TOTAL QUALITY MANAGEMENT

IN THE

NHS

(SEPTEMBER 1991)

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Director

Organisational Audit Programme

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INTRODUCTION

In 1989, the Department of Health embarked upon a programme to encourage the introduction of a managed approach to quality in the NHS. In 1990 it extended this programme to include 23 sites ranging from departments within units to total districts. The criteria for inclusion in the programme were loose, but all successful pilots marched under the banner of total quality management (TQM). TQM is a clearly defined concept with a well-documented history. If the NHS is to proceed down the total quality road, it is important that those taking part should understand that a map exists to guide them and have confidence that the road being followed will lead to the intended destination. In other words, that those so called TQM sites should not be misnamed and their performance judged at some future date by a set of criteria to which they have never subscribed.

To help in this process the King's Fund Centre, in conjunction with PA Management Consultants and funded by the Department of Health, designed an eight-day quality awareness programme (Appendix A). The programme was intended to educate a small group of managers in an understanding of the classic concept of TQM, why and how other organisations have used it and to explore the applicability of TQM to the NHS. Members were three district general managers (two from the Department of Health TQM sites), one regional general manager and the Quality Improvement Director of the King's Fund Centre.

This report is intended to share the learning which the group derived. It sets out to examine the relevance of TQM to the NHS, point out some of the very real challenges posed by it and suggest a framework for its implementation. It is prefaced by an account of TQM and its current place in the wider area of organisational development.

WHAT IS TOTAL QUALITY MANAGEMENT?

Total Quality Management (TQM) is not a single concept. It represents the convergence of ideas from a number of sources – a convergence packaged perhaps over-tidily by academics and consultancies, who see advantage in promoting a clear prescription, and by commercial organisations who find good public relations in exposing their internal workings in a favourable light.

In historic terms, the precepts of TQM derive from the teachings of certain gurus, mostly associated with the renaissance of Japanese industry – for example, Deming[1] and Juran[2]. These writers evolved their thinking from an emphasis on the task and techniques of quality management (for example, statistical process control) to a deeper concept based on 'cultural' or at least organisation-wide adoption of certain issues and principles about ideal organisational life.

The commercial significance of delivered and perceived quality was later supported by anecdotal 'evidence' put forward by popularist business writers such as Peters and Waterman[3] and by some harder data from American PIMs studies which suggested that the long-term commercial winners were those who combined market share with a reputation for declared quality. Academic and commercial interests coincided happily with the emergence of the idea that 'quality is free'. Crosby[4], who used this phrase as a booktitle, promoted the concept that the pursuit of quality could lead to both a reduction in unit costs (through the elimination of scrap, rework and unnecessary inspection) and the achievement of higher unit price through the delivery of a product that somehow better met customer specification.

Given an academically legitimised commercial incentive, many organisations found the TQM concept extremely attractive. At this stage in TQM's development the consultancies crystallised the concept in terms of certain principles and process steps. A helpful definition of total quality management is provided by Ron Collard[5]:
'cost effective system for integrating the continuous quality improvement efforts of people at all levels in an organisation to deliver products and services which ensure customer satisfaction'.

A typical list of those principles underlying quality management is to be found in PA's *How to take*

part in the Quality Revolution[6].

'Total quality management is:

- the approach: management led
- the scope: company-wide
- the scale: everyone is responsible for quality
- the philosophy: prevention not detection
- the standard: right first time
- the control: cost of quality
- the theme: continous improvement.'

More recent academic writings on the subject, the offerings of the more experienced consultancies and the more honest disclosures of aspirant quality organisations, accept a complexity of experience in pursuing quality management and, most importantly, accept the discontinuities and discomforts that attend the progressive cycles of real advance. It is clear that a simple set of principles and processes cannot be applied across organisations facing radically different external and internal circumstances. Rather they are learning to adopt the experience and 'best practice' of other organisations to their own specific circumstances. That is:

- to define quality as a recognisably delivered entity in the perception of their client or customers;
- to be clear about the benefits to be obtained by enhancing this perception;
- to define precisely what organisational processes have to change as a consequence;
- to have an organisational change model which guides intervention progressively through the turbulent waters of change.

Total Quality Management in the National Health Service

This report does not seek to describe in detail the process by which the managers participating in the TQM awareness programme were made familiar with the concept of TQM and its applicability to the NHS (see Appendices A, B and C). Rather it aims to address the questions:

1. Is it valuable/essential for the NHS to pursue TQM?
2. What are the barriers to overcome?
3. How is the introduction of TQM compatible with other NHS initiatives?

All the comments which follow are a result of deliberations which took place within the TQM awareness programme.

The Value of TQM to the NHS

While quality has always been a cornerstone of health provision and an essential, if implicit, component of professional training, it is only in the last few years that real interest has been expressed in the idea of organisational quality as a managed process. With the post-Griffiths development of general management and total service delivery concepts, an environment is being established in which TQM thinking becomes both relevant and attractive. It would be naive,

however, to assume that the experience of the majority of private sector TQM organisations can be translated directly to the UK public health sector. TQM has achieved maturity in a number of manufacturing companies, mostly overseas, and in a comparatively small number of commercial service companies.

Nevertheless, as a group we were encouraged to believe that current trends within the NHS are promoting an environment in which a specifically tailored version of TQM or quality management might flourish.

In attempting to assess the appropriateness of a TQM approach to the NHS (in the first instance we considered the total NHS as the organisation; later in examining the implementation process we focused on the unit) it was important to define quality in a way which was relevant to the service. We did so as follows:
'*Quality is continually meeting people's defined health care requirements*'.

The key word here is 'defined', which is intended to describe the process of negotiation and agreement which must take place between the provider and customer to achieve a deliverable level of service.

It was helpful in assessing the value of TQM to the NHS to establish a reference point in the commercial sector with which we could make comparisons to help us attempt an answer to the question 'why TQM inthe NHS?' and to develop the key principles to underpin a TQM initiative in the NHS. For this purpose we chose a bank and a hotel as representing two service industries which exhibit many characteristics in common with the NHS but also a number of key differences. We identified these as follows.

SIMILARITIES

- significant person-to-person contact;
- geographically dispersed;
- large workforce/labour intensive;
- bureaucracies (banks).

DIFFERENCES

The NHS

- has a much wider range of needs and services;
- has greater complexity;
- is less homogeneous;
- the customer has less product knowledge;
- service companies need customers, the NHS traditionally does not;
- has no financial bottom line (indirect versus direct source of income);
- has less of a managerial tradition.

Bearing in mind the key principles of TQM (see earlier) we evolved a list of key factors which we believed mitigated in favour of the NHS as an organisation for which the TQM approach would be appropriate:

STRENGTHS

- an intrinsic caring culture/tradition;
- much untapped talent within the organisation;
- management talent plus increasing management culture (the growing acceptance of management as a legitimate governing process);
- a committed workforce (the preparedness of professions to expose their performance to scrutiny, if only at peer group level);
- public support and involvement;
- public expectation (the development of the consumer voice in health matters);
- the time is right (the proposed introduction of a quasi-management culture and associated contracts for service delivery);
- the rapid increase across managerial and professional groups in quality as an organisational goal, as evidenced by pilot studies.

Matched against this impressive battery of arguments in favour of a TQM approach, we defined a similarly impressive array of difficulties and questions.

1. Scale

Are we one organisation? This question will become increasingly relevant as new market conditions pertain. The sheer scale of the NHS presents barriers to change not faced by most private sector organisations. While the individual units within the health service present an apparent opportunity for small scale experimentation, the forces of centralisation have been, to date, overwhelming.

2. Political and managerial versus professional agendas

In the commercial context, the concept of general management is well established, whereas in the public health sector an essentially non managerial – that is, 'professional' perspective – still holds sway over the practicalities of resource allocation, integration and service delivery.

3. Defining the customer requirements

In the commercial context, the application of market forces empowers the customer to a degree that forces organisations to reference their operating objectives externally. Both the near monopolistic status of the NHS and aspects of 'professionalism' conspire to produce an internally referenced set of values.

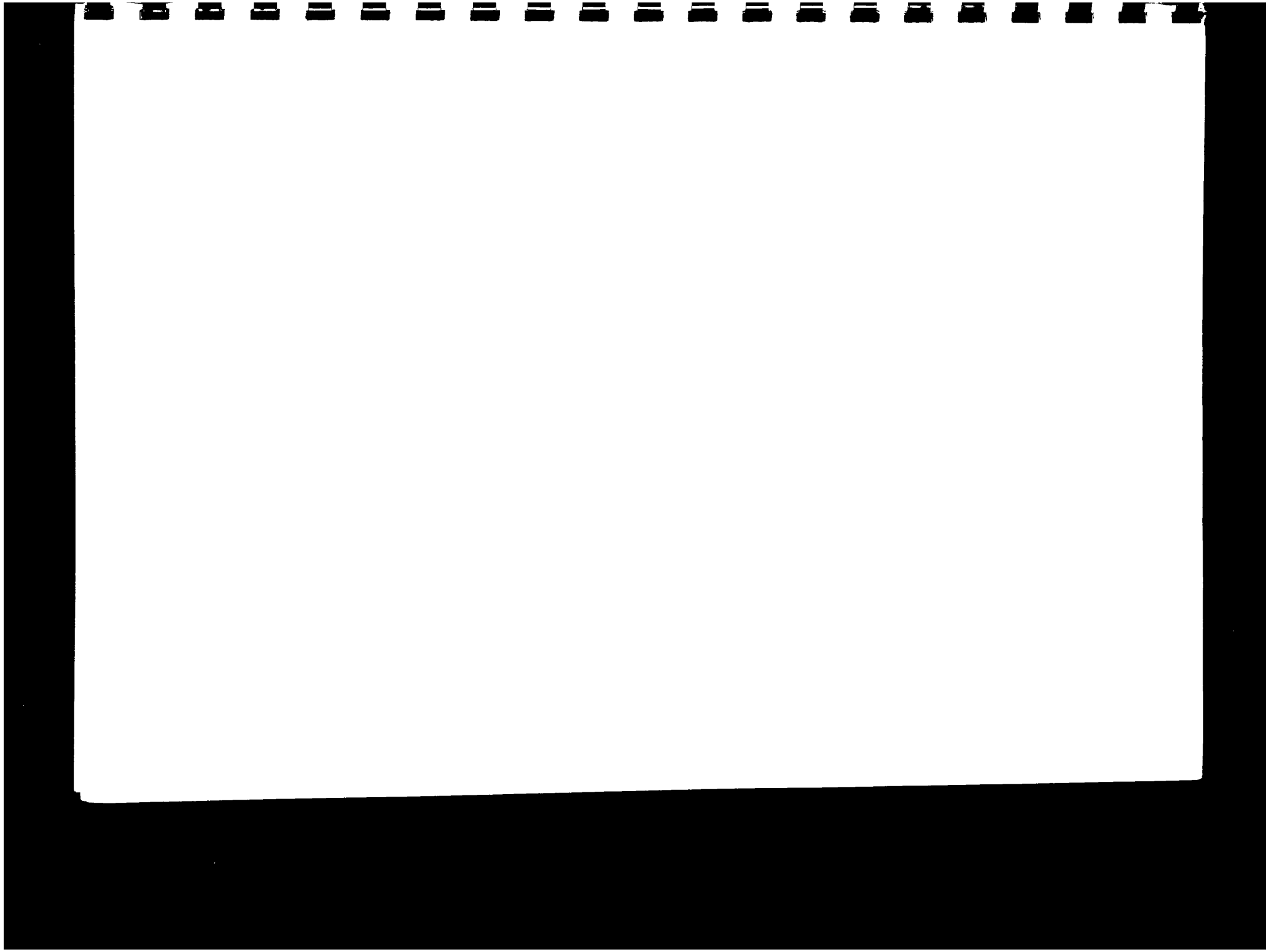
4. Meeting start up costs/continuing costs

5. Pay off versus political timescale

6. Workload overload

In summary, the concept of 'quality' in the service sector and in the NHS in particular is much more elusive than the relatively simple 'conformance to standard' demanded of the physical products of manufacturing companies. In the public health sector it is not clear who legitimately sets 'standards' or the scope of their application.

The benefits of a single-minded pursuit of quality are unclear, in the context of the multiple objectives that NHS management is asked to achieve. For a commercial company the achievement of delivered quality can potentially increase demand and lower operating costs (by 'getting it right



first time'). The strategic advantage in a competitive environment is therefore obvious. In the NHS it is not clear whether the stimulation of demand is necessarily a legitimate objective, nor whether the cost reductions of commercial TQM will be that easily attained.

Implementing TQM in the NHS

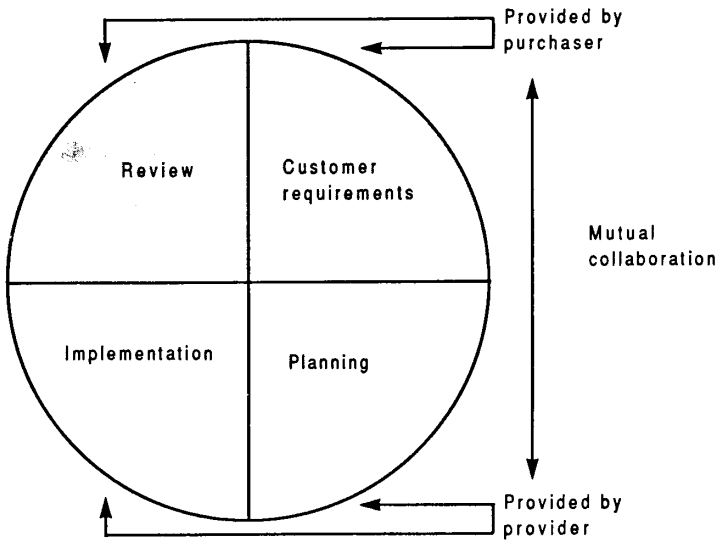
Facing up to the difficulties

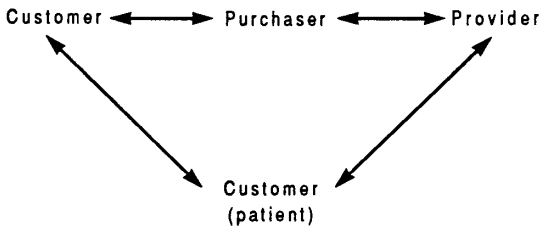
Scale and unit of the organisation

In contemplating the introduction of TQM and having identified the challenges to implementation in the NHS, outlined above, the first issue to be wrestled with is that of the natural unit of implementation. It is clear that in order to achieve maximum impact, the management executive itself should be seen to lead an NHS-wide initiative. However, the priorities of the executive and the occasionally conflicting political and managerial agendas make such an involvement unrealistic. Nor, it can be argued, is the development of a managerial culture in the NHS sufficiently advanced to make an NHS-wide commitment to TQM practical. The proper unit for implementation might be the region, district or, more probably, the provider unit. Indeed it is a prerequisite for successful implementation that the TQM unit must be discreet and self-sufficient. This makes the concept of TQM unsustainable in a department independent of its unit (for example, an outpatients' department).

The appeal of the trust as a natural TQM unit is obvious. In considering the directly managed unit, the position is slightly complicated by the unit's management relationship with the district. In this context, however, the district is a customer and its involvement in the phase I specification of customer requirements is therefore critical. Viewed in this way TQM can be seen as an important engine of the contract development process. The following diagram illustrates this involvement:

a)





Two points are worthy of repetition at this stage:

1) It seems clear that the realistic implementation of TQM demands no smaller unit than a whole hospital/community unit, except where a pilot is taking place within a department which forms part of a unit committed to TQM.

2) While the NHS as a whole is not ready for a TQM initiative, proper pilots which are championed by the management executive should be implemented. These will need significant investment (see later).

Competing priorities and competing agendas

The NHS is under siege. Resource management, the introduction of a market place and technological advances, all place immense demands on managers and professionals alike for time and resources. In addition, the competing professional and managerial agendas indicate difficult territory on which to build a TQM approach. TQM is potentially expensive and, to be successful, demands the involvement of all groups of staff and leadership from the doctors who are frequently regarded as the bastions of the traditional approach to quality. But it was the view of the group that the information base required for resource management, and the involvement of clinicians in the management of service delivery and the clinical directorate model, would provide the necessary structure upon which to build a TQM model.

Costs

There is a dangerous assertion among would be proponents of TQM in health care, that 'quality is free' (to borrow Crosby's[4] phrase).

Such a message would be greeted with some cynicism by those commercial organisations which have invested heavily in quality improvement programmes and which continue to invest in training and development. Indeed, it has been estimated that to introduce TQM through a 2,000 employee unit as outlined in Appendix D would cost approximately £500,000 over three years. This would exclude the labour costs of the eight facilitators referred to.

What is equally true, however, is that in the NHS, as in any other business, there are enormous costs – possibly as high as 35 per cent – associated with quality failure and the need to take corrective action. Audit is an example of just such a cost. There is, therefore, a powerful argument that getting it right first time will substantially reduce such costs over time.

Timescales

The NHS is governed by short timescales. We lurch from one reorganisation to the next on a regular five-year cycle and our lives are determined by the rhythm of the election process. Ministers, civil servants and managers look for successful outcomes in short timeframes. A year is a long time in health care. Indeed, funding is frequently made available on an annual basis, as in the case of the present Department of Health TQM initiative, and results are expected to emerge to suit that timing.

Commercial experience suggests that modest early results from TQM can be looked for in two to three years, culture change and an organisational, and philosophy which places quality at the centre of the way of running the business between five to ten years. The Japanese are still working at and investing in the approach after some 40 years. If we are to take TQM seriously in the NHS, we must clearly be prepared to invest in time, as well as money, acknowledging that quality management is not a quick fix but a continous process requiring commitment at all levels of the organisation. It is an acceptance of this by very senior managers in the NHS which poses one of the greatest challenges and threats to the success of TQM.

Conclusion

Why embark upon a process which by all accounts, even given its potential rewards, is fraught with barriers as hazardous as those listed above?

The imperatives to undertake TQM in the commercial sector are usually clear – to improve market share. At unit or provider level in the future service, market share may well be critical and it was our view that the future quality of the NHS, while not a survival issue, may not be guaranteed in its present form unless we are able to demonstrate an improvement in the quality of care to an increasingly discerning clientele. It is this need to improve the quality of care and the very real evidence from individuals who have successfully pursued the TQM route which led us to the conclusion that a quality managed approach is necessary to the NHS. Such an approach would act as a vehicle for bringing together the many current NHS initiatives; focus the NHS on the customer; engage all staff in the will to:

- improve the quality of care;
- empower staff;
- give a sense of purpose and identity to the NHS;
- increase the effectiveness and efficiency of the NHS;

and that an NHS-style TQM approach should be built on the following principles:

- clear purpose, shared values;
- led from the top;
- patient and client focused;
- investing in staff;
- continuous;
- fact-driven action;
- organisation-wide commitment (everybody's business);
- built in not inspected out.

This process is not glamorous, cheap or rapid and the NHS must be careful to resist all such claims that it is. The challenges to the successful implementation of TQM are significant but the rewards of success for staff, the organisation and for our customers – the public – are great if we have the patience and commitment to make it happen.

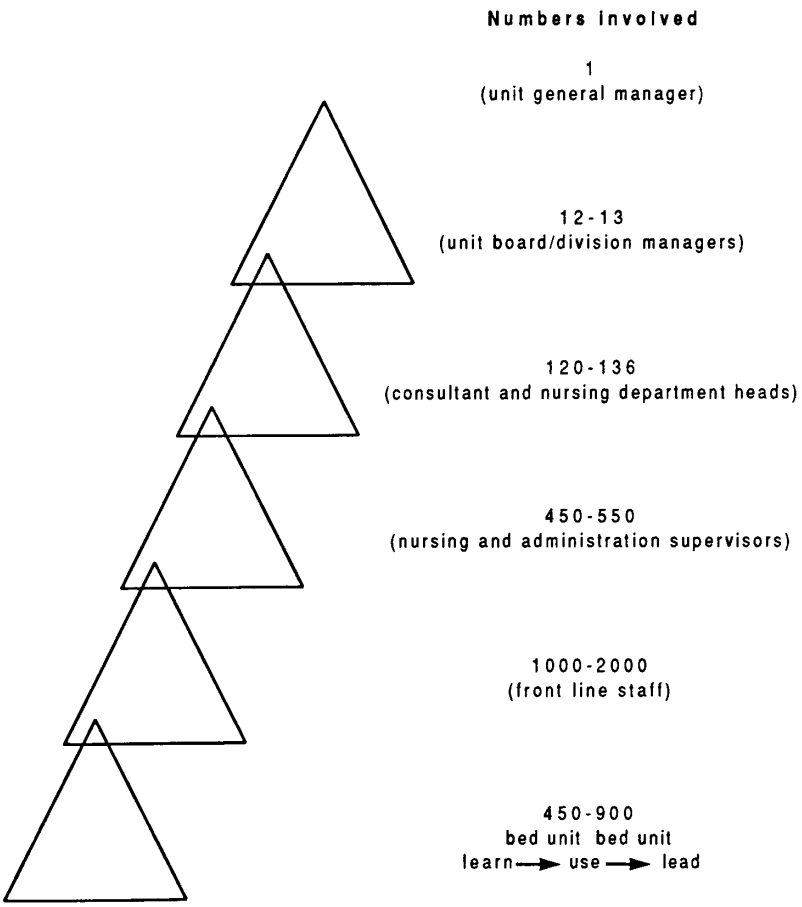
APPENDIX A

Outline of Programme Timetable

Day One	-	What is TQM and why do it?
Day Two	-	How to do TQM
Day Three	-	Quality improvement methodology
Day Four	-	Human resources management
Day Five	-	Measuring progress
Day Six	-	The future

APPENDIX B

Implementation Model



Appendix C

Senior Management Team for Implementation of TQM

- UNIT GENERAL MANAGER
- HEAD OF SURGERY
- HEAD OF MEDICINE
- HEAD OF PATHOLOGY
- HEAD OF NURSING
- HEAD OF IMAGING
- HEAD OF OBSTETRICS
- HEAD OF GYNAECOLOGY
- FINANCE MANAGER
- PERSONNEL MANAGER
- SUPPORT SERVICE MANAGER

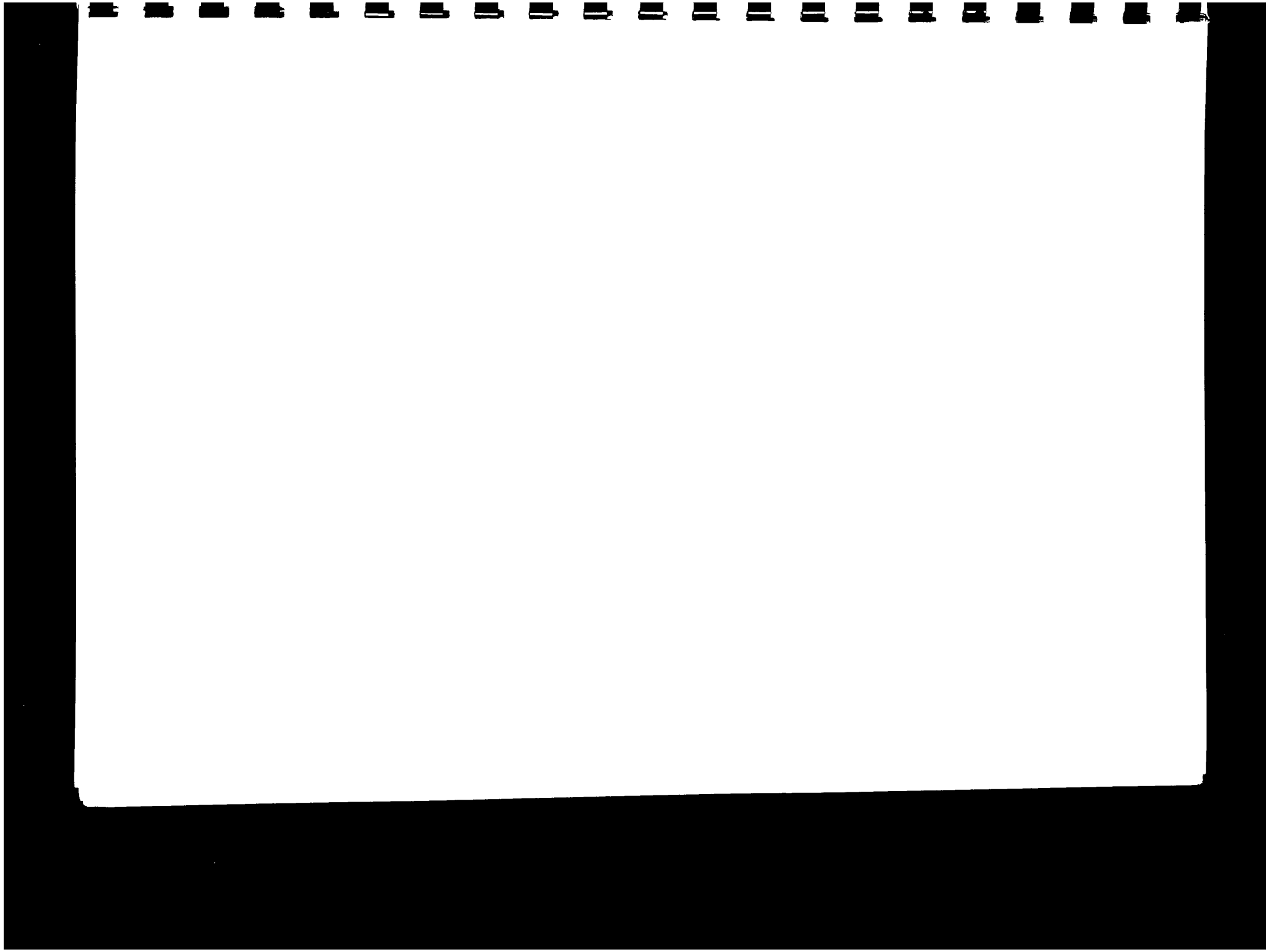
Appendix D

Areas Covered by TQM Training

- DIAGNOSTICS – CUSTOMER AND STAFF SURVEY
- COMMITMENT WORKSHOPS
- PLANNING

Resources Required

- FACILITIES/TRAINING MATERIALS
- EIGHT PART-TIME FACILITATORS (INCLUDING TRAINING)
- ONE CO-ORDINATOR (FULL TIME)
- ADMINISTRATIVE SUPPORT



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