

Quality management: lessons from the NHS

Quality Management: Lessons from the NHS

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Whether or not the average NHS patient would believe that the NHS had anything to teach the personal social services about quality is a highly debatable point. After all, the horror stories seem to be telling us that waiting lists are just as bad as ever in most places, cleanliness on the wards is said to be declining as more and more cleaning is being contracted out, massive cuts and closures are being put into effect, and patients are expected to travel the length and breadth of the country in search of the cheapest treatment their district health authority can find for them.

In spite of that, most surveys, predictably, seem to demonstrate relatively high levels of public satisfaction with the service they receive from the NHS. It is not often – to use Graham Gatehouse’s analogy – that the surgeon amputates the wrong leg.

Whatever the truth of these competing perceptions may be, it is correct to say that ‘quality’ has been a buzz word in the NHS for several years. Much time and energy has been devoted to the pursuit of quality during that time and so it is worth managers in the social services examining some of the lessons that have emerged – either to benefit from them (and so not to have to re-invent the proverbial wheel), or to avoid the pitfalls that some of their health service counterparts have fallen into.

The development of quality management

I want to start by making some general observations about the development of quality assurance (QA) and quality management in

the health service. First, it is worth remembering the environment into which the first stirrings of these activities were introduced. Directors of quality assurance suddenly seemed to emerge around 1985. Nobody seemed to know what they were or what they were supposed to do. Looking back at that time, it now seems clear that their introduction had much to do with the introduction of general management into the health service a year or two earlier.

It threw into turmoil the managerial structure of many of the professional groups within the service – particularly for nursing, the largest staff group, with the most highly developed professional-managerial hierarchy. It is probably fair to say that most quality assurance staff appointed since the mid-1980s have come from a nursing background. Certainly, in some research I was involved in at the Centre for Health Economics at York¹, over three fifths of the QA personnel in the districts responding to our questionnaire were reported as coming from a nursing background. The impact of general management meant, in many cases, that senior nurse managers had lost their managerial function; they had been replaced by general managers, certainly at the highest levels. Many of these senior nurses were appointed to quality assurance posts, often in combination with a nursing advisory role, in order, it seemed, to solve a problem of potential managerial redundancy.

The first concern for general managers was to build the corporate, generally-managed culture. The mission statement, the written philosophy, were first steps in this process. The stressing of the organisation's values went hand in hand with thinking about quality of service and customer satisfaction. Many district general managers became heavily committed to the development of customer relations programmes and to the adoption of a Total Quality Management approach which meant building a corporate quality culture all the way through the organisation. Such an approach, they believed, should be policy-driven, championed by senior general managers, turned into technical reality by expert professional staff, endorsed and supported by managers at all levels, finally meeting with agreement and commitment from practitioners at service delivery level. Thus it was a two-pronged approach: general managers taking the lead at the corporate level and former senior nurses taking the lead on establishing QA activities, largely dealing with clinical and technical issues.

But just as these developments were beginning to become established – the *Working for Patients* reforms came into effect. The purchaser/provider split has radically changed the internal structure of district health authorities. Managerial power has been transferred from district level to units (either directly managed units, or trusts); the lead on quality management (which Graham Gatehouse has already pointed out is crucial) no longer resides with the district general manager. Purchasers specify quality standards in the contract but providers *manage* the production of that quality. Or at least that is the theory. Nevertheless, in spite of these major changes at the top, much of the quality activity at other levels continues as before. One of the striking things that emerged from our research was the great variety of quality activities that were going on in all sorts of nooks and crannies of the service. Fifty different professional or occupational groups were cited as being involved in some way or another in particular activities – from district general managers to clinic clerks, from consultant surgeons to supplies officers, from health visitors to porters, from hospital nurses to medical electronics technicians, and from hospital chaplains to the cleaners.

This multiplicity was reflected in the sorts of activities in which they were engaged. Generally speaking, activities divided into those which were general management-led, to do with ‘cultural change’ and customer relations; those which were about clinical standards; and those which were to do with technical improvements. Some had been promoted at the very highest levels; others took place at ground level stimulated by the enthusiasm of particular groups of staff.

Issues emerging

That then is the broad picture. But what were the issues and the problems which seem to have emerged?

Top down/bottom up The range of activities, as I have said, is broad and the activities take place at all levels. This, however, seems to be one of the problems. There is relatively little integration between the different sorts of activities going on. The district-wide customer relations programme bears little relation to the quality circles set up to deal with specific problems at ward level. Much is said about the value of a ‘bottom-up’ approach because that way staff lower down the hierarchy develop a sense of ownership and therefore of commitment. But the danger with this approach is that if it is uncoordinated, there

may be little coherence in what goes on and certainly little integration of effort (and, indeed, some of it may run counter to policies declared at the top).

If the activities are instituted from the top, the problem is reversed. The assumption that ideas and enthusiasm will ‘cascade down’ may prove unwarranted. Senior managers may mistakenly believe that their ideas have been seized and acted upon lower down, only to find nothing has happened. Lines of communication (and inspiration) are frequently less than perfect.

Clearly the ideal mix is for the bottom to be integrated with the top – the ideas that bubble away amongst the people delivering the service at the front-line have to be encouraged and then consolidated within the broader strategic framework drawn up by senior management.

There are two crucial factors which may determine how far this integration can take place and these form the basis of the next two points.

Staff scepticism The first of them relates to the way in which staff perceive management’s motivation in relation to quality activity. The past decade has been a period of turbulent change within the health service. Staff have had to adapt to all sorts of new procedures and new expectations. A frequent response to suggestions about doing things differently in order to improve quality is ‘Not more change!’ And if the suggestions come from senior managers, the response may be more cynical and less resigned: ‘Why should we do anything to improve quality just so our general manager can sail through his or her performance review and get more money?’ On the other hand, if it is a question of developing quality initiatives themselves, they get very disillusioned if their immediate managers fail to give due recognition to those who came up with the ideas and then if the managers fail to take them up on a long-term basis.

The role of middle management The second point is that middle managers are key links in the process of quality management and yet, in our research, we found they were the least involved in the process. They had very little part to play in the top-down initiatives that were promoted by senior managers and had very little involvement in what was taking place at ground level. Motivating middle managers may be as important as carrying front-line staff along. And of course, now that management responsibility for quality has been pushed down a

tier, to unit level, the importance of motivating those who are what might be called middle managers is all the more necessary. Under the new regime, these managers are sometimes at the apex of the management hierarchy, having to take on many more of the leadership roles previously vested in management at district level. Their role in developing quality will be crucial.

The cost of improving quality The last issue is the cost of improving quality. We found that very little attention was paid to cost or to evaluating the effectiveness of supposed quality improvements. This seemed to tie in with the fact that many activities were established on a piecemeal basis with little thought to overall strategy. And in terms of that overall strategy, it seemed very difficult for senior managers to sit down and think ahead. Many recognised the truth in the assertion that investing in quality in the short-term would produce efficiency and effectiveness savings in the long-term. But few were able to make the financial commitment that such a policy would require at a time when resources were under so much pressure.

Applying the lessons to the social services

There are obviously clear differences between the situation faced by managers in the health service and the one which social services managers face. General management has not been introduced in the 'roots and branches' fashion that the health service experienced. Similarly, the variety of professional groups, layers of organisation and centres of activity is less for social services departments than for the health service. Nevertheless, there are parallels that are worth bearing in mind.

The purchaser/provider split in particular is already upon social services departments. Concern for quality is being voiced at every level from the Department of Health and the SSI downwards. At the same time, SSDs are facing acute pressures on resources and on staff at a time when they are faced with the duty of implementing radical new legislation in relation to children and to community care. Furthermore, uncertainties about the future structure of local government create yet more worries for management and staff alike. These interacting developments create a turbulent environment little different in many ways from that which has faced the health service.

Staff commitment Building on existing staff commitment and overcoming in-built tendencies towards scepticism has to be a key role

for management. Staff must be confident that their voices are heard and listened to. At the same time, systems of communication within the department have to be improved so that the strategy as it is devised and perceived at the top is understood and accepted by those lower down. Managers have to spend time building relationships above and below. Nevertheless, at times of change, it is often hard for those at the bottom of an organisation to accept that policies introduced higher up will ever have direct benefit for them. They have to be shown that improving quality of service to users will also enhance their own working situations. Monitoring standards, for example, should not be seen as a policing operation, otherwise those being monitored will resist.

Leadership The literature on managing change often talks about the importance of ‘product champions’ and ‘change agents’ – the determined advocates of new ways of doing things. Determined advocates do not have to be located at the top of an organisation – people fired with enthusiasm about improving the quality of the bits of the service they know best should be encouraged and allowed to test out their ideas. At managerial levels, these individuals can often inspire staff below them in a way no amount of training programmes can achieve. Where they are found at lower levels, their managers should be on the look-out to encourage and involve them in the wider quality assurance programme.

Peer review One of the defining characteristics of a ‘professional’ is the freedom to act autonomously. Attempts to impose managerial control over professional activity in order to measure quality of performance are fraught with difficulty. The medical profession, for example, is currently having to address the problem in the wake of the *Working for Patients* reforms and, gradually, medical audit, based on a system of peer review, is becoming established – with, it should be stressed, large cash injections from the Department of Health to facilitate the process. Scrutiny by one’s peers is obviously the most appropriate way of assessing the quality of professional work, but there may be dangers in it if it becomes separated off from the main body of quality activity in an organisation. The elitism inherent in the concept of ‘professionalism’ may be further bolstered, and attempts to build a corporate approach may suffer because other staff may feel that the professionals are being given special dispensation not to have their work open to general scrutiny.

Quality assurance systems One of the most difficult things to achieve is to know what a good quality service is (as Graham Gatehouse has stressed) and then to establish a system by which it can be assured. Defining acceptable standards – either minimum or target standards – is a challenge, and then monitoring whether the department is operating in the ‘comfort zone’ (again, Graham Gatehouse has graphically described this) may also be hard to accomplish. Who sets the standards? Can they be imposed from above or from outside? Can they be left to the staff who deliver a service to define? How can users of services be involved in defining – and monitoring – standards? All these questions are important because each relates to an issue that we found significant in our research – the role of professional bodies (nursing, paramedical, medical) in setting standards has to be recognised; the need to involve staff in defining quality of service in order for them to feel a sense of ownership is important, otherwise their scepticism will flourish; and involving users in quality issues has to be the key to building an accessible and acceptable service. But even once standards are agreed and set, the question of measurement has to be tackled. Against what indicators should performance be tested, and how far will users’ levels of satisfaction be taken into account, alongside the hard measures of economy and efficiency?

Faith in the contract Since the advent of the purchaser/provider split in the health service, there is no doubt that the role of the contract in ensuring quality is regarded as of great importance. Now that the district health authority has lost many of its direct managerial functions, specifying quality of service in the contracts it establishes with its providers is one of its remaining ways of ensuring quality. But this raises enormous questions which are pertinent to social services departments as they develop the purchaser/provider relationship as well. How far are quality standards generally agreed and accepted? How much detail in relation to standards can be built into the contract? What arrangements are there for monitoring performance on quality, especially if services are being bought from a wide range of providers? What sanctions can be brought to bear on providers who fail to measure up to the contract – not only at the end of the contract (by not renewing it), but during the course of the contract (in order to gain immediate rectification of the failure)? Will complaints procedures, for people using the services of the providers, have enough bite in them to act as a force for quality improvement?

The health service is currently struggling with many of these issues and they have not proceeded very far yet. The first years' contracts have tended to be broad rather than detailed and to have paid relatively little attention to the small print of quality. Purchasers are still busy assessing their populations' needs and of necessity cannot specify precisely optimum standards and levels of service. As for providers, they are mostly concerned with deciding how to price their services. The issue of whether they are of high quality is likely to take second place, particularly if it is not clearly specified in the contract.

These then are the sorts of issues faced by the health service which social services departments must address. However, while experience in the health service can provide some of the answers, for the most part it can really only suggest what the questions are.

References

1. Gillian Dalley et al, *Quality Management Initiatives in the NHS: Strategic Approaches to Improving Quality*, Centre for Health Economics, York, 1990.