving communication systems and effectiveness with regard to internal/external customer and supplier relationships, a number sought to establish where the Trust organisation was in order to determine where it needed to be strategically, exploring in macro terms a number of care systems and processes which they believed to be source of management and organisational difficulty.

A strong emphasis was placed on encouraging teams to consider appropriateness of performance measures used to indicate performance gaps, as means for identifying potential for improvement and change when standards were not met. This led, in some instances, to the identification of critical success factors and key tasks which focused performance standards and a more explicit development of continuous improvement and radical change objectives. Teams considering outcome performance measures were provided with copies of Ellwood's (1988) framework for and benefits of outcome management, Table 5. Barriers which prevented/reduced effectiveness and efficiency were also addressed, with particular focus on extent by which TQM sought to achieve desired outcomes and the efficient use of resources. Attention was drawn to identifying perceived value costs in preference to costs of quality, where added quality costs were less than perceived value satisfaction.

Overview of the NHS, Chapter 2, characterised it as more 'pluralistic' and 'structured' in organisation form than 'unitary'. Although some organisational aspects have been earlier noted in terms of bureaucracies, particularly machine and professional bureaucracy, Chapter 4 - 4.2, Morgan (1986) typifies pluralistic organisation as diversity of individual and group interests, where the organisation is viewed as a collection of various professions or special interest groups, each vying for position within the organisation. Depending on issue or circumstance, power requires to be more or less equally shared so as to maintain some semblance of balance. The hallmark of the pluralistic organisation, Morgan suggests, is acceptance of this inevitability and the use of some organisational politics to accomplish purpose. Curtis (1993), identifies authority, organisational hierarchy and chain of command as distinctive characteristics of the structured organisation. Job descriptions defined roles and rules and regulations govern behaviour, there are sharp distinctions between divisions of labour, he suggests. As in pluralistic organisations, the use of power is a key feature, but exercised more through formal negotiation than organisational politics.

TQM, it has been earlier suggested, is difficult to apply successfully in organisations, here described as pluralistic organisations and even more so in highly structured organisations,

some teams thus concerned themselves with uniting the organisation around common TQM vision, directing attention to the critical factors which produce quality of health care results and therefore success. Barrier breaking to more establish a number of unitary characteristics which better serve TQM implementation and successful application directed team attention towards issues which reduced cohesive culture based on practise of respect for organisation and TQM goals, missions and protocols and sovereignty of the organisation, wherein individuals and team members satisfy their own interests in the name of higher purpose, subordinating themselves in the service of the organisation, Morgan (1986). Other issues concerned resources, involvement of all Trust personnel, shared knowledge and understanding, team integration, information management, measurement and results.

Although it is not intention to report all team activities in detail since within the four month stage they were many and varied, one particular cross-functional team led by a consultant well demonstrated as an exemplar, multi-disciplinary problem solving and planning, participatory management through interdepartmental activity and individual accountable empowerment. The organised approach using TQM process, they stated, appealed to them. This involved them targeting barriers which they believed constrained quality of health care, concerning shortage of staff time and organisation of community services, between in-patient treatment and out-patient consultation involving the hospital staff, GPs and community health centres. Time was spent identifying common problems which needed to be addressed for all patients and specific problems concerning individual patients and interprofessional barriers which reduce efficacy of patient care and use of resources. As situation demanded (also noted in some other teams) method for brainstorming was used along with six-word, cause and effect diagrams and Pareto analysis to augment subjective review. Plans were set in motion for improving practice of Patient's Charter by focussing in particular, admissions and discharge procedures, number and control of in-patient beds, facilities for day patients, clinical management practice in the form of resources and deployment of medical and non-medical personnel and the availability of appropriate facilities for diagnosis and treatment.

A second, inter-organisational team concerned budgets and choice, taking as scenario patient persistence and availability of local budget or GP fundholding budget to pay. Choice and responsiveness issues were considered and plans laid to minimise barriers which curtailed Trust flexibility and responsiveness. Budget effect on health services calculated on population size in place of services led to the formation of pro-active plans for maintenance of quality health care when number of beds were further reduced. This involved identifying barriers which restrained shift from hospitals to community and primary services, and means for ensuring quality of acute services. Plans were established for informing the public that community services within the home, GPs surgery, health clinics and not least the resource centres with specialist provision in the community, sought to compensate bed loss and maintenance of high quality health care.

Consistent with the concern for 'whistle blowers' recorded during Pilot Site investigations, and despite a Trust Chief Executive who was most supportive of open culture, it was without exception that teams voiced concern of possible recrimination for speaking out, whether it be affect of staff shortages, cost savings taking precedence to quality performance or emergence of 'harder' commercialism since attainment of Trust status, feedback from the participating hospitals/Trusts and the 'Open' TQM Awareness and Action Workshops delivered by the researcher during this time period, which involved thirty-eight personnel from a variety of health care organisations, including some fundholding and non-fundholding GPs, also demonstrated concern, wherein views were expressed of 'unforgiving methods' of the private sector being applied. Although the researcher believes that there may have been influence from media focus on whistle blowing at this particular time, there was genuine concern for speaking out, evidenced not least by the number of seminars available concerning the ethics of speaking out in the NHS, ministerial statements and the introduction of the earlier mentioned 'Guidance for Staff on Relations With The Public and The Media', during 1993.

It was earlier reported that evidence was such to suggest that customer involvement in the Trust was little more than notional. During the Identification Stage, six members of the public participated in inter-organisational teamwork (increasing to seventeen by September 1994). Trust Board Executives did not support the principle of patients, family members, the public or purchasers having direct access to those in the Trust who had acumen and status to take immediate action on meritorious proposals from them, preferring instead to continue with processes which existed through the co-ordinating processes of the Complaints Officer (a part-time TQM facilitator). It had been recommended by the researcher, supported by the team of TQM facilitators, that the Chief Executive, Director of Operational Management and other Trust Board Executives avail themselves for regular surgeries to provide opportunity for patients, their relatives, staff members and the public to discuss matters of concern, not dissimilar to process noted in one of the earlier mentioned Demonstration Site Trusts.

Recognising that intent was for Identification Stage to take cognizance of requirements for user and purchaser empowerment and to consider outcome process for targeting users, purchasers and members of the public to establish extent by which TQM had improved sense of well-being, self-confidence and achievement of other criteria for stages which followed, the Chief Executive and Director of Operations agreed to the researcher undertaking summative and qualitative evaluation concerning attention directed to outcomes and service inputs, throughputs and outputs, involving some sixty-six Trust employees, representing the mix of Directorates and Departments in the form of 16 managers, 2 consultants, 7 hospital doctors, 18 nurses and 23 support services staff. In addition, 8 GPs, 63 randomly selected patients and 12 family members also participated in unstructured and semi-structured interviews (Appendix 23).

In the confidence of the investigation a number of views were expressed pertaining to socially responsible and environmental sensitive issues, needs, expectations, quality chain, internal market and delivery process value perceptions and matters which concerned

competition and survival. These views, added to those recorded from unstructured interviews and discussions during Awareness and Action Workshops and team meeting observations, provided a most useful information base for the Process and Implementation and Evaluation stages of the eclectic paradigm which followed.

Most respondents (56%), when asked what they thought was good about the reforms, referenced the changing emphasis placed on improving primary care, exampling GP practices and specialist clinics. A majority (63%), of patients and family members said they were dissatisfied with case Trust quality performance in terms of the TQM definition, and of the NHS in particular. Most Trust personnel and GPs, (66%), said they thought the reforms had made the NHS quality of health care worse. Although a minority, a significant number of Trust employees (21%) stated that should a close family member or themself become gravely ill, they would prefer not to be treated by their hospital. Referencing patient empowerment, a small proportion (11%) indicated that they would participate in quality improvement teams and (9%) in the design of quality care services, a larger number (65%) indicated that they would agree to provide information to 'tailor' services towards their needs and expectations. Many commented that such matters should be left to the professionals and the "experts".

A significant number of reasons were given for their responses, attempt has been made to note them under a number of headings. Matters concerning patients - consultants/doctors austere style, not listening, disinterest in alternative methods of medicine; clinical secrecy; discharged from hospital too quickly; poor follow-up care; insufficient information provided by medical personnel on matters pertaining to the health of the patient, and the converse, too much information provided; information given by junior personnel with good intentions but limited experience; consent form signing for surgery too informal; dissatisfaction with the way complaints were handled; difficulty in seeing GPs and receiving home visits; waiting long periods for attention at hospital clinics; abuse of Patient's Charter; unavailable

and unsatisfactory services in the community; poor balance between health care and social needs provision; cancelled operations; cancellation of admittance into hospital at extremely short notice; lack of sound proofing in consulting rooms; cramped clinics; poor quality food in hospital; inadequate nursing; poor standards of hygiene and cleanliness ..., other issues which also relate to patients are identified under the following headings.

Clinicians, GPs - one GP interviewed began by saying, "I'm sure all staff in and associated with health care are aware of the need to practice respect for people and be considerate to patients, but I'm not sure they all carry it out". Other matters noted included the need for GPs to meet providers to detail complaints; fundholding causing a two-tier service of winners and losers; fundholding meaning more competition and less co-operation; far more stressful profession than before the reforms; GPs and hospital doctors working excessive hours; difficulties of getting beds for patients; facilities idle due to lack of money and staff resource; senior managers from a non-medical background; difficulties of knowing how much information to give to the patient to service the needs of the patient; pressures of risks of litigation with regard to informed consent; discrepancies between discharge times; discrepancies of length of stay before operations; variations between consultants care episodes; too much paperwork; consultants accused of inefficiency; need for consultants to spend more time with junior doctors on case and training matters; poorly supervised junior doctors left to run things; juniors' practising on patients; through the night operations undertaken by junior doctors; criticism of unnecessary operations carried out on the old and terminally ill; fear of waking the consultant during the night; junior doctors trained by other junior doctors only one stage ahead of them; General Medical Council and the Royal Colleges preserving the status quo; some older clinicians reluctance to attend courses; worries about the competences of some colleagues, but not prepared to single them out; surgeons monitoring their own work amongst themselves; patients discharged from hospital when they are unfit to cope or be coped with; feeling trapped in a revolving door between hospital and community care; NHS consultants working excessive times in the private sector; need for different ways of handling complaints.

Management - shortage of money; need to control clinicians who let the hospital down; more surveillance of consultants; belief that clinical freedom and clinical secrecy has gone too far; mistrust of the term 'professional judgement'; requiring stricter regulation of the medical profession; clinical staff not always aware of what the protocols are; over-cautious treatment by some clinicians; some consultants and doctors not up-to-date with the results of clinical trials; reluctance to change which may result in patients not receiving best possible care; poor monitoring of medical personnel to ensure they know the side effects of drugs; difficulties of introducing scientific knowledge into everyday patient care (references to development of data base for areas of medicine); failures to get research information across to doctors and nurses and to get them to use it; changes in government direction; need for stronger understanding by many staff of the business focus within the reforms and hence the Trust.

Organisation - information systems not having attained the degree of perfection where data is easily and quickly retrieved; files lost; difficulties in establishing waiting times; works department personnel sent on jobs with incorrect information and material; ineffective accounting and pricing systems; problems in meeting Patient's Charter *time expectations;* ineffective HAs, not aware of the number of patients requiring operations, and the number of surgeons doing the right operations and failing to select and send patients to the right places because of their restrictive policy; conflict between continuing care beds and the residential homes; insufficient number of ambulances; ambulance crews going to unfamiliar areas to cover emergencies; Accident and Emergency Department designed for 30,000 patients per annum, providing for 80,000 throughput; added bureaucracy; availability and movement of equipment; finding high cost equipment not used; empty 'protected' beds when belief is that there is no available bed capacity; unwillingness to unlearn one system of care and replace it with another; no insistence on supervised training of surgeons; minimal access surgery poorly controlled and audited; poor training which has led to

morbidity and mortality; changes in clinical practice most difficult to introduce; shift overlaps wasteful; poor planning of the number of patients a doctor can treat relative to other support services available; need for everyone to attend discharge meetings; more efficiency and effectiveness if Trusts were freed from the constraints of the public sector; poor deals from suppliers and little cognizance of alternatives (pharmacy); poor use of block contracts to purchase blocks of treatment; requirement for personnel department to establish job-plans with doctors and consultants and to measure progress against them; continuing reduction of hospital beds; poor market balance-capacity/demand; power shift from hospital to community with GPs as the major driving force; need for a locality led service; health promotion should not only be GP led but complimented by vigorous government campaigns; trade unions out of touch with the realities of the reforms; too much duplication of work; inter-department rivalry; poor auditing of the operation of systems and procedures; performance related pay not linked to productivity or quality gains. One senior manager who attended a TQM Action Workshop pointed out that in her Trust, where quality assurance resulted in consultants rather than junior doctors seeing the patients in the hospital, the waiting lists dropped through the realisation that too many patients were being seen unnecessarily.

Competition and survival - as holders of taxpayers money a duty to deliver as much quality care as possible within a given budget; GP purchasers of care exploring alternative providers; GP control over community teams no longer powerless to make choices; a more informed public demand for ever-improving quality of care; patients switching to fundholding GPs to get a more responsive service; a need to evidence social context by close integration of hospital, social services, housing, leisure, education and social security; fewer than expected patients using some services resulting in less cash and more pressure to efficiency drive.

Telephone interviews with the named persons responsible for quality management at the sixty-eight participating hospitals/NHS Trusts, indicated that four of the eighteen who had

implemented TQM were re-assessing its value, in light of ever increasing demands for faster response to cut costs and achieve tangible results. Two were those who had the longest undertaking of TQM in the sample, ie. twenty months and twenty-three months respectively, while one had been undertaking it for thirteen months and one ten months. There was indication that the high optimism at the beginning, which had led to quality improvements had slowed down significantly. as further results became difficult to achieve. In addition, it was believed a lack of top management and senior clinician support had seriously constrained strategic focus and the redesign of process, systems and procedures necessary to maintain continuous improvement. There was little evidence to suggest that teamworking had involved more than department/functional activities and no attempt had been made to benchmark departments or functions to seek best practice or to get them to challenge or exert performance with each other. TQM it was suggested had failed to be the catalyst for change hitherto expected. It was clear that intention was to explore other approaches, two mentioned hospital process re-engineering, one the possible use of an alternative TQM process model and one the planned launch of a "motivation campaign" based on multi-functional teamworking.

Earlier responses from the eighteen hospitals/Trusts who were applying TQM at the commencement of the research indicated low or zero application of a number of the listed (Appendix 18), TQM process activities, Tables 8, 9 and 11. These concerned in particular radical change, patient focused care, leadership development, patient empowerment, performance measurement, ISO 9000/BS 5750 statistical methods and procedure for benchmarking. Before proceeding to the Process and Implementation and Evaluation Stages of the eclectic paradigm the researcher sought responses from the named persons in connection with these and other activities by returning postal questionnaires (Appendix 18), requesting that they consider eleven month Stage 4 and six month Stage 5 and identify the TQM activities which they envisaged undertaking during each Stage. Projecting activities was necessary since no participating hospital or Trust had completed Stage 4 or begun

Stage 5, fourteen completed questionnaires were returned. Table 13 indicates the views of those who envisage TQM activities at Stages 4 and 5.

TQM Process Activity	STAGE 4 % claiming application	STAGE 5 % expecting application	TQM Process Activity	STAGE 4 % claiming application	STAGE 5 % expecting application
Continuous quality improvement	71	71	Problem prevention procedure	100	100
Radical change	36	64	Performance measurement	43	64
Patient focussed care	29	64	Audit	86	100
Leadership development	5	0	ISO 9000/BS 5750	7	7
Staff empowerment	50	86	Statistical Method/	14	14
Patient empowerment	29	29	Benchmarking	21	29
Facilitator/Mentor development	29	0	Quality costing	57	64
Handling complaints	50	64	Rewards & Recognition	86	86
Patient's Charter focus	100	100	Method for voicing concern	100	100

Table 13

TQM Process Activities.
Analysis of Postal Questionnaire Results Returned from Fourteen Hospitals/NHS Trusts Involved with TQM Application Expecting Stage 4 and Stage 5 Application
(April 1993)

It is clear that Stages 4 and 5 were expected to concern Patient's Charter matters, problem-solving and prevention procedures, audit, method for voicing concern, rewards and recognition. Quality costing, which a few had begun during Stage 3, was predicted to continue through both stages and commence in the final stage, by one hospital. Radical change and patient focussed care which a few had concerned themselves with at earlier stages was expected to proceed to Stage 4 and involve more, in terms of the latter, during Stage 5. Leadership development which had been undertaken at preceding stages was not expected to be activity focus during the latter stages. A number envisaged performance measurement beginning during Stage 4 and increasing as TQM process activity during Stage 5. ISO 9000/BS 5750 continued to be important activity for one Trust. Statistical

Method and the use of Benchmarking continued to be focus for but a few, although a marginal increase was expected with the latter, contrary to expectation (Table 11).

There were similarities between process activities expected during Stages 4 and 5 by the Hospitals/Trusts who were undertaking TQM at the commencement of the research programme and that planned for the Process and Implementation and Evaluation Stages in the case Trust and Trust T2 using the eclectic paradigm. These included concern for continuous improvement, staff empowerment, handling complaints, Patient's Charter matters, problem prevention, audit, rewards and recognition.

There were differences also, in the form of stronger emphasis placed on radical change, patient focused care, performance measurement, translating quality requirements into action and teamwork techniques. Importance was placed on capability for understanding the needs and expectations of customers and means by which they perceive and evaluate quality of service. A central part of the final stages of the eclectic TQM paradigm concerned evaluation of TQM process in terms of improvements to organisation performance and the quality of care.

All the twenty-one earlier noted hospitals/Trusts, about to commence TQM, and ten of the sixteen recorded as positively thinking about it, were now in the process of implementation. Each were returned copies of their previously completed questionnaire (Appendix 18), concerning reasons for considering TQM application, requesting that they reconsider their responses now that TQM application had become a reality. All were subsequently returned with only minor changes, which mostly concerned their intentions to place stronger emphasis on activities which involve people in quality matters, increasing from (71%) to 100%. Detail was provided by seventeen of them (81%), of intention to establish cross-functional and multi-disciplinary teamworking. Seven of the thirteen who earlier said they were undecided, had also begun TQM implementation. Each agreed to complete postal

questionnaire (Appendix 17), relating to reasons for undertaking TQM. Analysis showed no marked differences to that contained in Table 6, with the exception of one who stated that TQM was a part of their drive for ISO 9000/BS 5750 recognition. The remaining nineteen hospitals/Trusts chosen for their quality management focus, but not undertaking TQM, were sent postal questionnaire (Appendix 24), to compare and contrast their reasons for undertaking quality management and activities undertaken, with those given by the hospitals/Trusts applying TQM.

Table 14 indicates reason for Quality management applications, responses relate to 3 and 4 scores on question 1 (Appendix 24).

Reason for Undertaking Quality Management - To:	Percentage Responses		
	Score 3	Score 4	Total
Achieve ISO 9000/BS 5750	0	5	5
Assist with standards setting	0	100	100
Ensure conformity to standards	5	95	100
Reduce costs	26	32	58
Provide reason for everyone striving for excellence	37	42	79
Get a more effective complaints procedure	32	47	79
Save time			
Involve more people in quality matters	5	26	31
Link with audit procedures	11	79	90
Better satisfy: Patients	0	63	63
Purchasers	11	42	53
The Public	21	16	37
Suppliers	11	53	64
Improve productivity/ cost performance (added to the list by some respondents)	0	5	5
Quality circle activities (added to the list by some respondents)	21	32	53
Establish quality costing procedure (added to the list by some respondents)	5	47	52

Table 14

Analysis of Postal Questionnaire Results Returned from Nineteen Hospitals/NHS Trusts Involved with Quality Management Application
(April 1993)

Comparison of Table 14 with Tables 6 and 7 indicates that more emphasis is placed on matters concerning standards - standard setting, conformity to standards and audit procedures by those undertaking quality management. There was strong reason given for seeking an effective complaints procedure, in addition to quality circles and quality costing.

Table 15 indicates quality management activities undertaken by nineteen hospitals/Trusts.

Quality Management Process Activity	% claiming application	mode, score response 1 = not successful, 4 = successful
Continuous quality improvement	95	3
Patient focussed care	16	2
Handling complaints	63	3
Patient's Charter focus	58	2
Problem Solving procedures	100	4
Problem Prevention procedures	100	4
Performance measurement	100	3
Standards setting	100	4
Audit	100	2
ISO 9000/BS 5750	5	4
Information/data collection	100	3
Statistical methods and procedures	68	2
Quality training	79	3
Brainstorming	89	4
Quality costing	79	1
Internal communication systems	95	2
External communication systems	84	2
Method for voicing concern	79	2

Table 15

Quality Management Process Activities.
Analysis of Questionnaire Results Returned from Nineteen Hospitals/NHS Trusts
not involved with TQM Application
(April 1993)

The reason for undertaking quality management application and process activities concerns assessing or measuring performance, determining whether performance conforms to standards and improving performance when standards are not met. The use of measurement in conjunction with improvement and correction methods is consistent with Quality Assurance focus. Quality Assurance refers to a planned system of activities which seeks to ensure that the service gets things right the first time, aiming to continually improve standards and consistency of outcomes and staff performance, reduction in staff errors and the reduction of costs associated with poor quality. Quality Assurance is an advanced state of quality by inspection method which involves pro-active measurement and the identification of root cause problems. Berwick (1988) suggests that continuous improvement application is the beginning of direction shift from quality assurance to TQM.

It would be ingenuous to suggest that four months application of any paradigm stage would be sufficient to change constraining culture which forty-five years of the NHS had created, but fact was some four hundred and eighty-one employees had joined self-managed teams by May 1993 (an increase of forty-four from January). Sixty-seven more Trust employees had attended additional training programmes by request and a further three cross-functional teams and one department/functional team had been formed. Other than natural staff wastage, there were no reported withdrawals from teams or discontinued teams, although five of the twenty-one department/functional teams had re-grouped to form cross-functional teams.

Despite the fact that some senior managers and clinicians had expressed expectation for early tangible returns, a significant part of the first eight months of TQM application had in fact involved important preparatory steps in readiness for application of the Process and Implementation and Evaluation Stages which followed.

7.4   Process and Implementation Stage

This stage advanced the earlier preparation stages by translating requirements into action and placed emphasis on decisions which concerned quality of care being made at the lowest possible levels in the case Trust, unless otherwise demonstrated that they needed to be made elsewhere. It was suggested from the outset that team and individual attention would be well served by focussing continuous improvement, radical change and patient focused care on structure (resources), process (activities) and outcomes (results), recognising that TQM deals with structure and process whilst the ultimate improvement was to be reflected in outcomes. Teams and individuals, in implementing TQM process activities would, it was recommended, target action on organisation performance and improvements in the quality of care.

In macro terms, and inherent in the TQM definition used, effectiveness was used with regard to the extent by which TQM objectives were achieved in the desired outcomes from the TQM process and from the process itself. Efficiency was concerned with the comparison of outcome benefits to resources used. In order to establish the extent by which certain outcomes were correlated with inputs and/or outputs, the intention was to establish existence of cause and effect relationships.

Evaluation focus involved comparisons from which teams and individuals were encouraged to view performance measurement in TQM as concerning competitive standard in which the benchmarking framework (Figure 29), was used to direct attention to continuous improvement through best practice. Although the diminished role of the TQM facilitators were earlier noted in context of some facilitation of teams, records kept by them suggested extensive involvement with some (30%) of the teams, during Process and Implementation Stage, intermittent involvement with (34%) of teams and no involvement with the remaining (36%). Differing interventions established impact concerning support and the 'natural' experimental and control teams which resulted, reduced risk concerning misinterpretation of reason for a number of outcomes. Trust T2 who chose not to provide staff resource for

team facilitators at this stage, preferred instead the formation of situational team leaders, also provided means for interpretation of effect of intervention.

The stage also provided an opportunity for involving customers, suppliers and purchasers more, particularly in seeking to establish that what delighted them and as such data collection competences were further developed.

Earlier (Identification Stage), had provided translation of a spread and mix of customer, professional and manager quality requirements from Trust employees, GPs, Patients, family members and TQM Awareness and Action Workshop participants, regarding socially responsible and environmental sensitive issues, needs, expectations, quality chain, internal market and delivery value perceptions and matters which concerned competition and survival. These were used by a number of teams to establish the value of Trust business for which they were responsible and to seek improvement of quality care provision. Some (mostly department/function teams), chose 'quick-fix' solutions to problems, others focused on more demanding issues. The number of suggestions put forward per team and categorised as problem solving, problem prevention, continuous improvement, radical change and patient focused care, and the number implemented, formed a means for measuring team activities and procedure for sharing ideas and experiences of what worked and what failed to work.

A major role of the TQM facilitators' during this stage, whether team facilitating or not was in fostering a trusting culture where Trust employees felt they were able to take risks and implement ideas, particularly in terms of fairness, openness, respect and value of each other and assisting people to remain motivated. Aim was to maintain TQM as change process by moving the Trust further from control and command culture to one which involved more people in achieving total quality care and resolving that which prevented and constrained regular consistent achievement of TQM definition, mission statements and protocols.

As stated with team activities at the identification stage it is neither intention or would it be practical to report detail of each team success and failure, since claims of six to one success of what worked and what failed to work were made listing one hundred and seven problem solving/prevention solutions during the eleven month stage. Eighty-three continuous improvement successes were claimed, particularly from cross-functional and inter-organisational teams, who collectively claimed had spent almost half of their time concerning end-to-end and large-scale process issues, (39%) results they claimed came from (48%) team activities. Radical change and patient focussed care initiatives introduced amounted to twenty-one whereby (10%) success from (34%) reported team activities indicated that substantially more time was spent on these. A project team formed towards the end of the stage reported quality costing successes in the Evaluation Stage. Successes varied from minor improvements concerning decor, for example, to radical rethink of beginning to end process which effected organisation performance and user/purchaser expectations. Whatever the scale they were neither no more nor no less celebrated as recognition (later). The following examples serve to provide an insight into TQM action and successes during the stage.

A cross-functional team explored issues concerned with patient embarrassment, finding for example that a majority of patients (63%) with urinary problems delayed seeing their doctor for this reason. Women, it was reported, failed to take 'smear tests' and people with obesity expressed concern with regard to embarrassment. Total confidentiality issues were targeted, for example, removing explicit signs, names on doors, better soundproofing and provision of help lines offering confidential advice of that available to assist with and prevent problems. Emphasis was placed on providing sympathetic and understanding staff to help handle crisis of self-confidence matters, following their attendance on inter-personal skills training courses where competences were developed for communicating in language which patients understand.

A professional team concerned itself with survival outcomes and the contentious subject of patients not getting best quality treatment because consultants and doctors may not always know what the best care is. Success claimed by the team concerned a shared understanding of the DoH initiative to up-date NHS treatment in the form of data base for various areas of medicine and the additional knowledge, expertise and application techniques which would be necessary for them to come to terms with change from a "mix of belief and factual evidence to a sound knowledge based health service". Numerous ideas were considered concerning method for learning about new research and putting it into practice and method for local audit. Consensus view was that good practice cannot be imposed, for professionals to change their practice they needed to be convinced that change was for the benefit of the patient, which should mean, it was recommended, "getting together with colleagues to discuss latest research".

An inter-organisation team which included patients and family members, targeted the Patient's Charter from a user/purchaser perspective, seeking to establish their expectations and priorities in terms of provider organisations and clinical issues, as means for establishing/re-focusing earlier mentioned user inspired charters, for promoting empowerment. Matters concerning provider performance against the ten patients rights and nine service standards were closely examined, and the extent to which providers performed well against them established. Some inter-organisation benchmarking took place involving a number of team members in competitive analysis and others seeking best practice to be incorporated into the appropriate Trust processes.

User/purchaser views concerned waiting lists, waiting times, standards of clinical competence and care, communications, response, matters of choice and co-ordinated services between health and social care, wherein the Patient's Charter focused acute care, whilst the Primary Care Charter focused general practice. Provider issues concerned extent to which users/purchasers chose a consultant which was acceptable to them and extent

also to which second opinion was sought and practised. Matters concerning how much information regarding patient's condition could be made available to family members, right to emergency medical care, access for special needs, procedure for dealing promptly with complaints and discharge methods were also explored.

A major aim of the team was to establish and report to the 'Steering Group' extent to which Charter's raised expectation without improving the services provided, and extent to which the Charter's needed to be part of the TQM process.

There was significant attention paid by teams (88%) to Patient's Charter issues and by a number (48%) to League Table expectation, following the arrival of the new Chief Executive in November 1993, and the subsequent appointment of a part-time Director of Quality in January 1994. Attention to Patient's Charter matters concerned the imminent publication of the DoH league tables (June 1994), which intended to show extent to which English hospitals and ambulance services were meeting Patient's Charter targets and which aimed to inform the public of the quality of service they were entitled to expect from the NHS.

Earlier recommendations from teams to target quality and effectiveness issues were seen by some, and commented upon by one TQM facilitator as, "somewhat thwarted by undue influence from the Chief Executive and Director of Quality to seek focus on measures which when published, would relate to length of waiting time, rather than the quality or outcome of the service waited for". This was later confirmed in the publication of the league tables, The Patient's Charter, Hospital and Ambulance Services Comparative Performance Guide (1993/94), Waiting Times for First Out-patient Appointments in England: quarter ended 30 September 1994, and Elective Admissions and Patients Waiting in England at 30 September 1994.

Some team members (9%), mostly non-clinicians, who favoured the league tables saw them as quality driven quality of service measures, which provided opportunity for the Trust to

improve its performance and find reason to practice functional benchmarking. Quality of outcome they suggested was available through the clinical audit processes.

Whether in support of league tables or not, fact was that performance successes were published with regard to three of the nine service standards, namely waiting times in out-patient clinics and accident and emergency departments and cancelled operations. Bayley (1994), later commented, that the one (of ten) patients right which had surfaced from the Patient's Charter into the league tables, namely the right for detailed information on local health services concerned waiting times, not the quality of treatment, or more specifically, whether the treatment was successful or not, which he suggests, is likely to be the most important indicator for the patient. This view was also expressed by one team who recommended means for measuring and publishing the outcome of individual operations, rather than on a Trust basis only, a suggestion which received more sympathy than applications support. It was also noted that such areas as care for the elderly and those with learning disabilities were not covered in the league tables.

Evaluation stage, later provided opportunity to measure aspects of the Trusts' services of care which were of importance to the patient. Satisfactory information was provided by the case Trust in all of the league table categories and employees were quick to express satisfaction of the star rating grades received.

Although department/functional teams were involved in many and varied activities, a number of which were earlier termed 'quick-fix' solutions, others concerned themselves with more demanding matters. One team targeted waste elimination with regard to in-house nursing audit, and the value of procedures for enabling total quality nursing care. Central issue was the Working for Patients (1989) requirement for re-examination and appraisal of all work areas to identify the most cost effective use of professional skills using nursing audit method to focus the management of resources. Standards and criteria were identified

to facilitate a responsive quality service and existing systems for evaluating care were revisited to establish appropriateness and consistency of approach across the Trust, and opportunity to suggest the replacement of constraining rules and convention with judgement. These included 'Quality Patient Care' (QUALPAC), a sixty-eight item scale designed to measure nursing care received by patients in any setting whilst care is in progress; 'Quality Assurance Ward Audit', concerning ward environment, patient care, ward management and administration of drugs and medicine; 'PHANEUF Nursing Audit', a fifty item scale aimed to measure retrospectively the quality of care received by a patient during a particular cycle of care; 'Slater Nursing Competences Rating Scale', which measures the competency of the nurse to assess, plan, implement and evaluate care; 'Monitor', an index of the quality of nursing care which uses observers (auditors), to perform concurrent review of the quality of the environment in addition to the care of patients; 'NATN Quality Assurance Tool', which is used to assess the quality of patient care within theatres and recovery units in terms of achievement of set standards; 'PA Nursing Quality Measurement Scale (1987)', which seeks to assess the overall quality of nursing care received by clients in a variety of specialities and Quality Adjusted Life Years (QALYs) a matrix which combines dimensions of distress and disability to produce a quality of life score.

In making recommendations to the Steering Group for a reduced number and consolidation of audit methods, the team also identified methods for building quality into nursing practice and care, consistent with points made by Duffin (1993), Chapter 3 - 3.7, that capability improvement (prevention) costs near to zero begin to diminish.

Three hundred and eighty four returned self-completion questionnaires from four hundred and eighty-one case Trust team members (80%), Appendix 25 at the end of the stage (March 1994), indicated that (67%) of them felt that they had followed a structured approach in team meetings, seeking adding value criteria (TQM definition), adding value activities, performance measurement and mission/mile stone objectives, not dissimilar to

Figure 21, Chapter 3, Hutt (1994), structure of personal performance guide. Disciplined

approach, it was suggested, led teams to experience cohesion and performance, Tuckman

and Jensen (1977), Figure 39.

Stage of Development	Process	Outcome
1. Forming	There is anxiety, dependence on leader; testing to find out the nature of the situation and what behaviour is acceptable	Members find out what the task is, what the rules are and what methods are appropriate
2. Storming	Conflict between sub-groups, rebellion against leader; opinions are polarized; resistance to control by group	Emotional resistance to demands of task
3. Norming	Development of group cohesion; norms emerge; resistance is overcome and conflicts are patched up; mutual support and sense of group identity	Open exchange of views and feelings; co-operation develops
4. Performing	Interpersonal problems are resolved; interpersonal structure becomes the means of getting things done; roles are flexible and functional	Solutions to problems emerge; there are constructive attempts to complete tasks and energy is now available for effective work

Figure 39

Stages in the Growth of Group Cohesion and Performance,
Tuckman and Jensen (1977)

Some (35%) claimed to have achieved team success through attempt for a balance of

people not inconsistent with Belbin's (1981) suggestion of useful people to have in a team,

Figure 40.

Type	Typical Features	Positive Qualities
Company Worker	Conservative, dutiful, predictable	Organizing ability, practical, common sense, hard-working, self-discipline
Chairman	Calm, self-confident, controlled	A capacity for treating and welcoming all potential contributors on their merits and without prejudice. A strong sense of objectives
Shaper	Highly strung, outgoing, dynamic	Drive and a readiness to challenge inertia, ineffectiveness, complacency or self-deception
Plant	Individualistic, serious-minded, unorthodox	Ingenious, imagination, intellect, knowledge
Resource Investigator	Extroverted, enthusiastic, curious, communicative	A capacity for contacting people and exploring anything new. An ability to respond to challenge
Monitor-Evaluator	Sober, unemotional, prudent	Judgement, discretion, hard-headedness
Team Worker	Socially orientated, rather mild, sensitive	An ability to respond to people and to situations, and to promote team spirit
Completer-Finisher	Painstaking, orderly, conscientious, anxious	A capacity for follow-through. Perfectionism

Figure 40

Useful People to have in Teams.
Belbin (1981)

Most (69%) claimed teamworking success through ensuring that each team meeting advanced progress from the previous meeting and a leadership which sought to involve every team member within the meeting and outside it. The majority of respondents (95%), claimed to have used the following techniques during teamworking - brainstorming (100%), process flow charting (44%), cause and effect analysis (81%), six-word problem solving method (52%), critical/regular criteria decisionmaking (18%), audit (55%), pareto analysis (81%) and benchmarking (34%). Only a minority (8%) claimed that the use of techniques had not been useful to them. Appendix 26 provides a synopsis of techniques.

More than half (52%), claimed to have experienced difficulty in accessing fast response technology to provide information on a need to act basis, wherein facilitator assistance was required, both in seeking availability of information and coaching matters. Most (71%) agreed to their results being stored in data base to enable access by others. A majority (86%) said that using such category headings as 'solvable problems', 'symptoms' and 'constraints', had helped them target the quality of care problems which were solvable, the underlying problems which caused undesirable symptoms and the Trust constraints which were less likely to be solved, but which provided opportunity for a more effective and efficient quality of care in terms of structure, process and outcomes.

A most difficult part of this stage was the affect caused by the departure of the Chief Executive (November 1993), who many wrote on their returned questionnaires, had been most instrumental in TQM implementation and maintenance, and who team reports and researcher observation had noted, 'chaired' most of the forty-nine meetings which teams had sought with the Steering Group from May to November 1993.

That which was fundamental to the process and implementation stage of TQM, namely continuous improvement, radical change and patient focused ACTION was undertaken and achieved by the majority of teams, which on numerous occasions also involved individuals who were not themselves team members. Consistent with Clutterbuck's (1993)

observations, a number of teams went through a period of initial enthusiasm and high motivation, then as they consolidated gains in readiness for continuous improvement and re-invention of quality performance, introspection led to a drop in morale, due partly to trepidation about their ability to cope with the next wave of intended changes, middle management resistance and some expectation of recognition and rewards, Appendix 25, question 3.

A number of middle managers voiced concern about teamworking and empowerment as erosion of their power base and status, despite the efforts of the Chief Executive, Director of Operational Management and a number of Trust Board Executives and Trust Management Team Members, in addition to the TQM facilitators', to regularly communicate results and achievement of vision, of which a number of them were a part. Conversation between a number of middle managers and the researcher directed to definite purpose, was such to suggest that not all fears and anxieties were overcome. Furthermore, observation also suggested some acts of overt and covert resistance towards TQM application.

Most teams defined quality relatively according to task, in terms of user/purchaser needs and expectations or professional, management and organisational quality. Observation and responses to Appendix 25, question 2 suggested that teams had aimed to be explicit about process quality and outcome quality as means of moving away from attitude and practice of doing enough only to reduce poor quality and customer annoyance. Consistent with that noted in Chapter 4 - 4.3, and by Øvretveit (1990), team focus concerned quality as meeting the requirements of users and purchasers at the lowest cost and involving the three points: customer quality, providing value satisfactions perceived and measured by them; professional quality, meeting customer needs as defined by professionals and extent by which standards were observed and process quality in the form of design and operation of the health care process in the efficient use of resources. Øvretveit, suggests that the process element of health services has been largely ignored in quality assurance and quality

programme discussions, which are pivotal to the strategies of most business organisations. This apart, most teams during the TQM application stage in the case Trust sought to eliminate waste in the delivery processes and thereby reduce costs, whilst being responsive to the value satisfactions and needs of customers.

Some fourteen teams (28%), concerned themselves with performance indicators, mostly by reference to the Health Service Indicators (first published by the DoH in 1983, reduced in number from thousands of performance indicators in the health service to hundreds, some ten years later), to establish performance matters against the Health of the Nation targets. A number of those who failed to thus concern themselves claimed that the software package, accompanied by three volumes of user manuals, were difficult to access and not user friendly. Others targeted CASPE Research (1987), identifying need to develop output measures to intensify information from the Trusts' resource management systems, seeking to ensure evaluation of quality care and outcomes in addition to focus on matters of efficiency.

Two teams used activity sampling method to establish adding value activities and productivity performance in connection with nurse and manpower issues, bed provision and queuing in waiting areas and clinics. One team, referencing Bull (1992), further formulated performance indicators in connection with nursing, Figure 41.

Rewards and staff recognition briefly mentioned in Chapter 3, were raised by some Trust personnel attending TQM Awareness Training Workshops, seeking indication of what they could expect in return for suggestions which improved organisation performance and quality of care and saved the Trust money. It was indicated that the Trust Board from the outset had not seen monetary reward as endeavour to enhance effectiveness of TQM implementation and application. It was clear that a number of staff were indifferent to expectation of time commitment (which many suggested was in short supply) to something which had uncertain outcomes in terms of reward.

STAGE 1   Identify Areas to be Considered

↓

STAGE 2   Define Standard Statement   ʼ ——▶   **Action**

                                                          Identify values and beliefs:
                                                          any internal or external factors
                                                          which affect statements. Use
                                                          research base where available.

STAGE 3   Identify the Questions which   ——▶   **Action**
            Arise from the Statements
                                                          Use a process outcome model.

↓

STAGE 4   Identify Clinical PI   ——▶   **Action**

                                                          Create and use an audit tool.
↓

            Collate and Compare Results

↓

            Access Hospital/Wards Progress
            and Review Values and Standards

Figure 41

Steps in Formulating Performance Indicators.
Bull (1992). Quality For Those Who Care. (IFS Publications).

Recognition, it was intended, would be based on sharing and celebrating TQM successes, in

the belief that the publicity value in recognition of ownership stake, power and influence

which the bottom-up eclectic TQM paradigm provided would be such as to encourage TQM

participation and commitment.

Emphasis was placed on communicating all TQM successes, however large or small and

TQM facilitators' sought to encourage Trust Board meetings and other appropriate meetings

to agenda TQM updates. The monthly newsletter had a page devoted to keeping readers

abreast of change and TQM progress and sought to continue culture change. Some teams

displayed information on a large noticeboard dedicated to TQM, placed in the hospital main entrance (later to become known as the 'Wall of Fame'), where detail of successes, storyboards detailing team missions, process, outcomes and team action plans were posted for up to one month. Suggestion for the award of certificates of appreciation as recognition of success was not thought to be appropriate by the majority to whom the suggestion was put.

Teams were continuously encouraged to determine their own recognition and rewards for contributing ideas, from which most were accepted. These included time-out for self-development, visits to other hospitals/Trusts to observe practice (and benchmark best practice), operation of staff managed flexi-time working arrangements, time-off for shopping and domestic matters and for a number, the opportunity for additional self-management and empowerment.

The stage provided opportunity for teams to further consider customer and purchaser involvement to that already undertaken, in seeking to establish customer satisfaction and delight. As such a number of data collection procedures were suggested as means for evaluation, particularly during the next eclectic paradigm stage.

The use of questionnaires, it was suggested, could identify quality criteria concerning treatment, communications, administration, health care processes, administration and environment matters, from which method for using benchmark points with questions set against them used.

Other means considered for establishing what delights internal/external customers and suppliers included random telephone calls, free phone lines, focus groups, naive listening calls and the notion of 'mystery shoppers' - covert observation and note of good and bad quality practice by person(s) not known to the Trust personnel.

Following presentation to the Director of Quality, agreed method concerned use of well defined questionnaires as qualitative evaluation in individual and group semi-structured interviews and use of focus groups, for concerning relationships between customers and suppliers and understanding further expectation and delight.

Telephone interview with named persons (some of whom had changed), responsible for quality management at the sixty-eight hospitals/NHS Trusts during March 1994 indicated that a further seven of the eighteen who were implementing TQM before the research programme began were re-assessing its value, thus leaving seven (39%) still applying it. Reasons given were more focus on cost cutting, fewer resources available, lack of top management support, failure to get clinicians involved, breakdown of commitment for teamworking, and moving on to other activities which more concerned hospital process re-engineering, patient focused care, care management and risk management. There was suggestion that TQM as evolution process had served them well.

Of the four who reported re-assessment of TQM in April 1993, three were particularly keen to emphasise their commitment to providing improving quality health care services, but indications were that they were placing less emphasis on using TQM method to achieve it and more focus on quality assurance personnel. One was in the early stages of seeking ISO 9000/BS 5750 accreditation, involving their Linen Services, Pharmaceutical Manufacturing Quality Control Unit and Engineering Services Departments, which they envisaged completing by the middle of 1995. Two were "looking at hospital process re-engineering" and one had re-introduced TQM using a different process model. Five of the thirty-one hospitals/Trusts who it was reported (April 1993) had begun TQM application were also questioning its appropriateness, reasons given were not dissimilar to those earlier recorded with the exception of one, who stated that their newly appointed Chief Executive had stated that "TQM was not appropriate for health care organisations". Nine reported they were making slow progress due to the resistance of "key players" and senior clinicians.

These apart, and with the good graces of the sixty-eight hospital/Trust participants, each agreed to complete a postal questionnaire concerning evaluation foci, targeting methodology used for measuring performance, identifying performance gaps and performance improvement. Contained in each of the fifty-nine returned questionnaires was suggestion for audit. Some (85%) placed evaluation emphasis on listening to patients, involving users and purchasers more, customer audit and means for user empowerment. Others (80%) ranked outcomes as important in terms of mortality, treatment successes, disease rates and quality of life issues. Those who suggested they would target process and organisation performance (93%), referenced matters concerning admissions, screening, referrals, discharge, protocols and consultant, doctor, nurse care matters.

A large majority (97%) identified the need for a more responsive complaints procedure, placing particular emphasis on the accessibility of procedures and means for understanding the motivation of complainants. Referencing DoH publication, 'Local Voices' (1992), one respondent suggested that, "to integrate local voices into a bureaucratic planning system required resources, time and considerable commitment!"

Two Trusts (3%), made reference to the use of method for measuring adding value activities and seeking elimination of work duplication. A number (12%) made reference for the need to focus the growth of administrators since the NHS reforms. One suggested that she had requested that a survey be undertaken at her hospital to establish, "unequivocal financial audit of how much money spent on management, had been diverted from patient care, since the reforms". There was suggestion by a small number (7%) that stricter conditions on treatments regarded as 'cosmetic' or low priority was needed. There was also reference, in this context, to cutting out ineffective and unnecessary treatments.

A number (24%) suggested audit to establish extent of a two-tier health service emerging with patients referred by GP fundholders receiving faster treatment. There were some suggestions (8%) to move more services provided by hospitals into the community, since extra NHS funding, it was suggested, was unlikely and resources would have to come from savings. One respondent wrote on his returned questionnaire that "there is a black-hole in the NHS, wherein rationed resources favoured younger patients at the expense of the elderly".

Some respondents (10%), stated that their 'episodes of care' procedure was confusing in that one patient may be counted as multiple episodes of care. There is, it was further stated, "no single set of unambiguous national rules to set procedure". There was suggestion (19%) that consultant surgeons needed to be more closely audited in terms of their NHS contracts, to establish how much 'unauthorised' time was spent treating private patients (this became unprecedented issued following the Yates (1995) report, 'Serving Two Masters').

At the end of March 1994, a total of forty-five self-managed teams were operational, a decrease during the process and implementation stage period of (10%). There were twelve department/functional teams, a decrease of (29%), one professional team, a decrease of (67%), twenty-nine cross-functional teams, an increase of (12%) and three inter-organisational teams, a decrease of (25%). A total of three hundred and ninety-seven case Trust employees were team members, (17%) fewer than at the commencement of the stage. Seventy-three additional employees joined teams or formed new ones (five in total) during the stage, thus indicating that one hundred and fifty-seven original (May 1993) team members had withdrawn (33%). This included some 38 managers, 4 consultants, 6 hospital doctors, 49 nurses and 60 support services personnel.

Approximately (30%) of the above were assumed to have withdrawn due either to no attendance (without reason given) at the last four consecutive team meetings or no team meeting taking place over a two month period (without reason given).

Reason given by those who indicated their withdrawal or team termination included: work

pressures, loss of interest, loss of belief, interference from the Chief Executive and/or

Director of Quality, poor response to suggestions which demanded extra resources, over-

emphasis on seeking to achieve cost reduction and statistical targets which focused less

quality of care, consequences of speaking out and personal reasons. Nineteen had

withdrawn because of job changes or natural wastage.

Analysis of success, however defined, continuation of teamworking into the evaluation

stage and the lowest number of team withdrawals are indicated in Table 16.

TQM Facilitator Involvement	Number of teams discontinued	Number of staff withdrawals	Number of Successes			Number of Failures
			(1)	(2)	(3)	
Extensive Involvement (30%)	0	22 (14%)	44 (41%)	43 (52%)	10 (48%)	7 (20%)
Intermittent Involvement (34%)	1 (20%)	37 (24%)	37 (35%)	28 (34%)	6 (28%)	9 (26%)
No Involvement (36%)	4 (80%)	98 (62%)	26 (24%)	12 (14%)	5 (24%)	19 (54%)

Note:

(1) = problem solving/problem prevention solutions.
(2) = continuous improvement successes.
(3) = radical change/patient focused care successes.

Table 16

Analysis of Continuation of Teamworking, Staff Withdrawals,
Successes and Failures Compared to Facilitator Involvement
During the Process and Implementation Stage
(May 1993/March 1994)

Trust T2, undertaking TQM application using the same definition and eclectic paradigm

reported that a total of thirty-one self-managed teams were operational at the end of April

1994, a decrease over the process and implementation stage period of (38%). There were

eight quality circles, a decrease of (69%), twenty-one cross-functional teams, an increase of

(11%), and two inter-organisational teams, a decrease of (60%). A total of three hundred and one employees were team members, (53%) fewer than at the commencement of the stage. Eighty-four additional employees joined or formed teams during the stage, indicating that three hundred and eighty-five original (June 1993) team members had withdrawn (68%). Information was not available to distinguish the proportion of managers/administrators, clinicians or support services staff who had withdrawn.

Reasons reported for withdrawal varied and included work pressures, loss of interest, reluctance to voice concerns, too much emphasis on cost cutting, loss of direction, change in strategic focus (league-tables), difficulties in receiving information, disinterest shown by clinicians, and poor middle management support. It was reported that two full-time 'Quality Facilitators' had been seconded, 1st April 1994, as attempt to "retrieve the TQM initiative".

Withdrawals and team terminations apart, it was stated, by the TQM Co-ordinator that, "a worthwhile number of successes had been achieved", which were described as problem solving/problem prevention achievements, estimated by him as involving (30%) of team activities. End-to-end process issues, described as "large scale and significant", accounted for (45%) of team activities, whilst the remainder, (25%), concerned radical change and patient focused care.

The Process and Implementation Stage, in the case Trust, had begun on the 1st May 1993 with a Chief Executive extremely visible and active in his support for TQM and bottom-up paradigm which aimed to encourage Trust employees to be part of quality solutions rather than a part of the quality problems and for them to determine the means for their participation in the TQM process, a process which had been well supported and co-ordinated by the Director of Operational Management.

The stage had ended with a new Chief Executive, also committed to TQM, supported by a part-time Director of Quality, both with a preference for leading more (top-down) the TQM process than was hitherto experienced and seeking team, individual and TQM facilitator focus on a number of performance issues, the least of which were not league table success, customer regard and cost containment. Although there were criticisms levelled at this approach there was also support from those who had sought stronger emphasis on tangible results.

Numerous successes were recorded during the paradigm stage in terms of translating customer, professional and manager quality requirements into action and criteria identified and used for evaluation and performance measurement. The Evaluation Stage which followed, further focused means for measuring and evaluating structure, process and outcomes whilst continuing to seek continuous improvement, radical change and patient focused care.

7.5   The Evaluation Stage

Three important foci were earlier noted concerning performance measurement, the identification of performance gaps and performance improvement, wherein reactive problem solving and pro-active problem prevention was important to team activities. Performance, although concerning quality also concerned productivity matters in terms of costs and time (access) issues.

The evaluation stage provided further opportunity for teams to evaluate the results of their actions and implemented solutions and identify means for evaluating structure, process and outcome quality. As a consequence, outcome management, Patient Charter/League Table and cost issues, in particular, continued their prominence throughout the stage application of TQM process.

No less contentious in securing team members agreement, than that reported earlier in this chapter - 7.1, Commitment stage, was concern for outcome management with its many and varied dimensions.

Al-Assaf (1993), explains that outcome measurement assists comparisons of past experience, stating that experiences between similar groups within the organisation are invaluable to benchmarking in an effort to learn from the successes to improve performance and select best practices. Two difficulties are noted, however, why health care organisations find it difficult to focus on outcome. One concerns outcomes requiring global attention, in that all of the results of patient episodes are required, and second, they consider outcomes to be consultant/doctor focused, or, at the other extreme, dependent on too many individuals.

Contrary to these views, the applied TQM paradigm involved some teams in the case Trust achieving results through the series of processes performed, continuous improvement, and other teams aligning themselves around the whole process, not the parts - radical change. Outcome, in these instances, was taken as being dependent on structure and process.

With regard to the second difficulty noted above, some teams focused consultant/doctor outcomes, as earlier reported, whilst other teams explored outcomes which occurred either without or with limited consultant/doctor participation, for example, hotel experience, patient satisfaction feedback, facilities, meals, visiting areas, car parking ...

Where outcomes were traced to original source, problems were solved and steps taken to prevent reoccurrence, concerning the processes lending to it. Data collection method, using fast response technology, where available and understood, and methodology developed during team training was such as to take account of means for measuring and evaluating structure, process and outcome quality.

There was particular focus on patient perspectives concerning the outcome of care. Some teams (31%), suggested procedure for patient feedback, mostly in the form of direct interview supported by the use of self-completion questionnaires and, where appropriate, such existing procedures as Sickness Impact Profile (SIP 1981), Nottingham Health Profile (NHS 1984) and recommendation by Kerruish et al (1988). These concerned establishing end result of process, protocol or procedure delivered in the form of improving medical status of the patient, as indicators of quality of care rendered during patient involvement with the Trust.

Since a number of team members continued to demonstrate a somewhat simplistic and varied notion of outcome management, they found it helpful to use Elwood's (1988) analysis outlined in Table 5. This the Executive Board and Management Team Members had agreed as basis for collaborative action in seeking ability to bring together aspects of outcome measures, with information regarding process and input, in order to address issues of effectiveness.

Noting Elwood's, reported by Coles (1990), acknowledgement that outcome information is less than perfect in the strength of causal links between medical care and effect of well-being, the varying reliability and sensitivity of patients' subjective opinions, and a lack of denominator for including patients' who fail to make contact with the health care system, the most immediate realisable benefits were sought in the subjective areas of creating participation, dispelling suspicion and progressing towards a fairer and more effective care system.

Despite pilot surveys, experimentation and attempt at simulation, no single procedure was agreed for data collection method. Consequently a number of questionnaire designs, approaches to interviewing, opinions concerning timing from patient discharge and likely effect of external factors (to the Trusts' involvement with the patient) resulted. Consistent

with, and a consequence of, recommendation that performance monitoring procedure should be recommended by those directly concerned, there were mixed feelings of correct method applied and varying successes claimed. Although some inter-team benchmarking took place, there was not support (by the Chief Executive) to permit benchmarking across the sixty-eight participating hospitals and Trusts, who the researcher had agreed with to take place. An opportunity lost to target sites with similar profiles and share data concerning best practice and procedures for outcome management.

A majority (76%) of teams who had earlier, at the process and implementation stage, accessed or developed flow charts or major trails of clinical, managerial and support services activities to seek continuous improvement, radical change and patients focused care, sought also to use the trails to determine appropriateness or establish and re-invent key quality indicators. A number of teams found it particularly helpful to reference Koch (1992) in order to establish key quality indicators for:

- **Clinical Activities - Patient Acceptance; Care; Assessment and Diagnosis; Treatment; Discharge.**

    ↓

- **Accept Patient - Accept Referral; Assess urgency; Appointment; Contact; Pre-Appointment Information; Links to Care and Assessment.**

    ↓

- **Care - Physical and Social Environment; Organisation and Management; Communications with Patients and Staff.**

    ↓

- **Assessment and Diagnosis - Listening to Patients; Observe, Question and Examine Patients; Organise Tests; Perform Tests and Commence Care Planning.**

    ↓

- **Treatment** - Development of Care and Treatment Plan; Implementation and Management of Plan; Clinical, Remedial and Support Services Provided; and Patient Management Reviewed.

↓

- **Discharge** - Discharge Plan; Home Support Assessment; Discharge Decisions; Discharge Arrangements with Patients; and Patient Departure.

Researcher observation of teams (7%), concern for measuring outcomes of medical care, some five years after, the 1989 Royal College of Physicians and the King's Fund Centre for Health Services Development Conference, which targeted the measurement of medical care outcomes, found it difficult to disagree with conclusions made by Clare (1990), namely that it is not easy to argue that the medical profession has really taken seriously the need to establish how the outcome of many of its interventions might be assessed and how appropriate many of the treatments might be in the first place. Two major conclusions made were that it is indefensible to avoid measures of outcome and rely only on measures of output, and secondly, such measurement cannot be left to any one group because it affects everyone - politicians, professionals and the public.

Recognising the growing concern about quality in the NHS in need to reassure that the best that can be afforded is available, and extent to which performance measurement is a research subject in itself, to seek best use of standards and exemplify good practice, the DoH (1993), commissioned Keele and Bath universities to study what accreditation could bring to the NHS. A starting point involved them in examining the organisation structures and procedures involved in hospital accreditation systems found in Australia, Canada, USA and UK.

Audit has a history of expectation in the NHS, the earlier mentioned Cogwheel Report (1967), Chapter 2, recognised it as proper function for practising clinicians, the Royal Commission Report (1979) re-emphasised it and the White Paper Working for Patients (1989) stated that all doctors should become involved in audit, which through NHS Circulars

extended it to include nursing and others, one year later. Audit had become the provenance of teams in the case Trust before TQM began. It was not unexpected then, that most teams (78%), in part and some significantly, concerned themselves further with method and management of audit. Some claimed they found it helpful to reflect Trust methods, with audit cycle recommended by Crombie et al (1993), as means for defining, refining and modifying quality standards of care, Figure 42:
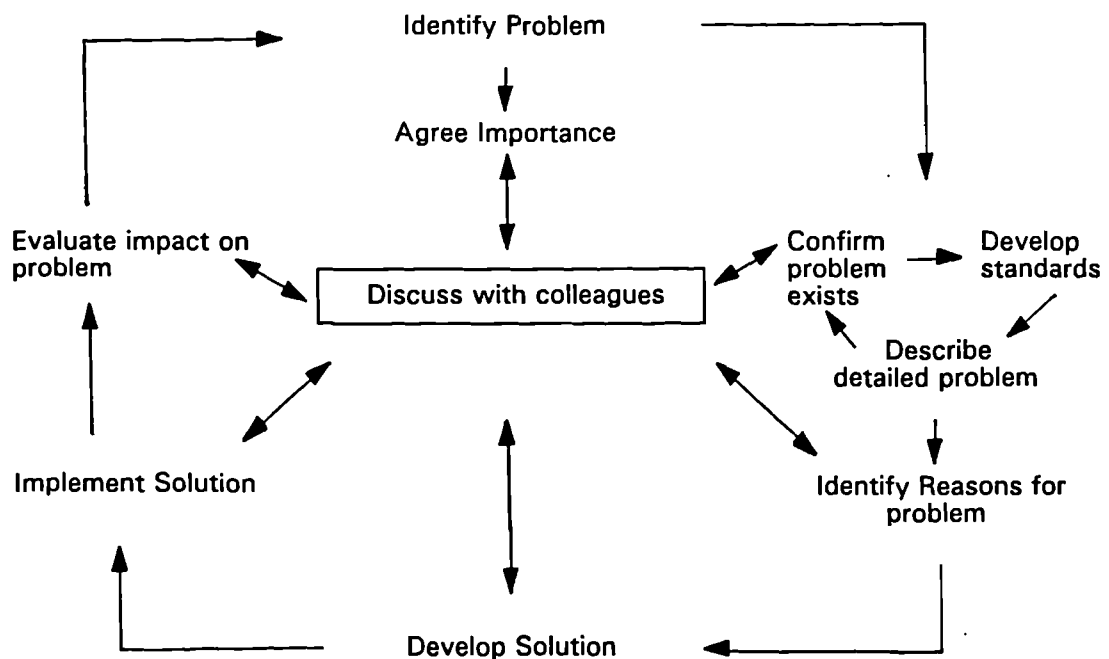
Figure 42

The Full Audit Cycle
Crombie et al (1993). The Audit Handbook (Wiley).

Procedure, such as audit cycle which is on-going and continually repeated provided some team members with the means to, review procedures and standards; apply innovation to continuous improvement, radical change and patient focused care; inform, more responsively, management and colleagues, in a manner which was not dissimilar to Table 4 comparisons of static and dynamic auditing, Barthelemy and Zairi (1994).

275

A number of audit issues were explored by teams and recommendations made to either the Steering Group or the Audit Advisory Group. These are reported under three particular headings, namely those which were supported and implemented, those which were supported but no action taken and those which were not supported.

Supported and implemented - stronger linking between Audit Advisory Groups, a fuller and more open use of audit results, seeking common agenda of what should be delivered and how it should be delivered, improvements in the quality of internal audit, wherein one team reported that results from activity sampling suggested that little more than half of the Trusts' internal audit sections complied with NHS mandatory audit standards, and organisational audit, as means for specifying quality and ensuring that organisation and communication systems were in place to support clinical care.

Supported but no action taken - forum for exchanging views, knowledge and understanding regarding information contained in healthcare bulletins, clinical guidelines and protocols recommended by the government, negotiation regarding audit topics, means for re-constituting Audit Advisory Groups to make them more multi-disciplinary so as to more reflect the user/purchaser agenda and the contracting processes, explicit clinical audit links with the TQM process and expanding further internal and functional benchmarking and more focus on competitor benchmarking.

Not supported - recruitment (or retraining of staff), to secure high quality, mixed skills audit staff, a 'purge' on professional secrecy and the protection of professional interests, focus on reducing bureaucracy, introduction of customer or independent led audits and the continuous re-invention of guidelines based on emerging evidence.

A number of recommendations made concerned educating patients and the formation of patient groups, for example, with the Community Health Council. Some favoured targeting

Community and user groups more, building stronger links between primary care teams and involving users and purchasers in monitoring standards. One team, in its earlier consideration of auditing, suggested, in context of the Patient's Charter, need to audit effectiveness of care protocols more.

Recommendations which received particular favourable response from the Chief Executive and Director of Quality concerned the performance measurement and reporting of the centrally monitored Charter Standards Team and management attention was drawn to matters of weaknesses in data collection procedure, trend analysis and clinical audit links to waiting time issues, for example, those concerning the effect of applying the two year requirement on patients with seriously disabling conditions, compared with those with minor ailments, and waiting list length of up to one year and one to two years, with regard to 'patients right to receive health care on the basis of clinical need'. Attention was also drawn to admission to hospital within one month of two earlier admissions cancellations, outpatients being seen within thirty minutes of appointment times and Accident and Emergency response rates. Emphasis, it was suggested, should be placed on opportunity to seek means by which the Patient's Charter could assist the Trusts' public relations.

The Chief Executive at one point reminded a multi-disciplinary team who were concerned with the choice of indicators for monitoring standards, that the Trust was "under no obligation whatsoever to make public its local charter, nor indeed to report detail of the Trusts performance results against their local charter standards".

The cross-functional project team, formed towards the end of the process and implementation stage from TQM team members, the full-time TQM facilitator and five others, to establish the costs of quality in the Trust, adopt definitions of conformity and non-conformity costs which were clear and unambiguous, and establish means for managing interface between TQM and financial accounting, reported back to the Steering Group on

the 1st August 1994, some six months from commencement. Most team meetings were attended by the researcher as observer and in some instances as contributing participant.

Early stages sought agreement regarding definition placed on cost categories and the elements used in compiling them, Dale and Plunkett (1990). Failure costs were regarded as work undertaken which failed to reach specified standards. These were broken down into internal failure costs, in terms of those costs which occur before delivery of service to the patient and the external costs not detected until service is delivered. Particular focus concerned the elimination of waste which resulted from poor organisation planning, ineffective use of time and resources, mistakes and their correction, the costs of receiving, investigating and dealing with complaints and the potential consequence of complaints on Trust reputation. Earlier TQM team outcomes, many of which were recorded in a way which enabled the use of fast response technology, provided access to information on a need to act basis, and in addition, research results available at the time provided an invaluable data source.

Appraisal costs concerned the Trusts' evaluation activities which sought to ensure that standards were met, the least of which were not, audit, patient satisfaction surveys and a growing focus, it was suggested, on vendor rating, particularly concerning pharmaceutical purchases. Prevention costs were defined as the costs of activities undertaken to ensure delivery of high quality health care from and including the design stage, through implementation and maintenance, to delivery. These included specification of service requirements through clinical and administrative protocols, Patient's Charter service standards and patients rights and attainment of the Trusts' mission statements. Quality planning, quality assurance, TQM, teamworking and training formed a significant part of the prevention costs.

The Director of Quality requested the project team to consider Activity Costing as method for underpinning analysis of activities and enabling stronger interface between quality

278

management and financial accounting. A half-day workshop, which he led, for team members and a number of Trust Board Executives and senior managers and clinicians, provided opportunity to describe methodology resulting from a Yorkshire Health funded quality costing project undertaken and staffed by Touche Ross health care group (1993-94), wherein procedure had been developed for establishing costs of quality problems, and guidelines produced for resolving them through quality improvement programmes.

A number of their recommendations available at the time were explored in the context of the Trust and suggestions made for their implementation. These included the design of a questionnaire which was distributed to Directorates and Departments to establish problems encountered by staff, amount of resource and time wasted and the establishment of activity maps, which identified the patient care processes in the form of patient flow (paths taken by patients through the care services), information flow and material flow. These were not dissimilar to service maps referenced, Chapter 3 - 3.6, which illustrated processes as flowcharts of inter-related activities and the major trails which teams had developed, of clinical, management and support service activities, making it possible to identify fail points within the processes where quality was perceived as inferior.

There was strong evidence of need for describing the services from the perceptions of the patient and their expectations, and also from the quality perceptions of the professionals and managers. The activity maps developed, identified the inputs which constituted each care activity and the resources used for achieving them. This provided a basis for quality improvement, firstly by identifying where improvements could be made in the detailed processes, secondly by the production of lists of problems associated with the processes and thirdly by tracking and reporting the severity of the problems encountered at the stage points in the patient care processes.

With assistance from Finance and Information Management, mapped activities were given a cost, thus assisting team members to establish the amount of money lost due to waste caused by the fail points. Through the TQM focus on continuous improvement, radical change and patient focused care, means were suggested for further improvements and the re-invention of quality performance.

The success of this project were such as to include the concepts of quality costing and methodology for Activity Costing in TQM Training Workshops which followed, involving a further seventy-three case Trust personnel.

In addition to the not insignificant role of Activity Costing method as part of the TQM process, Audit of Accounts Reports also provided useful review of, organisation arrangements and management/monitoring information for the delivery of services, the quality of inter-agency collaboration, particularly with the social services, FHSA and health purchasers and quality matters relating to the operational areas.

Three teams (7%), who regularly exchanged views and information with each other and on occasions held joint meetings, concerned themselves with competition, in terms of markets being user/purchaser driven, whose needs and expectations ranged from being well expressed to barely implied. They were particularly concerned at complaints concerning case Trusts' inability to provide a number of quality services, reported by a participating GP and endorsed by others, and their unwillingness to negotiate price.

They sought ways to empathise with user/purchaser needs, expectations and delights and to have them reflected in strategy. Customers in health care, particularly patients, family members and the public could provide information, although not necessarily insight, they believed, thus direct interaction and personal involvement, through focus groups enabled knowledge and understanding accumulation, for sharing with other teams, in the form of data information base for customer audit and patient empowerment.

Four Focus Groups involving thirty-seven patients/family members/public and six GPs, provided opportunity for shared decisionmaking to establish wanted standards of care and acceptable trade-offs once awareness was increased of limited resources and money. Discussions concerned information which patients should be provided with, concerning planning, contractual decisions and limited explanation of a number of treatment risks and benefits which engaged clinicians, GPs and to some extent patients, in discussion concerning balance of risks and benefits.

Each of the four Focus Group Meetings were attended by the researcher, which although pleasing the Director of Quality from a public relations perspective, appeared to the researcher to bring little more in the context of TQM evaluation than an indication that six patients, family members/public (16%) would consider participation in regular meetings (monthly), or teamworking concerning customer issues in health care delivery. Two GPs (33%) also said they would give consideration to such a request. As noted earlier, 7.3, seventeen members of the public and nine GPs participated in Self-managed teamworking during implementation and application of TQM in the case Trust, now resulting from Focus Group suggestions, followed by an inter-organisational team, concerning value of inter-organisational working in small teams. Resulting from the exploration two additional teams were formed, involving eight new and two existing Trust personnel, three GPs, two health authority staff, one Community Health Council Member and five members of the public. Intention was for them to establish clearly defined service-specific agendas (projects), aimed to promote exchange of ideas, opinions and perceived value satisfactions and to provide advice and support for Trust activities and endeavours to improve and evaluate quality health care provision. Some recommendations for improvements resulted, including one concerning complaints about complaining, in which, and consistent with earlier mentioned gurus Chapter 3, complaints rather than being buried were seen as a key to quality success.

A more responsive procedure was sought in connection with Patient's Charter requirement

for reply following complaint about medical care. Attention was first paid to GP complaint

systems, in particular the time·limit (thirteen weeks), to make a complaint should something

go wrong and value of appeals procedure heard at the FHSA (Family Health Services

Authority) panel, consisting of doctors and laypeople, wherein the doctors are local doctors

and are likely to know the doctor the complaint is against. Some patients were critical of

the low number of doctors who are found to be in breach of their contracts (stated to be in

the order of 10%).

Mindful of DoH constraints to make sweeping and radical changes and concern of the

Health Secretary to review all such procedures, team focus was directed to method for

attitude change from being defensive, to one of seeking learning experience from

complaints, in order to improve practice.

Suggestions were made for GPs to meet monthly with patients to listen and learn from each

other, and to: establish a patients' friendly (easy to use, non-intimidating) complaints

procedure; present analysis of complaints in an easy to understand way and actions taken

to prevent re-occurrence; and appointment of a patient representative to look after patient

interests and to avail themselves to patients, family members and carers to discuss their

concerns about the services offered. Their role, it was suggested, was also to advise on

options which were available for complaining and support patients' through the formal

procedures as appropriate. Two of the three team-member GPs visited a number of GPs in

West England, undertaking similar procedures to benchmark best practice and record views

concerning evaluation of outcomes.

Although change not dissimilar to that suggested concerning GP practice was recommended

to the case Trust, with regard to complaints about hospital clinical practice, they continued

to place faith in a system where a consultant looks at complaints from which there is right

of reply and where dissatisfied patients have access to the Regional Director of Health who

decides appropriateness of further investigation in the form of independent professional review undertaken by two further consultants' examination of patients case notes and meeting with the patient.

A major part of the evaluation stage from the researchers perspective was to use opportunity available to involve a spread and mix of people to establish their views concerning issue of service quality defined and measured by providers and evaluated by users, purchasers and the public, in that stated importance of the stage, Chapter 4 - 4.4, was capability to understand needs, expectations and the form by which customers perceive and evaluate quality of service.

Eighteen months earlier during the identification stage, 7.3, a total of one hundred and forty-nine Trust employees, GPs, patients and family members participated in summative and qualitative evaluation concerning attention directed at outcomes, service inputs, throughputs and outputs. These views and those from TQM Awareness and Action Workshops provided a most useful information base for team activities during the process implementation stage. No less important was data collected and analysed during the evaluation stage wherein two hundred and forty-nine Trust employees, representing the mix of Directorates and Departments, in the form of 59 managers, 7 consultants, 19 hospital doctors, 69 nurses and 95 support services staff and 6 GPs participated in individual, group or team structured and semi-structured interviews, Appendix 28. One hundred and twenty-one randomly selected patients involved with the spectrum of care services and twenty-one family members participated in indirect interviews, which in part were in the form of conversation directed to definite purpose. A total of four hundred and nineteen self-completion questionnaires, Appendix 29 were completed and returned from Trust employees (48%), patients (32%) and family members (20%).

The four hundred and nineteen earlier participants involved with the identification stage were invited to attend feedback meetings/workshops in which fifty-seven participated, providing further comparison between the two time points. These included 8 managers, 1 consultant, 3 hospital doctors, 11 nurses, 12 support staff, 3 GPs, 17 former/current patients and 2 family members. These, plus feedback from TQM Awareness and Action Workshops, established views and opinions concerning value satisfactions, impact of TQM application and extent by which TQM process had improved sense of well-being, self-confidence and changed perceptions regarding achievement of other criteria. Effectiveness issues concerned access to services, personal consideration and respect, information provision, waiting time and value satisfactions of care. Central to evaluation of efficiency was the elimination of waste in the form of failure to add value.

As spectator to quality activities, concerning provider, user and purchaser interface and the value satisfactions which resulted, the researcher, mostly through overt observation, was able to establish and report performance gaps between that which was said to take place and that which did take place.

During identification stage interviews earlier with Trust employees, (21%) indicated that should a close family member or themselves become gravely ill they would prefer not to be treated by the hospital. When asked the same question again some eighteen months later, (11%) gave the same response, which is not dissimilar to the (9%) response from those not previously involved in interview.

Earlier, (63%) of patients and family members said they were dissatisfied with Trust quality performance in terms of the TQM definition, when asked again to indicate their perceptions of Trust quality performance (37%) of the earlier participants said they were still dissatisfied compared with (43%) of those not previously interviewed. Referencing patient empowerment an arithmetic mean of (16%) of both patient/family member groups said they would consider team participation and/or attendance at meetings concerning the design of

284

quality services, (85%) stated that they would agree to provide information to 'tailor' services towards their needs and expectations.

Earlier participating Trust employees suggested that improvements had taken place, since the identification stage, in matters concerning interaction between people, across the Directorates and departments and between the professions, particularly citing that between clinicians and non-clinicians. Sharing information concerning Trust functioning which directly affected process of quality care and meeting standards and Patient Charter expectation was also said to have improved. Most felt a stronger feeling of influence over decisionmaking in relation to Trust changes, particularly those which affected them.

A majority (67%), who had actively participated in TQM process implementation and application said that it had proved worthwhile in providing focus on strengthening partnership between provider, user and purchaser and in achieving TQM definition, mission statements and protocols in many parts of the Trust. A minority (29%) said that many Trust improvements would have been made without the introduction of TQM method, in the light of the reforms, Patient Charter, Local Charters and the emergence of the NHS League Tables, a few (4%) said that they didn't know.

A number of the senior managers and clinicians interviewed and who completed questionnaires (54%) said that continued teamwork should concern more focus on hospital process re-engineering and patient focused care issues. Some respondents on the other hand (39%), said that two years of TQM application had been sufficient time for staff to target solvable problems, suggest means for preventing reoccurrence and establish more effective and efficient ways of working within the Trust constraints. There was suggestion during interview when probed, that it was time to consolidate the changes.

Some (14%) expressed opinion that they were tired of people placing so much emphasis on quality of health care which is what most people in the NHS did anyway, with or without TQM.

A majority (55%) of those who had not actively participated in TQM process said they had been supportive of change in their workplace, almost a third of them on the other hand (31%), said that given benefit of hindsight they had made the correct decision not to concern themselves. One respondent who claimed to be a non-participant wrote on the returned questionnaire that "if the Trust spent more time applying quality improvement than merely talking about it, we would all be better off".

The Chief Executive during interview said that in the short time he had been with the Trust he had seen a good mix of tangible and intangible results which he put down to sound and conscientious teamworking, "whatever label it carried". He was praiseworthy of his predecessor for taking the initiative in the first place and "carrying so many of the Executive Board Members with him". He hoped that teamworking would continue, probably through a fewer number of teams, aiming to strive for further excellence in the provision of quality health care. He was not convinced that 'Total' meant involving everyone in the organisation.

The Director of Quality expressed views and outline plans for placing more emphasis on matters concerning hospital process re-engineering, care management, patient focused care and shared decisionmaking. Rather than a 'bottom-up' paradigm he said, "he would have insisted on a strategy which phased-in TQM implementation, with top management and clinicians identifying where was most appropriate in the Trust to begin. Note of commitment for making continuous improvement and radical change would also have been essential for projects supported and financed".

The Director of Operational Management in endorsing the success of TQM application, praised the TQM facilitators for their "unstinted efforts" and everyone who was participating in the process. He indicated his regret at not continuing his co-ordinating role.

The TQM facilitators', who with the exception of one, had facilitated all the TQM eclectic paradigm stages, said that progress made in two years was more than their original expectation and it was their view that culture change was such and quality data base established to continue the spirit of self-managed teamworking into "other areas". Stronger focus was suggested for end-to-end radical change projects involving more users, purchasers and outside agencies, collectively asking the question of services, processes and procedure - why do it at all? They equally suggested further radical review of the way services were provided to patients, putting patients at the centre - patient focused care. Four of the six facilitators, including the full-time facilitator saw advantages of exchanging some of them each eighteen months to two years to bring to the team new ideas and new commitments.

The facilitator employed by the Trust as a Complaints Officer expressed belief that a stronger use of interview coupled with a well-designed self-completion questionnaire, from that currently used, listing one hundred and fourteen questions, would enhance customer involvement with the Trust. As facilitator to a number of teams (earlier mentioned) concerned with procedure for patients' feedback she was keen to establish agreement on procedure.

It was not intention to develop or undertake in-depth customer research for, as pointed out earlier, the health service has been deluged with methods of consumerism since the Community Care Act 1990 gave both health and local authorities a duty to consult users and carers. During the 1990s there has been a plethora of research undertaken and publications in the name of consumerism, the least of which were not: Mould (1991), Local Voices (1992), Barnes (1992), Brant (1992), Hayden (1992), Booz, Allen and Hamilton

(1993), DoH Being Heard (1994), Mawhinney (1994), Mulcahy and Tritter (1994) ...

Targeting and recording detail concerning statutory duty matters, or explicit detail of types and forms of medical information, ward matters, new treatments on offer at home or in hospital, arrangements for accident and emergency ... Many questionnaires referenced on such matters often run into hundreds of questions asked.

It was intention to compare responses from internal/external customers and suppliers in the form of patients, family members, members of the public, purchasers and Trust personnel to answers recorded at the identification stage concerning the researchers' summative and qualitative evaluation put into question form at the evaluation stage, some two years following implementation of TQM in the case Trust. Main concern, from the researchers' perspective, was to seek to establish views from respondents with regard to criteria status established from the views earlier recorded, in order to attempt identification of improvements from TQM definition used and eclectic paradigm applied.

Table 17 indicates responses from Trust personnel, Patients and Family Members, on matters earlier headed 'Patients', 7.3.

TQM activities (training and teamworking) earlier focused matters concerning attitudes, particularly at the Deconstraining Stage, and availability of information on a need to act basis, GP Complaints matters (hospital complaints procedure recommendations not implemented), waiting times (Patient's Charter/League Table criteria) at the identification, process and implementation stages wherein an inter-organisational team had also been concerned with services in the community.

Quality Criteria Used - Patients Focus	Trust Personnel Percentage Responses			Patient/Family Member Percentage Responses		
	Worse	No Change	Better	Worse	No Change	Better
Consultants/Doctors Attitudes	14	40	46	33	49	7
Nurses Attitudes	8	52	40	15	58	27
Support Services Staff Attitudes	22	57	21	20	52	15
Quality/Quantity/Availability of Information	5	27	68	14	51	22
Amount of Information given out by less experienced junior personnel	28	60	12	26	51	8
Handling Complaints	17	43	40	41	50	3
Waiting for Admittance for Treatment	29	55	16	46	43	4
Waiting for Treatment Clinics ...	7	23	70	8	26	66
Cancelled Admittance	10	51	32	41	48	0
Cancelled Operations	17	45	33	34	46	12
Abuse of Patient's Charter	4	31	56	15	22	8
Services in the Community	16	49	28	38	54	0
Balance between Health Care and Social Needs provision	27	46	21	40	51	0
Ward Comfort - hygiene, cleanliness, food, facilities	5	36	59	12	42	26
Adequacy and Availability of Nursing	15	43	36	12	49	39
Arithmetic Mean	15%	44%	39%	26%	43%	16%
	Sample size n = 485			Sample size n = 379		

Note: 'Don't Know' answers not indicated make up shortfall percentage balance.

Table 17

Responses from Trust Personnel, Patients and Family Members
Concerning Perceived Quality Matters. Evaluation Stage.

Responses from staff and patients/family members suggested that attitudes had improved, arithmetic means (36%) and (16%) respectively. Trust personnel suggested more attention towards improving the attitudes of Support Services Staff, confirmed to some extent by researcher observation of matters pertaining to organisation issues, information sharing and attitude towards their clinician colleagues. Patients/family members recorded lowest improvement in the attitudes of consultants and doctors. Probing suggested poor communication and inter-personal skills as major reasons.

Information availability, central issue in TQM application, had improved significantly from the perspective of Trust personnel. Further improvement from the patient/family members' perceptions, it was suggested, could be achieved by better quality and timed information concerning them understanding their illness more and the way it was to be managed.

Handling complaints, although perceived by (40%) of Trust personnel as improving, was seen by as many patients/family members as getting worse. Following publication of Table 17 to the Chief Executive and Director of Quality, a meeting was arranged with the inter-organisation team members and the Complaints Officer to explore recommendations earlier made with regard to complaints about hospital clinical practice.

Waiting for admittance for treatment, contrary to Trust statistical data concerning waiting lists of upto one year and one to two years, which indicated a reduction in both, was perceived to be deteriorating by (46%) of patients/family members, justifying earlier reported team concerns for data collection procedure, trend analysis and clinical audit links to waiting time issues.

Services in the community response was a particular disappointment to team members who had focused procedures and constraints concerning care in the community issues and concern for carers. The team chose to re-visit a number of key issues.

There remained a number of other differences between those which Trust employees believed they were providing as quality of care services and those perceived by the customer, the least of which were not, cancelled operations, care and social needs provision and abuse of the Patient's Charter. It was clear from patient/family member responses concerning Patient's Charter, (45%) that more needed to be done to communicate Charter expectation. The majority of those who perceived Patient's Charter abuse, exampled waiting to see a consultant or doctor or waiting in the accident and emergency department, for example, wherein a most minor interaction between them and a Trust employee constituted achievement of waiting time requirement.

Table 18 are recorded responses from non-clinician and clinician Trust personnel concerning matters which were reported under the heading, Clinicians and GPs, 7.3.

Although a substantial list and one which more communicates respondent concern for improvement and change rather than applications action, a likely consequence of relatively fewer consultants and hospital doctors being actively involved in TQM process, Table 18 does provide some evaluation of TQM application. These concern GP involvement in teamworking and focus group attendance, wherein opportunity was available and taken to detail complaints. Although not considerable, a consistency of views between non-clinician and clinician Trust personnel (15%), suggested improvements taking place in this area of earlier concern.

All teams had on some occasion been concerned with effectiveness and efficiency matters, of which concern for better use of facilities was prominent. Although suggested improvements were reported to the Steering group, and many implemented, this remained an area of reported concern with an arithmetic mean between both groups of (27%), indicating that there were even more idle facilities.

Quality Criteria Used - Clinicians/GP Focus	Non-Clinician Trust Personnel Percentage Responses			Clinician Percentage Responses		
	Worse	No Change	Better	Worse	No Change	Better
GPs meeting Providers to Detail Complaints	6	28	15	0	38	15
Fundholding Causing a Two-Tier System	41	36	12	18	63	0
Support Services Staff Attitudes	22	57	21	20	52	15
Fundholding Meaning More Competition/Less Co-operation	36	51	0	16	84	0
Working Excessive Hours	62	28	0	71	22	0
Stress of Working	58	31	0	66	30	0
Idle Facilities	24	60	16	29	55	16
Managers/Administrators from a Non-Medical Background	14	73	11	16	70	5
Establishing Amount of Information to give to Patients	-	-	-	31	43	22
Amount of Paperwork	13	34	48	29	48	18
Time Spent by Consultants with Junior Doctors	15	26	0	51	40	9
Supervision of Junior Doctors	13	29	4	46	36	12
Junior Doctor Training	-	-	-	48	37	10
Consultant Training	-	-	-	53	39	8
Own Monitoring of Work	4	32	59	4	51	33
Working in the Private Sector	46	31	0	13	42	45
Arithmetic Mean	28%	38%	14%	33%	47%	13%
	Sample size n = 273			Sample size n = 221		

Note: 'Don't Know' answers not indicated make up shortfall percentage balance.

Table 18

Responses from Non-Clinician and Clinician Trust Personnel
Concerning Perceived Quality Matters. Evaluation Stage.

The quality of paperwork required by the Trust was a major concern raised by a spectrum of personnel and one which many teams concerned themselves with in one form or another. Non-clinicians (48%) recorded improvements compared with clinicians (18%). In contrast, however, (29%) of clinicians, compared with (13%) non-clinicians, actually thought it had got worse.

Own monitoring of work was a particular, bottom-up paradigm approach and one in which teams had used to develop, share and benchmark processes and procedures. TQM application does appear to have had a beneficial effect in that (59%) of non-clinicians and (33%) of clinicians recorded improvements.

Quality Criteria Used - Management Focus	Management Trust Personnel Percentage Responses			Clinician Percentage Responses		
	Worse	No Change	Better	Worse	No Change	Better
Shortage of money	12	76	4	28	69	0
Control of clinicians	14	81	5	0	91	0
Surveillance of consultants	21	76	5	0	84	0
Clinical freedom issues	23	46	31	39	29	23
Professional judgement issues	14	33	0	41	57	0
Clinicians awareness of protocols	5	36	59	0	61	39
Consultants/doctors awareness of results of clinical trials	8	31	16	5	64	31
Patients receiving best treatment	6	24	70	11	30	59
Monitoring medical personnel to ensure awareness of drugs side effects	4	31	19	0	49	0
Introducing Scientific knowledge into everyday patient care	6	27	20	0	46	41
Getting research information across to clinicians	9	21	21	14	28	53
Changes in government direction	23	26	48	25	62	13
Arithmetic Mean	12%	42%	25%	14%	56%	22%
	Sample size n = 67			Sample size n = 221		

Note: 'Don't Know' answers not indicated make up shortfall percentage balance.

Table 19

Responses from Management and Clinician Trust Personnel
Concerning Perceived Quality Matters. Evaluation Stage.

TQM focus concerned teamworking addressing such issues as clinical freedom (undertaken by a professional team, who requested anonymity), clinicians awareness of protocols, patients receiving best treatments, introduction of scientific knowledge into everyday patient care and getting research information across to those who needed it. Other quality concerns earlier mentioned have not, to date, been targeted.

Clinician freedom was reported by (31%) of the managers as improving, reasons given included Trust management being more in control of hospital resources and matters concerning admittance, bed occupancy, protected beds, length of stay and discharge in particular. Some (39%) of clinicians and doctors saw this as deterioration, probing suggested encroachment on "professional judgement", as reason. Other clinicians, mainly nurses, (23%) also saw clinical freedom issues as getting better.

TQM focus from the point of introducing Trust personnel to the TQM definition and eclectic paradigm evidenced the further development of mission statements and protocols in a style which made them more explicit and understandable to those other than the immediate users. This appears, from both group responses, to have been most beneficial with (59%) of Trust managers and (39%) of Trust clinicians saying they were more aware of them now than they had been some eighteen months earlier. Researcher observation was such to note protocols being referenced in teamworking, further developed, re-written, used in audit activities and noted in written team reports.

A team was earlier reported as concerning itself with 'best' treatments, use of scientific knowledge and getting research information across to enhance patient care. A number of presentations [three over a ten-week time period) resulted in a number of changes being made. It would suggest, from an arithmetic mean of (37%) from management and (51%) from clinicians that improvements had resulted in the three earlier reported areas of concern - Patients Receiving Best Treatment, Introduction of Scientific Knowledge into Everyday Patient Care and Getting Research Information Across to Clinicians.

Table 20 notes recorded responses from Trust personnel which concern matters earlier reported under the heading, organisation 7.3.

Quality Criteria Used - Organisation Focus	Trust Personnel Percentage Responses		
	Worse	No Change	Better
Data Retrieval	5	41	64
Data Reliability	12	16	72
Planning/Control	15	53	32
Accounting Systems	9	21	57
Quality Costing	0	34	51
Effectiveness of HA	13	39	43
Conflict Between Continuing Care Beds and Residential Homes	19	46	4
Ambulances/Capacity	35	41	8
Ambulances/Planning	26	45	12
Availability/Use of Equipment	11	52	37
'Protected' Beds	14	28	49
Attendance at Discharge Meetings	0	31	47
Supplier Vendor Rating	0	18	35
Job Plans for Doctors and Consultants	0	36	19
Inter-Department Rivalry	4	29	67
Auditing	10	30	53
Arithmetic Mean	11%	35%	41%
	Sample size n = 485		

Note: 'Don't Know' answers not indicated make up shortfall percentage balance.

Table 20

Responses from Trust Personnel
Concerning Perceived Quality Matters. Evaluation Stage.

A number of TQM activities here listed under organisation focus concerned data retrieval and reliability, discussed earlier in connection with Table 17, where (68%) of Trust personnel said availability of information had improved between the time points. Equally, an arithmetic mean of (68%) of Trust personnel said that data retrieval (64%) and data reliability (72%) had also improved.

Quality costing, a TQM team activity, with Director of Quality influence, was reported by (51%) of respondents, as having got better. A similar number (53%) reported improvements in auditing, which was of little surprise to the researcher since so much team effort had gone into auditing procedures, processes and means for reporting, sharing and benchmarking outcomes in particular, during the process, implementation and evaluation stages.

A most significant response, particularly in terms of deconstraining stage efforts and focus was in the reported reduction of inter-department rivalry, wherein (67%) of respondents reported that this had improved, (got less). As spectator to a significant number, wide spread and mix of TQM activities in the case Trust during the two year and one month time period, barrier breaking was one of the most notable successes considering organisation, management and culture matters earlier reported.

Table 21 presents analysis of responses from Trust personnel, patients and family members on mattes which were earlier listed, 7.3, under the heading, competition and survival issues.

A similar number of Trust personnel (59%) and patients/family members (58%) stated that delivery of high quality care (however they perceived it), was better in September 1994 than it was one year earlier, even though, most thought, (87%) and (84%) respectively, that user quality expectations had also increased. Likewise, it was thought, by (73%) and (91%) respectively, that purchaser expectations had also risen.

Quality Criteria Used - Competition/Survival Issues	Trust Personnel Percentage Responses			Patient/Family Member Percentage Responses		
	Worse	No Change	Better	Worse	No Change	Better
Delivering High Quality of Care	10	31	59	18	24	58
Quality Expectation of Users	0	13	87	0	16	84
Quality Expectation of Purchasers	0	9	91	0	27	73
Patients Switching to fundholding GPs	0 (less)	81	6 (more)	0 (less)	63	8 (more)
Integration of Hospital with other Services and Agencies	29	45	20	38	53	2
Performance Against Patients Charter Requirements	6	26	59	13	23	8
Performance Against League Tables Criteria	9	30	49	-	-	-
Arithmetic Mean	8%	34%	53%	10%	29%	33%
	Sample size n = 485			Sample size n = 379		

Note: 'Don't know' answers not indicated make up shortfall percentage balance.

Table 21

Responses from Trust Personnel, Patients and Family Members
Concerning Perceived Quality Matters. Evaluation Stage

There was, however, a marked deterioration perceived by both Trust personnel (29%) and patient/family members (38%) in the integration of hospital services with other agencies, an identical perception held by the number of patients/family members (38%) concerning services in the community, Table 17. Concern for improvements with regard to health care and social need, also recorded in Table 17, gave further impetus for earlier mentioned team effort to revisit key issues.

Telephone interview with named persons (some who had further changed), responsible for quality management at the sixty-eight hospitals/NHS Trusts during September 1994 indicated that a further three of the original eighteen who were implementing TQM before the research programme began were reassessing its value, this leaving four (22%) still applying it. Reasons given were focus on other issues, for example cost-cutting, Patient's

Charter/league table matters, care management, hospital process re-engineering, shared decisionmaking and patient focused care. Lack of top management and senior clinician support, loss of interest, and a lack of problems to solve were also given as reason.

The eleven who had previously reconsidered TQM appropriateness, four in April 1993 and seven in March 1994, said that quality was primary concern, but for six of them, rather than attempt to continue to involve a spectrum of personnel with total quality matters, they thought it more appropriate for quality to be co-ordinated through quality assurance personnel and processes. Team working in nine of them was reported to be successful and on-going. One was awaiting accreditation to ISO 9000/BS 5750 quality standards and two others were in the early preparatory stages for ISO 9000/BS 5750 recognition.

Two Trusts were "successfully applying" hospital process re-engineering, but were not prepared to detail successes any other than indication of focus on matters which concerned individualised care; culture change; Patient's Charter, waiting times for in-patient admissions, bed occupancy and day-surgery rates. One provided an outline of their hospital process re-engineering paradigm:

- Develop a clear vision of potential for change.
- Ensure that there is support and commitment for the vision/process.
- Combine a broad view of all the necessary factors to achieve change with a narrow focus on action.
- Build on success, learning as you proceed.
- Communicate with everyone at every stage.

The one who had re-introduced TQM using a different process model reported "steady progress being made" and "more successes than with the previous method due to fewer people being involved". A further eight of the thirty-one hospitals/Trusts who it was reported

(April 1993) had begun TQM application were also questioning its appropriateness. In all, added to those reported in March 1994, thirteen (42%) had questioned its value within the first eighteen months of implementation. Reasons given were not dissimilar to those given by others, although one indicated that a newly appointed Quality Director was involving all Trust personnel in Quality Management/Process Re-Engineering Seminars. Other hospitals/ Trusts reported satisfactory progress, two others had begun TQM implementation.

Each agreed to complete postal questionnaire, Appendix 30, which asked them, on reflection, to list what they perceived to be the most important activities which would lead to TQM success (or Quality Assurance success, if not applying TQM). They were also asked to list reasons which they believed would constrain progress or lead to failure. Tables 22 and 23 indicate the five most important activities and the five most occurring reasons, from analysis of sixty-five returned questionnaires.

Activities	TQM Percentage Responses	Quality Assurance Percentage Responses
Top Management Commitment	100	
Quality Training	84	69
Teamworking	84	
Preparing Culture	82	
Use of Facilitators/Mentors	78	
Clearly Defined Quality Standards		94
Audit		100
Meeting Customer Needs		81
A Clear, Well Defined Quality Strategy		75
Number of Respondents	49	16

Table 22

Five Perceived Most Important Quality Activities For Successful
Application of TQM and QA. Analysis of Postal Questionnaire Results Returned
from Sixty-Five Hospitals/NHS Trusts (September 1994).

Table 22 identifies a number of fundamental differences in quality foci referenced in Chapter 3, wherein TQM was presented as extending beyond meeting standards by the development of culture which provides for employee involvement in continuous improvement and radical change. There is a strong closeness to activities suggested by the forty-nine respondents with TQM experience which they perceive will lead to TQM success and the TQM process activities applied in the case Trust and Trust T2.

Analysis of Table 23 records a number of fundamental differences between TQM and quality assurance activities by further emphasising differences in process, standards and teamworking focus.

Activities	TQM Percentage Responses	Quality Assurance Percentage Responses
Loss of Interest	63	
Cost Cutting Focus	59	69
Lack of Resources	67	
Over-Emphasis on Standard Setting and Performance Measurement	55	
'Flavour of the Month'	61	
Insufficient emphasis on process matters		69
Over-use of Teamworking		63
Too Little Emphasis on Standard Setting and Performance Measurement		63
Interference		56
Number of Respondents	49	16

Table 23

Five Perceived Reasons Which Constrain TQM and QA or Lead to Failure:
Analysis of Postal Questionnaire Results Returned from Sixty-Five
Hospitals/NHS Trusts (September 1994).

Although there has been cost reduction focus, some loss of interest, direction towards performance measurement and evidence of resource shortages in the case Trust, it has not been sufficient to have a detrimental effect in terms of constraining TQM application to the point of termination or need to reconsider the use of the eclectic TQM paradigm, fact was that during the evaluation stage twenty-six more Trust employees joined teams, although there were also some reported losses.

At the end of September 1994, a total of forty-one self-managed teams were operational, a decrease during the evaluation stage of (9%). There were ten department/functional teams, a decrease of (17%), one professional team remained, twenty-seven cross-functional teams, a decrease of (7%) and three remaining inter-organisational teams. A total of three hundred and sixty case Trust employees were team members, (9%) fewer than at the commencement of the stage. Twenty-six additional employees joined teams during the stage, thus indicating that sixty three team members at 1st April 1994 had withdrawn (16%). This included some 17 managers, 1 consultant, 3 hospital doctors, 20 nurses and 22 support services personnel.

Almost half were assumed to have withdrawn due to no attendance at the last four consecutive team meetings. Reasons given by those who indicated their withdrawal were not dissimilar to those earlier given by personnel, although two indicated disagreements which they felt could not be resolved with their team members. One indicated "intimidation for continuing", from their line manager (a Radiologist). Seven had withdrawn because of job changes or natural wastage.

Trust T2, undertaking TQM application using the same definition and eclectic paradigm, reported that a total of thirty-three self-managed teams were operational at the end of October 1994, an increase over the evaluation stage period of (6%). Facilitators indicated that teams had become total quality project teams, mostly made up of staff from a variety of departments and in some cases (four teams) involving people from outside the Trust, in

the form of GPs, health authority personnel and a number from "outside agencies". Data was not available to provide detail of number of Trust personnel or others involved, although it was estimated to be in the region of three hundred and fifty Trust personnel and twenty others. Patients and family members were not represented, although the facilitators stated that "patient empowerment was a possibility for the future". Problems envisaged with patient empowerment mostly concerned providing patients with more clinical information, which it was claimed, concerned "many professionals" in terms of the envisaged time required and the amount of "educating of patients", which would be needed for them to be involved in clinical audit and matters which relate to clinical performance and practice. They were keen to point out that patient empowerment had not been rejected, but merely delayed, since shared knowledge between patients and professionals had, they believed, advantages to offer the Trust, the least of which were not the likely benefits from patients feeling more involved in and committed to their treatment, and the envisaged improvements to outcomes.

Concern for evaluating the results of implemented improvements and team effectiveness was on-going it was pointed out and involved teams with audit, the use of patient questionnaires and cost analysis. Both of the Trust facilitators felt that the earlier decline in team membership, attendance at meetings and the number of teams, was a problem which they had overcome by team focus on specific projects (quality related or not), which were "visibly supported", by top management and senior clinicians.

A seminar organised by the researcher in September 1994 entitled 'Hot Topics in Health Care at the Turn of the Century', attended by eleven top managers and clinicians from a number of Trusts, provided opportunity not unlike earlier noted research approach of Gummesson (1990) and Larréch et al (1990), Chapter 3 - 3.8 to ask, what they thought would stand out at the turn of the century as having been hot topics in the business of health care during the 1990s? Nine said quality, two said better value for money.

CHAPTER 8   SUCCESSES-FAILURES IN TQM IMPLEMENTATION

8.0   Introduction

The NHS reforms, particularly since 'Working for Patients' (1989), Chapter 2, and the accompanying macro and micro systems in health care delivery has placed more emphasis on quality management in the NHS.

It was found whilst undertaking this research that twelve demonstration sites, sixty eight NHS hospitals/Trusts, a Trust identified as T2 and the case Trust had without exception, the management of quality, as important foci in their provision of health care. The majority (79%) were involved with activities, which the early Americans, Chapter 3-3.2, and others, identified as a new, more cogent and valid way of focusing the management of quality - TQM process. Others (21%) had moved from quality control application to quality assurance processes and procedures.

There does not appear to have been a single or common approach by any hospital/Trust, in that differently worded quality mission/policy statements existed along with a divergent mix and spread of process models applied. A number of approaches were styled on paradigms suggested by the newer Western approaches of Oakland and Crosby, in particular, Chapter 3-3.2, others evidenced the early Americans, notably Deming and Juran.

The TQM definition written and used for this research targeted those aspects of business which the writer identified as central to the business of health care in the 1990s, namely the need to eliminate waste, continue to practice respect for people, satisfy and beyond (delight) internal/external and potential customers and suppliers and seek a fuller and integrative participation of employees in achieving them, through the application of top-down supported and bottom-up applied eclectic paradigm. The TQM paradigm placed early emphasis on preparing and planning systematic implementation of TQM culture and process in the form of targeting constraints, resistance to change and attitude of own territories. It

was not until the later stages that concern was for TQM action in the form of continuous improvement, radical change and patient focused care followed by the evaluation of TQM action and activities in meeting patients and purchaser needs and expectations.

This chapter provides opportunity to summarise successes and failures noted in Chapter 7, which are presented as a similar number of successes to failures despite reality of six successes to each failure. By so doing, opportunity is taken to report acceptance and application of the TQM definition and paradigm in terms of researchable questions set in Chapter 5-5.4, whose aim was to enhance knowledge base, understanding and test issues concerning: organisation; management and culture; customers and suppliers; competitive advantage; and challenge to improve users and purchaser care through the improvement of provider performance, and therein test the broad hypotheses. Opportunity is also taken to compare case Trust findings in connection with matters which pertain to the researchable questions and hypotheses, with those recorded by demonstration site and participating hospitals/Trust research.

8.1   Organisation, Management and Culture

Hypotheses: TQM enables organisational integration in organisations which through size and bureaucracy operate with diverse missions, a growing range of systems and procedures and are characterised by degrees of rigidity from an employee mix of multiple knowledge, understanding, competences, skills and commitment.

Consistent with recommendations made by gurus and others, Chapter 3, regarding need for top management commitment, support leadership, and clear direction when introducing TQM, a major strength of the commitment stage concerned the involvement of Trust Board Executives and Trust Management Team members in their attendance at a full day TQM Workshop away from Trust premises. Awareness training and detailed explanation of proposed definition intent, and paradigm application, provided forum to inculcate common goal and strategic purpose for TQM implementation and to identify Trust strengths which facilitated application and weaknesses which did not. Success at this formative stage was

leadership of TQM and the need to target continuous improvement and radical change using the proposed TQM definition and paradigm, from the Chairman, Chief Executive, Medical Director (Nursing) and Director of Operational Management. As time went by, top management support was particularly consistent with steps proposed by Change, Labovitz and Rowansky (1993), noted in Figure 13, Chapter 3 as allow-support-manage-lead.

Visible commitment was in the form of leading subsequent TQM Awareness Workshops, sharing strategic vision, enabling employees to question and challenge them, participation in discussion and debate and the implementation of plans aimed to achieve vision by results. Support was by providing opportunities and encouragement for any Trust employee, despite their status level, to participate in bottom up paradigm application and to enable them to achieve this by the provision of training workshops, team formation, and direct access to those where decisions would be made responsively, least of which was not in the formation of the Chief Executive led Steering Group. Furthermore, leadership was practised by most, in assisting Trust preparation for TQM implementation, in advance of expectation of tangible results, through large-scale application. This was particularly evident with issues concerning barriers and organisational constraints, which if left unresolved would have impeded process and progress.

Support and leadership was also present in the form of speed of response to recorded suggestions resulting from group questioning and in-depth individual interviews, particularly in seeking statement concerning the ten points noted in Chapter 4-4.4 the commitment stage. A particular success and one which was envisaged for the early paradigm stages only, but which continued throughout the research period, was the selection and training of TQM facilitators, whose role in monitoring and facilitating groups, teams and individuals concerned with TQM implementation and application proved invaluable. In addition their observation of poor quality service concerning patients, family members,. purchasers, internal/external customers and suppliers provided opportunity for fast response from those responsible, to make improvements.

A particular success at the commitment stage in terms of organisation, management and culture was recommendation from those who had thus far been involved with TQM implementation to proceed to the next stage to further facilitate the re-shaping of the organisational framework into an environment of quality expectation. Contrary to that reported from a significant number of hospitals and Trusts involved with the research, there was more support from consultants and hospital doctors for a paradigm which a number commented on as providing opportunity to exceed problem solving/prevention and continuous improvement only. This the researcher believes owes much to recognition from the outset that consultants and hospital doctors were unlikely to respond to 'soft sell' approach and recognition that TQM encompasses departure from traditional practice wherein clinical personnel are sole determinants of patient quality care. Emphasis was placed on need for all personnel working together to achieve high level quality performance and recognition that analysis of aggregate patient outcomes is not insignificant in defining quality performance.

A further noticeable success was recognition and expression of Trust barriers, weaknesses and problems which if left unresolved would limit application and integration of definition and paradigm. These concerned audit matters, Patient's Charter requirements, performance measurement, staff, user, purchaser empowerment and intent concerning continuous improvement and radical change. The strength of the early paradigm stages was demonstrated by top/senior personnel focus on TQM strategy and bringing problems and barriers out into the open.

There were some similarities of support reported by other participating hospitals and Trust, particularly the need for high level commitment for quality management leadership ensuring high quality profile, but there were differences also. A large number of demonstration site top managers (92%) said that they gave it, Chapter 6-6.2, but a minority of their personnel (32%) said that they received it, Figure 32.

Although (89%) of the hospitals and Trusts undertaking TQM application and all of the those planning application placed first stage emphasis on seeking top management commitment, Table 8, Chapter 7, a number of complaints were levelled at poor top management response and support for matters concerning middle management commitment, problems caused by internal politics, and over-reaction to market forces from customer imposed quality rather than concern for internal customers and suppliers. There were complaints of an unwillingness to facilitate employee attendance at training seminars and to permit participation in meetings and teamworking. Some reported an over-emphasis on systems, rather than on people.

Chapter 2, outlined a NHS as one which through size and bureaucracy remained segmented and heavily driven by healthcare professionals often with diverse missions. In addition, Morgan (1986), Chapter 7-7.3 typified healthcare organisations as being more pluralistic than unitary wherein TQM was difficult to apply. Chapter 4 records aspects of machine and professional bureaucracy, where it is stated, that change may be regarded as moves away from or towards bureaucracy and TQM was suggested as unifying bond of common corporate purpose. By this recognition and cognizance of a number of references, Chapter 3, for need to focus delivery process system, for example, Brooks (1992), recommendation for involvement of all functions and Feigenbaum's (1951), suggestion to interconnect activities which impinge provision of quality for customers, the deconstraining stage paid particular attention to human direction, multi-directional communications, integration, and matters earlier referred to as culture change.

There was significant support from case Trust managers (72%) for all employees to be given opportunity to attend TQM training, mostly on a vertical (organisational) basis, in itself a direct means for re-shaping organisation framework into an environment of quality expectation and improving multi-directional communications and integration, in which (59%) of all Trust personnel participated. Opportunity was taken to provide participants with

copies of the TQM definition and paradigm which were explained in strategic and tactical terms and time was set aside for group discussion and ideas sharing to encompass TQM principles necessary for achieving common purpose.

Culture audit was undertaken to reduce organisation segmentalism, targeting that which prevented organisation integration concerning cross-functional, inter-organisation and multi-directional communications. Such attention resulted in particular success during and beyond the deconstraining stage in that (67%) of Trust respondents, Table 20, Chapter 7, stated that inter-department rivalry had got less, (68%) said that data was more available, Table 17, (72%) said it was more reliable and (64%) indicated that data retrieval had improved.

A fundamental part of seeking organisation integration was in providing common language aimed at maximising individual empowerment, and although involving a minority of Trust employees (25%), in fifty-seven self-managed teams, TQM facilitators reported that at least as many none team members had contributed in some way. Some thirty-one non-Trust employees (GPs, Health Authority staff, Community Health Council Members and members of the public) had also been active members of a number of teams.

Attention to barrier breaking in the case Trust was consistent with recommendation from demonstration sites where 92% of all respondents recommended that TQM process should seek to break down barriers between staff in the same Directorates, different Directorates at different levels and in different units, to seek to unlock valuable information concerning procedures and problems which might otherwise remain untapped.

A significant number of the hospitals and Trusts (77%) undertaking TQM application said they focused culture preparation during stage 2, Table 9, but significantly fewer (33%) of those planning implementation identified it as important early stage issue. There was

considerably less emphasis reported, compared with the cast Trust, of TQM facilitator/ mentor involvement, (31%) and (21%) respectively. Later results from a number of them suggested that lack of attention to issues concerning organisation, management and culture had resulted in TQM re-assessment and withdrawal, fewer TQM teams formed, a smaller cross-section of teams and team membership and less focus on radical change and patient focused care issues. It is noted in Table 12, for example, that hospitals/Trust, D; F; H and I who had earlier reported high top management commitment, the development of TQM mentors/facilitators and the targeting of culture barriers were perceived to be stronger in matters concerning teamworking than those who had not, namely hospitals/Trusts B; C; G; J and L (four of which discontinued TQM application during the research time period).

Later, by the end of the deconstraining stage, Trust T2 using the same definition and eclectic paradigm as the case Trust and having earlier reported top management and clinician support for TQM, reported a reduction (38%), of self-managed teams and fewer (38%) of employees actively involved in TQM activities than at the commencement of the stage. Reasons given were failure to develop and use facilitator support, difficulties in accessing information and middle management/ clinician dis-interest.

Similarly, decision by some teams in the case Trust noted in Table 16, not to involve TQM facilitators resulted in a larger proportion of discontinued teams compared with those who had involved them. There were also fewer TQM successes recorded.

In excess of two hundred team successes were earlier noted in connection with the case Trust's TQM process implementation, some focused continuous improvement, problem solving and problem prevention regarding coherent packages of care, others were concerned with integrating socially responsible and environmentally sensitive issues. A number targeted barriers which constrained quality of health care concerning shortage of staff time, resources, money and adequacy of procedures for care planning, others concerned survival outcomes and patients not getting best care. Radical change and patients focused care

team activities included scenario concerning patient persistence and availability of local or GP fundholding budgets to pay and integration/organisation of the hospital with other services and agencies including services in the community.

Although quality of care improvements were noted by a majority of Trust personnel (59%) and patients/family members (58%) Table 21, during the paradigm evaluation stage, Chapter 7-7.5, some two years following implementation of TQM, and detailed in Tables 17 to 21 inclusive, there were failures also. These included response to team suggestions with regard to complaints concerning clinical practice, waiting time for admittance for treatment (contrary to Trust statistical data), services in the community, particularly since a number of socially responsible and environmental sensitive issues had been targeted and some radically changed, care and social needs provision and matters concerning care beds and residential homes. Although GP fundholding was thought to have created a two-tier system and resulted in more competition and less co-operation, Table 18, no team had chosen to target this particular issue.

Reported activities, actions and successes are such to imply TQM capability for enabling organisational integration in a NHS Trust organisation. Despite size, bureaucracy, diverse missions, range of systems and procedures and its mix of employees with varying levels of knowledge, understanding, competences and skills a significant number of department/ functional, professional, cross-functional and inter-organisational teams were formed involving some 25% of Trust employees. Organisational barriers were targeted which if left unresolved would have constrained TQM implementation. Trust employee attention was concerned with continuous improvement, radical change and matters of patients focused care.

8.2 Customers and Suppliers

Hypotheses: TQM improves attitude and practice towards internal, external and potential customers and suppliers, seeks to establish what quality performance in health care is and directs attention towards improving input, process, output and outcome performance.

References were made in Chapters 2 and 3 with regard to customer and supplier satisfactions, identifying external, potential and internal customers and suppliers as paramount to TQM implementation and application. It was noted, Chapter 2-2.6 that following the re-election of the Conservative Government in 1987 and consistent with their manifesto statement, that the NHS, while not a business, required to be run in a more business-like way, review followed concerning alternative funding and means for allocating resources. Three important outcomes emerged in context of this research programme, namely the White Paper 'Working for Patients' (1989), with its focus on patient choice, service efficiency and quality, leading to the internal market for healthcare based on a system of separating the service into purchasers and providers, the Patient's Charter (1991) (1995), outlining what people can expect of the health service by right and the DoH league tables which indicated extent to which English hospitals and ambulance services were meeting Patient's Charter targets.

Numerous references were made to customers in Chapter 3, Garvin (1987), identified User Based perspective of quality, equating it with satisfaction. Pall (1992) suggested three fundamental customer requirements concerning need, manner of meeting needs and some measure of benefits which resulted. Hospital Process Re-Engineering, Lister (1994) pointed out, challenges hospitals to question their ways of working from the patient's perspective. A significant amount of team working, in the case Trust sought to apply Lister's recommendation for TQM not to exclude hospital process re-engineering or patient focused care, which he described as individual holistic care dictated by the needs and wishes of the patient, rather than by the values or conveniences of the providers. On-going focus, begun at the deconstraining stage, also sought radical change of processes and the integration of, Peters (1992), warring functional areas.

Team attention, also concerned continuous effort, Al-Assaf and Schmele (1993), by Trust

employees, seeking to meet the needs and expectations of patients and purchasers,

particularly through focus on the healthcare cornerstones, quality, access and costs.

Quality performance, throughout TQM application in the case Trust, was concerned with

seeking understanding or internal, external and potential customer/supplier needs and value

satisfactions, in seeking to establish how service quality was perceived and evaluated.

Chapter 3 referenced numerous quality definitions and perspectives, whilst early TQM

paradigm implementation stages sought culture transformation and cascaded training to

strengthen role and integration in the quality chain, internal market and the delivery

processes by which health care was produced. Successes to these ends came from people,

methods and internal market focus, Figure 10, Chapter 3, wherein teams with their mix and

blend of knowledge workers, Macdonald (1994), Chapter 3-3.5, focused and achieved

successes concerning process quality and outcome quality as key issue in providing quality

care. Cross-functional and inter-organisational teams in particular, provided clearer

knowledge and understanding of work undertaken with regard to professional standards and

integrity in the provision of care, and for those concerned with continuous improvement,

radical change and patients focused care matters, the means for establishing necessity and

improving it.

Some teams successfully negotiated perceived value costs in preference to costs of quality

which were greater than perceived value satisfactions, others, for example, concerned

process quality of professional standards and integrity in the provision of care. Team

attention, particularly those who drew on facilitator support, targeted the important foci,

suggested by Donabedian (1990), Chapter 4-4.3 concerned with measuring performance,

identifying performance gaps and performance improvement activities in which clarity of

process quality and outcome quality was used to attempt attitude change from doing just

sufficient to reduce poor quality and customer annoyance, to one of operationalising quality

of care in terms of perceptions and expectations. As means for improving contracting

agreement between purchasers and providers in the quality and cost of care delivered, inter-organisation team focus in particular concerned quality perspectives of care provision. Quality outcomes concerned a number and mix of teams, from department/functional teams to inter-organisational teams, wherein successes were claimed and failures noted.

Successes included a reduction in the number, and a consolidation of, audit procedures, common agenda of what should be delivered and means for delivery, procedure for building quality into practice; formulation of performance indicators and the use of flowcharts/major trails to re-invent quality indicators; development of output measures to further ensure evaluation of quality care and outcomes, in addition to focus on efficiency matters and outcome tracing to source to prevent re-occurrence of quality problems. Following focus group attention as a part of TQM implementation and group discussions, additional inter-organisational teams were formed to establish service-specific agendas aimed to promote exchange of ideas in connection with contractual decisions and provide advice and support for Trust endeavours to improve and evaluate quality health care provision.

A particular target concerned complaints procedure, where more responsive procedures were established with regard to complaints concerning GPs, and hospital clinical practice. A success concerned the implementation of the former, but not the latter, which later proved to be a reported deterioration concerning Trust procedure, Table 17, Chapter 7, which records a significant number (41%) of patient/family members perceiving it to have got worse, although a noted not dis-similar number (40%) of Trust personnel indicated that handling complaints had improved!

Other failures recorded included a failure to agree procedure for data collection to establish patient/purchaser perspectives of outcomes of care; an over-simplistic and varied notion of outcome management; failure to establish procedure concerning outcome assessment from a number of interventions and the appropriateness of treatment; explicit clinical audit links with TQM process; focus on customer involved audits and the re-invention of guidelines

based on emerging evidence, and towards the later stages, an over-focus on measures which related more to waiting time length than the quality of outcome services.

Although the TQM eclectic paradigm used in the case Trust targeted increased customer, supplier and purchaser involvement, than that earlier reported as notional by Trust personnel, the successes and failures were perceived by the researcher as no more or no less than those observed and reported by demonstration site and participating hospital/Trust personnel where there was strong support (71%) and (75%) respectively for listening to patients more and seeking to involve users, purchasers and the public in focus shift from provision of health services designed by experts only.

Equally consistent with response from the other sites, was note of some consultants' and doctors' scorn towards patient involvement, questioning whether they could constructively comment on clinical aspects of care, and their suspicion of reason for quality switch from professional quality to customer quality strategies. Strong support apart, it was noted earlier that the majority of demonstration sites and hospitals/Trusts who participated in the research programme were unable to provide little more than notional evidence of involvement with customers, suppliers and purchasers, in activities other than customer research. Reason is unlikely to be other than that recorded in the case Trust during summative and qualitative evaluation at the identification stage, Chapter 7-7.3, wherein a minority (11%), of the seventy-five patients and family members said they would wish to participate in teamwork or meetings which concerned quality care services.

A not dissimilar number later (16%) during focus group activities, Chapter 7-7.5 said that they would give it consideration only. Although not a large number of participants, a more positive response was noted from GPs (33%). Case Trust successes claimed in the form of employee empowerment, measured as number of self-managed team participants and achievements at a rate of six successes to each failure, were in part over-shadowed by failure to involve more users and purchasers in team working.

TQM application evidenced improvements in provision of internal/external customer and supplier value satisfactions wherein respect for needs and expectations were targeted. TQM application proved not to be successful as means for introducing patient empowerment. Team recommendations were implemented concerning quality health care provision in terms of improvements to inputs, process, output and outcome performance.

8.3   Competitive Advantage

> Hypotheses: TQM application through a planned and preparatory approach
> with clear missions and tangible goals, facilitates the fundamental changes
> necessary to achieve competitive advantage through continuous
> improvement, radical change and patient focused care.

A number of references have been made to the internal market of purchasers and providers, Figure 1 Chapter 2-2.6. In context of this, Baggott (1994), stated that the internal market was an idea whose time had come. A caution directed at over-emphasis on competition was made by the writer, Chapter 2-2.7, in seeking avoidance of temptation to cut corners to minimise costs, and/or reduce or eliminate the service(s) if high standards oblige them to charge higher prices, where price might take precedence over value for money.

Numerous references were made in Chapter 3 to TQM being viewed and implemented as an organisation-wide integrating process with three major-foci, satisfying customers, improving organisation effectiveness and responding to market pressures, none of which are strangers to competitiveness. To some extent, TQM has been acted upon by the case Trust as a driving force for competitiveness in terms of Citizen's Charter objectives announced in 1991, which set standards, ensured greater competition and accountability in the form of application of Patient's Charter standards and patients' rights, local charter development and focus on the mission statements and protocols which resulted.

Team attention to structure (resources), process (activities) and outcomes (results), resulted in improvements to organisation performance and the quality of care in a number of areas.

Identification stage provided translation of a spread and mix of customer, professional and

quality requirements, included in which were issues concerning competition and survival,

used by a number of teams to establish the value of Trust business for which they were

responsible.

With regard to enhancing organisation quality, including suppliers, and through it improving

flexibility, responsiveness and competition, team attention was drawn to user/purchaser

views regarding waiting lists, waiting times, standards of clinical competence and care,

communications response, matters of choice and co-ordinated services between health and

social care in particular. Teams, in addition to seeking improvements and change in these

areas sought also to determine and improve information provision regarding patients'

condition, emergency medical care, access to special needs and methods of discharge.

Waiting list successes and failures have already been discussed, but waiting time for

consultation and treatment at clinics, had according to most Trust personnel (70%), and

patients/family members (66%), got better, although some abuse of Patient's Charter

requirements were noted. One team concerned with standards of clinical competence and

care, established procedure for better sharing of treatment in the form of database for

various aspects of medicine, and knowledge concerning application techniques necessary for

local audit once change was put into practice. Concern was expressed and

recommendations made to improve consultant training, which later, a majority of clinicians

(53%), said had got worse, Table 18, Chapter 7. A not dissimilar number of Trust

personnel (36%) and patients/family members (39%) reported that the adequacy and

availability of nursing care had improved, which was particularly well received by the not

insignificant number of nurses involved with TQM application. Ward comfort-hygiene,

cleanliness, facilities (the hotel experience as a whole).... were seen to have improved

significantly by Trust personnel (59%) and by a number (26%) of patients/family members

also. No attempt was made to compare either nursing care or hotel experience perceived,

with the private sector.

Competition through a high, consultant/hospital doctors profile and reputation, from either a user or purchaser perspective was not noted as a central issue during any part of the research, in fact there was only little focus on such matters. Observation, in addition to responses from junior doctors and a number of nurses was such as to suggest divisions between senior consultants and junior doctors. These were manifest in time spent by consultants with junior doctors, which a majority of clinicians (51%) said had worsened, and supervision of junior doctors, reported as having worsened by almost half of the clinicians interviewed and evidenced in returned questionnaires, (48%).

Response of successes regarding availability of information, data retrieval and reliability have been earlier reported. These apart, a number of Trust personnel (28%) and patient/family members (26%) expressed concern to that which they perceived as deterioration in the increased amount of information given out by junior less experienced personnel. This, a number believed, was detrimental to the patient and/or family member understanding of important matters which concerned their illness and the means by which it was to be managed. A number of patients and family members, during conversation aimed at definite purpose suggested this was practice they would not expect from the private providers of health care. Some named senior consultants in the case Trust and in other hospitals/Trusts whom they were familiar with, who they claimed would not permit such practice.

Matters concerning choice and co-ordinated service successes and failures have been earlier reported, but few considered proactively using TQM to compete with private providers or with other hospitals/Trusts. Zairi (1993) referred to need for developing business culture aimed at superior competitiveness, Chapter 3-3.3, within which he emphasised the importance of competitive benchmarking as means for comparing service quality with best practice. Although benchmarking methodology was a part of all team training, it was practised by but a limited number of case Trust teams. Some inter-team benchmarking took

place to establish successes concerning competition in terms of markets being user/purchaser driven, for example. Inter-organisation benchmarking sought competitive analysis and best practice to be incorporated into processes regarding matters which concerned patients' condition, emergency medical care, access to special needs and procedures for discharge. Successes claimed in each of the areas showed evidence of benefiting from inter-organisation benchmarking with a number of other hospitals/Trusts.

During Steering Group presentations a number of teams indicated desire to extend their use of inter-functional benchmarking and develop competitor benchmarking more in connection with continuous improvement, radical change and patient focused care intentions, particularly those concerning audit. Not withstanding the approval given, there were no recorded increase in these activities. Inter-organisational benchmarking with the participating hospitals/Trusts was not encouraged by the case Trust Chief Executive.

Some training programmes used in the demonstration sites (23%) included benchmarking practice wherein a number of active TQM participants (11%) provided evidence of using internal benchmarking involving personnel department protocols and performance measures, in connection with Patient's Charter requirements. Trust T2, who also included benchmarking methodology in their training programmes, reported notional benchmarking practice across a number of Directorates. Some of the hospitals/Trusts (15%), undertaking TQM application expected using benchmarking during TQM application, Table 9, whilst fewer (7%) of those planning implementation anticipated its use. Expectation increased concerning its application at later stages, to 21% and 29% respectively.

Oakland (1989) Chapter 3-3.3, suggested that quality is the most important of the competitive weapons which any business possessed identifying the sensitive core of his paradigm as the customer-supplier interface. Three teams jointly recorded successes with regard to complaints of case Trust inability to provide a number of quality services and their unwillingness to negotiate price. Procedure was established for strengthening links between

Trust contracts management and GP practice/fundholding administration in seeking to establish method for getting patients seen fairly and appropriately. Exchange of ideas and views concerning maximum delivery of high quality care within given budgets were considered and recommendations for improvements implemented. Closer and more open exchanges of information regarding clinical outcomes were agreed and method to achieve stronger interface with community teams recommended. Issue of balance between poor urban areas concerning fundholding causing two-tier system and competition reducing co-operation were raised as issues, but were not targeted by any team. A similar number of non-clinician and clinician Trust personnel (15%) reported improvement in GPs meeting providers to detail complaints.

Towards the end of the research programme, an inter-organisation team was seeking to explore benefits of GPs purchasing all their patient care needs, by-passing the District Health Authority. Benchmarking with a similar Midlands project involving 22 GPs was suggested.

TQM application identified opportunities to gain competitive advantage through a well received mix and spread of continuous improvement, radical change and patient focussed care initiatives which were recommended and implemented. Competition however, despite clear missions and tangible goal achievement was viewed more in implicit, rather than explicit terms as reason for undertaking TQM process application. Intention was to satisfy users, purchasers, the public and supplier value satisfactions, provide value for money and enhance Management Executive, DoH and public opinion of them. Few said it was to facilitate competition with private providers or with each other.

8.4   Challenge

Hypotheses: TQM challenges costly inefficiencies by making high cost non-adding value activities more explicit.

It would be foolhardy to attempt quality improvement in any organisation and ignore other important performance criteria concerned with time, costs, efficiency and effectiveness. It was earlier noted, Chapter 2-2.2, that the NHS had barely begun before it was facing financial problems, the Guillebaud Committee (1953), for example, sought to investigate reasons why the NHS had consistently exceeded cost estimates. Numerous other committees are noted in Chapter 2 with not dissimilar foci of financial stringency. Chapter 2, an overview of a number of important events in the health care services, has included such terms as 'period of economic restraint', 'need for efficiency savings', 'requirement to improve accountability', 'cash limit budgets', 'performance review', 'efficiency initiatives'.....

Greenwood (1988), it was noted, Chapter 2-2.5, identified the 1980s as time for managerialist developments, placing particular emphasis on economy, efficiency and effectiveness in the public sector. Chase (1990), Chapter 3-3.1, predicted challenge to business organisations for surviving the 1990s, in the form and extent to which they made quality management their business goal. The writer earlier noted, Chapter 2-2.6, direction in the NHS, requiring managers and clinicians to provide increased services, delivered with a business management vigour towards cost effectiveness and efficiency with an emphasis placed on quality.

Intention was, that application of the eclectic TQM paradigm, with its focus on the TQM definition, would facilitate economic efficiency in the case Trust by encouraging individuals and team members to give consideration to the question, do we do things right and target high cost non-adding value activities by asking, do we do right things, Drucker (1968), Chapter 5-5.0.

Some teams showed a reluctance to detail economic expectation in their recommendations for improvements and change, due mainly to their perception of poor interface between quality improvement and financial accounting and a shortage of reliable cost data. Others attempted to measure their successes in terms of tangible and intangible measures of performance. Consistent with recommendations made by Creelman (1993), Chapter 3-3.6, some sought to establish intangible performance (measurement) successes concerning improvements in attitudes, accountability, commitment, comfort, leadership, teamworking and less rivalry .... some of which have been earlier noted in the chapter. Others, consistent with points made in Chapter 3, sought quality improvements combined with cost reductions, reduced error rates and cost value, Webster (1992), Tenner (1993), Øvretveit (1993), Joss (1995) and Waddington (1993), some sought to improve Trust efficiency, Lascelles and Dale (1992). There was particular team focus on progress measures concerned with productivity improvement and waste reduction/elimination - Baldridge National Quality Award Criterion, Figure 8.

A number of teams claimed successes concerning waste elimination in the delivery processes, wherein cost reductions were demonstrated without deterioration to customer value satisfactions and needs. Others claimed success by attention to establishing adding value activities and productivity performance improvements in connection with limited and scarce resources. These concerned the availability and use of expensive and/or scarce equipment, which a number (37%) of Trust personnel said had improved, discouragement of the use of 'protected' beds, resulting in almost half (49%) of the personnel perceiving improvements and planning/control activities, which a little less than one third (32%) said had improved, Table 20. More non-clinician Trust personnel (24%) and clinicians (29%) said that the number of idle facilities had worsened, than those who perceived it to have improved, Table 18.

There was considerable concern by a number of teams to establish reliable and well defined performance indicators concerning Patient's Charter and League Table criterion, wherein (59%) and (49%) of Trust personnel respectively perceived improvements having taken place. Caution however was earlier noted regarding team concerns for data collection procedures, trend analysis and clinical audit links. A number of formulated performance indicators were developed and implemented, particularly in connection with nursing.

Other team success in making quality more explicit in health care provision, challenging costly inefficiencies and high cost non-adding value activities concerned 'softening' inter-professional barriers which reduced efficacy of patient care and use of resources, scenario concerning economic efficiency in terms of likely budget effect on health services calculated on population size and waste elimination within nursing audit and the value of procedures for enabling total quality nursing care.

One success concerning TQM link to economic efficiency concerned closer examination of cost categories and the establishment of commitment for determining true costs of quality and interface between quality improvement and financial accounting in the case Trust. A balance was achieved between quality and cost factors, Oakland (1989), in that analysis of quality costs was such as to provide means for assessing the effectiveness of TQM activities in determining problem areas and priorities for action. Rather than focusing economic balance between failure costs and prevention/appraisal costs, attention was placed on constant improvement, recommended by BS 6143 (1990), Chapter 3-3.7, which was illustrated as probable trends in quality related costs.

Procedure was established based on agreement regarding definition placed on cost categories and the elements used in compiling them. Activity Costing concerned problems encountered by staff, resources and time wasted whilst the establishment of activity maps provided opportunity to identify the inputs which constituted each care activity, the resources used for achieving them and the fail points where quality was perceived as

inferior. Interface between the team, finance and Information Management was such to cost mapped activities and establish losses caused by fail points. Team activities established the means to make improvements and the re-invention of quality performance where appropriate.

A majority of Trust personnel (51%) at the evaluation stage, said quality costing information had got better, none said it had worsened. In connection with this and other team activities requiring financial information, the least of which was not fast response technology, a similar number (57%) said accounting systems had improved, Table 20.

A number of TQM definitions and strategies provided by the demonstration sites made reference to challenge and competitive advantage to be gained from high quality cost effective services, and the need for standard setting and success monitoring. There were numerous references to need for economic efficiency. It was clear from the demonstration site personnel involved with the investigation and researcher observation of TQM processes and procedures applied, that more emphasis needed to be placed on quality costing and performance measurement method to establish costs and returns.

Trust T2, whilst using the same TQM definition and paradigm had not, it was reported "made serious attempt to measure costs associated with TQM activities, nor, other than estimation, sought to measure successes and outcomes. This it was stated was an intended team project for the future. They, consistent with case Trust practice, had attempted to make quality more explicit in health care provision, by openly displaying and communicating definition, mission statements and protocols whilst visibly celebrating quality successes through their communications procedures for such matters. It was their belief that team membership experience was such, as to collectively be able to identify the high cost non-adding value activities.

A number (45%) of the hospitals/Trusts undertaking TQM gave reason of cost reduction, Chapter 7, Table 6, whilst, marginally more (51%) planning implementation indicating it as reason, Table 7. Quality costing was identified as TQM activity expected at some stage of application by 77% and 64% respectively of those undertaking application or planning implementation, Tables 11 and 13. Some provided the researcher with examples of methodology undertaken, which were in the form of identifying prevention, appraisal and failure costs; costs analysis concerning costs of conformance and non-conformance; and categories of quality costs identified by Musgrove and Fox, Chapter 3-3.7, Figure 26. Four were aware of Activity Costing, one claimed to be developing it to "fit their data"! References were made to teams and individuals targeting high cost non-adding value activities, but only a *limited number of examples were provided*. A number of hospitals/case Trusts were earlier reported as not continuing with TQM because of demands for faster response to reduce costs and achieve tangible results. Most involved with TQM application sought to make quality more explicit in their provision of healthcare, a number, Chapter 7, Table 12, used a mix of teams from department/functional to inter-organisational teams to target explicit and major quality objectives concerned with work quality and quality of working problem prevention and problem solving, continuous improvement, radical change and patient focused care. Their perceived successes are also noted in Table 12.

TQM application provides opportunity to challenge costly inefficiencies once attention is drawn to economic advantage in doing things right and adding value activity of doing right things. Challenge is for this mindset to detail economic expectation and for TQM to facilitate strong interface and procedure between quality improvement and financial accounting to achieve it.

CHAPTER 9   CONCLUSIONS AND DISCUSSION

9.0   Introduction

The NHS, it was noted in Chapter 2, has undergone numerous and often contrasting direction changes. In an age of rapid healthcare reform, particularly since 'Working for Patients' with its accompanying macro and micro system changes, the healthcare environment will undoubtedly continue to undergo change. Change in such areas as technology advances, treatments which outstrip governments ability to pay for them, an aging populating, ever increasing demand for better healthcare, lengthy waiting lists, bed closures, staff shortages in key areas and rationalisation of resources, are but a few of the changes.

One could envisage limited resources for healthcare provision resulting in increased competition, a diminution in the services provided and less co-operation and collaboration. To reduce such risks and still control expenditure, consensual solutions for problem prevention, problem solving, continuous improvement, and radical change were recommended and implemented as part of TQM process.

9.1   TQM - A Sustaining Force in Healthcare Organisations?

Organisation, management and culture changes earlier described, it is suggested, could result in any coherent and on-going vision, such as TQM being difficult, if not unlikely, to maintain. By the end of the research investigation, a majority (67%) of the TQM demonstration sites involved, claimed not to be focusing TQM with the same vigour as earlier recorded. Three claimed to have re-assessed its value in terms of driving quality of care, having returned to involving fewer people in quality matters, four claimed to have proceeded to hospital process re-engineering and patient focused care, reflecting TQM as important evolution process. One claimed to be more concerned with quality systems approach, identifying BS 5750/ISO 9000 achievement as important to them. Each emphasised importance of quality in health care delivery for organisational success and competition, but indications were that TQM was only one of many ways perceived to attain it.

A majority also (78%), of the participating hospitals/Trusts who claimed TQM application at the commencement of the research programme were looking elsewhere for performance improvement, in the form of cost cutting projects, shared decision-making process, hospital process re-engineering and patient focused care, suggesting that TQM had failed to challenge costly inefficiencies in a meaningful way. Others were seeking systems BS 5750/ ISO 9000 focus. Almost half (42%) of the other hospital/Trusts who commenced TQM implementation during the research programme were also questioning its appropriateness as process for supporting their intentions to continue to make quality improvements.

Failures concerning top management commitment, quality training (availability and content), response to teamworking, preparation of culture and the none use of TQM facilitators were earlier noted, Table 22, Chapter 7. Constraints to on-going TQM application were also suggested, these concerned loss of interest, over-focus on cost cutting, lack of resources, unreliable performance measures and 'flavour of the month' belief, Table 23. A cash-stretched NHS, it might be concluded, where quality is seen to be not free, may be reluctant to commit long term investment to TQM.

Trust T2, undertaking TQM application using the same TQM definition and eclectic paradigm as the case Trust, also changed direction after commencement, in that teams had become 'total quality project teams', involving a spread and mix of employees and persons external to the Trust. This emphasis change was, despite earlier claims that quality improvement in the Trust, required to move away from project activities, towards being more seen as holistic in matters concerning organisation, management and culture.

The case organisation, with its many successes earlier noted, concerning TQM application also showed strong likelihood of direction change towards the end of the evaluation stage. A little over half (54%) of senior managers and clinicians interviewed said that continued teamwork should concern more focus on hospital process re-engineering and patient focused care.

The Chief Executive, although praiseworthy of the tangible and intangible results, hoped that teamworking would continue to strive for further excellence in the provision of quality healthcare. Implication was that he expected fewer teams and that 'total' in the term TQM meant not necessarily seeking to involve every Trust employee.

The Director of Quality sought direction change towards hospital process re-engineering, care management, patient focused care and shared decisionmaking, he favoured not 'bottom-up' paradigm approach.

TQM facilitators opinion was such as to build on culture change and data base established to continue teamworking into end-to-end radical change projects, involving more users, purchasers and outside agencies, in putting patients at the centre of quality improvement intentions.

A major conclusion to be drawn from those involved with TQM, irrespective of their applications paradigm, is that quality is sacred, TQM is not. Results from the research might question the view that TQM is long-term process.

9.2 TQM - The Eclectic Paradigm and the Case Trust

The introduction of the internal market concept into health care, separating it into purchasers and providers introduced contracting procedure, within which purchasers required assurances not of minutiae of quality but of processes in place to ensure quality services.

TQM process is based on collaboration by employees, Chapter 3, such collaboration required significant support and commitment from the top of the case Trust. Training and skills development was a key aspect of commitment, wherein one thousand four hundred and thirty-three personnel attended TQM Awareness Workshops. In addition, team training sought to empower those who joined self-managed teams. Based on empowerment,

collaboration and teamwork the eclectic paradigm provided opportunity for change from traditional Trust management, to one of involving Trust employees more in continuous improvement, radical change and patient focused care. Intention was that organisational milieu should be one of supporting vision of quality patient care by deeds and action.

Whilst TQM application worked simultaneously from the top down and the bottom up, the paradigm sought and achieved top management and clinicians communicating their commitment to TQM and setting clear vision of quality goals. A further key aspect of commitment required a softening and elimination of organisational barriers, earlier referred to, Chapter 3, as 'own territories' and 'fortress mentality', recognising that professional groups, the least of which were not consultants and hospital doctors, have power to set agenda and resist change. Involvement of consultants and doctors, many of whom showed distrust of TQM, which to them was management initiated, was an essential part of the TQM process, since much of patient care was driven by them. Suggestions were made that it was incumbent of them, in the market orientated climate, to be a part of solution in preference to a part of problem.

Compared with the demonstration sites and other participating hospitals/Trusts there was clear support, in that forty-six consultants and hospital doctors attended early (Stages 1 and 2) training workshops, twenty-three were supportive from the outset, followed by a further five shortly after, two were involved in TQM facilitating, a number led TQM Awareness Training Workshops whilst twenty-eight participated in TQM teams.

A strength of the paradigm, it was concluded, was in its early focus on need for commitment, culture transformation and identification of internal/external customer needs and expectations and seeking to establish opportunities for continuous improvement and radical change, before commencement of in-depth implementation and evaluation. The approach was most certainly consistent with points made by Hudson (1992), Chapter 3 - 3.8, in that

new quality paradigm was required for the NHS, based on a rational model for planning and analysis; a focus on environments and individuals; qualitative and quantitative value based approaches; and performance measures based on user-defined outcomes.

More treatments, does not necessarily mean better treatments, TQM application in the case Trust sought not only to do things right (efficiency), but also to do right things (adding value). More successes than failures (at a rate of six to one), were recorded from 1st January 1993 to the 1st October 1994, from fifty-seven TQM teams. Not all teams were able to handle radical change in that quick-fix solutions were implemented, others made conscious attempts at changing end-to-end processes, seeking to re-shape the Trust behind TQM definition and corporate vision concerning markets and customers, using holistic fresh start approach, this appealed to a number of the senior consultant/manager participants. Greater adaptability and flexibility, in the context of radical change focus, was sought and found by a number of teams, despite reported changing social and political circumstances from which a number developed confidence and ability to introduce and manage through to implementation a number of end-to-end innovations which benefited the quality of patient care. Such practice is inconsistent with views expressed by some proponents of Business Process Re-Engineering who suggest that it has superseded TQM, which they brand as failing to exceed continuous improvement focus. Macdonald (1995) suggests that TQM and BPR are complimentary rather than opposition, in that almost without exception the successful exponents of BPR have been and continue to be committed to the TQM process.

This apart, it cannot be ignored that a majority of Trust participants, earlier noted, 9.2, sought direction change, some two years following TQM application, which was consistent with a number of demonstration sites and participating hospitals/Trusts earlier reported, 9.1, moves towards hospital process re-engineering. Whether this may be concluded as desire to integrate TQM with other foci or vacuum sucking in panaceas was unclear.

The TQM eclectic paradigm proved most appropriate in focusing case Trust employees attention towards quality of service defined and measured by the Trust and evaluated by users and purchasers, in which customer perceived quality, professional quality and management quality were paramount. In addition, TQM was used to take a corporate approach for establishing quality relationships between internal customers and suppliers. The earlier reported successes which pertained to culture transformation and the deconstraining of barriers and hence in turn the internal customer and supplier chain, the writer believes, were most influential in seeking understanding of the needs, expectations and form by which service quality was perceived and evaluated. Furthermore it is not difficult to conclude that the combination of culture, change, motivation and shared values were such as to achieve high level strategic management focus concerning the paradigms intent of vision to results, in the noted attitude changes towards doing more than merely enough for reducing poor quality and customer annoyance.

Seedhouse (1994), it was earlier noted, Chapter 2 - 2.8, viewed absence of lucid and practical quality definition as laying open to interpretation and manipulation by any group laying claim to it. Contained in case Trust application of TQM, it was concluded, was team focus on explicit aspects of process quality and outcome quality of health care.

In addition to team attention concerning process quality and outcome quality, TQM paradigm induced a number of teams to explore the appropriateness of Trust performance measurement procedures and audit methods. TQM teams sought to establish clinical practice and procedures which maximised patient well-being. Although a number of views were expressed concerning patient outcomes, there was some consensus of belief that organisation performance was an important determinant of patient outcomes and the achievement of cost effective value satisfactions. In spite of failure to agree a number of fundamental points and issues concerning performance measurement, earlier reported Chapter 7, team focus concerned methodology for measuring outcomes in preference to inputs, as a part of their continuous improvement effort, in place of conforming simply to

existing good practice. Questions asked and answers sought were consistent with questions asked by Scrivens (1995) concerning accreditation research, as means for promoting quality and assessing performance.

These concerned extent to which Trust processes and systems contributed to improved patient outcomes; amount by which processes constrained clinical attempts to improve patients health, although improving welfare; the degree by which clinical processes should be subject to scrutiny and rejection of process measures in favour of outcome measures. A most fundamental and important point made by Scrivens, and one which must be concluded as requiring further team investigation, concerns extent by which organisation processes contribute to increased patient welfare.

It would not be over-statement to conclude that the majority of senior Trust managers and clinicians were unaware of the costs of getting things wrong. The majority involved with TQM implementation and application had limited idea of how much non-quality cost them, indicating they had not earlier been asked to measure the costs of none or low quality. Not inconsistent with the contradictory views of costs and quality improvements noted in Chapter 3 - 3.8, were views expressed by case Trust personnel in connection with TQM process, in that quality improvement was likely to increase costs, quality improvement was expected to reduce costs and there were diminishing costs associated with quality improvement application.

Although it was intention from the outset for TQM application to require valid comparisons between cost data sets across a spectrum of organisational activities, whereby emphasis was to be placed on costs incurred in developing, implementing and maintaining TQM process, it has to be concluded that application of bottom-up paradigm failed to establish procedure for this. It was not until top down request was made for quality costing procedure that multi-disciplinary audit method was established in the form of Activity

Costing which sought and achieved agreement on cost categories, low quality performance areas and the identity and cost of process fail points.

TQM definition and paradigm development was in recognition of markets being driven by customers whose needs and expectations ranged from being clearly expressed to being barely implied. Application was intended to establish customer and supplier role into the Trusts' quality chain, internal market and delivery processes, from which healthcare is produced and provided through direct interaction and personal involvement. Terms such as patient empowerment and patient focused care have been used to infer that high quality service needs to be a part of high quality relationship with customers. In this context, measured from customers describing to the researcher (through interview and returned questionnaires), their experiences, opinions and needs, one may conclude a measure of success, but as direct involvement in TQM process concerning continuous improvement, radical change and patient focused care, there is little alternative but to conclude failure. Data earlier showed, Chapter 7 - 7.2, that only 17 members of the public and 14 GPs, HA staff and Community Health Council Members (2%), had been active TQM teamworking participants, not withstanding numerous attempts at involving them. This was despite significant media concern for cradle to grave provision and references made to need for giving patients 'real power' and informed choice.

It is not difficult to conclude from patients, family members and healthcare professionals responses strength in belief that healthcare professionals are seen as leaders, (possibly sole leaders), in matters which concern healthcare provision and that others are disadvantaged to the point of excluded through lack of appropriate information, a reluctance by professionals to share knowledge and the choice between rationality and mystery.

A further emphasis expected from case Trust application of TQM was concern for competition through reputation for best practice, in which benchmarking would seek to establish it and best practice would gain competitive advantage over private providers of

healthcare services and other competing hospitals and Trusts. Conclusion however is such that despite the use of benchmarking during a number of the implementation and application stages, there was lost opportunity to use it more and to take seriously the results gained from it.

Although a number of attempts were made by the TQM facilitators to encourage spirit of competition as a fundamental part of TQM application, there was reluctance by team members and others to turn discussion into practice. It was not difficult to conclude that competitiveness is alien to the NHS, and that custom, practice and culture focuses co-operation rather than competition, and belief that best practice was already practised, thus making less attractive that which could be provided from elsewhere.

9.3   The Methodology

Methodology which focused individuals, team and group attention on developing and using performance measures which identified gaps, was an essential part of paradigm process, which resulted in many recorded successes concerning improvements when standards were not met. Application of Schein's (1969), recommendation for group processes being evaluated by group members themselves with the aid of a facilitator, were applied to TQM teams where appropriate. Methodology which placed emphasis on setting clear and explicit goals, supportive leadership and provider-receiver participation well matched the eclectic paradigm implementation stages.

Focus on effectiveness, in the form of desired outcomes as end results, drew both individuals and team members attention to appropriateness of protocols and procedures delivered. Although outcomes are end results, analysis was undertaken as part of the total process concerning team focus on opportunities for continuous improvement, radical change and patient focused care. Team successes, it was concluded, came from the application of sound methodology which concerned them in collaborative effort in the collection, analysis,

evaluation and dissemination of results from the TQM processes for improving the outcomes of Trust healthcare provisions. Some measurement was undertaken by team members and the TQM facilitators to establish impact which particular outputs had on customers and suppliers. Summative and qualitative evaluation undertaken by the researcher, provided additional information regarding attention placed on outcomes, service inputs, throughputs and outputs by targeting users, purchasers and members of the public, in addition to Trust employees.

A particular advantage of the broad TQM definition, it is concluded, concerned the development of detailed mission statements which targeted such important aspects of the Patient's Charter as access to services, personal consideration and respect, availability and appropriateness of information, waiting time matters and the provision of value satisfactions of care as precondition for assessing TQM effectiveness and the resulting effectiveness of the quality care outcomes.

Team attention did not solely regard effectiveness issues in the form of quality standards of care and service levels, concern was also for efficiency in the control of resources. Methodology, particularly that developed concerning multi-disciplinary audit method in the form of activity costing, earlier reported, 9.3, concerned efficiency of outcome benefits to the costs of providing them and the targeting of high cost non-adding value practices.

Strength of methodology, the writer concludes, resulted from application of framework which combined a number of approaches to enable method to best fit major foci. Empirical enquiry, in the NHS case Trust, was invaluable in providing opportunity to investigate contemporary phenomenon with real life content, earlier advocated by (Yin, 1989), in the form of in-depth action research, wherein close involvement by the researcher enabled high level participation and means of regular feedback.

It was earlier noted, in Chapter 1, that research and hence methodology intention concerned the effective application of TQM in a healthcare service setting. This was in order to provide healthcare organisations with information concerning the practical aspects of implementation, letting them build on the experiences of others and generalise from the research findings, Schmele (1993). To this end, building a reliable TQM knowledge base was essential within which methodology was established for incorporating the findings of others and where appropriate replicate a number of their findings.

Pilot study concluded the need to guarantee absolute confidentiality of findings, for enabling collection of reliable and worthwhile data. Environment was such that numerous job changes were taking place, requiring some employees to re-apply for jobs and one in which whistle-blowing was perceived to be threatening to security of employment. Patients and family members also required such guarantees.

Although 'traditional' methods of data collection were extensively used concerning face-to-face interviews, telephone interviews and the use of self-completion questionnaires, an invaluable method applied concerned TQM Awareness and Action Workshops both within the case Trust and external to it. Time was made available, and procedures established, for collecting individual and group data. By careful planning of delivery material used and the relevance of scenario set, it is concluded that criticism of such procedure, in connection with difficulty of data analysis, was not experienced.

Observation, particularly non-participative observation proved a most beneficial procedure concerning provider, user, purchaser interface and means for reporting quality performance achieved compared with that claimed to be achieved. A most important part of observation, it is concluded, concerned practice of immediate action, wherein responsive feedback concerning ineffective and inefficient practice observed, provided opportunity for those responsible to prevent reoccurrence.

9.4 Issues for Implementation

Disparate approaches to TQM have been noted from a number of participating hospitals/Trusts, some of which have lacked integration. Successful application of TQM in the case Trust and other hospitals/Trusts has identified a number of critical elements or variables which research results suggest contribute to success. Rather than imply any particular 'best-fit' TQM paradigm, results are consistent with Chang, Labovitz and Rosansky's (1993) suggestion, Chapter 3 - 3.3, that any paradigm can work, providing that facilitating and mentoring leadership is present to make it work.

Without exception, those involved with the research programme who reported TQM success, be it on-going success or a part of evolutionary process, recommended need for top management/clinician commitment and support. But, in addition, they also recommended a planned implementation process which recognises need for TQM preparation BEFORE seeking application results. This, in addition to facilitating and mentoring leadership sought also to address organisation and culture issues.

Early stage TQM paradigm application sought and received majority top management/ clinician support following Awareness Training and meetings which aimed to distinct strategic orientation and identify TQM opportunities. Opinion regarding Trust strengths and weaknesses with regard to TQM implementation were noted wherein plans were set to build on the strengths.

Opinions concerning stage plans and response to ten-point statement were used to gauge support for bottom-up eclectic paradigm.

A number of hospitals/Trusts, claimed advantage of TQM facilitator support, particularly at the formative implementation stages. A number, including Trust T2, using the same TQM definition and eclectic paradigm as the case Trust, voiced regret in not considering facilitator support earlier.

Broad TQM definition is recommended which inculcates common goal and strategic purpose. Broad definition encourages development of succinct mission statements and protocols which identify individual directorate, cross-functional and inter-organisational intentions for targeting continuous improvement, radical change and customer/patient care focus. Broad definition requires a flexible and responsive participative approach to plan, analyse, implement and evaluate TQM practice.

Means for establishing culture of openness, the elimination of constraining barriers and the empowerment of employees during preparatory stages is recommended. Established practice was followed concerning communicating directly with Trust employees to indicate intention and provide detail of stage plans, as means of seeking their support and participation in TQM implementation. Opportunities were available for all employees to attend awareness training. Recommendation on the basis of case Trust results and information provided by the participating hospitals/Trusts, suggest that it would not be unreasonable to expect some 20-25% of employees in hospitals and organisations not dissimilar, being prepared to actively participate in TQM activities.

Numerous references have been made to TQM identifying internal/external customers and suppliers and establishing their needs expectations and delights, included in which was professional and managerial expectation. Opportunities for TQM training and teamworking development against 'live' continuous improvement and radical change projects is recommended, to seek to remove further, constraining barriers which inhibit responsive customer/supplier chains, open channels of communications and access to information on a need to act basis.

Further recommendation for preparatory focus concerns the establishment of support plans for funding; translating requirements into practice; actioning change and improvement; replacing constraining rules and convention with judgement; and addressing performance before procedure. In addition, planning concerns identifying customers and suppliers and establishing what quality performance in healthcare is.

Paradigm application in the case Trust translated service requirements into practice and identified appropriate criteria for evaluation and performance measurement concerning implementation of continuous improvement, radical change and patient focused care. A particular recommendation in this context is to provide opportunity for participants to create their own environment in which they believe in their ability to continuously improve and constantly re-invent quality performance. A mix of department/functional, cross-functional and inter-organisational teams, well facilitated this, wherein application of techniques and procedures were developed for problem-solving, evaluating performance and implementing solutions. Central issue, throughout case Trust application of TQM, concerning process evaluation, were the seeking of answers to two fundamental questions:

- How will proposed action improve organisation performance?
- How will it improve the quality of care?

Beyond preparatory stages, on-going evaluation formed an important part of TQM process application for understanding and providing the value expectations of internal/external customers and suppliers and a fuller knowledge of work as process across the barriers, enabled participants to seek improvements to those processes. Evaluation, which formed an important part of team training, enabled team members to seek and, through internal functional and competitor benchmarking, identify and agree situational performance measures for evaluating the qualitative and quantitative aspects of structure, process and outcome quality.

In spite of recorded successes, recommendation concerns NHS hospitals/Trusts seeking a fuller and more consistent use of benchmarking practice to these ends, in addition to seeking competitive advantage. More benchmarking application by the case Trust could, in addition, the writer believes, reduce the paradox of response earlier recorded, Chapter 5, in which a majority of Trust employees regarded relationships with customers, suppliers and co-workers in terms no less monolithic than competition between hospitals and purchasers, wherein many claimed to favour TQM as driving force for survival and competition, and that later recorded, Chapter 7, where few saw TQM process application as facilitating competition with private providers or with each other.

A more than notional response to customer involvement in the case Trust is also recommended, initially by providing direct access to Trust representatives with acumen and status to act on meritorious proposals from them and secondly by involving more the local community in determining health priorities of action and patients/family members in the establishment of treatment plans.

A most important recommendation concerns the use of fast response technology to record team successes and failures, which are accessible to other team members, individuals, customers and suppliers and in which means are provided for sharing information gained concerning evaluation processes.

A final recommendation regards interpretation of the word 'total', used in TQM, whereby research results would question the wisdom of implying requirement for total involvement of every aspect of the organisation and every person in it or associated with it, striving for excellence in everything undertaken or done. To the contrary, successful application has been noted in the case Trust and recorded by each of the participating hospitals and Trusts without a total cascaded commitment or involvement of employees, customers and suppliers. On the basis of proportion of case Trust personnel involved to quality of success

implemented, it would be difficult not to empathise with the sentiments expressed by the Chief Executive, in connection with his conviction that total does not mean involving everyone.

9.5   Areas for Future Research

Resulting from two-and-a-half years of in-depth field research in a total of eighty-three NHS hospitals and Trusts, three suggested areas for future research are common to each. These concern, empowerment and consumerism, accreditation, and laws, ethics and TQM.

Patient empowerment and consumerism, it is suggested need to be researched from a strategic change process perspective. This would likely involve seeking fuller understanding of the term and the establishment and testing of methodology concerning:

- provision of suitable clinical information, including clinical audit information;
- shared decisionmaking;
- engendering genuine openness concerning planning and contractual decisions;
- independent patient representation;
- consultation and complaining.

Accreditation, could be further researched at the hospital/Trust level to compare the benefits of local set standards which reflect local needs to national standards to which professionals subscribe. This would likely involve suggested procedure for establishing:

- consensus of what constitutes good organisational practice;
- appropriateness of standards and systems for monitoring compliance;
- benchmarks for best practice;
- appropriateness of involving external accreditation bodies.

A possible criticism may be in the scant regard paid to the impact of laws and ethics on TQM. The extent of such an undertaking is a subject in its own right, contained in which would be requirement to establish the:

- weight of law and ethics on TQM concerning what should be done and what is being done;

- relevance of law and ethics for TQM process application;

- standards of ethics effect on TQM;

- interaction between law and ethics.

Such research would contribute significantly to the wider implications of implementing TQM on both a specific and global level.

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342

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356

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APPENDICES 1 - 30.

APPENDIX 1

STRUCTURE OF THE NATIONAL HEALTH SERVICE - 1948

PARLIAMENT

SECRETARY OF STATE FOR SOCIAL SERVICES
(advised by Central Health Services Council
and Standing Advisory Committees)

PUBLIC HEALTH LABORATORY SERVICE

SPECIAL HOSPITALS
Broadmoor, Rampton
and Moss Side

BOARDS OF GOVERNORS

Teaching hospitals
and specialists

REGIONAL HOSPITAL BOARDS

HOSPITAL MANAGEMENT COMMITTEES

Hospitals

Specialists

Blood transfusion service

EXECUTIVE COUNCILS

Dentists

Family doctors

General ophthalmic services

Medicines and appliances

LOCAL HEALTH AUTHORITIES

Vaccination and immunisation

Maternity and child welfare (including midwifery and priority dental treatment)

Health centres

Ambulances

Health visiting

Home nursing

Home helps

Prevention of illness Care and after-care of the sick

Health education

——— Direct responsibility

– – – General supervisory powers

This diagram gives a broad view of the organisation of the National Health Service and omits or simplifies some of the details.

Mays et al (1975)   Penelope Hall's Social Services of England and Wales (Routledge & Kegan Paul).

358

APPENDIX 2   THE WHITE PAPER, PROMOTING BETTER HEALTH (1987): MAIN
PROPOSALS

Consumer choice

- The procedure for changing doctors to be altered (permission from current doctor no longer necessary).

- The procedure for making complaints against family practitioners simplified (oral complaints allowed, complaints period extended to thirteen weeks).

- More information on practices to be made available (opening hours, services offered by practices and so on).

Health promotion/illness prevention

- Targets (with financial incentives) for GPs to encourage immunisation, vaccination and screening.

- Fees for GPs performing health checks on new patients.

- Amendments to GPs' terms of service to clarify their role in relation to health promotion and prevention of ill-health.

Remuneration of doctors

- GPs to receive a higher proportion of their income from capitation fees (that is, the fee received for each NHS patient).

- Tighten the qualifying criteria for the GPs Basic Practice Allowance by raising the minimum number of patients on the GPs lists (from 1000) and the minimum number of hours spent on direct services to patients (from 20 hours) and making payment dependent on the doctors carrying out prevention and health promotion work.

- Financial incentives for GPs carrying out minor surgery, comprehensive care for the elderly, and child health surveillance.

- Financial incentives for GPs working in deprived areas.

- A new postgraduate allowance for GPs to encourage regular training and education throughout their careers.

Dentists

Renegotiation of dentists' contracts to place greater emphasis on prevention.

- Initiatives to increase funds for water fluoridation and to promote dental awareness among the young, particularly in deprived areas.

Primary health care teams

- Removal of restrictions on types and number of staff employed by GPs. Part of the costs of employing health care staff reclaimable. Additional resources to be allocated for this purpose.

Family Practitioner Committees (now Family Health Service Authorities)

- FPCs encouraged to collaborate with other NHS agencies.

- FPCs to have increased responsibilities for improving practice premises, allocating resources for practice staff.

- FPCs, in conjunction with DHAs, to agree appropriate targets for disease prevention.

- FPCs to monitor performance of family practitioner services.

- FPCs (along with DHAs) to ensure cost-effective use of hospital facilities.

- FPCs to develop systems to encourage more effective and economic prescribing by GPs.

- FPCs to undertake evaluation of public attitudes in order to ensure that such views are taken into account.

- FPCs to identify underprovision of dental services and to have the power to inspect dental surgeries.

Charges/Finance

- Charges to be imposed for optical and dental checks.

- Dental charges to relate more directly to treatment received.

- The amount of money available for directly reimbursed GP expenses provided by FPCs to be cash-limited (including the employment of ancillary staff, improvement grants for premises, and loans for new premises).

- General Practice Finance Corporation (which provided loans for GP practices) to be privatised.

Other items

- Encouraging the use of information technology in primary care.

- Encouraging women to enter and remain in general practice.

- Distribution of GPs to be determined locally.

- Retirement age (70) specified for GPs and dentists.

Baggott (1994)   Health & Health Care in Britain (St Martins Press)

THE WHITE PAPER, WORKING FOR PATIENTS (1989): THE MAIN
AREAS OF REFORM

(a)   Changes at the centre

Within the Department of Health, the establishment of a new policy board
responsible for strategic decisions and an NHS management executive, responsible
for the running of the service.

(b)   Health authorities

1.   Regional Health Authorities to focus on monitoring performance, evaluating
effectiveness and reviewing the state of their population's health, and to
concentrate less on managing services directly.

2.   District Health Authorities to delegate service delivery to hospitals wherever
possible, and to set targets and monitor performance of providers.

3.   Family Practitioner Committees to become more managerial in outlook and
organisation. (They were later renamed Family Health Service Authorities.)
FPCs to have extra responsibilities for monitoring GP budgets, prescribing
and the quality of care provided by GPs. FPCs to be responsible to the
Regional Health Authority rather than directly to the Department of Health.

4.   The composition of Health Authorities to be altered. Health authorities to be
smaller, comprising executive members (managers) and non-executive
members appointed for their skills and experience. Health Authorities no
longer required to include local authority representatives.

(c)   The internal market

1.   RHAs in future to receive funding for their resident populations, weighted by age and
morbidity. Districts also to receive funding based on a 'weighted' resident popula-
tion. Regions and districts to purchase services on behalf of their populations from
providers in the public or private sector.

2.   Hospitals and community units allowed to apply for self-governing trust (SGT) sta-
tus. Trusts remain within the NHS, but given much more freedom to buy and sell
assets, to build up financial surpluses, to establish their own management struc-
tures, to employ staff, and to set pay and conditions. Trusts' income generated by
selling services to the purchasers of health care (GPs, health authorities and the
private sector).

3.   GP practices with more than 11,000 patients (subsequently reduced to 9,000 and
later 7,000) permitted to apply to manage their own budgets (fundholding). These
GPs able to buy selected non-emergency services from providers (directly managed
units, trusts, the private sector) on behalf of their patients. In addition, all GPs to
have prescription budgets.

4.   Purchasers and providers to operate on the basis of contracts specifying the price
and level of the service provided.

5.   Capital charging. To encourage the efficient use of assets and to promote fair
competition, NHS providers to be charged for their use of assets such as land, build-
ings and equipment worth over £1,000.

(d)   *Hospital consultants and quality of service*

1.   Districts to agree 'job descriptions' with each consultant.

2.   General managers to have a role in merit awards for consultants.

3.   All hospital doctors would have to take part in medical audit.

4.   Resource management to be introduced to all hospitals.

5.   The Audit Commission, a body which investigates the efficiency of local government, to have its brief extended to the NHS.

(e)   *The private sector*

1.   People aged over 60 to be given tax relief on their private health insurance premiums.

2.   Health authorities and GP budget holders encouraged to use private health facilities for their patients where this is cost effective. Further joint ventures between private and public sectors to be encouraged.

Baggott (1994)   Health & Health Care in Britain (St Martins Press)

STRUCTURE OF THE NATIONAL HEALTH SERVICE - FOCUS ON INTERNAL MARKET COMPETITION

PARLIAMENT

SECRETARY OF STATE FOR HEALTH
(Advised by NHS Policy Board and NHS Management Executive)

SPECIAL HEALTH AUTHORITIES
Different arrangements for:
Northern Ireland, Wales and Scotland.

REGIONAL HEALTH AUTHORITIES
Plan services in each region and award money to DHA's, Family Health Service Authorities and GP's who manage their own budgets.

Non-Management responsibilities and relationships

COMMUNITY HEALTH COUNCILS
For establishing a consumer voice in the NHS. Rights to: information, consultation and to observe proceedings at health authority meetings.

FAMILY HEALTH SERVICES AUTHORITY
Manage the services provided by GP's, NHS dentists, pharmacists' shops and opticians.

DISTRICT HEALTH AUTHORITIES
Each is usually responsible for 1 large district hospital and 2-3 smaller hospitals, plus clinics.

OTHER CONTRACTING PROFESSIONS
Dentists, Pharmacists and Opticians

NON-FUNDHOLDING GP
Can send patient to a hospital with which their health authority has a contract, or to other hospitals if the service needed cannot be obtained locally, and the local DHA is willing to pay.

FUNDHOLDING GP
Can send patients to three types of hospital, depending upon which will provide (in the GP's opinion) the best treatment for the lowest price. Cost of treatment is paid for by the GP unless over £5,000, when the DHA pays.

DIRECTLY MANAGED UNITS
Managed by the DHA but they have to win contracts to treat patients from health authorities or fundholding GP's.

NHS TRUSTS
Hospitals or services that have 'opted out' of health authority control

This diagram gives a broad view of the organisation of the NHS and omits or simplifies some of the detail

Dewsbury District Health Authority Staff Handbook (1992)

———— = Direct Responsibility
········ = Internal Market Relationships

<u>Note</u>:

THREE TYPES OF HOSPITAL

- Directly managed. Managed by the DHA but they have to win contracts to treat patients from health authorities or budget holding GP s.

- NHS Trusts ('opted out'). They obtain their money by competing with other hospitals to treat patients.

- Private. Fee paying hospitals. Individuals can pay to go there, or budget-holding GP s can decide to send their patients. DHA's can buy services from private hospitals.

1. *Create constancy of purpose* to improve product and service.

2. *Adopt new philosophy* for new economic age by management learning responsibilities and taking leadership for change.

3. *Cease dependence on inspection* to achieve quality; eliminate the need for mass inspection by building quality into the product.

4. *End awarding business on price;* instead minimise total cost and move towards single suppliers for items.

5. *Improve constantly and forever the system of production and service* to improve quality and productivity and to decrease costs.

6. *Institute training on the job.*

7. *Institute leadership;* supervision should be to help do a better job; overhaul supervision of management and production workers.

8. *Drive out fear* so that all may work effectively for the organisation.

9. *Break down barriers between departments;* research, design, sales and production must work together to foresee problems in production and use.

10. *Eliminate slogans, exhortations and numerical targets* for the workforce, such as 'zero defects' or new productivity levels. Such exhortations are diversory as the bulk of the problems belong to the system and are beyond the power of the workforce.

11. *Eliminate quotas or work standards, and management by objectives or numerical goals;* substitute leadership.

12. *Remove barriers that rob people of their right to pride of workmanship;* hourly workers, management and engineering; eliminate annual or merit ratings and management by objective.

13. *Institute a vigorous education and self-improvement programme.*

14. *Put everyone in the company to work to accomplish the transformation.*

Walton (1986)   The Deming Management Method (New York, Dodd Mead and Co)

1.   Implementation of TQM.

2.   Training for quality.

3.   Teamwork and culture change.

4.   Communications for quality.

5.   Organisation for quality.

6.   Capability and control.

7.   Tools and techniques for improvement.

8.   Costs of quality.

9.   Measurement.

10.   Systems for quality.

11.   Planning for quality.

12.   Design for quality.

13.   Commitment and leadership.

14.   Understanding quality.

Oakland (1989)   Total Quality Management (Butterworth/Heinemann)

APPENDIX 7   CROSBY'S 14 STEPS TO QUALITY IMPROVEMENT

1. Make it clear that management is committed to quality.

2. Form quality improvement teams with senior representatives from each department.

3. Measure processes to determine where current and potential quality problems lie.

4. Evaluate the cost of quality and explain its use as a management tool.

5. Raise the quality awareness and personal concern of all employees.

6. Take actions to correct problems identified through previous steps.

7. Establish progress monitoring for the improvement process.

8. Train supervisors to actively carry out their part of the quality improvement programme.

9. Hold a Zero Defects Day to let everyone realise that there has been a change and to reaffirm management commitment.

10. Encourage individuals to establish improvement goals for themselves and their groups.

11. Encourage employees to communicate to management the obstacles they face in attaining their improvement goals.

12. Recognise and appreciate those who participate.

13. Establish quality councils to communicate on a regular basis.

14. Do it all over again to emphasise that the quality improvement programme never ends.

Crosby (1984)   Quality Without Tears (McGraw-Hill)

APPENDIX 8 MOLLER'S 12 GOLDEN RULES TO HELP IMPROVE ACTUAL PERFORMANCE LEVELS

1. Set personal quality goals.

2. Establish your own personal account.

3. Check how satisfied others are with your efforts.

4. Regard the next link as a valued customer.

5. Avoid errors.

6. Perform tasks more effectively.

7. Utilise resource well.

8. Be committed.

9. Learn to finish what you start - strengthen your self-discipline.

10. Control your stress.

11. Be ethical - maintain your integrity.

12. Demand quality.

APPENDIX 8 (cont)   MOLLER'S 17 HALLMARKS OF A QUALITY COMPANY

1.   Focus on quality - quality development is just as much a part of company life as budgets and accounts.

2.   Management participation in the quality process - Management visibility strives to meet the high standards the programme sets for efficiency and human relations.

3.   Satisfied customers/users - they remain loyal to the company.

4.   Committed employees - Employees thrive. Turnaround and absenteeism are well below normal.

5.   Long-term quality development - The company invests more in long-term quality development than in short-term profits.

6.   Clearly defined quality goals - quality goals are clearly defined. Results are published.

7.   Quality performance rewarded - quality performance is rewarded visibly, and is a pre-requisite for promotion.

8.   Quality control perceived positively - quality control is not perceived as a sign of distrust, but rather as a means to develop and maintain quality.

9.   Next person in work process is a valued customer - No link/person in the chain should suffer because of mistakes made by others.

10. Investments in personnel training and development - Employees are the company's most important resource.

11. Prevention/reduction of mistakes - sizable investments are made to prevent and limit mistakes.

12. Appropriate decision level - the level of decision-making is placed no higher in the organisation than is necessary.

13. Direct route to end users - products and services are produced and delivered by the most direct method available.

14. Emphasis on both human and technical quality.

15. Company actions directed towards customer needs - meeting the customer's needs is reflected in all company actions.

16. Ongoing value analysis - work which does not create value is dropped.

17. Company recognition of its role in society - the company assumes its role in contributing to society.

Moller (1987)   Personal Quality (Time Manager International)

PETERS' 12 ATTRIBUTES, OR TRAITS OF A QUALITY REVOLUTION

1.   Management obsession with quality - this stresses the importance of practical action to back-up the emotional commitment.

2.   Passionate systems - failure is inevitably due to passion without system or system without passion. Both are necessary and an ideology is important whether based on gurus or not.

3.   Measurement of quality - this should begin at the outset of the programme, should be visible and should be carried out by the participants.

4.   Quality is rewarded - quality based incentive compensation can cause an early breakthrough in top managements attitude.

5.   Everyone is trained for quality - every person in the organisation should be extensively trained. Instruction in cause and effect analysis, statistical process control and group interaction should be given to all.

6.   Multi-function teams - quality circles or cross functional teams such as Error Cause Removal or Corrective Action Teams should be introduced.

7.   Small is beautiful - there is no such thing as a small improvement. There is significance in the fact that a change has occurred.

8.   Create endless 'Hawthorne' effects - this is the antidote to the 12-18 month doldrums. New goals, new themes, new events are the antidote.

9.   Parallel organisation structure devoted to quality improvement - this describes the creation of shadow quality teams and emphasises that it is a route through which hourly paid workers can progress.

10.   Everyone is involved - suppliers especially, but distributors and customers also must be a part of the organisations quality process. Joint improvement teams may be formed.

11.   When quality goes up, costs go down - quality improvement is the primary source of cost reduction. The elementary force at work is simplification of design, process and procedure.

12.   Quality improvement is a never ending journey - all quality is relative. Each day, each product or service is getting relatively better or worse. They never stand still.

Peters (1988)   Thriving on Chaos (Macmillan)

TEN STEPS TO THE QUALITY DELIVERY PROCESS

1. Create mission statement - a mission statement is a sentence that defines the work group's activities. It is focused on the end objective rather than the means of achieving it.

2. Determine the outputs of the work group and check that they fulfil the mission.

3. Identify the customer(s), both internal and external, who receive the outputs.

4. For each output, define agreed customer requirements which must be met in order to achieve customer satisfaction.

5. Develop the work group's output specification for each output.

6. Determine the group's work processes, including the identification of inputs, which will deliver the outputs to the customer(s) at the lowest internal cost.

7. Identify the measurements of each output which will compare the 'actual' quality level delivered with the output specification.

8. Identify any problem caused by a measured 'shortfall' to target (or identify an 'opportunity' to exceed target at no additional cost; or an 'opportunity' to meet customer requirements at a lower internal cost).

9. Establish a project team to solve the identified problem which will improve the 'actual' quality level delivered to the customer (or capture the 'opportunity' in step 7).

10. Measure customer satisfaction against the agreed customer requirements.

Bank (1992)   The Essence of Total Quality Management (Prentice Hall)

THE POLYTECHNIC OF HUDDERSFIELD

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Facsimile   : (0484) 516151

SCHOOL OF BUSINESS

Dean: Professor E C LEA
BSc(Econ) London
CERT ITP Harvard

APPENDIX 11   TQM QUESTIONNAIRE FOR DIRECT INTERVIEWS

Date: _____

Time began: _____

Time ended: _____

Before commencement:

1.   Confirm intentions and introduce self.

2.   Ask for name of respondent: _____

3.   If Trust Employee, ask for job title: _____

      If Patient, establish something of them: _____

      If GP, establish fundholder or not: Y/N

      If Family Member, establish their connection
      with the Trust: _____
      (ie. reason for being there)

4.   THANK THEM FOR PARTICIPATING IN THE INTERVIEW.

TRUST EMPLOYEES; GPs; PATIENTS and FAMILY MEMBERS:

Question 1:   How well informed do you feel you are about TQM matters?

```
         1     2     3     4     5
         |-----+-----+-----+-----|
       Not At                  Very Well
       All                     Informed
```

PROBE to establish own
view by asking them to
say what it involves:

```
         1     2     3     4     5
         |-----+-----+-----+-----|
       Not At                  Very Well
       All                     Informed
```

Interviewers
rating of inter-
viewees under-
standing

Question 2:   *Is there a written policy/mission statement/definition for

                         Quality?   :   Y/N
                         TQM?   :   Y/N

         If Yes: Can you please briefly describe the focus or some aspects of its content?:

         _____

         _____

Compare their response to the copy (should one be available), I have received in advance of interviews beginning. *IF ONE IS NOT IN EXISTENCE ask instead if they would wish for one to be available and why? ie. Y/N   reason:_____

Question 3:   Is there a process model, paradigm or method for introducing and applying TQM that you know of?   Y/N

         If YES is it used here in your Trust?   Y/N

         (If YES) Can you please briefly describe it: _____

         _____

         _____

How important do you think it is to have a process model when producing, applying and maintaining TQM?

                    1   2   3   4   5
                    ├───────┼───────┼───────┼───────┤
                    Not   Very
                    Important   Important
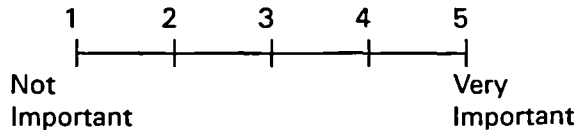
PROBE for reasons: _____

_____

_____

_____

SHOW A COPY OF THE PROPOSED DEFINITION AND SEEK A FIRST IMPRESSION RESPONSE
(If necessary focus attention on ci, rc, pfc):

_____

_____

_____

SHOW A COPY OF THE PROPOSED ECLECTIC PARADIGM AND SEEK A FIRST IMPRESSION
RESPONSE (If necessary focus attention on ci, rc, pfc):

_____

_____

_____

Seek a response for time expectation to cover all the stages of the paradigm:

```
....  |----+----+----+----+----+----+----|  ....
      1         2         3         4    5
                        Years
```
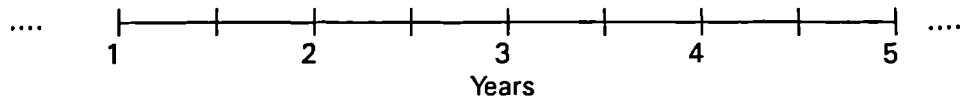
Question 4:   IF NOT ALREADY ESTABLISHED IN ANSWERS TO Q3 seek to establish views
               regarding TQM providing for flexibility and responsiveness:

               _____

               _____

               _____

Question 5:   Have you been trained in TQM?   Y/N

               By what means: _____

               Over what time period?   _____

               What are your overall impressions of the training you have undertaken?

               _____

               _____

               _____

QUALITY

Flexibility

Where do you think
health care priorities
lie? _____

_____

_____

COST   TIME
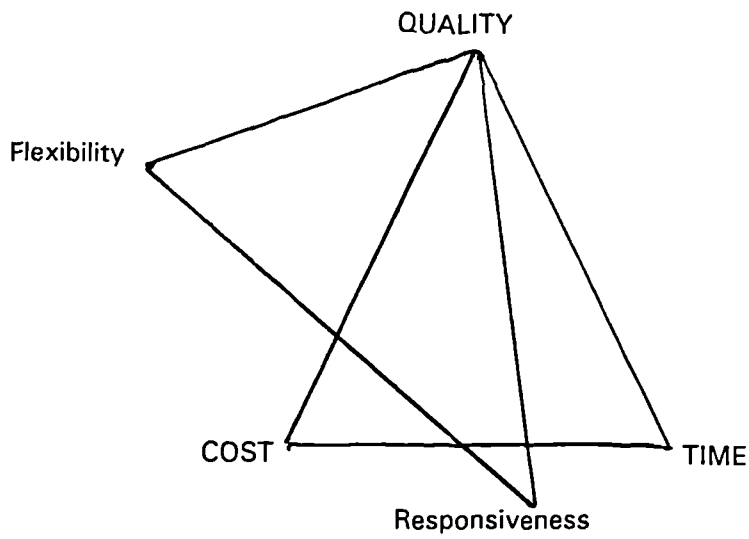
Responsiveness

PROBE: Why do you think health care priorities lie there?   _____

_____

_____

_____

PROBE: For performance measures concerning quality, costs, time, flexibility and
responsiveness: _____

_____

_____

SEEK: VIEWS CONCERNING TOP DOWN (Management led) OR BOTTOM UP (employee
led) establishment of performance measures: _____

_____

_____

SEEK: examples of poor quality performance: _____

_____

_____

SEEK: examples of good quality performance: _____

_____

_____

Question 7: What methods are there for establishing the costs of quality related problems?

_____

_____

_____

_____

PROBE: for strength of inter-face between financial accounting and quality management:

_____

_____

_____

SEEK: to establish existence of guidelines and procedures for resolving quality problems through continuous improvement activities:

_____

_____

_____

Question 8:   Please list what you believe are the Trust/Practice:

Quality Strengths: Quality Weaknesses:

seek to establish rank   seek to establish rank

Question 9:   I have covered the questions I intended asking you. MANY THANKS for your participation. Finally, I would be grateful if you would:

(1)   Make any point or statement concerning quality matters and TQM not covered:

_____

_____

_____

_____

(2)   Suggest how I could improve both the interview and the questions asked:

_____

_____

_____

_____

PATIENTS and FAMILY MEMBERS

Question 10: You have identified Trust and Practice quality strengths and weaknesses (last question). To what extent do you feel quality weaknesses may be resolved by adherence to Patients Charter targets, rights and standards?

_____

_____

_____

Question 11: How confident are you concerning complaining (using a complaints procedure) about poor quality service at:

GP Practice:
Hospital Trust:

PROBE: for reasons if a low score (1 or 2): _____

_____

_____

Question 12: To what extent do you think the following should be involved in:

   (1)   Quality matters concerning provision of health services:

```
                              1      2      3      4      5 .
The Patient:            .     |------|------|------|------|
The Patient's Family Member:  |------|------|------|------|
The Public:                   |------|------|------|------|
                              Not at                As much
                              all                   as possible
```

   (2)   Matters concerning the design of health services:

```
                              1      2      3      4      5
The Patient:                  |------|------|------|------|
The Patient's Family Member:  |------|------|------|------|
The Public:                   |------|------|------|------|
                              Not at                As much
                              all                   as possible
```

NOW GO TO QUESTION 9

APPENDIX 12

I am currently undertaking an investigation concerning quality matters and Total Quality Management in the NHS.

I would be most grateful if you would complete this questionnaire and return it to me in the pre-paid envelope provided by _____ .

The CODE LETTERS: _____ , I have used indicates whether you are a Hospital Trust or Health Authority employee, I do not intend referencing anyone by name.

<u>Question 1</u>: How well informed are you concerning TQM?

```
PLEASE PUT A
CIRCLE AROUND THE   ──►
APPROPRIATE NUMBER
```

```
1      2      3      4      5
├──────┼──────┼──────┼──────┤
Not                      Very
Informed                 Well
                         Informed
```

Would you please briefly indicate what you see is its main purpose:

_____

_____

_____

<u>Question 2</u>: Here is a definition which could be used for TQM:

Total Quality Management is continuous involvement and effort by all concerned with health care to continually seek and apply quality improvement and radical change to achieve the elimination of waste, the practice of respect for people and the provision of value satisfactions perceived by the external, internal and potential customers and suppliers.

Please indicate how <u>appropriate</u> you feel this <u>definition</u> is for:

		1	2	3	4	5
(i)	use in hospitals:	└────┴────┴────┴────┘				
(ii)	use by GPs:	└────┴────┴────┴────┘				
(iii)	use by health authorities:	└────┴────┴────┴────┘				
(iv)	use by patients (patient focussed care PFC):	└────┴────┴────┴────┘				
(v)	seeking continuous improvement:	└────┴────┴────┴────┘				
(vi)	radically changing things:	└────┴────┴────┴────┘				
(vii)	getting a more integrated organisation:	└────┴────┴────┴────┘				
(viii)	improving management:	└────┴────┴────┴────┘				
(ix)	improving culture (behaviour):	└────┴────┴────┴────┘				
	Other, please state: _____	└────┴────┴────┴────┘				

Not   Most
appropriate   appropriate

379

Please briefly indicate reasons for low appropriateness scores (ie. 1 and 2):

_____

_____

_____

Question 3:   Here is a method for integrating, applying and maintaining TQM:

EVALUATION STAGE

Expected Service ⟷ Perceived Quality ⟶ Perceived Health Care Service

Judge TQM

Action TQM

Plan/Organise TQM

Culture

Information

PROCESS AND IMPLEMENTATION STAGE

Translating requirements into action. Determines and measures performance. Implements solutions.

IDENTIFICATION STAGE

Internal/External customer needs and expectations. Professional and management quality. Opportunities for continuous improvement and radical change.

DECONSTRAINING STAGE

Culture transformation deconstraining barriers.

COMMITMENT STAGE

Corporate and strategic

TO VISION RESULTS

Customer Supplier Chains

Top Management Support/ responsive

(Questions relating to this method next page)

380

Please note: This is a 'bottom-up' method led particularly by employees and supported by top management in preference to a 'top-down' method led by management and supported by employees.

Please indicate which you feel would be most appropriate for TQM activities in the NHS:

(i)   Bottom-up method: ☐
(ii)   Top-down method: ☐
(iii)   Some other: ☐   please briefly indicate:

_____

_____

_____

_____

Which ever you have preferred above ((i), (ii) or (iii)), please indicate how appropriate you feel the suggested method is for:

		1	2	3	4	5
(i)	use in hospitals:					
(ii)	use by GPs:					
(iii)	use by health authorities:					
(iv)	use by patients (patient focussed care PFC):					
(v)	seeking continuous improvement:					
(vi)	radically changing things:					
(vii)	getting a more integrated organisation:					
(viii)	improving management:					
(ix)	improving culture (behaviour):					
	Other, please state: _____					
	_____					
	_____					

Not   Most
appropriate   appropriate

Please briefly indicate reasons for low appropriateness scores (ie. 1 and 2):

_____

_____

_____

381

Question 4: Using definition and method such as exampled here, how long would you expect it to take to move from Commitment Stage to Evaluation Stage?

```
        l____l____l____l____J
... |         |         |     ...
    1         2         3
            Years
```

Question 5: I would be grateful for any further information you may wish to add concerning TQM definition and method:

_____

_____

_____

_____

Thank you very much for completing this questionnaire.

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SCHOOL OF BUSINESS

Dean: Professor E C LEA
BSc(Econ) London
CERT ITP Harvard

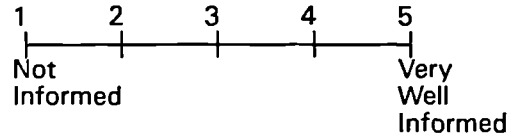**APPENDIX 13**   TQM QUESTIONNAIRE FOR DIRECT AND TELEPHONE INTERVIEWS

1.   Confirm intention and introduction of self.

2.   Confirm confidentiality and no reference to Trust or person by name.

3.   Ask them if they are prepared to give their job title and status:

_____

Date: _____ 199

4.   Indicate expected time for interview   -   45 to 60 mins   Direct Interviews
                                              -   15 to 20 mins   Telephone Interviews

5.   Say you will be asking them at the end if they would like a copy of the results of data collection when completed.

6.   Thank them for agreeing to be interviewed.

EXPLAIN YOU ARE GOING TO USE A 1-4 SCALE
WITH A NUMBER OF QUESTIONS WHERE 1 MAY BE
POOR AND 4 MAY BE VERY GOOD

Question 1   (All respondents)

How well informed do you feel you are about TQM being undertaken in your Trust?

1   2   3   4

L_____I_____I_____J

Not very   Very well
well informed   informed

IF A SCORE OF 1 THANK THEM AND END INTERVIEW.

Would you describe yourself as   :   an active participant in TQM?   ☐
                                 :   a non-active participant?   ☐

<u>Question 2</u>   (All respondents)

Is there a written policy/mission statement/definition for:

        Quality?   'Y/N
        TQM?   Y/N

<u>If Yes</u>:   Could I please be provided with a copy? | Once I have received 3 <u>similar</u> copies no need to ask this question |

Can you please briefly describe the focus or some aspects of its content?

_____

_____

<u>Question 3</u>   (All respondents)

Is there a TQM process model/paradigm/or particular method of approach for:

        Quality?   Y/N
        TQM?   Y/N

<u>If Yes</u>:   Could I please be provided with a copy? | Once I have received 3 <u>similar</u> copies there is no need to ask this |

Can you please briefly describe it:

_____

_____

_____

How important do you think it is for written policy/mission statement/definition to precede TQM process?

        1   2   3   4
        L___I___I___J
        Not very   Very
        important   important

Please briefly give reasons:

_____

_____

(All respondents)

.   What is your preferred method for introducing, applying and maintaining TQM?

Focus on some important issue, eg. team working and use that?   ☐

Use a process model/paradigm which involves steps or stages?   ☐

Other   ☐

Please indicate: _____

Please briefly give reasons for your choice:

_____

_____

Do you prefer focus on: top-down management led approach?   ☐

:   bottom-up employee led approach?   ☐

Other   ☐

Please indicate: _____

Question 5   (All respondents)

When embarking on TQM what would you say are the 6 most essential requirements which need to be in place?

Please indicate your level of satisfaction that they have been achieved

RANK

1   2   3   4

Not
satisfied

Very
satisfied

DIRECT INTERVIEWS ONLY - PROBE FOR:

Reason for low level of satisfaction (1 and 2 scores):

_____

_____

_____

Example where there is high level of satisfaction (3 and 4 scores):

_____

_____

_____

Views regarding TQM failing or disappointing to enhance them:

_____

_____

_____

Question 6   (All respondents)

Have you been trained in TQM?   Y/N

IF YES   By what means? Attended Course ☐   Distance Learning ☐
Reading Books and Articles ☐   Other ☐   Please indicate _____

Over what duration was the training? _____

Where did it mostly take place? _____

What, in a few words, was the TQM message put across?

_____

_____

How well did the training programme:

Achieve Intended Purpose?	Satisfy Your Requirements?
1 2 3 4	1 2 3 4
├────┼────┼────┤	├────┼────┼────┤
Didn't Very	Didn't Very
well	well

386

DIRECT INTERVIEWS ONLY   -   for those who answered Yes to Question 6

> INDICATE THAT I INTEND TO RETURN TO TRAINING
> PROGRAMMES TO ATTEMPT TO ESTABLISH KNOWLEDGE
> AND UNDERSTANDING OF A NUMBER OF TQM TOPICS
> AND ISSUES AND ALSO EXTENT TO WHICH METHOD HAS
> BEEN DETAILED FOR APPLYING AND PRACTISING TQM.

Question 8   (All respondents)

Please briefly describe the type of activities, projects, actions ... which you have
participated in as part of TQM process:

_____

_____

_____

_____

_____

PROBE to establish   :   which went beyond incremental change?
                      :   success/failures?

_____

_____

_____

_____

_____

<u>Question 9</u>   (All respondents)

To what extent do you think TQM process should involve the following in design of health services?

	1	2	3	4

GPs:

Fundholding GPs:

DHA's:

Directly Managed Units:

Purchasing Authorities:

Other Agencies:

Patients:

The Public:

Not at   As much
all   as possible
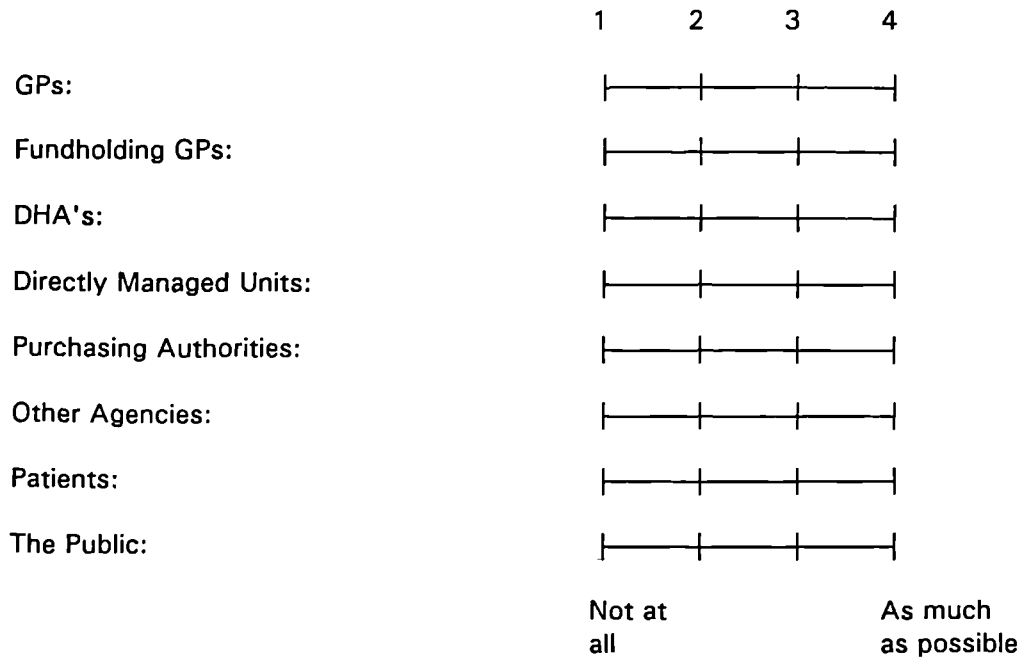
DIRECT INTERVIEWS ONLY:

PROBE for reason of low level scores (1 and 2):

_____

_____

_____

_____

_____

<u>Question 10</u>   (All respondents)

	Frequency

Are patient surveys undertaken by the Trust?   Y/N

(or any other body on behalf of the Trust?   Y/N)

Are purchaser surveys undertaken by the Trust?   Y/N

(or any other body on behalf of the Trust?   Y/N)

IF YES: Please briefly indicate the major reasons for undertaking them:

_____

_____

What are the major methods used?

☐   Interviews (Direct/Telephone)

☐   By self-completion questionnaires

☐   Meetings

☐   Other - please indicate :   _____

To what extent are these surveys part of the TQM process?

```
1        2        3        4
L_____L_____L_____J
Not any              A major
part                 part
```

Question 11   (All respondents)

To what extent do you think TQM process should involve the following?		Please indicate your understanding of method for applying

                              1   2   3   4   1   2   3   4

Collection of up-to-date
and relevant Information,
Data and Facts: ├──┼──┼──┤   ├──┼──┼──┤

Standards setting by
management: ├──┼──┼──┤   ├──┼──┼──┤

Standards setting by
personnel who perform
the work: ├──┼──┼──┤   ├──┼──┼──┤

Systems (ISO 9000/
BS 5750) focus: ├──┼──┼──┤   ├──┼──┼──┤

Explicit measures to
establish TQM successes: ├──┼──┼──┤   ├──┼──┼──┤

Complaints focus: ├──┼──┼──┤   ├──┼──┼──┤
                              Not   Fully   Not   Fully

Others, please specify: _____

DIRECT INTERVIEWS ONLY

PROBE   these areas to establish reasons for response. Attempt to establish
               methodologies used:

_____

_____

_____

_____

_____

TRY TO GET EXAMPLE(S) OF MEASURED IMPROVEMENTS RESULTING FROM TQM
PROCESS:

_____

_____

_____

Question 12 (All respondents)

What would you say are the most appropriate means for involving Trust personnel in TQM process. (Remind that I am referring to all personnel: managers, clinicians, nurses, support services ...)?

	Which do you participate in?	Which would you participate in?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DIRECT INTERVIEWS ONLY

PROBE   to establish reason for those, which by implication, they are not prepared to participate in:

_____	_____
_____	_____
_____	_____

Question 13 (All participants)

Please indicate what opportunities TQM:

- has provided for the Trust?	Please indicate how well they have been provided?	- could provide for the Trust?
_____		_____
_____	1 2 3 4	_____
_____	├───┼───┼───┤	_____
_____	├───┼───┼───┤	_____
_____	├───┼───┼───┤	_____
_____	├───┼───┼───┤	_____
_____	Not Very well	_____

391

PROBE   (1) to establish reasons for low scores (1 and 2)

_____

_____

_____

_____

_____

PROBE   (2) to explore those areas which could provide opportunities for the
             Trust

_____

_____

_____

Question 14   Do you wish to make any other statement or observation you have regarding TQM?

_____

_____

_____

MANY THANKS FOR YOUR ASSISTANCE. (Give card with name, address and telephone number, should they wish to make contact with me.)

Ask if they would like a copy of the results from this data collection which aims to involve 50 in direct interviews and 70 in telephone interviews, with expectation of a minimum 100 to agree. For those involved in direct interview provide each with:-

First a copy of the Proposed TQM Definition.

Second and following responses a copy of the Proposed Eclectic Paradigm.

Third, following responses a copy of Sheet A with prepaid envelope. Request a data for returning this.

APPENDIX 13 (cont)

Date: _____

Code: _____

I am grateful to you for agreeing to be interviewed. Your answer to question 6, was that you have received training in TQM. It would be most helpful for my investigation, if you would spend a little time to reflect the training which you have undertaken, and then record below what you feel is your knowledge and understanding of TQM topics and issues and the extent to which you gained detail of method for applying and practising TQM.

May I remind you again that no reference will be made to you or your Trust by name. The letter(s) I have written against code above serve only for me to establish whether you are a consultant (C), manager (M), nurse (N), administrator (A) and so on ... I am again using the four-point scale which I used for questions during our interview.

TQM Topics and Issues:	Your Knowledge and Understanding level:				Your understanding of method detail for application and practice			
	1	2	3	4	1	2	3	4
■ TQM - Strategic focus:	├──┼──┼──┤				├──┼──┼──┤			
■ Preparing the organisation:	├──┼──┼──┤				├──┼──┼──┤			
■ Preparing management:	├──┼──┼──┤				├──┼──┼──┤			
■ Preparing others:	├──┼──┼──┤				├──┼──┼──┤			
■ Preparing culture:	├──┼──┼──┤				├──┼──┼──┤			
■ Continuous quality improvement:	├──┼──┼──┤				├──┼──┼──┤			
■ Radical change:	├──┼──┼──┤				├──┼──┼──┤			
■ Patient focused care:	├──┼──┼──┤				├──┼──┼──┤			
■ Teamworking:	├──┼──┼──┤				├──┼──┼──┤			
■ Leadership:	├──┼──┼──┤				├──┼──┼──┤			
■ Facilitating (mentoring):	├──┼──┼──┤				├──┼──┼──┤			
■ Staff empowerment:	├──┼──┼──┤				├──┼──┼──┤			
■ Patient empowerment:	├──┼──┼──┤				├──┼──┼──┤			
	None		Very Good		None		Very Good	

Rector : Professor K J DURRANDS

TQM Topics and Issues:	Your Knowledge and Understanding level:				Your understanding of method detail for application and practice			
	1	2	3	4	1	2	3	4
■ Handling complaints:	├──┼──┼──┤				├──┼──┼──┤			
■ Patients Charter in TQM:	├──┼──┼──┤				├──┼──┼──┤			
■ Problem solving:	├──┼──┼──┤				├──┼──┼──┤			
■ Problem prevention:	├──┼──┼──┤				├──┼──┼──┤			
■ Performance measurement	├──┼──┼──┤				├──┼──┼──┤			
■ Standards setting:	├──┼──┼──┤				├──┼──┼──┤			
■ Audit:	├──┼──┼──┤				├──┼──┼──┤			
■ ISO 9000/BSI 5750:	├──┼──┼──┤				├──┼──┼──┤			
■ Information/Data collection:	├──┼──┼──┤				├──┼──┼──┤			
■ Statistical Method:	├──┼──┼──┤				├──┼──┼──┤			
■ Benchmarking	├──┼──┼──┤				├──┼──┼──┤			
■ Cause and effect analysis:	├──┼──┼──┤				├──┼──┼──┤			
■ Pareto analysis:	├──┼──┼──┤				├──┼──┼──┤			
■ Brain-storming:	├──┼──┼──┤				├──┼──┼──┤			
■ Report writing:	├──┼──┼──┤				├──┼──┼──┤			
■ Presentation skills:	├──┼──┼──┤				├──┼──┼──┤			
■ Quality costing:	├──┼──┼──┤				├──┼──┼──┤			
■ Feedback procedures:	├──┼──┼──┤				├──┼──┼──┤			
■ Rewards and recognition:	├──┼──┼──┤				├──┼──┼──┤			
■ Method for voicing concern:	├──┼──┼──┤				├──┼──┼──┤			
■ Internal politics:	├──┼──┼──┤				├──┼──┼──┤			
■ External politics:	├──┼──┼──┤				├──┼──┼──┤			

PLEASE FEEL FREE TO ADD OTHERS

■ _____ :	├──┼──┼──┤				├──┼──┼──┤			
■ _____ :	├──┼──┼──┤				├──┼──┼──┤			
■ _____ :	├──┼──┼──┤				├──┼──┼──┤			
■ _____ :	├──┼──┼──┤				├──┼──┼──┤			
■ _____ :	├──┼──┼──┤				├──┼──┼──┤			
	None			Very Good	None			Very Good

Thank you very much for taking the time to complete this. I think we agreed that you would post it in the prepaid envelope not later than _____ .

If you have any specific detail of TQM applications, activities and results which you have been concerned/involved with, I would be most appreciative of copies:

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Fax: 0484 516151

THE POLYTECHNIC OF HUDDERSFIELD

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Facsimile : (0484) 516151

SCHOOL OF BUSINESS

Dean: Professor E C LEA
BSc(Econ) London
CERT ITP Harvard

APPENDIX 14

I am currently undertaking an investigation concerning Total Quality Management (TQM) in 12 DoH funded NHS Trust Demonstration Sites. To provide me with up-to-date information, it would be most helpful if you would complete this questionnaire and return it to me in the pre-paid envelope provided by _____ .

I CAN GUARANTEE ABSOLUTE CONFIDENTIALITY IN THAT NO REFERENCE WILL BE MADE TO YOU OR YOUR TRUST BY NAME.

It would be helpful if you would indicate your professional/role title as simply - manager, consultant nurse, radiographer, clerical officer, laundry worker ..., so that I can group responses.

Professional/Role Title: _____

Question 1:   How well informed are you concerning TQM in your Trust?

| Please put a circle around the appropriate number | → |

```
1      2      3      4
├──────┼──────┼──────┤
Not                  Very well
informed             informed
```

If you are not informed, ie. number 1, please return the questionnaire without going any further. Many thanks for your assistance.

Question 2:   Would you describe yourself as: Please tick

an active participant in TQM: ☐
a non-active participant: ☐
not interested in TQM: ☐

Question 3:   Do you know of a written policy/mission statement/definition for TQM?

Yes   ☐
No   ☐

If Yes, what would you briefly say is its main focus?

_____

_____

Rector : Professor K J DURRANDS

Question 4: Do you know if a TQM process model/paradigm/method of approach is being used by your Trust?

Yes ☐
No ☐

If Yes, would you please briefly describe it?

_____

_____

_____

Question 5: How important do you think it is for written policy/mission statement/definition to precede TQM process model?

```
1    2    3    4
├────┼────┼────┤
Not              Very
important        important
```

Would you please briefly indicate why you think that:

_____

_____

_____

Question 6: Do you have preference of approach for introducing, applying and maintaining TQM?

Yes ☐
No ☐

If Yes, please indicate:

(i)   Focus on some important issue, for example teamwork, and using that as approach ☐

(ii) Using a step-by-step approach/process model/paradigm ☐

(iii) Other: please briefly detail _____

_____

What, briefly, are the reasons for your preference? _____

_____

_____

Question 6:   (continued)

Do you prefer focus on: top-down (management led) approach? ☐
bottom-up (employee led) approach: ☐
` other, please indicate:

_____

Question 7:

When embarking on TQM application what would you say are the 6 most essential requirements which need to be in place? Please list them most important to least important:

Please indicate your level of satisfaction that they have been achieved in your Trust:

1   2   3   4

_____   ├───┼───┼───┤

_____   ├───┼───┼───┤

_____   ├───┼───┼───┤

_____   ├───┼───┼───┤

_____   ├───┼───┼───┤

_____   ├───┼───┼───┤

Not   Very well
satisfied   satisfied

Would you please indicate reason for low level satisfaction, ie. scores 1 or 2:

_____

_____

_____

Question 8:   Have you been trained in TQM?   Yes   ☐

                                                                           No   ☐

If your answer is YES, please indicate by what means:

Training course   ☐
Distance Learning Programme, eg. Correspondence Course   ☐
Reading books, articles, media coverage   ☐
Other, please indicate   _____

Over what time duration was your training? _____

Where did it mostly take place? _____

Please indicate in a few words the TQM message put across in your training:

_____

_____

_____

How well do you think the training you have undergone:

(i)   Achieved Intended Purpose?   (ii)   Satisfied your Requirements?

```
1      2      3      4                          1      2      3      4
├──────┼──────┼──────┤                          ├──────┼──────┼──────┤
Not at        Very                              Not at        Very
all           well                              all           well
```

Question 9:   Please briefly describe the type of activities, projects, actions ...... which you have
participated in as part of TQM process. YOU MAY PREFER TO APPEND DETAILS
AND MATERIAL ALREADY PREPARED:

_____

_____

_____

_____

_____

Question 10: To what extent do you think TQM process should involve the following in design of health care services?

	1	2	3	4
GPs:	├──────┼──────┼──────┤
Fundholding GPs:	├──────┼──────┼──────┤
DHAs:	├──────┼──────┼──────┤
Directly Managed Units:	├──────┼──────┼──────┤
Purchasing Authorities:	├──────┼──────┼──────┤
Other Agencies:	├──────┼──────┼──────┤
Patients:	├──────┼──────┼──────┤
The Public:	├──────┼──────┼──────┤

Others: (please indicate)

_____   ├──────┼──────┼──────┤

_____   ├──────┼──────┼──────┤

Not at   As much
all   as possible

Question 11: Are patient surveys undertaken?   Yes ☐   If Yes, how often? _____

                                       No ☐

Are purchaser surveys undertaken?   Yes ☐   If Yes, how often? _____

                                       No ☐

If Yes, please briefly indicate reason:

(i)   for patient surveys: _____
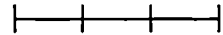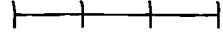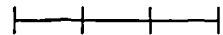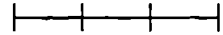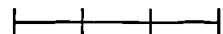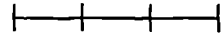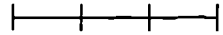
(ii)   for purchaser surveys: _____

To what extent are they part of TQM process?   1   2   3   4

                                               ├──────┼──────┼──────┤

                                               Not any   Fully a
                                               part   part

To what extent do you think TQM process should involve the following?	Please indicate your under-standing of method for applying it in practice:

	1	2	3	4		1	2	3	4
Collection of up-to-date and relevant Information; Data and Facts:	├──┼──┼──┤					├──┼──┼──┤			
Standards setting by Management:	├──┼──┼──┤					├──┼──┼──┤			
Standards setting by personnel who do the work:	├──┼──┼──┤					├──┼──┼──┤			
Systems focus (eg. ISO 9000/BS 5750):	├──┼──┼──┤					├──┼──┼──┤			
Explicit measures to esta-blish TQM successes:	├──┼──┼──┤					├──┼──┼──┤			
Complaints focus:	├──┼──┼──┤					├──┼──┼──┤			
Others: please specify:									
_____	├──┼──┼──┤					├──┼──┼──┤			
_____	├──┼──┼──┤					├──┼──┼──┤			
	Not Much			Fully		Not Much			Fully
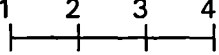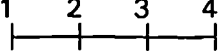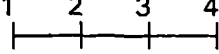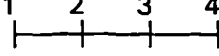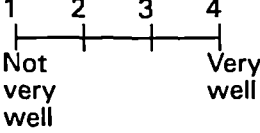
Question 13: Would you please list what you believe are the most appropriate means for involving Trust personnel in TQM process. (By Trust personnel I refer to all personnel, eg. managers, clinicians, nurses, administrators and all support service staff):

Means for Involving Personnel in TQM:	Please indicate whether you participate in them or not:	Please indicate those which you would be prepared to participate in:
	YES □ NO □	YES □ NO □
	YES □ NO □	YES □ NO □
	YES □ NO □	YES □ NO □
	YES □ NO □	YES □ NO □
	YES □ NO □	YES □ NO □
	YES □ NO □	YES □ NO □
	YES □ NO □	YES □ NO □

If you have said you don't participate in any of the activities listed OR that you would not be prepared to participate, would you please indicate why:

Activity: Reason:

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

Question 14: Please indicate the opportunities which TQM:

(i) Has provided for the Trust:	Please indicate how well you think each of those in column (i) have been put into practice:	(ii) Could have provided for the Trust:
	1 2 3 4	
	1 2 3 4	
	1 2 3 4	
	1 2 3 4	
	1 2 3 4 Not very well Very well	

Question 15: I would be grateful for any further information you may wish to add concerning TQM:

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire.

If you have any specific detail of TQM applications, activities and results which you have been involved in, I would be most appreciative of copies or extracts.

M E Waddington
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The Polytechnic of Huddersfield
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APPENDIX 15 RESPONSES FROM PARTICIPANTS DURING DIRECT INTERVIEW TO: PROPOSED TQM DEFINITION

Give out a copy of the proposed definition and ask interviewee to read it.

Question: Please compare this definition with your Trusts' policy/mission statement/definition for quality/TQM.

Seek a response: 1   2   3   4

Much   Much
Prefer   Prefer
Own   Proposed

PROBE for reasons

_____

_____

_____

_____

_____

_____

_____

_____

If not included in the response, attempt to establish reasons in terms of organisation, management and culture issues:

_____

_____

_____

_____

_____

If not included in response, attempt to tease-out political issues:

_____

_____

_____

Give out a copy of the proposed paradigm and ask interviewee to read it.

Question: What are your views regarding appropriateness of the paradigm for introducing,
applying and maintaining TQM?

```
1      2      3      4
L_____I_____I_____J
Not                  Most
appropriate          appropriate
```
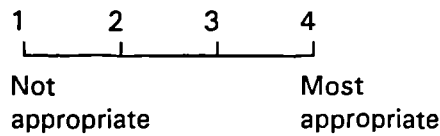
PROBE   for strengths:

_____

_____

_____

PROBE   for weaknesses:

_____

_____

_____

How long would you expect it to take to introduce TQM process to the point of
'success' using:

your Trusts' approach?   _____

this suggested approach?   _____

PROBE   if views have not been established in connection with definition and/or
paradigm facilitating organisation segregation and ability to inculcate
common goal and strategic purpose:

_____

_____

_____

_____

If not already established PROBE to seek views and opinion in connection with
paradigm use for identifying performance gaps:

_____

_____

_____

APPENDIX 16 TQM COMMITMENT STAGE QUESTIONNAIRE FOR DIRECT INTERVIEWS WITH TOP MANAGEMENT, AND SENIOR CASE TRUST PERSONNEL: CONSULTANTS, DOCTORS, SENIOR MANAGERS, SENIOR NURSING OFFICER (and above), AND SENIOR SUPPORT SERVICES MANAGERS/ADMINISTRATORS

Date: _____

Job Title: _____

Confirm confidentiality in no reference to Trust or person by name.

Question 1: The Commitment Stage of the proposed TQM paradigm described in the TQM Awareness Workshops noted 10 important points. [Provide them with a copy.]

I would welcome your views on the Trusts' likely intention to practice and maintain each of them.

	1	2	3	4

- On-going commitment to Effective Leadership and Quality

PROBE FOR REASONS WHY THEY HAVE SUGGESTED THIS:

_____

_____

_____

_____

- A formal TQM Budget:

Not Likely   Most Likely

PROBE FOR REASONS:

_____

_____

_____

_____

■   Improving Internal Relations:

                                                          1   2   3   4
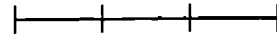
PROBE FOR REASONS:

_____

_____

_____

_____

■   Support and Commitment for People
      Involvement Whatever the Work Pressures:
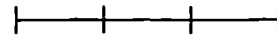
PROBE FOR REASONS:

_____

_____

_____

_____

■   Conscious Effort and Availability to
      Mentor People:
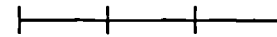
PROBE FOR REASONS:

_____

_____

_____

_____

■   Commitment to Responsiveness in
      Providing Information and Action: Not   Most
                                                             Likely   Likely
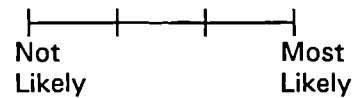
PROBE FOR REASONS:

_____

_____

_____

_____

■   Focus on Relationships with Customers,   1   2   3   4
       Suppliers and Co-Workers: ├──┼──┼──┤
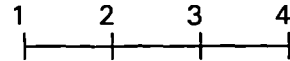
PROBE FOR REASONS:

_____

_____

_____

_____

■   Recognition That Small Improvements   ├──┼──┼──┤
       are as Important as Large-Scale Radical
       Change:

PROBE FOR REASONS:

_____

_____

_____

_____

■   On-Going Consideration for and   ├──┼──┼──┤
       Visibility of Target Sectors, Customers,
       Market and Service Position:
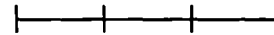
PROBE FOR REASONS:

_____

_____

_____

_____

■   Monitoring Performance Against   ├──┼──┼──┤
       Customer Needs and Expectations: Not   Most
                                      Likely   Likely
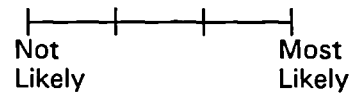
PROBE FOR REASONS:

_____

_____

_____

_____

THOSE OTHER THAN TOP MANAGEMENT

Question 2:   Corporate Objectives and Strategic Planning were described and discussed at the TQM Awareness Workshops concerning TQM implementation. (Briefly re-cap these in connection with TQM definition and paradigm adopted.)

What are your views on these?

_____

_____

_____

_____

PROBE (if unclear above) to establish commitment and support for that which has been collectively suggested and accepted:

_____

_____

_____

_____

Question 3:   What are your views of the next stage of the TQM process, namely the 'Deconstraining Stage'? Will you please indicate your views concerning:

	1	2	3	4

- Everyone being required to attend a half-day TQM Seminar:

PROBE FOR REASONS:

_____

_____

_____

_____

- Attendance to be in vertically 'sliced' groups of about one hundred people:

Don't support   Fully support
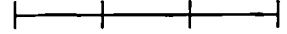
PROBE FOR REASONS (Low scores 1 and 2):

_____

_____

_____

_____

410

| | 1 | 2 | 3 | 4 |

- Top Management openly committing the Trust to TQM:

```
1       2       3       4
|-------|-------|-------|
```

PROBE FOR REASONS (Low scores 1 and 2):

_____

_____

_____

_____

- Everyone being provided with a copy of:

the TQM *definition:*

```
|-------|-------|-------|
```
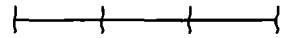
the TQM *paradigm:*

```
|-------|-------|-------|
```
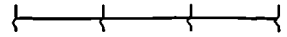
PROBE FOR REASONS (Low scores 1 and 2):

_____

_____

_____

_____

- Team ownership of TQM

In the form of:

Staff empowered department teams:

```
|-------|-------|-------|
```
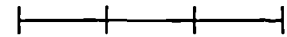
Cross functional teams:

```
|-------|-------|-------|
```
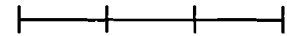
Multi-disciplinary teams:

```
|-------|-------|-------|
```

Other: please specify

_____

```
|-------|-------|-------|
Don't                    Fully
support                  support
```
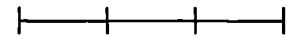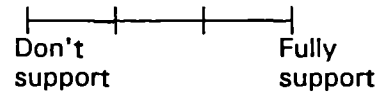
PROBE FOR REASONS (Low scores 1 and 2):

_____

_____

_____

_____

_____

_____

1   2   3   4

■   Everyone being provided with a copy of
     the ten-point statement (covered in
     Question 1 above):

     With Analysis of Top Management/
     Senior Personnel Responses: ├───┼───┼───┤
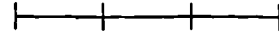
     Without Analysis of Top Management/
     Senior Personnel Responses: ·   ├───┼───┼───┤

PROBE FOR REASONS (Low scores 1 and 2):

_____

_____

_____

_____

_____

_____

■   Asking everyone to identify the   ├───┼───┼───┤
     constraining barriers which affect
     service quality:

PROBE FOR REASONS (Low scores 1 and 2):

_____

_____

_____

_____
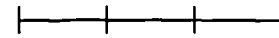
■   Asking everyone to suggest/undertake   ├───┼───┼───┤
     improvement/elimination of constraints: Don't   Fully
                                             support   support
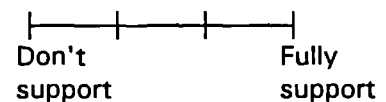
PROBE FOR REASONS (Low scores 1 and 2):

_____

_____

_____

_____

Question 3:   Do you wish to make any other statement or observation you have regarding:

TQM Stage 1 - 'COMMITMENT STAGE':

_____

_____

_____

_____

TQM Stage 2 - 'DECONSTRAINING STAGE':

_____

_____

_____

MANY THANKS FOR YOUR ASSISTANCE, SUGGESTIONS AND ADVICE

APPENDIX 17

Date: _____

Following our recent telephone discussion, I have forwarded the questionnaire which you agreed to complete concerning the possibility of you applying TQM process in your Hospital/Trust.

As I said to you on the telephone, I guarantee absolute confidentiality in that no reference will be made to you or your Hospital/Trust by name.

I will forward a copy of my analysis of the results which could have reached sixty-eight hospitals/ Trusts before I have completed my investigation in September 1994.

Many thanks for agreeing to participate.

Question 1:   This question relates to possible reasons for undertaking TQM.

Please indicate which (if any) are likely reasons for your hospital/Trust deciding to undertake TQM, should you decide to go ahead. They are not listed in any particular order and you may wish to add to the list.

Possible Reason for Undertaking TQM:	1	2	3	4
Achieve ISO 9000/BS 5750	├——┼——┼——┤			
Assist with standards setting	├——┼——┼——┤			
Ensure conformity to standards	├——┼——┼——┤			
Reduce costs	├——┼——┼——┤			
Provide reason for everyone striving for excellence	├——┼——┼——┤			
Get a more effective complaints procedure	├——┼——┼——┤			
Save time	├——┼——┼——┤			
Involve more people in quality matters	├——┼——┼——┤			
Link with audit procedures	├——┼——┼——┤			

Not a reason   A most important reason

Better satisfy:

	1	2	3	4

Patients

|———|———|———|

Purchasers

|———|———|———|

The Public

|———|———|———|

Suppliers

|———|———|———|

Others, please list:

_____

|———|———|———|

_____

|———|———|———|

_____

|———|———|———|

_____

|———|———|———|

_____

|———|———|———|

_____

|———|———|———|

Not a
reason   A most
                         important
                         reason

Question 2:   Please try to imagine TQM process as involving 5 Stages covering a time period of a little over 2 years as follows:

Stage 1	taking	1 month
Stage 2	taking	3 months
Stage 3	taking	4 months
Stage 4	taking	11 months
Stage 5	taking	6 months

Please tick the following activities which you would plan to undertake as part of your STAGE 1 and STAGE 2 application, indicating in the column headed 'Stage' whether you would expect it to be 1 (Stage 1) or 2 (Stage 2).

I AM NOT INTERESTED AT THIS POINT IN YOU PROVIDING INFORMATION/ RESPONSE IN QUESTION 2 BEYOND STAGE 1 AND STAGE 2 SUGGESTED ABOVE. THANK YOU.

POSSIBLE TQM PROCESS ACTIVITIES:

Stage:

Activity		
Strategic focus:	☐	
Preparing the organisation:	☐	
Preparing management:	☐	
Preparing others:	☐	
Preparing culture:	☐	
Continuous quality improvements:	☐	
Radical change:	☐	
Patient focussed care:	☐	
Teamworking:	☐	
Leadership development:	☐	
Staff empowerment:	☐	
Patient empowerment:	☐	
Facilitator/Mentor development:	☐	
Handling complaints:	☐	
Patients Charter focus:	☐	
Problem solving procedures:	☐	
Problem prevention procedures:	☐	
Performance measurement:	☐	
Standards setting:	☐	
Audit:	☐	
ISO 9000/BS 5750:	☐	
Information/data collection:	☐	
Statistical method and procedure:	☐	
Benchmarking:	☐	
Cause and effect analysis:	☐	
Pareto analysis:	☐	
TQM training:	☐	
Brain storming:	☐	
Quality costing:	☐	
Seeking top management commitment:	☐	
Rewards and recognition:	☐	

		Stage:
Method for voicing concern:	☐	
Focussing internal politics:	☐	
Focussing external politics:	☐	
Internal communications systems:	☐	
External communications systems:	☐	
Others, please list:		

_____

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire.

M E Waddington
Principal Lecturer
School of Business
The University of Huddersfield
Queensgate
HUDDERSFIELD HD1 3DH   Telephone: 0484 422288 ext 2557
                         Fax   0484 516151

I think we agreed that you would return the questionnaire in the prepaid envelope not later than _____   .

I expect to telephone you again during _____   .

417

APPENDIX 18

Date: _____

Following our recent telephone discussion, I have forwarded the questionnaire which you agreed to complete concerning Total Quality Management in your Hospital/NHS Trust.

As I said to you on the telephone, I guarantee absolute confidentiality in that no reference will be made to you or your Hospital/Trust by name.

I will forward a copy of my analysis of the results which could have reached sixty-eight hospitals/ Trusts before I have completed my investigation in September 1994.

Many thanks for agreeing to participate.

Question 1:   This question relates to reasons for undertaking TQM.

Please indicate which, if any, were reasons for your hospital/Trust deciding to under-take TQM. They are not listed in any particular order and you may wish to add to the list.

Reason for Undertaking TQM, to:	1	2	3	4
Achieve ISO 9000/BS 5750	├───┼───┼───┤			
Assist with standards setting	├───┼───┼───┤			
Ensure conformity to standards	├───┼───┼───┤			
Reduce costs	├───┼───┼───┤			
Provide reason for everyone striving for excellence	├───┼───┼───┤			
Get a more effective complaints procedure	├───┼───┼───┤			
Save time	├───┼───┼───┤			
Involve more people in quality matters	├───┼───┼───┤			
Link with audit procedures	├───┼───┼───┤			

Not a   A most
reason   important
                                   reason

| | 1 | 2 | 3 | 4 |

Better satisfy:

Patients

├──────┼──────┼──────┤

Purchasers

├──────┼──────┼──────┤

The Public

├──────┼──────┼──────┤

Suppliers

├──────┼──────┼──────┤

Others, please list:

_____   ├──────┼──────┼──────┤

_____   ├──────┼──────┼──────┤

_____   ├──────┼──────┼──────┤

_____   ├──────┼──────┼──────┤

_____   ├──────┼──────┼──────┤

_____   ├──────┼──────┼──────┤

Not a
reason

A most
important
reason

Question 2: Please try to imagine your TQM process as involving <u>5 Stages</u> covering a time period of a little over 2 years as follows:

```
Stage 1    taking   1 month
Stage 2    taking   3 months
Stage 3    taking   4 months
Stage 4    taking  11 months
Stage 5    taking   6 months
```

Please tick the following activities which you have undertaken as part of your STAGE 1 and STAGE 2 application, indicating in the column headed 'Stage' whether it was 1 (Stage 1) or 2 (Stage 2).

I AM NOT INTERESTED AT THIS POINT IN YOU PROVIDING INFORMATION/ RESPONSE IN QUESTION 2 BEYOND STAGE 1 AND STAGE 2 <u>SUGGESTED ABOVE</u>. THANK YOU.

POSSIBLE TQM PROCESS ACTIVITIES:

Stage:

Please indicate your views regarding the success of this activity:

Activity		Stage	1 2 3 4
Strategic focus:	☐		├──┼──┼──┤
Preparing the organisation:	☐		├──┼──┼──┤
Preparing management:	☐		├──┼──┼──┤
Preparing others:	☐		├──┼──┼──┤
Preparing culture:	☐		├──┼──┼──┤
Continuous quality improvements:	☐		├──┼──┼──┤
Radical change:	☐		├──┼──┼──┤
Patient focussed care:	☐		├──┼──┼──┤
Teamworking:	☐		├──┼──┼──┤
Leadership development:	☐		├──┼──┼──┤
Staff empowerment:	☐		├──┼──┼──┤
Patient empowerment:	☐		├──┼──┼──┤
Facilitator/Mentor development:	☐		├──┼──┼──┤
Handling complaints:	☐		├──┼──┼──┤
Patients Charter focus:	☐		├──┼──┼──┤
Problem solving procedures:	☐		├──┼──┼──┤
Problem prevention procedures:	☐		├──┼──┼──┤
Performance measurement:	☐		├──┼──┼──┤
Standards setting:	☐		├──┼──┼──┤
Audit:	☐		├──┼──┼──┤
ISO 9000/BS 5750:	☐		├──┼──┼──┤
Information/data collection:	☐		├──┼──┼──┤
Statistical method and procedure:	☐		├──┼──┼──┤
Benchmarking:	☐		├──┼──┼──┤
Cause and effect analysis:	☐		├──┼──┼──┤
Pareto analysis:	☐		├──┼──┼──┤
TQM training:	☐		├──┼──┼──┤
Brain storming:	☐		├──┼──┼──┤

Not successful   Very successful

420

Stage:

Please indicate your views regarding the success of this activity:

		1 2 3 4
Quality costing:	☐	├──┼──┼──┤
Seeking top management commitment:	☐	├──┼──┼──┤
Rewards and recognition:	☐	├──┼──┼──┤
Method for voicing concern:	☐	├──┼──┼──┤
Focussing internal politics:	☐	├──┼──┼──┤
Focussing external politics:	☐	├──┼──┼──┤
Internal communications systems:	☐	├──┼──┼──┤
External communications systems:	☐	├──┼──┼──┤

Others, please list:

_____

_____

_____

_____

_____

_____

├──┼──┼──┤
├──┼──┼──┤
├──┼──┼──┤
├──┼──┼──┤
├──┼──┼──┤
├──┼──┼──┤

Not successful   Very successful

Please briefly indicate reasons for low success scores (1 and 2):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

421

Question 3:   In terms of the suggested five stages noted in Question 2 and the times relating to them please indicate your current stage:

Stage 1   ☐
Stage 2   ☐
Stage 3   ☐
Stage 4   ☐
Stage 5   ☐

Question 4:   I would welcome any additional information you wish to add concerning TQM:

_____

_____

_____

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire.

Should you have any specific detail of TQM applications, activities and results, I would be most appreciative of copies.

M E Waddington
Principal Lecturer
School of Business
The University of Huddersfield
Queensgate
HUDDERSFIELD   HD1 3DH   Telephone: 0484 422288 ext 2557
                         Fax   0484 516151

I think we agreed that you would return the questionnaire in the prepaid envelope not later than _____   .

I expect to telephone you next _____   .

HEALTH AUTHORITY - PROVIDER UNIT

DISTRICT HOSPITAL

▉

▉   *Tel:*

___

Enquiries to:

Your Ref:

Our Ref: ▉

02/09/92

Dear

Please find attached your personal copy of our Total Quality Management (TQM) definition,adopted for our drive towards quality excellence. You may wish to use this in its entirety or as a means for developing mission statements or protocols aimed at improving the quality of care we already provide and better patient and purchaser focus where possible.

Also attached is a diagram (model) of the method we intend to follow for putting TQM into practice.

Mr Mike Waddington of the University of Huddersfield Business School with our team of TQM facilitators has arranged half-day TQM training sessions.Each will be attended by myself and,or members of the Trust Board to voice our support for TQM and answer questions you may have regarding its implementation.

Mike has asked me to point out that if anyone is unable to attend at any of the suggested times,he is willing to arrange other times between now and the end of the year.We,like him,hope you will make every effort to attend.

Yours Sincerely

Chief Executive

Total Quality Management (TQM)
Definition

Total Quality Management is continuous involvement and effort by all concerned with health care to continually seek and apply quality improvement and radical change to achieve the elimination of waste, the practice of respect for people and the provision of value satisfactions perceived by the external, internal and potential customers and suppliers

USERS - PURCHASERS - PUBLIC

EVALUATION STAGE

| Expected Service | ⟷ Perceived Quality ⟹ | Perceived Health Care Service |

PROCESS AND IMPLEMENTATION STAGE

Translating requirements into action. Determines and measures performance. Implements solutions.

IDENTIFICATION STAGE

Internal/External customer needs and expectations. Professional and management quality. Opportunities for continuous improvement and radical change.

DECONSTRAINING STAGE

Culture transformation deconstraining barriers.

COMMITMENT STAGE

Corporate and strategic

Judge TQM

Action TQM

Plan/Organise TQM

Culture

Information

RESULTS

Customer Supplier Chains

TO

VISION

Top Management Support/ responsive

_____
_____
_____
_____

_____
_____
_____
_____

_____
_____
_____
_____

_____
_____
_____
_____

426

Organisation Culture Check List

	NO			YES	
	1	2	3	4	5
■ Organise people into bureaucracies					
■ Operate a 'Council of Elders'					
■ Insulate as they rise					
■ Suspicious of ideas from below					
■ Insist on many hierarchy levels					
■ Pick the winner at any cost					
■ Express criticism freely, withold praise and instil job insecurity					
TOTAL SCORE					
Other Comments:					

APPENDIX 22

Date: _____

Following our recent telephone discussion, I have forwarded the questionnaire which you agreed to complete concerning TQM Teamworking in your Hospital/NHS Trust.

As I said to you on the telephone, I guarantee absolute confidentiality in that no reference will be made to you or your Hospital/Trust by name.

I will forward a copy of my analysis of the results which will have reached sixty-eight hospitals/ Trusts before I have completed my investigation in September 1994.

Many thanks for agreeing to participate.

Question 1:   This question relates to the approximate number (as a percentage) of your hospital/ Trust employees who are members of TQM Teams.

Managers/Administrators	:	%
Consultants	:	%
Doctors	:	%
Nurses	:	%
Support Services	:	%

Please indicate, as a percentage, the number of employee team members compared with the total number of hospital/Trust employees   %.

Please indicate the number of non-hospital/Trust employees who are team members:

Number:

Patients	:	....
Family Members	:	....
GPs	:	....
Health Authority Personnel	:	....
Member of the Public	:	....

Other agencies: please detail and indicate numbers:

_____

_____

_____

Question 2:   This question concerns types of teams

Please indicate the percentages of employees involved in the following teams:

Individual department or
particular function teams: %

Teams consisting of a
particular group of professionals
only: %

Cross-functional teams across·
functions, departments,
Directorates: %

Inter-organisational, similar to
cross-functional teams <u>BUT</u>
also involving team members who
are <u>not</u> hospital/Trust employees
(eg. GPs, Patients, Members of the
Public ...)   %

Other - please list: —————————   %

                             —————————   %

Please indicate the total number
of TQM teams <u>currently</u>
operational: ....

Question 3:   Please indicate whether training in teamworking skills took place:

	Please tick
before commencing with teamworking:	☐
during teamworking:	☐
Other, please indicate:	
not at any time:	☐

Question 4:   Please indicate the:

-   team size in terms of average number of team
    members: ....

-   expected frequency of meetings in days or
    weeks: ....

-   expected length of time each meeting should
    take: ....

-   team leader   :-   formal (dept or hospital/
                        Trust Manager/Clinician)
                        leader: ☐

                 :-   quality function/department
                        leader: ☐

                 :-   any leader as the situation
                        demands it: ☐

                 :-   no leader: ☐

Please indicate whether a Quality Council or TQM Steering Group is operational:

Yes/No

If Yes, please briefly indicate its constitution and the way it operates:

_____

_____

_____

_____

Question 5:   Please indicate the major team objectives concerning TQM activities:

                                                        Please tick

        Work quality problem solving: ☐
        Quality of working problem solving: ☐
        Work quality problem prevention: ☐
        Quality of working problem prevention: ☐
        Continuous improvement focus: ☐
        Radical change focus: ☐
        Patient focused care: ☐
        Other: please detail: _____

        _____

Question 6: Please indicate your views concerning the successfulness of TQM Teamworking in your hospital/Trust:

```
      1       2       3       4

      ├───────┼───────┼───────┤
      Not                     Very
      successful              successful
```

Question 7: I would be grateful for any other information you may wish to add concerning TQM Teams:

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire.

M E Waddington
Principal Lecturer
School of Business
The University of Huddersfield
Queensgate
HUDDERSFIELD   HD1 3DH   Telephone: 0484 422288 ext 2557
                         Fax   0484 516151

I think we agreed that you would return the questionnaire in the prepaid envelope not later than _____ .

APPENDIX 23

TQM QUESTIONNAIRE FOR DIRECT INTERVIEWS

Date: _____

1. Confirm intention and introduction of self.

2. Confirm confidentiality and no reference to Trust or person by name.

3. Trust employees: ask for job title: ....

4. If GP, establish whether fundholder: Y/N

5. If patient establish something of them: ....

6. If family worker establish connection: ....

7. Other interviewee seek detail/connection: ....

8. Indicate expected time for interview: Trust employee: 30 - 45 mins
   Others: 30 mins

9. Thank them for agreeing to be interviewed.

Question 1: Many changes have taken place over the last few years in the NHS in the form of reforms. What benefits do you think have come from them?

_____

_____

_____

_____

_____

What do you think has worsened?

_____

_____

_____

_____

_____

Question 2: (Non-Trust Employee Participants)

<u>Show copy of TQM definition</u>

In terms of this definition would you say the quality of services offered by this hospital/Trust was:

   Satisfactory/Not Satisfactory?

<u>PROBE</u> for reasons - try to get personal details/experiences

<u>re-emphasise</u> confidentiality and that I am undertaking University research:

(Trust Employees)

If you or a close family member became gravely ill, would you wish them to come to this hospital for treatment?   Y/N?

PROBE for reasons. Re-ensure confidentiality is necessary.

With those giving a YES answer go on to ask if they are able to identify any poor quality aspects of the hospital/Trust.

PROBE for detail.

Question 3: (Patients/Family Members/Members of the Public)

If you were asked would you:

- Participate in <u>quality improvement</u> teams (explain) along with hospital/Trust personnel?   Y/N

- Participate in teams, or meetings, or other activities aimed at designing quality care services?   Y/N

- Provide information about your experiences with this hospital/Trust so that services might be better 'tailored' to your and others needs and expectations?   Y/N

<u>PROBE</u>   for reasons (whether a yes or a no answer)

_____

_____

_____

_____

_____

Question 3: (Trust Employees/GPs/HA staff ....)

Would you say patient empowerment is:

A good thing? / A bad thing?

PROBE   for reasons:.   -   Try to seek views on methodology

-    Try to get any material published on this or detail of methodology they know of else-where

_____

_____

_____

_____

_____

MANY THANKS FOR ASSISTANCE, SUGGESTIONS AND ADVICE.

APPENDIX 24

Date: _____

Following our recent telephone discussion, I have forwarded the questionnaire which you agreed to complete concerning Quality Management in your Hospital/NHS Trust.

As I said to you on the telephone, I guarantee absolute confidentiality in that no reference will be made to you or your Hospital/Trust by name.

I will forward a copy of my analysis of the results which I anticipate will involve thirteen Hospitals/ NHS Trusts.

Many thanks for agreeing to participate.

Question 1: This question relates to reasons for undertaking Quality Management.

Please indicate which, if any, were reason for your hospital/Trust deciding to undertake Quality Management. They are not listed in any particular order and you may wish to add to the list.

REASON FOR UNDERTAKING QUALITY MANAGEMENT:	1	2	3	4
Achieve ISO 9000/BS 5750	⊢——┼——┼——⊣			
Assist with standards setting	⊢——┼——┼——⊣			
Ensure conformity to standards	⊢——┼——┼——⊣			
Reduce costs	⊢——┼——┼——⊣			
Provide reason for everyone striving for excellence	⊢——┼——┼——⊣			
Establish a more effective complaints procedure	⊢——┼——┼——⊣			
Save time	⊢——┼——┼——⊣			
Involve more people in quality matters	⊢——┼——┼——⊣			
Link with audit procedures	⊢——┼——┼——⊣			

Not a reason   A most important reason

Better satisfy:

	1	2	3	4

Patients   ├────┼────┼────┤

Purchasers   ├────┼────┼────┤

The Public   ├────┼────┼────┤

Suppliers   ├────┼────┼────┤

Others, please list:

_____ ├────┼────┼────┤

_____ ├────┼────┼────┤

_____ ├────┼────┼────┤

_____ ├────┼────┼────┤

_____ ├────┼────┼────┤

_____ ├────┼────┼────┤

Not a   A most
reason   important
                reason

Question 2:   Please tick the following activities which you have undertaken as part of your Quality Management applications:

POSSIBLE QUALITY MANAGEMENT PROCESS ACTIVITIES:

Stage: Please indicate your views regarding the success of this activity:

		Stage	1	2	3	4
Strategic focus:	☐		├─┼─┼─┤
Preparing the organisation:	☐		├─┼─┼─┤
Preparing management:	☐		├─┼─┼─┤
Preparing others:	☐		├─┼─┼─┤
Preparing culture:	☐		├─┼─┼─┤
Continuous quality improvements:	☐		├─┼─┼─┤

Not   Very
successful   successful

Please indicate your views regarding the success of this activity:

		Stage:	1	2	3	4
Radical change:	☐	☐	⊢—+—+—⊣
Patient focussed care:	☐	☐	⊢—+—+—⊣
Teamworking:	☐	☐	⊢—+—+—⊣
Leadership development: .	☐	☐	⊢—+—+—⊣
Staff empowerment:	☐	☐	⊢—+—+—⊣
Patient empowerment:	☐	☐	⊢—+—+—⊣
Facilitator/Mentor development:	☐	☐	⊢—+—+—⊣
Handling complaints:	☐	☐	⊢—+—+—⊣
Patients Charter focus:	☐	☐	⊢—+—+—⊣
Problem solving procedures:	☐	☐	⊢—+—+—⊣
Problem prevention procedures:	☐	☐	⊢—+—+—⊣
Performance measurement:	☐	☐	⊢—+—+—⊣
Standards setting:	☐	☐	⊢—+—+—⊣
Audit:	☐	☐	⊢—+—+—⊣
ISO 9000/BS 5750:	☐	☐	⊢—+—+—⊣
Information/data collection:	☐	☐	⊢—+—+—⊣
Statistical method and procedure:	☐	☐	⊢—+—+—⊣
Benchmarking:	☐	☐	⊢—+—+—⊣
Cause and effect analysis:	☐	☐	⊢—+—+—⊣
Pareto analysis:	☐	☐	⊢—+—+—⊣
Quality training:	☐	☐	⊢—+—+—⊣
Brain storming:	☐	☐	⊢—+—+—⊣
Quality costing:	☐	☐	⊢—+—+—⊣
Seeking top management commitment:	☐	☐	⊢—+—+—⊣
Rewards and recognition:	☐	☐	⊢—+—+—⊣
Method for voicing concern:	☐	☐	⊢—+—+—⊣
Focussing internal politics:	☐	☐	⊢—+—+—⊣
Focussing external politics:	☐	☐	⊢—+—+—⊣
Internal communications systems:	☐	☐	⊢—+—+—⊣
External communications systems:	☐	☐	⊢—+—+—⊣

Not successful   Very successful

Stage: **Please indicate your views regarding the success of this activity:**

Others, please list:

_____

_____

_____

_____

_____

_____

1 2 3 4

├──┼──┼──┤

├──┼──┼──┤

├──┼──┼──┤

├──┼──┼──┤

├──┼──┼──┤

├──┼──┼──┤

Not successful   **Very successful**

Please briefly indicate reasons for low success scores (1 and 2):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Question 3   I would welcome any additional information you wish to add concerning Quality Management:

_____

_____

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire.

Should you have any specific detail of Quality Management applications, activities and results, I would be most appreciative of copies.

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                              Fax   0484 516151

I think we agreed that you would return the questionnaire in the prepaid envelope not later than _____ .

I expect to telephone you again during _____ .

APPENDIX 25

I would be most grateful if you could complete this short questionnaire concerning your involvement in TQM Self-Managed Teamworking, and return it to me in the envelope provided.

Confidentiality is guaranteed, in fact I don't require to know your name, although it would assist me if you identified your position in the Trust:-

Manager/Administrator	☐
Consultant	☐
Doctor	☐
Nurse	☐
Support Services Staff Member	☐

Question 1:   In your opinion were team meetings which you attended:

Please tick

structured?	☐
semi-structured	☐
unstructured?	☐

In terms of seeking to achieve specific objectives or targets set.

Question 2:   Please list the main objectives or targets your team set to achieve in terms of TQM:

_____

_____

_____

To what extent were these influenced by TQM definition used?

```
1      2      3      4
|------+------+------|
Not                Influenced
Influenced         A Lot
```
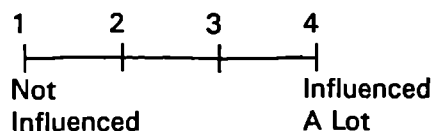
How well do you rate TQM Teamworking for achieving them?

```
1      2      3      4
|------+------+------|
Not well           Very well
```
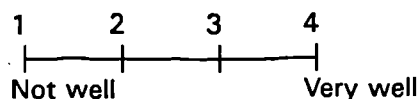
Question 3: How appropriate do you feel current Trust procedures are for rewarding and recognising team successes?

```
1       2       3       4
├───────┼───────┼───────┤
Not                     Most
Appropriate             Appropriate
```
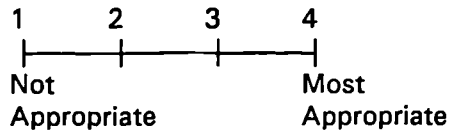
Please briefly give reasons for your answer:

_____

_____

_____

_____

Question 4: Please indicate which of the following techniques you have used during TQM teamworking:

brainstorming	☐
process flow charting	☐
cause and effect analysis	☐
six-word problem solving method	☐
critical/regular criteria decisionmaking	☐
audit	☐
pareto analysis	☐
benchmarking	☐
Others - please list _____	

_____

_____

Please indicate the usefulness of such techniques:

```
1       2       3       4
├───────┼───────┼───────┤
Not                     Very
Useful                  Useful
```
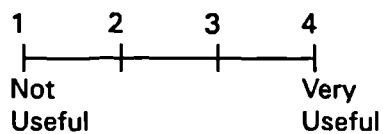
Please rank in order of importance those techniques which you found particularly useful in TQM teamworking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Question 5: Please indicate ease of accessing fast response technology for providing you with information which you needed in connection with TQM teamworking:

```
1       2       3       4
├───────┼───────┼───────┤
Most                    Most
Difficult               Easy
```

Please briefly give reasons for your answer: _____

_____

_____

_____

Question 6: Have you agreed to your team results being stored in data base to enable others to access them?   Yes/No

Would you agree to such a request: Yes/No

Question 7: How often have you involved others who are not members of your TQM team in matters concerning team objectives or targets?

Never   ☐
Quite Often   ☐
Often   ☐

Question 8: I would be grateful for any further information you may wish to add concerning TQM Teamworking:

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire.

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Brainstorming	:	a free flow of ideas from encouraging lateral thinking. Self-disciplines sought - no criticism, emphasis on quantity, rather than quality of ideas, sequence and incubation.
Process Flow Charting	:	a visual presentation, using arrows and symbols of people, information and material flow through the care systems which identify process activities in the form of adding value, checking, waiting and movement.
Cause and Effect Analysis	:	a visual display of the major causes perceived to cause an effect with sub-causes added to branches during brainstorming activity. Intention being to identify a small proportion of sub-causes which cause a large amount of effect.
Six Word Problem Solving Method	:	procedure used with brainstorming activity focused towards problem areas and non-problem areas by the use of such 'key words' as what; why; when; how; where; and who in the context of seeking 'cause and 'not cause'.
Critical and Regular Criteria Decision Making	:	process of elimination procedure using a chart which seeks critical criteria and regular criteria to be listed, wherein critical criteria eliminates and regular criteria uses weights and rankings to establish best choice.
Audit	:	method for measuring performance in terms of inputs to process, the process itself, process outputs and the outcomes resulting from the utilisation of resources.
Pareto Analysis	:	procedure for identifying what variation can be attributed to each cause of effect, avoiding over-concentration on any one particular cause to the exclusion of others due to the over-subjectivity of bias.
Benchmarking	:	method for measuring Trust services and practices against best practice elsewhere in the Trust or with organisations external to it.

APPENDIX 27

Following our recent telephone discussion, I have forwarded the questionnaire which you agreed to complete concerning evaluation. I am particularly keen to receive information concerning methodology used by your hospital/Trust for:

    (i)   Measuring performance.
    (ii)   Identifying performance gaps.
    (iii)   Improving performance.

As before, I can guarantee absolute confidentiality in that no reference will be made to you or your hospital/Trust by name.

I have attached a copy of my paper entitled 'Quality Management In Services - Soft to Sell, Extraordinary To Implement', and would welcome comments.

Many thanks for agreeing to complete another questionnaire.

Question 1:   Please imagine that in connection with TQM process you are introducing **for the first time** method for measuring performance. Please list in priority order method you **would choose** for identifying quality performance gaps and that what you **would seek to improve.**

METHOD FOR MEASURING PERFORMANCE RANKED IN PRIORITY ORDER	REASONS FOR USING THIS METHOD OF PERFORMANCE MEASUREMENT

Question 2: Please list the methods which you current use for measuring performance, briefly indicating the strengths and weaknesses.

METHOD CURRENTLY USED FOR MEASURING PERFORMANCE	STRENGTHS	WEAKNESSES

Question 3: I would welcome any additional information you wish to add concerning performance measurement:

_____

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire.

Should you have any specific material of performance measurement applications, activities and results, I would be most appreciative for copies.

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I think we agreed that you would return the questionnaire in the prepaid envelope not later than _____ .

APPENDIX 28

TQM QUESTIONNAIRE FOR DIRECT INTERVIEWS

Date: _____

. 1.   Confirm intention and introduction of self.

2.   Ask if I have interviewed them before: Y/N

3.   Confirm confidentiality and no reference to Trust or person by name.

4.   Trust employees: ask for job title: ....

5.   If GP, establish whether fundholder: Y/N

6.   If patient establish something of them: ....

7.   If family worker establish connection: ....

8.   Other interviewee seek detail/connection: ....

9.   Indicate expected time for interview: Trust employee: 30 - 45 mins
                                                                   Others: 30 mins

10.   Thank them for agreeing to be interviewed.

Question 1:   **TRUST EMPLOYEES:**   As you know the Trust has been applying TQM process since September 1992, have you noticed any changes which have taken place since then which you would put down to TQM application?

OTHERS: Did you know that the Trust has been applying TQM since September 1992?   Y/N

Have you noticed the TQM Definition or Mission Statements displayed?   Y/N

Have you noticed what some call the 'Wall of Fame', which display quality successes?   Y/N

Have you noticed any changes which have taken place during the time that TQM has been applied?   (Decide whether to show copy of TQM definition.)

_____

_____

_____

_____

Question 2:   **TRUST EMPLOYEES**

If you or a close family member became gravely ill would you wish them to come to this hospital for treatment?   Y/N

<u>PROBE</u> for reasons: re-ensure confidentiality.

With those giving a YES answer go on to ask if they are able to identify any poor . quality aspects of the hospital/Trust. Probe for reasons: re-ensure confidentiality.

Question 2:   **OTHERS**

Are you saying that you are mostly Satisfied with hospital/Trust quality performance, OR Dissatisfied?

PROBE to see if there are any other reasons to those already given - try to establish personal details/experiences, re-emphasise confidentiality and that I am undertaking University research.

Question 3:   (Patients/Family Members/Members of the Public)

If you were asked would you:

-        Participate in <u>quality improvement</u> teams (explain) along with hospital/Trust
         personnel?   Y/N

-        Participate in teams, or meetings or other activities aimed at designing
         quality care services?   Y/N

-        Provide information about your experiences with this hospital/Trust so that
         services might be better 'tailored' to your and others' needs and
         expectations?   Y/N

<u>PROBE</u> for reasons (whether a yes or a no answer)

_____

_____

_____

_____

_____

Question 3:   (Trust Employees/GPs/HA staff ....)

Would you say patient empowerment is:

         A good thing? / A bad thing?

<u>PROBE</u> for reasons: -   Try to seek views on methodology.
                            -       Try to get any material published on this or detail of
                                    methodology they know of elsewhere.

_____

_____

_____

_____

_____

Question 4: **TRUST EMPLOYEES**

Do you think the Trust should continue applying TQM process?   Y/N

Could you suggest any changes:

_____

_____

_____

_____

_____

Question 5: **TRUST EMPLOYEES**

Would you describe yourself as:

        An active participant in TQM?   ☐

        Not an active participant in TQM?   ☐

        Not an active participant in TQM
        but nonetheless supportive of
        changes which have resulted?   ☐

With the benefit of hindsight do you think you made the correct decision to:

        Actively participate in TQM?   Y/N

        Not to actively participate in TQM?   Y/N

Seek (briefly) reasons: _____

_____

_____

Question 6: **ALL INTERVIEWEES**

I would be grateful for any further information you may wish to add concerning TQM and its effect on the quality of services provided by this hospital/Trust:

_____

_____

_____

_____

MANY THANKS FOR ASSISTANCE, SUGGESTIONS AND ADVICE.

APPENDIX 29

I would be most grateful if you could complete this questionnaire concerned with quality matters at this hospital/Trust, and return it to me in the envelope provided.

Confidentiality is guaranteed, although it would be most helpful to me if you ticked one of the following to identify your job/role in the hospital Trust:

Manager/Administrator	☐
Consultant	☐
Doctor	☐
Nurse	☐
Support Service Staff Member	☐

Question 1:   Would you describe yourself as an active participant in the Trusts' TQM activities?

Yes	☐
No	☐

Question 2:   How would you currently in 1994 compare each of the following to one year ago.

Quality of Service	Worse	No Change	Improved
	Please tick		
Consultants/Doctors Attitudes Towards You?			
Nurses Attitudes Towards You?			
Other Staff Attitudes Towards You?			
Quality of Information Provided?			
Amount of Information Provided?			
Quantity of Information given to Patients by Inexperienced/Junior Personnel?			
Procedures for Handling Complaints?			
Waiting for Admittance to Hospital?			
Waiting for Treatment at Clinics or Elsewhere?			
Cancelled Admittance?			
Cancelled Operations?			
Abuse of Patients Charter?			
Services in the Community?			

Please don't tick any column if you don't know or are unsure

Quality of Service	Worse	No Change	Improved
	Please tick		
Balance Between Health Care and Social Needs Provision?			
Ward Comfort/Hygiene, Cleanliness, Food, Facilities?			
Adequacy and Availability of Nursing?			
GPs Meeting Providers to Detail Complaints?			
Fundholding Causing a Two-Tier System?			
Fundholding Meaning More Competition/Less Co-operation?			
Medical and Other Personnel Working Excessive Hours?			
Stress of Working?			
Idle Facilities?			
Managers/Administrators from a Non-Medical Background?			
Deciding How Much Information to be Given to Patients?			
Quantity of Paperwork?			
Time Spent By Consultants With Junior Doctors?			
Supervision of Junior Doctors?			
Junior Doctor Training?			
Consultant Training?			
Own Monitoring of Work?			
Working in the Private Sector?			
NHS Shortages of Money?			
Control of Clinicians?			
Clinical Freedom Issues?			
Professional Judgement Issues?			
Clinician Awareness of Protocols?			
Consultants/Doctors Awareness of Clinical Trials?			
Patients Receiving Best Treatments?			
Monitoring Medical Personnel To Ensure Awareness of Drugs Side Effects?			
Introducing Scientific Knowledge Into Everyday Patient Care?			
Getting Research Information Across to Clinicians?			
Changes in Government Direction?			
Data Retrieval?			
Data Reliability?			
Accounting Systems?			
Quality Costing?			
Effectiveness of Health Authority?			
Conflict Between Residential Care Beds and Residential Homes?			

Please don't tick any column if you don't know or are unsure

Quality of Service	Worse	No Change	Improved
	Please tick		
Ambulances Capacity?			
Ambulances Planning?			
Availability/Use of Equipment?			
Protected Beds?			
Attendance at Discharge Meetings?			
Supplier Vendor Rating?			
Job Plans for Doctors and Consultants?			
Inter-Department Rivalry?			
Auditing?			
Delivering High Quality of Care?			
Quality Expectation of Users?			
Quality Expectation of Purchasers?			
Patients Switching to Fundholding GPs? (Please record as less, no change or more)			
Integration of Hospital with Other Services and Agencies?			
Performance Against Patients Charter Requirements?			
League Table Performance?			

> **Please don't tick any column if you don't know or are unsure**

Question 3: I would welcome any additional comments or information you wish to add concerning Quality of Service:

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire.

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456

APPENDIX 29 (Continued)

I would be most grateful if you could complete this questionnaire concerned with quality matters at this hospital/Trust, and return it to me in the envelope provided.

Confidentiality is guaranteed, although it would be most helpful to me if you ticked one of the following to identify your job/role in the hospital Trust:

Patient   ☐
Family Member   ☐
Other, please specify   _____

<u>Question 1</u>:   How would you now in 1994 compare each of the following to one year ago.

Please don't tick any column if you don't know or are unsure

Quality of Service	Worse	No Change	Improved
	Please tick		
Consultants/Doctors Attitudes Towards You?			
Nurses Attitudes Towards You?			
Other Staff Attitudes Towards You?			
Quality of Information You Are Provided?			
Amount of Detailed Information You Are Provided?			
Amount of Information You Receive From Inexperienced/Junior Personnel?			
Procedures for Handling Complaints?			
Waiting for Admittance to Hospital?			
Waiting for Treatment at Clinics or Elsewhere?			
Cancelled Admittance?			
Cancelled Operations?			
Abuse of Patients Charter?			
Services in the Community?			
Balance Between Health Care and Social Needs Provision?			
Ward Comfort/Hygiene, Cleanliness, Food, Facilities?			
Adequacy and Availability of Nursing?			
Delivery of High Quality Care?			
Your Expectation for Higher Quality of Healthcare?			

Quality of Service	Worse	No Change	Improved
		Please tick	
Quality Expectation of GPs?			
Number of Patients Switching to Fundholding GPs?	Fewer:	Same:	More:
Hospital Liaison/Integration with Other Services and Agencies?			
Performance Against Patients Charter Requirements			

Please don't tick any column if you don't know or are unsure

Question 2: I would welcome any additional comments or information you wish to add concerning Quality of Service:

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire.

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APPENDIX 30

Date: _____

Following our recent telephone discussion, I have forwarded the last questionnaire concerning my research programme into quality management, which asks you to list activities you feel lead to quality management success or which constrain it.

I have ticked either TQM or Quality Assurance below which I wish you to focus please.

My promised results should be available by the end of November. I would welcome any feedback from you.

Many thanks to those of you who provided me with comments and recommendations concerning my paper 'Quality Management In Services - Soft To Sell, Extraordinary To Implement', they were most helpful.

Many thanks for your support since I began this research programme. As I have promised from the outset, confidentiality will be maintained.

PLEASE ADDRESS YOUR RESPONSES TO:

TOTAL QUALITY MANAGEMENT ☐
QUALITY ASSURANCE ☐

<u>Question 1</u>: Please list those activities which you perceive to be essential to achieve success:

_____

_____

_____

_____

_____

_____

_____

Question 2: Please list what you perceive constrains implementation, application and success:

_____

_____

_____

_____

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire.

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                        Fax   0484 516151

I think we agreed that you would return the questionnaire in the prepaid envelope not later than _____ .