UNIVERSITY OF SOUTHAMPTON

STRATEGIC CHANGE IN CONTEXT

A CASE STUDY OF A TOTAL QUALITY MANAGEMENT INITIATIVE IN THE NATIONAL HEALTH SERVICE

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ABSTRACT

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STRATEGIC CHANGE IN CONTEXT: A CASE STUDY OF A TOTAL QUALITY MANAGEMENT INITIATIVE IN THE NATIONAL HEALTH SERVICE

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This thesis investigates strategic change in a district health authority between 1985 and 1993 when the district implemented a series of top-down initiatives concerned with fundamentally transforming the service, based on the introduction of general management, the implementation of a quality management initiative and the subsequent internal market reforms. The particular initiative which forms the central focus of this thesis was a Department of Health TQM demonstration site which was established in the district in 1989 and continued until 1993.

The research started from a concern to reveal the process of managing strategic change in the district through the implementation of TQM. The research, comprising focused interviews, was guided by a contextualist approach, and conducted with senior managers, members of the quality team and training staff who were directly involved with the demonstration site. The case study data was analysed against theories derived from the literature about strategic change in the public services and particularly the NHS.

The analysis of the case study data revealed that in spite of initial enthusiasm on the part of a small core of managers and staff, the TQM initiative quickly experienced setbacks, resulting from its rejection by clinicians, internal disagreements about priorities, failure to diffuse quality management techniques and the loss of key personnel. These difficulties were intensified by the impact of the *Working for Patients* reforms on the district, resulting in the growing demands of a parallel and powerfully driven change agenda which led to the break up of the district into separate units in preparation for trust status, with a reduction in the activities of the TQM demonstration site. The demonstration site finally closed in 1993 when funding came to an end, although there had been diminishing interest on the part of the Department of Health from 1990.

Analysis of the data revealed that the TQM initiative was part of a wide-ranging Government drive to transfer private sector techniques into the NHS, but which took place at a time when professionals and support staff were deeply sceptical of the Government's intentions for the service as the growing impact of resource constraints and the *Working for Patients* reform agenda dug more deeply into the service. This internal resistance to the initiative was mirrored in a loss of commitment by the Department of Health as a consequence of shifting political priorities which saw private sector initiatives reduced in order to maintain the Government's wider reform agenda. The study concludes with a discussion of recent quality initiatives, which will again face challenges in their implementation in a service where quality remains a contested concept and the power of professionals still present obstacles to strategic change.

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List of Abbreviations

BMA	British Medical Association
CEO	Chief Executive Officer
CHI	Commission for Health Improvement
CNO	Chief Nursing Officer
DGM	District General Manager
DHA	District Health Authority
DHSS	Department of Health and Social Security
DMB	District Management Board
DMU	Directly Managed Unit
DTM	District Training Manager
DoH	Department of Health
NAHA	National Association of Health Authorities
NHSTA	National Health Service Training Authority
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NMA	New Management Agenda
NHSME	National Health Service Management Executive
QF	Quality Forum
RCGP	Royal College of General Practitioners
RGM	Regional General Manager
RHA	Regional Health Authority
SWTRHA	South West Thames Regional Health Authority
TQM	Total Quality Management
UGM	Unit General Manager

1 Introduction and Outline of the Thesis

This thesis is concerned with an account of nine years of strategic change and innovation in a district health authority (DHA) between 1985 and 1993. In that period the management of the NHS was transformed by a series of top-down initiatives which impacted on all areas of the service. The traditional assumptions about the direction and management of the services were cast aside under a welter of initiatives intended to fundamentally transform the service from a traditionally administered organisation to one that would increasingly mirror the private sector in its organisational and management arrangements.

The events that took place during the period researched, and which provide the main focus of the case study, concern a Department of Health (DoH) demonstration site, one of a number which introduced 'total quality management' (TQM) into the NHS. This initiative was intended to radically change the culture of the NHS and was in keeping with a wider Government agenda to increase the efficiency and the effectiveness of the service through the transfer of private sector management techniques into the NHS. TQM was one of a number of business sector methods which were 'tested' at that time in the public sector, and an investigation of the origins, impact and responses to the TQM initiative constitutes the broad aims of the research.

Although the TQM demonstration site operated between 1989 and 1993, the research begins at an earlier stage corresponding with the introduction of general management which was to transform the service from a traditionally administered service into one that embraced managerialism and laid the foundations for the later more radical changes to the service in the early 1990s. In extending the time frame back to the introduction of general management, it is recognised that the decisions to adopt TQM in the district had their roots earlier in 1980s and particularly from 1983 with the recommendations of the Griffiths Report (DHSS, 1983). These recommendations were implemented in 1985 when this research begins and when a more active approach to the management of the district was introduced. Consequently the thesis explores the antecedent conditions which influenced the decision to experiment with quality management in the district, and specifically those factors which led the DHA to bid to become a demonstration site.

In researching the implementation of strategic change through the mechanism of TQM, this study has been influenced by Pettigrew's (1987; 1990) work on the contextualist approach to change, which focuses on an holistic and dynamic analysis of change, rather than a narrow concern with the details of a particular change strategy. In this sense the contextualist approach is concerned with those antecedent factors that shape the present, as well as the interplay between the context, process and content of change. This approach to the study of change acknowledges historical and current power struggles in organisations and how these influence what issues surface and receive attention, which groups gain or lose as change agendas evolve, and which changes are implemented or fail to gain support and meet an early demise or fail to surface at all.

A further influence on this research is the work of Pettigrew et al (1992) which examined the processes of strategic change in a number of district health authorities who were implementing change following the introduction of general management. In their detailed and multi-layered analysis of the NHS during a period of significant restructuring, they introduced the model of the receptive and non-receptive contexts for change, which in turn has provided an important focus for analysing the implementation of TQM in the district studied. A subsequent study of the response to HIV/AIDS in the NHS (Bennett and Ferlie, 1994) which provided an opportunity to test the early research on receptivity to change has also been an important underpinning source in the development of this thesis.

The research methods adopted are those of the case study, with analytical themes established prior to the commencement of fieldwork through a preliminary review of the literature, but with other themes emerging inductively from the data during the course of fieldwork or subsequent analysis. In adopting a qualitative approach to the research, emphasis has been placed on an in-depth investigation of how the strategic management of the DHA unfolded, revealing the interaction between strategy and the people in the organisation.

The structure of the thesis is as follows. In setting the scene for the fieldwork the first three chapters constitute a critical review of the literature relevant to the research focus.

Chapter two sets the context for the research by examining the politically driven reforms of the management of the NHS and consequences for the service. This chapter focuses particularly on the Griffiths reforms of 1983 and the introduction of general management, which is seen historically as the critical juncture in the management of the service, and the *Working for Patients* (DoH, 1989) reforms which introduced the internal market and the self-governing trusts which replaced DHAs.

Chapter three focuses on the concept of 'quality', from its origins in the manufacturing sector, through the Japanese quality revolution and the emergence of strategic management concepts such as TQM which were widely adopted by the public sector in the wake of the 'excellence movement' inspired by the work of Peters and Waterman (1983). Although experiments in the transfer of quality management techniques to the NHS were tested in the late 1980s, these initiatives had limited impact due to the complex nature of the NHS and the power of professionals resistant to ideas transplanted from the private sector.

Chapter four, which completes the literature review, is concerned with strategic management in the NHS. It returns to the broader themes of organisational change and the demands made on the service as a result of its complex structure, processes and management arrangements. In locating TQM within the context of wider organisational change, particular attention is given to programmatic change models which were promoted by consultants during the implementation of the demonstration sites.

Chapter five turns to a discussion of the reasons for researching TQM in the DHA and the research questions which guided the fieldwork. This is followed by a discussion of the methods selected, including the assumptions underlying the chosen research methods, their strengths and weaknesses, and operational issues arising from the choices made. This is followed by a discussion of the fieldwork, including issues of access and ethical considerations. Data collection and analysis is examined and the particular demands of the chosen methods are presented. The particular approaches used, including case study methods, empirical approaches, and grounded analysis of the data are discussed.

Chapters six to nine are a suite of empirical chapters, each following a similar format, which constitute the case study. Each chapter begins with a brief examination of the main themes which emerged from the empirical data, followed by the case study findings and concludes with a detailed analysis integrating the data with the theoretical concepts. The case study material presented in these chapters is based on interviews with staff who were directly involved in the TQM demonstration site, with the verbatim statements of informants used as far as practical in their original form in order to maintain the immediacy of the events and issues. The statements are grouped around a series of themes which illuminate the events that took place during the period researched.

Chapter ten concludes the thesis, beginning with a review of the research questions, and then examining these in relation to the findings of the case study. This is followed by a discussion of the concept of 'receptivity to change' and how far the DHA was a receptive context for the implementation of TQM. The penultimate section discusses the TQM initiative in a wider context of Government policy and the response of professionals and staff to what were seen as threats to the ethos of the service. This section concludes with a recognition that in spite of the rejection of TQM it was nevertheless part of longer-term changes in the service which would ultimately transform the role of quality in the NHS.

Finally, the chapter moves to a broader level of analysis, linking the TQM initiative with more recent Government policies on quality which offer new opportunities for a more integrated approach that eluded the original DoH demonstration sites. The new initiatives suggest that policy makers have learnt some of the lessons of the past and are now more realistic about the potential of new policies and their timescale for implementation. Nevertheless the service still retains a number of structural features which suggest that strategic change remains potentially problematic and provides an opportunity for future research on quality in the NHS.

2 A Service Tranformed

Introduction

This chapter describes a period of change in the 1980s, when the Conservative Government of the day began a series of far reaching reforms. The stream of policy initiatives which commenced at the beginning of the decade are discussed, with the main focus on the two major reforms concerned with management arrangements and structural change, which taken together, fundamentally changed the service. The first of these reforms was the introduction of general management following the recommendations of the Griffiths report (DHSS, 1983) and succeeded by the introduction of the internal market proposed in the White Paper, *Working for Patients* (DoH, 1989). It is argued that these reforms, which saw the transfer of private sector management techniques to the NHS, created the conditions in the late 1980s for an increasing range of business methods, which were adopted by managers as part of the process of seeking to transform a service which still remained largely resistant to change.

The response to the Royal Commission

Although this chapter focuses on events that took place in the 1980s, it is useful to begin the account of the changes a little earlier. In 1979 the report of the Royal Commission on the NHS (Royal Commission, 1979) was published. The Royal Commission had been set up in 1976 by the Labour Government. At that time there had been considerable labour unrest in the services culminating in industrial action by groups of ancillary workers, and discontent by doctors following the decision by Government to phase out pay beds (Ham,1999). The Commission' s remit was to 'consider in the interests both of patients and those who work in the National Health Service on the best use and management of the financial and manpower resources of the National Health Service' (1979). The Commission's report endorsed the existing structure and financing of the NHS and rejected the introduction of chief executives. It recommended some organisational change, including the abolition of one tier of

administration below regions, the abolition of Family Practitioner Committees and the strengthening of Community Health Councils (Royal Commission, 1979).
The Royal Commission, although established by the Labour Government, had by the time of its publication seen the Conservative Government take office and it fell to them to respond to the report. The response in the form of *Patients First* (DHSS, 1979) was a consultative document on the reorganisation of the NHS. This confirmed that the Government was in agreement with the Royal Commission's recommendations to remove one tier of administration, and suggested that district health authorities should be established, combining the functions of existing area and district authorities. *Patients First* also confirmed that Family Practitioner Committees would be retained and sought views about the role of Community Health Councils. Similarly the Government confirmed the Royal Commission's rejection of chief executives to health authorities (DHSS, 1979).

The Government recommended that the structure of the service be simplified and responsibility for making decisions moved closer to the locality for which the health service was being provided. It wanted large areas broken up into districts and recommended that 'natural communities' be the catchment area for hospitals rather than coterminosity with local authorities (which was broken by the subsequent abolition of area health authorities). *Patients First* (DHSS, 1979) recommended that the district should become the key accountable body in the new structure, with responsibility for providing as well as planning services. This change saw decision-making related more to local need, with a tighter system of management and a simplified planning structure (Allsop, 1995).

The Government's response to the consultative document was published in 1980 (DHSS, 1980) and largely endorsed its *Patient First* proposals with the creation of 192 district health authorities. These came into operation on 1 April 1982, and within the districts, emphasis was placed on the delegation of powers to units of management. Other changes included the reduction of local authorities' right to nominate members of health authorities from 30 to 20. Further changes that took place as a consequence of the Royal Commission included consultants being permitted to undertake more private work, and from 1981, health authorities were

permitted for the first time to contract with profit-making hospitals for NHS treatment. Districts were expected to establish their new management structures within overall costs set by the DHSS. The reduction in administration led to an estimated saving between 1979 and 1983 of management costs for the NHS as a whole of £64m (Ham, 1999). These early changes, following *Patients First*, can be seen in retrospect as the early building blocks of Government policy which would increasingly emphasise a more business-like approach to the management of the service, in the quest for efficiency in the delivery of health care.

The drive for efficiency

Soon after the *Patients First* changes had been introduced in 1982, the NHS entered into a decade of financial constraint, with a series of centrally driven initiatives with the service expected to make 'efficiency savings'. This meant districts outturn expenditure would need to be less than their nominal budget by a specified percentage (Harrison, 1988). The required figures were 0.2% in 1981–2, 0.3% in 1982–3 and 0.5% in 1983–4, and were clearly in line with the Government's pledge to reduce public spending in order to honour election pledges to reduce taxation (Ham,1999). Ham concludes that this financial regime had already by 1984 achieved an annual saving of £1bn in hospital and community services, at a time when demand was increasing and the service faced recurrent funding crisis.

The consequence of this new financial regime was to shift the focus of the service on to managers, who were claimed to have increasingly been portrayed as culpable for the shortcomings of the service (Harrison, 1988). The delegation of powers to districts, with the responsibility for making choices about spending decisions and rationing services pushed to the local level, meant that blame for any deterioration in service levels therefore lay with the districts and not central Government (Klein, 1982). This left managers open to the difficulties of managing within a shrinking resource base and at the same time having to deal with criticism from local groups.

Following the introduction of the 'cost improvement' initiative came the introduction in 1982 of the 'Rayner Scrutinies' named after Sir Derek Rayner, Managing Director of Marks and Spencer, and a part-time efficiency adviser to Government. The

scrutinies involved intensive studies of a particular area of expenditure led by Rayner and his staff (civil servants seconded specifically for that purpose) which examined transport services, staff recruitment, payment collection and (controversially) staff residential accommodation which would lead eventually to the sale of hospital property. The Labour opposition saw the cost improvement programme as a euphemism for cuts and a step towards the privatisation of the service (Mohan, 1995).

Alongside the cost improvement schemes, 1982 also saw the introduction of performance indicators covering a wide range of health authority activities, which would enable DHAs to compare their performance with other districts, in what amounted to an early benchmarking exercise. The Government stated that these would provide a continuing assessment of performance, with the intention that districts would take remedial action where necessary. The performance indicators would enable comparisons to be made between districts and assist ministers and regional chairmen to assess the performance of authorities in using manpower and other resources efficiently (DHSS, 1982).

The fourth element of this drive for efficiency was launched in September 1983 when districts were instructed to test the cost-effectiveness of catering, domestic and laundry services by inviting tenders for the provision of these services from their own staff and outside contractors. It was estimated that the first round of competitive tendering achieved savings of £110m (Social Services Committee, 1990), with some districts extending tendering to other services such as engineering and building maintenance (Ham, 1999).

A final thrust of the Government's quest for efficiency was introduced some years later in 1988 when an income generation initiative was launched, with the intention of encouraging districts to find ways of generating additional income. These included charging private patients, charging for car parking and encouraging retailers to establish outlets on hospital premises, although Mohan (1995) saw the exercise as largely symbolic (although raising £51m in 1990/1), with the DoH income generation unit being wound up in 1992 as enthusiasm for the scheme quickly evaporated.

The business solution

Although the changes introduced by the Conservative Government since their election in 1979 had focused on controlling the costs of the NHS as part of the wider strategy to reduce public sector expenditure and the attempt to increase the efficiency of the service, the most significant change of this period was the introduction of general management following the Griffiths Report of 1983. The Secretary of State for Social Services invited Roy (later Sir Roy) Griffiths to head an inquiry into the management of the NHS. This inquiry would examine the effective use of manpower and related resources in the NHS. The inquiry had two main tasks, firstly, 'to examine the way in which resources are used and controlled inside the health service, and secure the best value for money and the best possible service for the patient [and secondly] to identify what further management issues need pursuing for these important purposes.' (DHSS, 1983).

The inquiry team led by Roy Griffiths, who was Deputy Chairman of Sainsbury's supermarket chain, included the Personnel Director of British Telecommunications (Michael Bett), the Group Finance Director of United Biscuits (Jim Blyth) and the Chairman of Television South West (Sir Brian Bailey). They submitted their report in the form of a 24-page letter to the Secretary of State in October 1983 (DHSS, 1983). The team's recommendations included:

- the creation of a Health Services Supervisory Board (Chaired by the Secretary of State, and including the Minister for Health, the Permanent Secretary, the Chief Medical Officer, the Chairman of the NHS Management Board) and two or three non-executive members with general management skills and experience. The full-time multiprofessional NHS Management Board would oversee implementation of the strategy for the service (p.3)

- general managers proposed for regional, district and unit levels of organisation, regardless of discipline, to carry overall management responsibility for achieving the relevant health authorities' objectives, with substantial freedom to design local functionally-based management structures, ensuring that day-to-day decisions were taken at unit level, rather than higher up the organisation (pp.4-5)

- the review process, begun in 1982, was to be extended to unit level and efficiency savings replaced by 'cost improvement programmes' aimed at reducing costs without impairing services (pp.4-5)

- clinical doctors were to become more involved in local management, with a proposed system of 'management budgets' and the allocation of workload-related budgets to consultants (pp.6-7)

- more attention paid to patient and community opinion, expressed both through Community Health Councils and market research methods (p9)

The Government accepted the recommendations applicable to the DHSS and put the other recommendations out for a short period of consultation. There were adverse reactions to the recommendations, particularly on the part of nursing and ancillary staff, with the British Medical Association (the representative of medical opinion) strongly opposing the recommended changes. Administrators and treasurers, however, favoured the changes. (Mohan, 1995). In spite of the wide-ranging changes proposed by Griffiths, it was the proposal for the appointment of general managers that became the main focus of those opposed to the changes.

In June 1984 the Secretary of State finally accepted the recommendations, including the principle of individual general managers in place of consensus teams. The Government view was that the appointment of managers with personal and visible responsibility was essential if there was to be a commitment to improving services (DHSS,1984). The Secretary of State made clear that consensus in a multiprofessional organisation such as the NHS was valued, but that consensus as a management style would not secure effective and timely management action, nor would it initiate the kind of dynamic approach needed in the health service to ensure the best quality of care and value for money (DHSS, 1984).

The Griffiths solution to the problems of the NHS was essentially the introduction of business management into a service that had previously been based on consensus

management. This was not surprising considering the Government's preoccupation, which was to introduce a particular set of political ideas to the public services. These were: the importance of a sound economy (with social policy subservient to economic policy); that nothing should be done in the public sector that could just as well be done in the private sector; and finally, an assumption of organisational inefficiency based on corporate groups' desire to preserve their privileges rather than with modernising their attitudes and activities (Butler, 1992).

The Conservative Government came to power in 1979 on a broadly anti-managerialist ticket, promoting the view that British public administration was over-managed, with the first Secretary of State rejecting the notion of general management in the NHS, finding it incompatible with professional independence (DHSS, 1979). Four years later all that had changed. By 1984 the Secretary of State unreservedly accepted the Griffiths managerialistic diagnosis for the ills of the service and enthusiastically implemented general management at all levels of the NHS, with general managers in post at regional, district and unit level by 1985 (Butler, 1993).

Changing the management culture

The Griffiths solution was to change the organisational culture of the NHS by introducing features of business management (Allsop, 1995). Griffiths (DHSS, 1983) saw the newly appointed general manager's task as providing the driving force for developing management plans, including taking personal responsibility for providing appropriate levels of service; ensuring the quality of care; meeting budgets; achieving cost improvements; increasing productivity; monitoring performance and rewarding staff; ensuring research and development and initiating measures to assess health outputs. The report also recommended the appointment of directors of quality assurance in each district to improve performance, and the introduction of private sector practices such as performance-related pay.

Roy Griffiths identified four main concerns that summed up the problems of the NHS as he (and his team) saw them. First, that consensus management led to the lowest common denominator decisions, and the importance of getting decisions was more important than the substance of a particular decision. This criticism led to the oft

quoted remark in the report that '...*if* Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge' (DHSS, 1983:22).

The second criticism in the report was that of weak implementation, without a driving force, which did not seek and accept direct and personal responsibility for developing management plans and securing their implementation, nor for monitoring actual achievement. This, it was claimed, risked causing difficulties in implementing major initiatives (a risk reinforced by the lack of general management processes) which meant it was extremely difficult to achieve change. The report argued for a more thrusting and committed style of management and this style was seen as implicit in all its recommendations.

The third criticism was the lack of orientation towards performance in the service. Griffiths found that the service lacked any real continuous evaluation of its performance, and rarely were precise management objectives set. There was little measurement of health output, with clinical evaluation of particular practices by no means common and economic evaluation extremely rare.

The fourth criticism concerned the lack of consumer views of the health service. The service was said to be unable to demonstrate any means of assessing its effectiveness in terms of meeting the needs and expectations of those it served, and Griffiths stated that it was open to question as to whether the service could achieve this.

This diagnosis of the ills of the service was seen to correspond closely with the empirical evidence about the pre-Griffiths management of the service identified by Harrison (1988) in terms of known problems. Griffiths's failure to find one person in charge was seen to relate directly to the evidence of the power of the medical profession and its resistance to management. Secondly, Griffiths identified a lack of action on the part of the service, with problems in acting on plans which corresponded with research showing that managers mainly reacted to problems thrust upon them, rather than proactively seeking solutions. Thirdly, Griffiths's criticism about the failure to set and pursue goals was seen to confirm the 'taken for granted'

incrementalism of the service. Finally, the criticism that managers failed to take notice of patients was said to be borne out by the preoccupation with the internal provider concerns of different professional groups, rather than with patients' needs.

What was witnessed in the Griffiths report was a rejection of the earlier forms of management of the service which were seen to have failed. It is argued by Harrison (1988) that during the first 20 years of the service the manager was seen as a diplomat (as stated in *Patients First,* DHSS, 1979) with the job of solving problems and maintaining their organisations rather than securing major change. Their role was to conciliate and coordinate, as far as possible, all the different sub-groups within the service. As far as Griffiths was concerned, the manager was no longer to be a 'diplomat', as this was not an acceptable model for managing the service, and the Griffiths prescription aimed to change the prevailing model of management. The previous behaviour of managers based on the assumption that managers would assume a diplomatic character, shifted with Griffiths to one in which managers would become responsible for their service, with the incentives necessary to make this work (Harrison, 1988).

Involving clinicians in management

Following the implementation of Griffiths and the appointment of general managers, the Government extended management arrangements in line with Griffiths' recommendation that clinicians be involved in management. In 1986 management budgeting was introduced, with the term 'resource management' adapted to describe the initiative as this placed the emphasis on management as opposed to budgeting and the medical and nursing ownership of the system (Harrison and Pollitt, 1994). Resource management was launched in six acute hospital sites established as pilot projects. This particular initiative was designed to give doctors and nurses a more significant role in the management of resources, through devolved budgetary responsibility to clinical teams within hospitals. It was also intended to enable managers to negotiate workload agreements with clinical teams and to improve information systems to provide staff with better data about their services (Ham, 1992). The DoH set aside central funding to support the implementation, and particular emphasis was placed on training and organisational development.

Subsequent research on the impact of resource management (Packwood et al, 1991) suggested that, although some progress had been made in involving doctors and nurses in the management of the service, this would be a slow evolutionary process and could not be achieved easily within the parameters of a specific project. Where this initiative would eventually have its impact was in preparing clinicians for the world of markets and competition that followed in the *Working for Patients* reforms (DoH, 1989).

Funding crisis

In spite of these initiatives, the 1980s witnessed a widening gap between the money provided by Government for the NHS, and the funding needed to meet increased demand. By 1987/8 the cumulative shortfall in hospital and community services since 1981/2 amounted to £1.8bn (Ham, 1992). For 1987/8 alone expenditure was estimated to be £400m below its target level (King's Fund, 1988). The consequence of this underfunding reached crisis point during autumn 1987, with many health authorities closing beds on a temporary or permanent basis or cancelling operations to reduce activity levels, and not filling staff vacancies (NAHA, 1987). The funding shortfall generated a full-scale political crisis with media stories of patients, especially young babies, suffering or even dying as a result of bed closures. Alongside this publicity there were motions and debates in the House of Commons about local failures in services. Unprecedented calls for additional resources were made from the British Medical Association and the Royal Colleges of Surgeons, Physicians, Obstetricians and Gynaecologists, with statements that the NHS was reaching breaking point and that additional finance had to be provided to 'save the service that had once been the envy of the world' (Mohan, 1995:16).

The response of the Government was twofold. First, it announced that an additional £101m was to be made available to the UK to tackle immediate difficulties, and second, the Prime Minister had decided to initiate a ministerial review of the future of the NHS, which she announced on the BBC TV Panorama programme in January 1988. This review by a small working group – in effect a committee of the Cabinet – was to be composed of three senior ministers, chaired by the Prime Minister, supported by civil servants and political advisers (Ham, 2000). This was

controversial, with the traditional consultative process ignored, and resulted in the professions feeling excluded from deliberations about the future of the service (Lee-Potter, 1997) – although this was in keeping with a Government that felt secure in ignoring professional opinion, and relied on advisers who would provide the ideological justification for policy decisions as witnessed in the earlier Griffiths inquiry (Thatcher, 1993). This exclusion of the medical profession was particularly interesting as traditionally they had had a privileged role in policy formation, but had by the late 1980s been perjoratively labelled as a 'trade union' and perceived as a reactionary force (Mohan, 1995).

In view of the financial problems that had preceded the review, it was assumed that radical alternatives to finance would be proposed. At the outset of the review there was discussion of an insurance-based service and plans that would have allowed people with private health insurance to contract out of the service. The early deliberations of the review group were around finance and ways that more resources could be generated. During the second half of the review the agenda changed, and the review team's concern shifted from issues about financing the NHS to the efficient use of its resources (Butler, 1992). When the White Paper *Working for Patients* (DoH, 1989) was published in January 1989, it was clear that the basic principles of the NHS remained, and funding would continue to be provided mainly out of taxation. Although there were some minor changes in tax relief on private insurance premiums for people aged 60, 'the vast majority of the population would still have access based on need not ability to pay' (Ham, 1999:49)

Working for Patients

When published, *Working for Patients* (DoH, 1989) placed particular emphasis on what had come to be seen as characteristic Conservative policies for the service: concern for enhanced performance and efficiency, consumerism and managerial authority. There would be further delegation of responsibility for the management of the service to local tiers, with problems of service delivery seen as the inadequacies of management (Mohan, 1995). The main changes concerned the structure of the service, with the intention of stimulating competition between hospitals and other service providers through the separation of purchasing and provision of services.

Local health authorities would in future purchase services from a range of public, private and voluntary providers. These providers would include hospitals and community services who would opt out of health authority control and become self-governing NHS trusts.

Other significant changes included GP fundholding, where practices that were eligible (based on a specific list size) would receive a budget to purchase services for their patients. The cost of the services purchased would be deducted from the allocation to the relevant health authorities. The basic tenet of this change was that money would follow patients, thereby rewarding hospitals and GPs able to provide services in demand by patients and those purchasing care on their behalf.

Other changes included new managerial arrangements (with a Policy Board and Management Executive replacing the Supervisory Board and Management Board). At local level, health authorities would be revised along business lines, with chief executives sitting as directors of trusts and health authorities alongside health professionals, non-executive directors and a chairman. Non-executive directors would be appointed for their individual skills and experience, and paid a fee for the first time, in order to attract people to serve in these new roles.

A further important theme of *Working for Patients* was the need to make doctors more accountable for their performance. This was to be achieved by general managers having a larger role in the management of clinical activity and also participating in the appointment of consultants, drawing up job plans and deciding which consultants should receive distinction awards. The earlier resource management initiative was to be extended, and medical audit was to become a routine part of clinical work in general practice and hospitals (Ham, 1999).

The fundamental change that underpinned the reforms was the way in which financial resources were to be allocated. *Working for Patients* proposed that health authorities should receive funds to purchase services for their resident population instead of being allocated funds to provide services in their hospitals. This involved a change from funding authorities as providers of services to funding them as purchasers. The

main aim of separating the purchase of health care from its provision was to subject providers to an element of competition for contracts which was intended to provide an incentive to cut costs, improve quality and become more responsive to consumers (Ranade, 1994).

Working for Patients and its management consequences

The implementation of *Working for Patients* (DoH, 1989) led to strong reactions on all sides. Clinicians, and particularly doctors' representatives, notably the British Medical Association, launched high profile campaigns against the changes that they believed would diminish their power in relation to managers. This was to be expected, as clearly the intention of *Working for Patients*, as with the earlier Griffiths Report (DHSS, 1983), was intended to increase the influence of managers in relation to doctors. The new powers managers would wield in relation to doctors included: specific contracts of employment, the abolition of medical representation on health authorities and the introduction of management criteria for distinction awards (Harrison et al, 1990). More radical would be the need for managers to secure contracts in the new internal market, which would mean challenging the legitimacy of medical decisions and the perceived defensiveness of the professions (Harrison et al, 1990).

On the other hand, as might be naturally assumed, managers and health authorities were more supportive of the reforms, although cautious about whether the timetable for implementation was realistic considering the radical changes to the structure and processes of the service (Ham, 1999). The support of managers for the reforms needed to be seen in the light of their experience since Griffiths. The implementation of general management had not proved smooth in all districts, and a review of the impact of Griffiths as part of a study of strategic change in districts (Pettigrew et al, 1992) suggested that the increased power and influence of general managers could not necessarily be taken for granted. Hunter (1984) was sceptical about the potential of general management, based on difficulties with previous reorganisations, and particularly in view of the delicately balanced relationships between different professional groups. His view was that change would be embraced on the surface, but in reality little would change.

Similarly, research on the introduction of general management in a sample of districts saw evidence of both continuity and change. This was largely because the newly appointed general managers were trapped within the traditional hierarchy of the service, with its political sensitivity and control over funding remaining key issues. This clearly thwarted the hopes of general managers that their new authority would be influential in shaping the service (Strong and Robinson, 1988). Where general management had achieved influence was in relation to nurses, with Griffiths being seen to pay little regard to the central role of nurses in the service. Of all the occupational groups, nurse managers were stated to have suffered more than any other group following the implementation of the Griffiths proposals (Strong and Robinson, 1988). In contrast, doctors had greater political power, and were able to retain their influence in the post Griffiths NHS. This perception was further reinforced by Harrison's (1989) study, which found that it was difficult to detect any reduction in the power of doctors to obstruct management actions, and that the manager's role was still seen as that of the 'diplomat', concerned primarily with facilitation, the provision of resources and managing conflict, rather than controlling professionals or changing the direction of the service.

Power to the managers

Clearly *Working for Patients* (DoH, 1989) provided managers with potentially new powers that had been denied them in the earlier Griffiths changes. The intention was that the service would now be based on managed competition within a new system of contracts between purchasers and providers. In managing the contract system, it was intended that managers and clinicians would need to co-operate as they had a common interest in demonstrating to purchasers that they were able to provide good quality cost-effective services. Furthermore, resource management would now need to be rolled out to all units, and medical audit (introduced as part of the *Working for Patients* reforms and concerned with the quality of interventions) would be compulsory. In practice, each of these changes would in turn strengthen the managers' formal powers over clinicians and contribute to undermining medical resistance to involvement in management (Ranade, 1994).

The concern for effectiveness

A further consequence of the *Working for Patients* (DoH, 1989) reforms was the increased concern for consumerism, improving quality and evaluating effectiveness (Ranade, 1994), seen as essential in a market-based service. These concerns had of course been raised originally by Griffiths (DHSS,1983), although a study of the implementation of general management suggested that these had remained marginal to the main activities of managers (Hunter, 1989). Other researchers, notably Ferlie et al (1996), saw the early concerns for efficiency which were dominant in the early to mid-1980s being replaced in the late 1980s with a concern for excellence, influenced by the work of Peters and Waterman (1982). Increasingly the importance of organisational culture, charismatic leadership and the transformational nature of change became more dominant symbols of management at the end of the decade, a shift which was necessary in the rapidly changing world of the *Working for Patients* (DoH, 1989) reforms.

Ferlie et al (1996), looking back to the 1980s, delineated the 'elements of excellence' model for the public service, with the emergence of top-down visions, charismatic leadership, culture change programmes and the identification of private sector role models that would influence the service. To support these changes intensive corporate training programmes were introduced, alongside the growth of corporate logos and other means of service identity, including mission statements and explicit communications strategies to promote organisational culture change. This model resonated closely with the developments that took place in the research location, which had by the mid-1980s begun to adopt many of the elements of the excellence model, confirming Ranade's (1994) claim that *In Search of Excellence* (Peters and Waterman, 1982) was increasingly appearing on general managers' bookshelves as they searched for management tools to transform their services in the turbulent world of *Working for Patients* (DoH, 1989).

Reflections on a decade of change

It is clear from the preceding account that the NHS experienced a continuous and relentless series of changes throughout the 1980s culminating in the *Working for Patients* reforms that concluded the series of initiatives discussed in this chapter. The early changes, with their emphasis on economy and efficiency, characterised the

Thatcher years, with an agenda that placed economic values above social values and views about the efficiency and effectiveness of public services. These changes occurred at a time when it was becoming apparent that the service was underfunded, and that patterns of service were changing with the move towards more community-based services and growing demands as a result of demographic changes.

With the enthusiasm for business values and the market seen as a solution to the perceived problems of the public services and resulted in a series of initiatives starting with Griffiths (DHSS, 1983) and culminating in *Working for Patients* (DoH, 1989). The reforms of the 1980s were symptomatic of the view that the consensus management of an earlier NHS had no place in the future, with the changes intended to encourage enterprise and the entrepreneurial spirit. In fact the 1980s were marked by the continual attempts by Government to increase the power of management, which according to Ranade (1994) were based on the ideological assumption 'that the private sector had everything to teach the public sector and nothing to learn' (p82).

Certainly by the late 1980s (to use Harrison's (1988) typology) the NHS manager was now a 'scapegoat', particularly in their inability to control doctors, whose clinical freedom and consequent disregard for resource levels preoccupied a Government trying to reduce public spending. The earlier 'manager as diplomat' was replaced by a series of initiatives and reforms that fundamentally changed the nature of management in the NHS. Pollitt (1990) suggests that it was a commonly held assumption that better management would solve a range of social and economic problems, with the Government seeking the views of management theorists, particularly from the USA, for ideas about how to run public services in Britain (for example, Drucker (1974); Enthoven (1985), and Osborne and Gaebler (1992)).

A consequence of these management changes, following Griffiths, was the emergence of managerialism drawing on techniques from the private sector and described as neo-Taylorism, based on strengthening and incentivising line management, setting clear targets and developing performance indicators to measure achievements, with awards and promotion for those who got 'results' (Pollitt, 1993). Sadly the NHS experienced some of the worst examples of 'macho management'

(Ranade, 1994) which led to what have been described as 'low trust' relationships between managers and professionals in the service (Hunter, 1996). Clearly the subtext of Griffiths was the control of professionals, particularly doctors, but the Taylorian management models adopted by some managers would influence relationships negatively long into the future, when successive adoptions of more humanistic management approaches were seen as more likely to support the changes needed with the implementation of *Working for Patients* (Ranade, 1994).

Conclusions

This chapter has described a series of changes that impacted on the NHS throughout the 1980s which fundamentally changed the management and ultimately the structure of the service. These changes – driven by goals of economy and efficiency – had severe consequences for the service and led ultimately to the funding crisis of the late 1980s and the subsequent market-based reforms. Throughout this period the management of the service was also in a state of constant change as general managers sought to manage a service under increasing pressure and at the same time transform the service in response to Government directives. As we have seen, a consequence of these demands was the adoption of management models that veered between the neo-Taylorist and the excellence school, but in the end created a culture of mistrust which would contribute to the difficulties in implementing the larger changes to come in the early 1990s. We now turn to an examination of the quality initiatives which coincided with *Working for* Patients (DoH, 1989), with the Government again drawing on the world of business for ideas in transforming a troublesome service.

3 The Quality Revolution

Introduction

The quality management initiatives which reached the NHS in the late 1980s had their roots far back in the beginning of the twentieth century. 'Quality' as a concept had progressed through a series of distinct phases of development throughout the twentieth century, for example, inspection, statistical control, quality assurance and strategic quality management, which in turn gave way to the 'total quality management' which came to dominate the agenda of many private and public sector organisations searching for routes to improved performance. This chapter briefly describes the development of the concept of quality, before discussing its transfer to the public sector and the adoption of total quality management techniques by the DoH during a period of radical reform. The chapter concludes with a discussion of the roots of quality in the NHS in the context of wider changes in public sector management.

Development of the concept of quality

The development of the concept of quality has progressed from the early concern with inspection and later statistical control techniques in manufacturing industries (Garvin, 1988), through the era of quality assurance with its emphasis on 'zero defects' (Crosby,1979), particularly in the context of military needs in the second world war and the subsequent demands of missile technology and space exploration. The increasing requirement for highly sophisticated products meant that quality became even more important, and shifted the emphasis towards a human relations approach to workforce management and the coordination of activities, as a primary concern (Garvin, 1988).

The further stage in the development of quality, which later ushered in total quality management (TQM), was the recognition in the 1970s that increasing competition from the Japanese consumer industry with their superior quality and reliability was making major inroads into the United States and European markets. It was ironic that the success of Japanese industry was based to a large extent on Deming (1988) and

Juran (1988) whose work in Japan in the early 1950s had laid the basis for the subsequent Japanese success.

By the 1980s the cost of defective products (and in the USA expensive law suits, with their impact on market share and profitability) ultimately led to the adoption of strategic approaches to quality which had originated in Japan. A shift took place in many companies from the earlier quality assurance and zero defects approach to one that embraced the total organisation, with the growing realisation that meeting customer expectations and continuous improvement would be essential in the increasingly competitive international markets (Garvin, 1988). The influence of Deming and other TQM 'gurus' (Bendall, 1991) was increasingly seen in this period in a number of organisations as they adopted 'new manufacturing philosophies based on teamwork, employer involvement and collaborative customer–supplier relations' (Dawson, 1994:70).

The emergence of excellence

Although total quality management had begun to make an impact on British business by the early 1980s, it was the work of Tom Peters, whose book (with Robert Waterman) *In Search of Excellence* (1982) popularised the notion of the 'Quality Improvement Process'. This was followed by his second book (with Nancy Austin) *A Passion for Excellence: The Leadership Difference* (1985) which identified leadership as central to the quality improvement process, with the manager as cheerleader and facilitator. The notion of 'management by wandering about' (MBWA) would subsequently become the basis for leadership and excellence in a number of organisations, enabling leaders to keep in touch with staff and customers.

This 'excellence' approach struck a chord with business leaders and also had an increasing impact on managers in the public sector, particularly in the context of Government exhortations to mimic the practices of the private sector. The claims of *In Search of Excellence* were reinforced by the new organisational processes and performance of Japanese companies located in Britain. Although confined to isolated sectors of industry until the 1980s these companies had begun to challenge established ways of working based on traditional organisational hierarchies and

social relationships. This changed with the publication of *In Search of Excellence* which appeared to act as a catalyst, at a time when the political climate was receptive to its focus on customer relations as the key to commercial success and the pursuit of quality as a central managerial goal. It was seen to promise managers a strategy for the survival of their organisations in a rapidly changing, competitive environment, and, in its pursuit of quality as the only means of long-term survival, it contrasted with the traditional survival strategies of accumulating tangible assets.

As we have seen in the previous chapter (Ferlie et al, 1996), the organisational consequences of this approach meant a move away from the older managerial systems based on Taylorism and Fordism involving traditional hierarchies in favour of new avenues of influence. Bureaucratic procedures would be replaced by output strategies which focused on results produced. In turn, management would embrace notions of leadership with mission statements proclaiming the organisation's guiding philosophy, the intention being that workers and customers would share in and work towards achieving its goals. The previous era based on scientific approaches to quality would shift to one which stated that quality was everyone's responsibility (Bendall, 1991).

This approach, with its emphasis on customer satisfaction, would of course only work where the relationship between producer, provider and customer was a close one. This again pointed to the need to move away from vertically integrated, bureaucratically-controlled, rule-bound organisations where employer/employees relationships are controlled through hierarchies, to small-scale units which have clear, contractual relationships with their customers. This would in effect replace control by ownership with control by contract. Contracts focus on output, not how something is achieved. Contractual relationships can be placed both inside and outside an organisation, hence the idea of the internal customer, a key element in quality management (Bendall, 1991).

Attractions to the public sector

We can see here a convergence of a number of ideas in the 1980s. The restructuring of the public sector along business lines and the introduction of markets acted as a

spur to more effective management of resources and delivery of quality, supported by the influence of business leaders such as Roy Griffiths with his retailing background, and by the impact of the 'excellence' movement in the wake of *In Search of Excellence.* The 'excellence' approach was now being embraced widely by the public sector. Pfeffer and Coote (1991) describe a series of reorganisations in the public sector, including British Rail, the Royal Mint, the Meteorological Office and the Driver Vehicle Licensing Agency. All would see their management structures radically changed and replaced with profit centres run at arm's length from Whitehall, with quality as a key component of change.

Similar things began to take place in the NHS from the late 1980s with the *Working for Patients* reforms (DoH, 1989). Ideally, managers would no longer just run services within policies laid down by Government, but they would organise the delivery of contracted services, within quality and quantity specifications, to clients in return for agreed levels of income. The 'excellence' approach would make each unit responsible for its performance, with a named person (manager) in charge, and staffed by people who were sensitive to customers' needs. This was seen by the Government as a way of revitalising the public service ethic. This would mean that instead of developing services that offered people what providers thought they should have, responsive services would pay attention to giving people what they wanted.

Questions about transfer to the public sector

In questioning whether quality could be as effective a driver in health and social services as it had been in the commercial sector, Pfeffer and Coote (1991) identified two problems. First, its driving force in the commercial sector was profit, and secondly, the increased power of managers associated with the 'excellence' approach suggested that a new managerial discipline suited to the public sector was needed. The pursuit of quality in order to satisfy customers is seen by Pfeffer and Coote as straightforwardly (and quite properly) a means to commercial success. Public services on the other hand, have more complex functions and are concerned to serve the community as a whole and to meet the needs of individuals within the community. Meeting needs is not necessarily the same as satisfying tastes and wants, and much public sector work is undertaken with users who reluctantly accept the

service or even have the service imposed upon them for their own and for society's good (Flynn, 1997). Furthermore the public sector is one where numerous stakeholders have a legitimate right to participate in decisions about service provision, which can significantly affect decisions about service quality (Stewart and Ranson, 1988).

Although Ferlie et al (1996) described the emergence of the excellence model as a turning away from the earlier crude notions of efficiency and the adoption of more human relations approaches, Pfeffer and Coote (1991) saw managerialism as a necessary requirement if managers were to have the power required to take on public sector professionals in meeting quality goals. They saw the rejection of consensus management following Griffiths (DHSS, 1983) giving managers the legitimacy to challenge professionals, even though they acknowledged that this would be difficult in dealing with the established professions such as medicine. Prophetically it would be this very issue of the relationship between managers and doctors which would become a battleground in the later implementation of quality initiatives in the NHS.

Managers move in on quality

The tensions between managers and professionals which began with the Griffiths changes were at the root of the quality debate, with the tentative intrusion of non-clinicians into the previously guarded territory of doctors (Ovretveit, 1998). Economic pressures meant that doctors could no longer resist the attacks on their sovereignty by general managers who, following the Griffiths and later with *Working for Patients* reforms (DoH, 1989), were given more power to challenge clinicians. Medical sovereignty has traditionally been extensive within the service, and Pollitt writing in 1987 saw no fundamental change with consultants' lifetime appointments and GPs' independent contractor status in spite of general management. Both the DHSS and health authority managers were seen to 'have danced carefully round the borders of this unsupervised autonomy, but have yet to summon the nerve for any major incursions' (Politt, 1987:79).

So what changed in the late 1980 and early 1990s? The quality initiatives of this period can fundamentally be seen as a struggle for control. Quality was given a

higher prominence in the service and was part of a highly political process concerned with issues about who managed health resources (Harrison and Pollitt,1994). Quality initiatives, particularly the TQM demonstration sites, were an attempt to introduce a managerial agenda that was fundamentally at odds with the previous experience of NHS professionals. The emphasis on a corporate approach to quality and the dissolution of departmental barriers were examples of the radical changes that would be necessary with the introduction of TQM in the service.

It is important to question what led to the increased attention to quality and how quality was defined during this period. It is clear that these initiatives came at a time when managerial changes ushered in by the Griffiths reforms in the mid-1980s were being reinforced by the market-driven policies of *Working for Patients* (DoH, 1989). The policies of this period required a clearer definition of management, and hence management control of the professionals who had responsibility for the allocation of resources. The quality initiatives were seen as a key feature in improving services, but at the same time contained definitions of where power was located in the service. *Working for Patients* was seen by Harrison et al (1992) as a genuine watershed in placing power and persuasion in managers' hands, something that Griffiths had been unable to achieve. Although they are referring to managers' power in relation to the medical profession, one aspect of this power was clinical quality. The introduction of general management had increased the power of managers, particularly in relation to nurses and other professional groups, although this had not been the case with doctors.

Sources of ideas for quality management

In seeking to identify the roots of the quality movement in professions in the late 1980s we must turn to Pollitt (1987) who suggests a number of possible sources. Firstly, there were the professional institutions themselves (Shaw, 1986; RCGP, 1985), with their genuine altruistic desire for self-improvement, the need to protect the integrity of existing services against financial economies, actual or expected, and also pre-emptively to ward off an external quality audit of the service.

Secondly, an important source of quality initiatives was research and training institutions, such as the King's Fund and the Birmingham Health Services Management Centre. These centres were both working in health authorities on consultancy and research activities throughout the 1980s, and were seen to have influenced districts who were searching for ideas to relate quality to costs during the straightened times of the mid-80s. In the case of the King's Fund, work on quality management initiatives had been promoted as early as 1982 (Maxwell, 1983), and pre-empted the later total quality management initiatives.

Thirdly, Griffiths (DHSS, 1983) in his report with its consumerist philosophy, had struck an early blow for the need to listen to patients. This was to be expected from the author of the report, who had a background in the retail sector and who continued to champion the needs of the consumer in later lectures and articles (Griffiths, 1992). In fact consumer groups such as the Community Health Councils, National Consumer Council and the College of Health were seen to have little influence and were politically weak, although Pollitt (1987) believes they were able to establish a small bridgehead into the provider dominated world of the NHS.

Fourthly, private sector management consultants played an increasing role in the service during the 1980s and their advice reflected the contemporary preoccupations of business, that quality and service responsiveness were national weaknesses. When these consultants began to transfer their interests to the public services – with the advent of general management and the internal market and the contemporary interest in quality, particularly following the publication of *In Search of Excellence* – it became apparent that quality management would be promoted as the 'new idea' for the NHS. The influence of management gurus with their simplified messages on organisational improvement was taken up by consultants (Huczinski, 1996) and found a ready ear in the senior managers of the service. Similarly the large consultancy firms such as Coopers and Lybrand, along with other business consultancies, promoted the success of Japanese business and recommended that the service should take the (then) revolutionary step of asking patients what they wanted (Coopers and Lybrand, 1986).

Government interest in quality

At a time when there was 'a mixed stew of (quality) initiatives bubbling through the NHS' (Ranade, 1994:116) it is instructive to examine how well quality fitted with the Government plans to reform the service. The concern for quality needs to be seen in the context of Government plans to reform the NHS. As far as the Government was concerned, the NHS was a monolithic organisation which was essentially producer oriented. It was seen to be controlled by the producers (medical and other professionals, and trade unions) rather than serving the needs of patients. One way the grip of professionals could be broken was with the introduction of market forces, where the service would be hopefully shaped by the needs of the consumer. (Ruane and Robins, 1994).

In keeping with the policy of devolution of responsibility to the local tiers of management, in the early 1980s the choice of quality initiatives was left very much for district health authorities. With the advent of the Griffiths Report (DHSS, 1983) all districts found themselves increasingly subject to pressure from the DoH and the regional health authorities to tackle key areas for improvement – waiting times, facilities in public areas and provision of more choice for patients (Sutherland and Dawson, 1998). The introduction of general management coincided with the emergence of the 'excellence' model (Ferlie et al, 1996) as witnessed by growing numbers of references to quality in the weekly *Health Service Journal* and later books and training packages on introducing TQM (Oakland, 1989; Koch, 1991).

With the publication of *Working for Patients* (DoH, 1989) and the process of implementing the market-based system of quality, management became much more visible. Joss and Kogan (1995) believe this was because quality management resonated strongly with some of the key features of the reforms in the NHS. They suggest that the three principles of TQM; a corporate approach to planning, continuous improvements through systematic measurement and putting the customer at the centre of process improvement, all resonated with the concerns of general managers as they embarked on the reform agenda and were directly related to the main policy changes sought by the Government. In effect, quality management would become one of the mechanisms for generating change in the service and would be

embraced by a wide range of managers, as borne out by the number of articles in the professional and quality journals (for example, Kelly and Swift (1991); Ward (1991)).

Total quality management initiatives

The final seal of approval in the rise of quality management in the NHS was gained in 1989 when the NHS Chief Executive, Duncan Nichol, wrote to all district health authorities and required them to have programmes of quality assurance in place by the end of the year (NHSME, 1989). Following this letter, the DoH began piloting TQM in 17 district health authority demonstration sites. In introducing the TQM initiatives the approach to quality chosen by the DoH as a mechanism for generating change related directly to the main policy changes sought by Government. These were, the strengthening of senior management and involving doctors in the management of the service, achieving value for money and placing greater focus on patient choice and involvement.

TQM was seen to have particular relevance for the NHS, where traditionally the dominant culture had been to view the individual professional prescribing for and treating the individual patient as a unique set of problems to be solved. Professionalism was primarily individualistic, whereas planning and organisation are intrinsically collectivist. The TQM projects sought to promote managerial approaches to quality, with emphasis on requirements and standards where measurements of non-conformity could be established. This also requires a shift from individual altruistic and unilateral relationships between doctor and patient, towards the empowerment and participation of the patient as an equal partner in the process of achieving their own health goals (Joss and Kogan, 1995).

Although the process of implementation differed across sites, most followed a similar pattern. These included: the establishment of a senior management group, chaired by the Chief Executive to drive project activity; the appointment of a manager with specific responsibility for quality, a staff training programme using both internal and external trainers; the employment of management consultants (from the business sector) to advise on implementation, and the establishment of a basic philosophy and

common definitions of quality. Specific activities were then identified with multi-disciplinary groups meeting to work towards continuous improvement of a particular aspect of the service.

The projects which commenced in late 1989 ran for three years until 1993, with a progressive reduction in the level of activity from 1992 as the *Working for Patients* reforms (DoH, 1989) increasingly impacted on the districts and political priorities changed (Ham, 2000) resulting in reducing funding and support by the DoH. The sites chosen by the DoH were not necessarily sites where there were particular issues that could be addressed by a quality management initiative (Joss and Kogan, 1995). In fact, a range of factors triggered the decision to apply for funding for TQM projects, including preparation for trust status, district general managers with an interest in the principles of TQM, a desire to change the culture of the service, or simply pragmatic reasons such as DoH money was available. By 1992 some sites were already cutting back on their commitment, and making quality managers redundant. The decline in funding meant that the continuation of the projects was increasingly dependent on the commitment of senior managers. The reduction in posts or TQM activity was seen to send a powerful message to frontline staff that TQM 'was being put on the back burner', if not being abandoned altogether' (Joss and Kogan, 1995:87).

Evaluation of the TQM demonstration sites

With funding for TQM projects ending by 1993 and the results of the evaluation of project sites completed, it was clear, according to the findings of Joss and Kogan (1995), that most of the demonstration sites had failed to make significant progress in implementing the orthodox model of TQM. The evaluation team identified a number of reasons for the limited success of TQM. Taking the definition used by the team as its starting point for evaluating projects, TQM was seen as 'an integrated, corporately-led programme of organisational change designed to engender and sustain a culture of continuous improvement based on customer-oriented definitions of quality' (Joss and Kogan, 1995:150). Given this definition as the starting point it was seen as essential that the following features were in place at each site if the progress was to be achieved: that senior management demonstrated their commitment to, and

understanding of TQM; that there was a well developed and documented implementation strategy with clear objectives, timescales, action plans and review mechanisms; sufficient funding for TQM facilitators; a full structure for overseeing the implementation of TQM; the support of medical consultants; standard setting; comprehensive TQM training; recognition and reward for progress achieved; and changes to organisational structures and systems using the principles of TQM. Although Joss and Kogan (1995) are cautious about which factors were most significant, they see the word 'demonstrated' as most important, with respondents interviewed for the evaluation commenting on the difference between the rhetoric of quality and the lack of demonstrable commitment at local level. This could be seen in the gap between official statements of the DoH, communicated through upbeat promotional literature (NHSME, 1993) and the challenges of implementation in demonstration sites (Joss and Kogan, 1995).

Similarly, issues about the complex multi-professional nature of the service were identified by Joss and Kogan (1995). The culture of the service (which had evolved over many years with its unique knowledge base alongside complex relationships between different groups of staff) made it difficult to secure consensus on both quality criteria and organisational mechanisms for improving quality. That TQM would be challenged by the professional nature of the service was always likely where professionalism was characterised by autonomy and self-regulation, and where management control, particularly among the more powerful groups, was regarded with suspicion (Harrison et al, 1994). Furthermore the changes wrought by Griffiths (DHSS, 1983) and *Working for Patients* (DoH, 1989) had led many professionals to view further organisational change with suspicion and lack of trust (Hunter, 1996).

A range of further difficulties was identified by Joss and Kogan (1995). The relatively small budgets made available to NHS sites, although varying significantly between £45,000 and £250,000 for the duration of the initiative, compared badly with £1m a year for three years for similar projects in Post Office Counters and Thames Water, with workforces roughly equivalent to small NHS provider units. In fact, as early as 1992, Joss and Kogan found that quality managers in some sites were fighting to secure small amounts of funding to maintain training for key staff.

An additional difficulty was at all sites was the implementation of *Working for Patients* (DoH, 1989), that begun to impact on managers leading the TQM initiatives, who were also by this time members of directly managed units preparing for trust status. These units were keen to establish their own ways of working, and the resulting different approaches within a single district began to undermine the corporate approach to TQM inherent in the demonstration site initiatives. With the drive to implement the market reforms, districts began to fragment, and acute and community services (and in some cases ambulance services) in many areas separated as they established their own identity and budget processes prior to applying for trust status (Ham, 1999). Similarly, the influence of the market reforms introduced competitive behaviour into districts, which undermined the cohesive approach that had been experienced by managers prior to the implementation of *Working for Patients* (DoH, 1989).

A further element that destabilised the TQM initiatives was the introduction in 1991 of the *Patient's Charter* (Cabinet Office, 1991). This initiative was introduced by the Prime Minister John Major with the intention of providing accountability and standards in public services based on individual standards for different services. The thrust of the Charters was to ensure that managers and staff would focus on service standards and provide information on what patients could expect (Flynn, 1997). Importantly the charters had statutory powers which meant that the NHS had to comply with the requirements of the charter for the service .

In a review of TQM and Citizen's Charter, Morris and Haigh (1995) found that although both initiatives were concerned with challenging the status quo and were vehicles for change, and fitted well with the Conservative Government's intention to transform the public sector modelled on the more dynamic organisations in the private sector, they were nevertheless strongly divergent approaches. TQM was seen as a carefully planned approach to meeting needs through the design of processes that delivered a quality service to customers, whereas the Citizen's Charter was unconcerned with the design of services, and only emphasised the 'cost reduction and freedom from deficiencies' element of quality, and recompensing patients when providers failed to meet specified standards. In this way Morris and Haigh (1995)

saw the Charters as provider and not customer-driven, emphasising the detection of errors (quality control) in service delivery as opposed to the prevention of errors in the delivery system developed within TQM.

As far as managers and staff implementing TQM were concerned, the introduction of the Charter meant another quality initiative was now in competition for scarce resources, with the essentially quantitative nature of the charter requirements undermining the qualitative nature of the TQM initiatives. A further complication identified by Joss and Kogan (1995) was that the introduction of other initiatives took no account of the coordinated approach which was central to TQM, with no linkage between the new initiatives and existing TQM activities.

In a survey of 17 TQM sites, Nwabueze (1995) found a range of factors inhibiting TQM. First, a lack of personal involvement of senior managers, particularly at board level where financial and contract issues dominated. Second, a narrow perception of quality, based on professionally determined standards rather than the holistic approach of TQM. Third, a competing range of initiatives such as medical and clinical audits, the *Patients Charter* (Cabinet Office, 1991) and subsequently purchaser specification, which were antagonistic to the principles of TQM. Fourth, the culture of the NHS, including the hierarchical and stratified culture of the service, with the workforce divided and structured along professional lines and with structural factors inhibiting communication and resulting in a fortress mentality among staff. Fifth, turf wars between different departments for resources which polarised conflict between managers and clinicians. Sixth, apathy and a lack of commitment by staff, due to fear of losing their jobs, the continual process of reorganisation and the closure of units due to financial crisis.

A more fundamental criticism (Nwabueze,1995) is that only a change in the culture of the NHS would enable it to embrace TQM, and that the work in the sites researched suggested that the holistic approach essential to TQM was lacking and that it had been 'bolted on' to the existing culture with only limited progress at the end of the demonstration period. In making this claim Nwabueze is suggesting that culture change is something that can be accomplished in preparing the ground for the

introduction of TQM initiatives. Alternative perspectives on culture (Meek, 1988) suggest that it is not something that can be easily manipulated by managers, and that popular writings fail to fully recognise the complex nature of culture in organisations. How far it is possible to make the cultural shifts needed for the level of adoption of TQM in the NHS desired by Nwabueze (1995) remains open to question.

Further perspectives on TQM in the NHS

Other researchers similarly claimed that TQM had failed to meet its objectives, and argued that the definition of TQM adopted was too wide and encompassed virtually any approach to quality improvement, and was therefore presumably set up to fail (Ovretveit, 1994). Ovretveit claimed that the evidence from evaluations showed that it (TQM) had not been a success, and had resulted in considerable dissatisfaction and few tangible results. Although he acknowledges that there was insufficient evidence to state that TQM could work in the NHS, evidence from the demonstration sites reinforces the view that large-scale, top management driven (TQM) strategies adopted in the business sector were inappropriate for the NHS.

In discussing the failure of TQM in the NHS, Ovretveit (1994) identified four reasons. First, that the frequent changes of policy and directives which are a feature of the NHS require immediate management attention and undermine attempts to develop and sustain long-term strategies. Second, that the NHS is unable to secure the level of financial investment needed to support full TQM strategies, as Joss and Kogan (1995) had described in the commercial sites. Third, the simple notion of giving customers what they want is much more complex in the NHS than in commercial organisations, with customers representing a complex mix of patients, carers, purchasers and other interested groups. Finally, the multi-professional nature of the NHS was identified, where interest groups can effectively block change, and where the involvement of representatives of the professions is essential.

An additional perspective on TQM in the NHS is provided by Hart (1996), who researched the application of TQM to out-patients clinics in a general hospital. He comments on the difficulty of identifying the customer in a service, where customers and end-users are different. He also argues that satisfying the needs of one customer

may be at the expense of other actual or potential customers, with all the problems of rationing and equity central to the delivery of health care. This, he argues, is a recurring dilemma for the NHS, and a situation which is problematic in relation to TQM with its central focus on meeting customers' needs and expectations.

The second of Hart's criticisms, and here he confirms Nwabueze's (1995) concern, is the implementation of TQM in contending with a number of other initiatives that were concurrent in the NHS at that time. He cites, for example, medical and clinical audits, resource management and waiting list initiatives with 'TQM seen as another 'bolt on'. In other words, a set of procedures to be carried out in addition to the multiplicity of similar initiatives and where the 'total' of TQM gets misplaced' (pp 22–23).

But perhaps the most telling of Hart's criticisms concerns the wider problem of introducing TQM, with its origins in industries in the USA and Japan where the power of the workforce is relatively weak, in contrast to the NHS where high status professionals owe their allegiance to professional norms and reference groups, rather than to the management of the service. This takes us right back to the initiatives from Griffiths (DHSS, 1983) onwards which have been concerned with seeking ways to control and redirect the efforts of clinical staff. In this sense Hart sees TQM as another potential weapon in the armoury of the NHS management which has attempted to extend their span of discretion and control.

Reflections on quality and the NHS

What had changed in the 1980s to make quality such as issue? Why did the 1980s and the period prior to the NHS reforms suddenly see quality become centre stage in the NHS? Pollitt (1987), reviewing quality issues in the UK and USA, argues that quality had become high on the health policy agenda in both countries. He poses a number of questions, including, what forces were projecting quality issues into increasing salience? Pollitt saw economic issues in health care, both in the USA and UK, influencing the interest in quality initiatives. In the 1980s in the USA, the costs of health care were rising faster than inflation, with federal and state support for Medicare exceeding the budget estimates for the programme. Similarly, in the UK

there were warnings that even by the early 1970s a crisis was looming in financing health care, with annual increases in health care expenditure consistently outstripping increases in national income (Maxwell, 1981). The Government responded by cutting back the high growth rates in health care spending seen in the early 1970s, with only modest growth maintained between 1979 and 1985, but with the level of financial support becoming increasingly inadequate in the face of demographic changes and the rapidly increasing developments in medical technology.

Alongside economic changes, the power of the medical profession was also influential in how quality issues were managed in the NHS. In the USA, managerial control of health care through corporate institutions, and their concern to control medical activity that had significant financial consequences, was a major factor in clinical loss of sovereignty to the demands for greater financial control (Pollitt, 1987). In the NHS, in contrast, medical sovereignty had always been much greater and quality initiatives had made little impact on doctors' actions, with the potential to influence performance more circumscribed.

Although there were a number of centrally inspired initiatives in the NHS throughout the 1980s, Pollitt (1987), in his review of the origins of the early literature on quality, identified North America, particularly the USA, as the source of ideas for the market model of care, with its focus on cost containment and consumerism having an impact much earlier than in the UK. The twin forces of cost minimisation and consumerism in the USA drove the demand for quality assessment in the 1950s and 1960s and resulted in the development of professional standards review systems by the 1970s. Similarly, but somewhat later, it was the determination of the Thatcher Government to restrain public spending (allied with a suspicion of the professions and an enthusiasm for better management and the potential expansion of the private sector into health care) that led to the changes witnessed in the 1980s in the NHS. These changes would in turn attempt to make inroads into professional autonomy and introduce opportunities to develop quality management techniques.

TQM, and later the *Patient's Charter* (Cabinet Office, 1991) were examples of the growth of managerially led quality initiatives, with TQM being the most visible.

Klein (1982), writing at an earlier stage on the changes in the service, was prophetic in warning that it was necessary to be cautious about the impact of any one initiative. Klein saw the health policy arena as characterised by complexity, heterogeneity, uncertainty and ambiguity. Complexity in the range of professions involved in delivering service; heterogeneity in the variety of services provided; uncertainty in the absence of a clear relationship between inputs and outputs, and ambiguity in the meaning of the information which is available. All factors that he was writing about had resulted in the underdevelopment of monitoring and evaluation of quality in the NHS, and would dog the service a decade later when the TQM initiatives had almost run their course.

Although it is important to recognise some of the barriers to change identified by Klein (1982) the changes introduced during the 1980s were increasingly concerned to control the costs of health care, acknowledging that there were limits to the efficiency savings that could be made in non-clinical areas, and that the wider issue of clinical decision-making would begin to drive the later quality initiatives in the service (Ranade,1994). It was in the clinical areas that it was recognised that significant potential existed to redeploy resources from less effective to more effective therapies. Here would be the opportunities to link quality with efficiency, which would justify Griffiths' (1983) original concern that managers must take control of the service and that clinicians become involved in the financial management of the service.

Conclusions

This chapter has reviewed the growth of quality from its origins in manufacturing, through its transformation as part of the Japanese quality revolution, and eventually to the development of strategic management approaches that later become known as TQM. The popular writings of consultants and the promotion of the 'excellence' model would in turn influence the public sector, at a time when Government was promoting business approaches to the management of these services. The convergence of quality approaches and Government reforms, seeking to make services more efficient and effective, led to the TQM initiatives in the NHS. Although a number of demonstration sites experimented with TQM, the evaluation of the sites suggested that these had limited impact, with the complex structure of the

NHS, the power of professionals to resist change, and the pressures of a crowded reform agenda all being factors which undermined attempts to reshape the service through quality management initiatives derived from experience in the private sector.

4 Dilemmas of Strategic Management

Introduction

With the changes that began to impact on the NHS following the Conservative Government agenda for the public services in the 1980s, the role of strategic management became more important. The earlier focus on strategic planning in health care was superseded as the Government, seeking ways of ensuring its policies were implemented, placed particular responsibilities on the newly appointed district general managers and their senior management teams to introduce changes in the service. These would reflect the recommendation of the Griffiths report (DHSS, 1983) that a more committed style of management was required, with managers accepting direct and personal responsibility for the development of the service. This would later be reinforced by *Working for Patients* (DoH, 1989), with its market imperatives requiring even more radical change in the service. This chapter will examine some of the particular demands strategic management made on the service during this period of rapid reform, specifically in relation to the role of senior managers, as they strove to implement the Government reform agenda.

Defining strategic management

Before examining some of the issues concerned with managing strategy in the NHS, it is useful to define what is meant by terms such as 'strategy' and 'strategic management', as this will enable a more informed discussion of the activities undertaken in the NHS. Strategy is concerned with the long-term direction of an organisation, where senior managers take action to create some advantage for the organisation. This is achieved through the management of resources, in response to the changing environmental pressures or trends, in order to meet internal and external stakeholder expectations (Johnson and Scholes, 1999). The actions involved in strategy-making have traditionally been associated with the deliberate top-down formal process, although this perception of strategy is changing following Mintzberg's (1990) concept of an 'emergent strategy'. This concept challenges the notion of deliberate strategy formation and argues that a series of actions converging into a pattern that are recognised and legitimated by senior management also have the qualities of strategy, although a combination of the deliberate approach with

flexibility and organisational learning can create a relationship that falls between the two positions (Pettigrew et al, 1992).

Turning to strategic management, it is recognised that this is a relatively recent import into the NHS, with a shift from the 'focus on policy to one of strategy, which implies a greater concern with securing action around espoused policies' (Pettigrew et al, 1992:19). The expectation is that senior managers in the public sector are now 'expected to lead their organisations in a particular direction, and that strategy is the instrument that enables them to do that' in order to ensure short-term survival and ideally long-term development (Joyce, 1999:1). It is clear that strategic management differs from other aspects of routine and operational management due to the complexity arising out of the non-routine nature of organisation-wide issues, the analysis of the strategic position facing the organisation, choices about courses of action and planning how the strategic choices are to be put into effect through implementation processes. (Johnson and Scholes, 1999). It is in public sector organisations such as the NHS that this process is likely to be more complex, where the influence of professionals produces constraints on the service which can differ from strategic management in industrial organisations, and where the results of strategic change initiatives can be extraordinarily difficult to accomplish (Garside, 1998).

Shifting approach to strategy in the NHS

Strategic management was relatively new to the NHS in the 1980s with systematic attempts to develop priorities assuming greater importance (Harrison et al, 1990), although there had been concerns as early as the 1970s among policy-makers over the gap between policy and its implementation. Throughout the 1980s there was increasing interest in managerial efficiency as part of a wider Government concern to strengthen the service's ability to transform itself. The successive attempts to reform the management of the service were also concerned with policy makers achieving greater control over the strategic direction of the service, whose slowness of response had frustrated the Government. The Griffiths report (DHSS, 1983) was an early example of this, with the recommendation that there should be more coherent

management processes throughout the service, in order to achieve the changes regarded as necessary by the Government.

Although strategy had been in and out of fashion in the NHS during the previous 20 years, it saw a revival in the form of strategic management from the mid 1980s in order to prepare for the major changes imposed on the service by Government policies (Elcock, 1996). Increasingly the NHS would witness the transfer of private sector techniques into the service, with senior managers encouraged to review their organisation's activities in relation to the changing environment of the NHS, and analyse the strengths and weaknesses of their organisations as they begun to imitate the private sector more closely (Stewart and Ranson, 1994).

This would also be the period in the history of the service when senior managers were increasingly required to make strategic choices from among the many initiatives emerging from Government as the service was driven ever more relentlessly towards commercialisation. It would in turn create an enormous pressures on senior managers to respond to changing relationships with a range of external organisations (NHSME, regional health authorities, local authorities) and the service's numerous stakeholders, many of whom would contest the direction of the service demanded by Government (Mohan, 1995). Managers also needed to respond to the increasing demands for improved performance, particularly in areas such as customer care and the quality of services, which would take on more significance as the internal market for health care took hold as part of the *Working for Patients* reforms (DoH, 1989).

In spite of the clear direction of Government policy, and the remit for senior managers to reshape the strategic future of their services, the importation of strategic management in the service was far from straightforward. Two particular dilemmas faced senior managers as they crafted the new strategies for their service. The first was how to manage the sheer number of policy initiatives thrust on the service at any one time, and which increased significantly in the 1980s as the Government placed unrelenting pressure on the service to achieve its economic goals for the public sector. The second was the matter of NHS workforce which was highly professionalised and was likely to have firm views about any future direction of the

service, particularly one where the administrative ideology of public service was threatened by managerialist and marketisation processes (Ferlie, 1999).

Implementing national policies

Despite an increase in management influence, which had grown since Griffiths, policies could still fail at the implementation stage. One of the main factors undermining implementation is the sheer number of policies that are required to be implemented at any one time, and which can lead to priority overload and conflict between different initiatives, with some policies receiving less attention than others (Ham, 1999). This situation was also reinforced by the DoH which sent out signals that some policies had greater priority than others, with politically sensitive policies attracting more Government interest and the expectation that districts would comply with policy guidance.

This situation had considerable consequences for the strategic management of the service, as senior managers are always highly sensitive to the political importance of different policy initiatives, and to which issues to allocate scarce time and resources. How far policies get turned into local strategies is dependent on the priority given to them, how sensitive they are in political terms and whether there is strong pressure from the Government through bodies such as the NHSME. This is particularly the case with Executive Letters which are the means by which Government describes what local services were expected to carry out. Although some letters were prescriptive and specified procedures that must be implemented, others were only advisory and allowed scope for local interpretation (Ham, 1999). Researchers, such as Korman and Glennerster (1985), go even further, stating that some policies were not intended to be implemented and no one expects them to be, and therefore civil servants in the DoH do not strain themselves too hard to achieve results as they recognise some policies are purely symbolic, with reforms becoming part of a routine which is stronger in talk than in action.

This approach to policy is further complicated by the various bodies, such as regional health authorities and district health authorities, whose remit is to ensure that services are provided in a way which is consistent with national policies and priorities, but

which also have policy-making responsibilities in their own right and make decisions about priorities from amongst a range of policy initiatives they receive from the Government (Ham, 1999). Consequently policy initiatives have to negotiate an extraordinarily complex network of relationships, power and influence (Fallon Inquiry, 1999) that exemplifies the NHS, and which they must pass through to progress to local implementation.

This was certainly the case with the quality management initiatives in the late 1980s when circulars from regional health authorities (for example, SWTRHA, 1988) and executive letters from the NHSME (1989) began to land on the desks of district general managers. Although Government was keen to influence the extent to which quality would become a higher priority in the service, this had varying impacts at district level, dependent on local interest and management effort. In contrast the implementation of the *Patients Charter* (Cabinet Office, 1991) was much more successful with its statutory basis in law and requirement that all districts (and later trusts) complied with the performance indicators on their service's response times.

Clearly this situation meant that managers had to make decisions about how far to pursue a particular initiative and whether it was possible to build a sufficiently strong coalition around that initiative (Bennett and Ferlie, 1994). This presents challenges in terms of strategic management, and whether there is sufficient support for the promotion of a new policy initiative, particularly where there is awareness among individuals and groups that non-compliance (with a policy) carries little risk, particularly if the DoH sends out equivocal signals about the policy. This is doubly reinforced where the independence of some professional groups, particularly doctors, means that there is no guarantee that policies will be carried out (Ham, 1999). All this points to the complex web of relationships that exist between the different parts of the service, which policies have to pass through, and in turn seek the support of sufficient numbers of managers, professionals and other staff to stand any chance of successful implementation.

Where policy initiatives are seen as important to the service and dependent on the level of commitment, senior managers can then develop their strategy for the

implementation of the policy, leaving it to operational managers to undertake the detailed activities with their staff to meet the policy objectives. The problem is that strategic management is seen as primarily concerned with organisational structures and control systems (Johnson and Scholes, 1999). These aspects of strategic management receive particular attention, because they focus on the actions of senior managers as the agents or controllers of change, but leave staff responding to the systems imposed upon them from above. This top-down view of change highlights the dangers of assuming that changes in structures and control systems will subsequently change behaviour. Although there may be conformity to the new structures and systems, staff will continue as they did before the change on a day-to-day basis, particularly if they believe their professional judgements outweigh those of management (Harrison and Pollitt, 1994).

The difficulty that strategic managers face is that their attention is inevitably focused on the *overt* aspects of the service, for example, strategic objectives and plans, and changes in management structures and systems. Whereas it is in fact the *covert* aspects of the organisation, which involve all those subjective and qualitative elements which are essential for the day-to-day maintenance of the service, which are more problematic to observe, more complex to measure and more difficult to influence. These areas, including trust and attitudes, are essentially concerned with the deepest layer of the culture of the organisation, with far more known about the overt than the covert organisation (Caple, 1990). Much senior management action is concerned with the measures of effectiveness 'above the waterline', whereas the covert is much more difficult to change. Nevertheless, the success of many major changes, such as quality management initiatives, depends on shifts and changes in the covert organisation. Although senior managers may have well-developed strategies in response to policy initiatives, these may be far removed from the preoccupations of other people in the organisation. Those affected by change often have a very different vision of the changes compared with the strategists (Johnson and Scholes, 1999).

People leading change

Studies of strategic management in the NHS (Pettigrew et al, 1992; Bennett and Ferlie, 1994) have identified the importance of key people who can lead change, with

the leadership of change less to do with the heroic or macho manager, but rather the more subtle and pluralist approach to leadership, which could mean one person or a small group. What both of these studies identified was the critical role of continuity, and the need for stability in the management of strategic change. Pettigrew et al (1992) identified the unplanned movement of key personnel draining energy and commitment from the change process, with the risk of regression, and successors having to start again in a less receptive context. The ideal is to ensure that key change leaders stay in position long enough to see the change through, and that their successors share the same value position and vision as their predecessor.

Both Pettigrew et al (1992) and Bennett and Ferlie (1994) stress the importance of the strengths in a diversity of leadership which is collective, complementary and multi-faceted. This meant that leadership includes frontline staff who demonstrate commitment and skills in the development of services. It is here that personalities and skills are more important than formal status or rank in the organisation. The evidence of this was seen in services studied by Bennett and Ferlie (1994), where a wide range of staff were successful change agents, confirming the need to broaden and deepen leadership in organisations. However, they make the point that staff who drive forward change still needed access to power centres to support their efforts. It is here that the role of the sponsor of strategic change is important (Bryson, 1995).

Bryson considers sponsors as typically senior managers who have the prestige and authority to commit the organisation to strategic change and to hold people accountable. This leadership is particularly important, according to Bryson, where the organisation itself is required to change as a result of strategic decisions. Sponsorship does not mean detailed involvement, with sponsors of strategic change unlikely to be involved in the day-to-day activities of the process of change – that role falls to the 'product champion' who is crucial if significant strategic change is to succeed. Product champions are identified as 'people with particular personal characteristics, entrepreneurial skills and leadership qualities which enable them to play major roles in shaping the structure and content of service delivery' (Bennett and Ferlie, 1994:87), and who are comfortable working on innovations in what can be uncharted territory. They are, according to Peters and Waterman (1982), people with the ability

to take responsibility for converting ideas into actions. They are the 'doers', which is in their view the key attribute of the product champion.

Of course, the motivation for choosing to take on the role of product champion is likely to be highly personal, with some individuals sensing the importance of new and emerging issues, with a vision and the potential to drive forward change. On the other hand there are the 'climbers', who emerge when new initiatives surface with funding available for development which can provide opportunities for individuals who are at an early stage of their career. These are individuals who hope to make their mark, and use a new initiative to gain a toe-hold on the career ladder. A less effective category of individuals associated at least temporarily with strategic change are the 'management butterflies' identified by Bennett and Ferlie (1994) – those who flit in and out of the change process and fail to demonstrate sustained interest and commitment

The role of professionals in strategic change

Although the NHSME had the responsibility to translate Government policies into plans and priorities, this did not necessarily ensure that policies were successfully implemented. Policies can easily be modified during the course of implementation, as local staff from non-executive members through to individual professional staff make decisions based on their own interpretation of what is appropriate for the service. One of the particular features of the NHS is its employment of large numbers of highly trained professionals who have strong expectations about being consulted, and participating in decisions about how the service should change – with consent likely to be withheld from those changes they do not agree with (Joyce, 1999). As Malone-Lee (1981) observed, the NHS is a diffuse organisation with centrifugal loyalties. For policies to be effective it 'requires at least the acquiescence of a large number of individual or interest groups whose first loyalty is not to the health authority or its senior officers' (p1448)

Throughout the period beginning in the early 1980s, staff witnessed a series of perceived assaults on the service (Cox, 1991) and attempts to shatter the historic paradigm of the NHS, exemplified by its public service ethos. This assault on the

service made it much harder for senior managers, with their reform agenda, to persuade staff that it was in their interests to embrace change. Throughout this period of intense reform there was also a close association between managerial reforms and financial cutbacks which were hard to dislodge in the minds of staff, with no surprise that managerial overtures were viewed sceptically (Pollitt, 1990). The years prior to the *Working for Patients* (DoH, 1989) reforms when the service experienced its worst financial crisis, were a period of significant retrenchment and cutback, which became associated with the new management styles and coping strategies of general management (Flynn, 1991). This 'cutback management', in the view of Flynn, made it 'more difficult than usual to maintain consensus, promote innovation and reward enterprise' (p217). Yet this was just the time when Government was increasing pressure on general managers to manage strategically and transform their service, but in a climate of contracting resources and low morale.

The pressures on the service at this time were immense, with districts expected to reduce costs and expenditure, and regulate clinical activity more closely (Flynn, 1990). Although this agenda increased managerial controls over the service, and provided managers with the opportunity to extend their influence over clinicians and other professional groups, it also meant that professionals were less than enthusiastic about new initiatives such as resource management where clinicians and other professionals would take on budgetary responsibilities (Ham, 1999), and the subsequent TQM demonstration sites concerned with improving customer care and service quality (Joss and Kogan, 1995).

Managerial–clinical relations

The extent to which there is an effective relationship between managers and clinicians is seen as particularly important by Pettigrew et al (1992), whose study of the implementation of general management in district health authorities identified this as one factor likely to support receptivity to change. Their research found considerable variation in the quality of relationships in different districts, with managers responding differently to the importance of relationship-building as part of their brief. Because of the crucial nature of this relationship, the extent to which managers involved clinicians and identified their needs in building a climate of trust

and effective communications was seen as significant. On the other hand, where clinicians had gone into opposition to management they were seen to exert a powerful block on change.

Nevertheless Pettigrew et al (1992) found grounds for optimism, particularly where managers had made a concerted effort to understand what was important to clinicians and where hybrid roles (clinical and management roles) had developed, and some of the negative stereotypes had been broken down. Those clinicians who had roles on executive boards and thought managerially and strategically were seen as critical to the change process, with managers needing to foster and encourage good relationships and avoid driving them into opposition by conflicts over trivial issues. It was recognised that this sort of activity required considerable management acumen, with deals struck and incentives offered, whilst managers remained true to their strategic objectives. In spite of these efforts by managers, relations were not necessarily stable in all districts, with some spiralling up and down, leading to the risks of soured relationships and the attendant problems of rebuilding them again.

The focus on culture

It is the limit to top-down strategic management which has led managers to seek ways of influencing the culture of their organisations, spurred on by a movement that began with the work of Peters and Waterman (1982) and their promotion of the notion of culture as the dominant and coherent element in excellent companies. To achieve 'excellence' in organisations Peters and Waterman argued that leadership, particularly transformational leadership, was essential. This form of leadership placed emphasis on creating meaning and purpose for staff, shaping the values of the organisation, and acting as an exemplar to followers, as they 'engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality' (p83).

Further examples of the prominence of culture at this time can be found in the work of Metcalfe and Richards (1984) who argued that 'the accepted concept of management was too narrow and restricted to do justice to the full range of public management problems', and that 'political clout needs supplementing by cultural

changes which can sustain a broader concept of management' (pp452–3). This critique was one of the growing number that acknowledged the potential role of organisational culture in the management of change, although Metcalfe and Richards sensibly cautioned managers that broadening the meaning of management would mean overcoming some of the deeply entrenched attitudes among staff in a highly politicised service.

These concerns for culture change, promoted originally (as we have seen in the previous chapter in the private sector) would eventually take firm root in the public sector, and particularly in the NHS, as the Government moved the service towards a more commercial approach which would find its apotheosis in the internal market. The concern for culture and the potential it offered to transform the service appealed to many of the new cadre of general managers, with the opportunity of securing action around the espoused policies of that period (Pettigrew et al, 1992).

This growing interest in organisational culture during the mid 1980s was also fuelled by its potential, at least in the views of its adherents, to provide the tools that management lacked in persuading staff to commit themselves to the mission of the organisation, to respond more flexibly to the changing circumstances of the service and to the delivery of a quality service. Although this somewhat instrumental and prescriptive approach is challenged by Meek (1988) in a critique of culture management which argues that culture is not something an organisation 'has', so much as something an organisation 'is', and is therefore not an independent variable that can be 'created, discovered or destroyed by the whims of management' (p279).

Meek (1988) contends that the assumption that a corporate culture can be created in order to unite members for the attainment of corporate goals flies in the face of the experience of organisational life. In Meek's view, organisations are more likely to be arenas for dispute and conflict, with one of the main areas of conflict concerned with values. Organisations are seen as 'multicultural', with cultural conflict most likely in professional organisations such as hospitals where professionals give their allegiance to their profession. This can produce a conflict between the interests of the individual and those who manage the organisation.

The problems that many managers in the NHS faced was the very thing that Meek (1988) describes – a deeply rooted culture, described by Johnson and Scholes (1999) as the 'cultural web', with its representations of the taken-for-granted assumptions, or a paradigm of the service and the physical manifestations of the organisational culture. It is the influence of the paradigm which is seen to have important implications, both for the development of strategy and the management of strategic change. The NHS, according to Johnson and Scholes (1999), was a system fundamentally concerned with medical practice, with distinct power bases and a clear division between the clinical aspects of the service and its management, with management seen traditionally as trivial in relation to the clinical aspects.

The latter perception, held by many professionals in the service, severely limited the extent to which managers could influence the culture of the service and stemmed from the different interests and perspectives of clinicians and managers, making it difficult to establish harmonious relationships (Dopson, 1994). In research on clinicians' attitudes to management, Dopson claims that managers stress the virtues of interpersonal skills, enlisting the co-operation of others, and have an expectation that staff subsume their individual interests to those of the organisation, whilst being resource conscious and having long-term goals. Clinicians, on the other hand (and here the discussion concerns doctors, although this analysis could justifiably be extended to other professionals) work to short-term operational goals, make decisions based on the best available evidence, limit their social contacts with other staff, and do not usually receive any training in management or organisational skills until they are quite senior. In Dopson's study, medical consultants viewed the service as under-resourced and undervalued by politicians, and any involvement in management would have meant acknowledging that resources were totally inadequate to meet health needs. As one consultant put it: 'management was the one disease I did not think existed' (p35).

Consequently it can be seen that in the period since 1985, as external pressures built on the service, some district general managers adopted a more strategic approach to the development of their service. This was based on notions of transformational change, which did not provide an easy fit with the existing paradigm for the service

and challenged the taken-for-granted assumptions and 'the way of doing things around here' (Johnson and Scholes, 1999:76). Applying Johnson and Scholes's analysis to the NHS would mean that managers were trying to change the service in response to Government policy developed in the late 1980s, but that the degree of strategic change required was always likely to be beyond the scope of the existing paradigm and the constraints of the cultural web, with staff having to substantially change their long held assumptions and routines.

The extent to which organisational culture creates a receptive or non-receptive context for strategic change is supported by Pettigrew et al (1992). One of the difficulties facing researchers, as acknowledged by Pettigrew et al, is that culture is a difficult topic to study although fashionable in the service. From their research in district health authorities, they found that history played an important role in shaping the values of a service, creating expectations about what was possible. This could either be a weakness or a strength as the past was projected into the present, and confirmed Wilson's (1992) assertion that the internal context of an organisation will have strong historical roots that have developed and been sustained over a long time period. As a result, managing change will mean unravelling a great deal of that history, with its well-developed assumptions.

What Pettigrew et al (1992) did recognise was the tremendous energy that was required to effect cultural change, with programmatic change strategies having important weaknesses. They were more optimistic about the value of leaders who could act as role models as part of a wider diffusion process, and where action to change behaviour could precede subsequent attitudinal change. Where they did witness effective cultural change, for example, was in the response to HIV/AIDS in some district health authorities, with ad hoc groups of committed staff from different backgrounds, with high energy and a strong value base, able to introduce innovations and develop a strong sense of achievement. However, the culture in these services was seen to have emerged organically, rather than having consciously been created by culture change programmes.

Throughout the period, following the introduction of general management, there was a concerted attempt by senior managers to change the culture of the service, inspired by the popular business press (Huczynski, 1996) which promoted culture change as a panacea for managers seeking solutions to strategic dilemmas. With the benefit of hindsight this can now be seen as over-simplistic, based on assumptions about the power of managers and the malleability of organisational cultures. Senior managers in all public services at this time were in the business of re-defining their services, in response to Government ideology, but as Butler and Wilson (1990) have argued in reference to the voluntary sector, managers had the sensitive task of meeting the challenge of strategic change, without destroying the altruism and commitment of staff. A sentiment that applied with equal force to the NHS.

The challenges faced by senior managers and alluded to by Butler and Wilson (1990), would intensify as the pace of the reform agenda increased towards the end of the decade. The reforms would bring more clearly into relief the tensions between the public service ethos of the NHS and the commercial ethos that was playing a more significant role, tensions which senior managers were required to meld together (Hunter, 1996). It was the clash of the two cultures which Hunter felt was at the root of the instability and low morale evidenced in the service at that time. His analysis concluded that the introduction of private sector practices into professional areas of work would replace the high-trust relationships, which had been traditional in the service, by those of low-trust, with the emergence of suspicion and defensiveness in organisational relationships. This analysis is supported by Wilson (1992) who argued that excessive competition and commercialisation would be more likely to stifle flexibility and innovation.

Programmatic change strategies

In identifying a rival to culture as a means of organisational transformation, Wilson (1992) sees total quality management fulfilling that role, and states that it is difficult to encounter any medium or large organisation which has 'not already installed some variation of TQM as a cornerstone of its transformation' (pp 92–93). The 1980s saw a distinct shift towards the introduction of programmatic change strategies, with TQM one such example. What any programme of change offers, according to

Wilson, is a plausible strategy of change, with a specific goal achievable through a series of planned steps. For the NHS, one of the first attempts to change the culture of the service in the direction of quality-based values, was put to the test in some TQM demonstration sites using a programmatic change strategy.

What many organisations are led to believe, according to Dawson (1994) in his description of research in the manufacturing sector, is that TQM is a 'quick fix' package to be purchased, rather than concentrating on the transformation of the organisation's operations. He sees organisations misled by 'flashy presentations and snappy illustrations', rather than concentrating on 'solving people problems' and 'picking the eyes out' of proven techniques and using them intelligently' (p71). TQM is seen as prone to hype, faddism and consultant-driven claims which Dawson believes have influenced the spread of this management technique.

The TQM sites were susceptible to some of these problems, as they relied on consultants to develop training devices which offered staff, unfamiliar with the world of quality management, a step-by-step guide that would give confidence that the process of implementing TQM would be successful (Huczynski, 1996). Eclectic models of quality (loosely formulated on the work of Deming and Crosby) were introduced into services and bore many of the features of the programmatic change models (Wilson, 1992). In discussing programmatic models, Wilson (1992) cautions against the 'recipe-book thinking about change which detracts from the complexity and necessary analytical sophistication for characterising change' (p3), where assumptions are made about the potential of staff training to fundamentally change services through brief exposure to quality improvement techniques based on step-by-step guides (for an NHS example, see Koch, 1991). This view is reinforced by Kanter (1985) with her comment on the – 'imposition of mindless formulae for action – giving people a set of role models to go through that have worked somewhere else or have been specified in minute detail' (p25). These can prove ultimately unhelpful as they promote generalisable templates for change based on examples of 'success' in other organisations (Wilson, 1992).

With these cautions in mind it is important to examine some of the other tensions inherent in programmatic approaches to change. One of the main difficulties identified in these approaches is that they can be insensitive to the local conditions of the organisation, and attempt to impose a template on a service which may be inappropriate. Research by Butler and Wilson (1990) on strategic change in voluntary organisations found that 'the heavy hand of history and organisational ideology' was able to frustrate leaders who introduced initiatives to improve the effectiveness performance of their services. In circumstances reminiscent of the NHS, Butler and Wilson describe the frustration of leaders with their new found strategic autonomy, confounded by an organisation which tenaciously clings to its old ways of doing things and effectively blocks the new leadership's change initiatives.

When this happens, managers can be lured into trying a rapid succession of programmes in the search for the 'magic bullet' according to Beer et al (1990), although this can only exacerbate the problem, because programmes are so general and standardised that they do not match the realities of particular organisations. Programmes are also strong on buzzwords, so that 'quality', 'excellence', 'empowerment' and 'leadership' become substitutes for a detailed understanding of the organisation's needs (Beer et al, 1990). A further difficulty created by change programmes is that they can take up energy that is needed to solve more pressing organisational problems, and this is one reason why many managers do not support such programmes, even when they acknowledge that the underlying principles are sound.

These concerns echo the experience of the TQM demonstration sites which were implementing the new initiative at a time when the service was quickly becoming submerged under the pressures of implementing *Working for Patients* (DoH, 1989), with senior managers' priorities focused on creating the directly managed units which would later become separate trusts. The issue is of one set of initiatives overwhelming the previous set. In some districts supporting strategic change discussed by Pettigrew et al (1992), specific attempts were made to insulate change programmes from the short-term pressures which drained the energy of participants.

These limitations of programmatic change are reinforced by problems identified in a survey of senior managers (Wilson, 1992). Although the managers identified a series of problems with TQM programmes, there are some particular issues which resonate with the difficulties experienced in the NHS. These included: the intangible benefits of TQM, (seen to be effective in creating a wide range of activity but much more difficult to measure in terms of benefits to the organisation) and the sectional interests of programmatic change approaches (with TQM creating its own evangelists who can become fanatical supporters, but which leads to fragmentation in a service between those who support a programme and those who are less enthusiastic). Further, TQM programmes can actually make things worse for an organisation – particularly where there is insufficient 'slack' to provide the resources a programme needs. For those organisations which are close to crisis (and the NHS was clearly in this situation in 1987/88), introducing change programmes offers little opportunity to enable a programme to work. Finally, there is evidence from large-scale evaluations that such change programmes have mixed results, as they are mainly derived from manufacturing organisations and this experience does not translate directly into public sector organisations (Joss and Kogan, 1995).

The message that emerges from the evidence of programmatic models of change as a means of strategic change is that a blanket strategy is undesirable, particularly if it is one where the model promoted in the service has clearly been developed in a different context (Hart, 1995). It is argued by Wilson (1992) that if programmatic change models are to be 'anything other than a general vocabulary of organisational improvement' (pp 99–100) then it is important to be able to adapt programmes to the highly differentiated needs posed by different types of organisations. This is doubly important in the case of the NHS with its deeply rooted organisational culture and well established structures and processes which have evolved over many decades.

Sectional interests and limits to diffusion

The final area for discussion, and one that has connections with the role of product champion, is concerned with sectional interests (Wilson, 1992). Any change programme can create 'evangelists' who can experience a 'road to Damascus' conversion in their championing of a particular change process. The risks this poses

concern the fragmentation that can take place in an organisation between those who support a change programme and those who view it less enthusiastically (Wilson, 1992) and as a consequence limit its diffusion beyond project sites.

The problem of diffusion is discussed by Pettigrew et al (1992) who argue that change relies on diffusion through 'pilot sites' or 'experiments', or other forms of diffusion strategy rarely spread to wider populations. Pilots may be successful on their own site, but their very success may generate tension and therefore rejection elsewhere. Pilot sites are also seen to fail because they are too small-scale or not sufficiently cumulative or because timescales are too short or the experiment has been under-resourced. Similarly Bennett and Ferlie (1994) argue that where groups are innovating there can be a tension 'between "exclusive" and "inclusive" approaches to the management of their boundaries with the wider system' (p113). Where groups retain their exclusiveness in order to maintain their distinctive identity there is a risk of them having little influence over the rest of the system (Bennett and Ferlie, 1994)

The dilemma posed for groups involved in innovative change processes is that of signalling a distinctive and culturally deviant image of itself to the wider organisation, with the consequence that this very distinctiveness means that the group has little influence over the wider system (Bennett and Ferlie, 1994). Where innovating groups move from an exclusive to a more inclusive position is characterised by Bennett and Ferlie as having more permeable boundaries, sharing cultural similarities and diffuse values, with a broad range of transactions and mutual exchanges with their environment and well developed networks and linkages within the organisation.

A further critical factor in the effectiveness of the diffusion change strategies is that of consistent visible leadership pressure (Pettigrew et al, 1992). This is seen as something that is persistent and consistent and links the tiers leading change with the front line where operational implementation is carried out, maintaining the bridge between the strategic and operational dimensions of change. It is the importance of enduring leadership that maintains commitment to change over time, recognising that

a weakening of the leadership position (for example, the loss of a key sponsor of change) can quickly undermine the change process. It is here that the changing priorities and attention spans of senior managers who originally championed the ideas for change are most critical.

Conclusions

This chapter has reviewed the growth of strategic management in the NHS as part of the Government reform agenda for the service. The service in embracing this change has witnessed a shift from the administration of Government policy to one where the service was required to adopt a more proactive approach to strategic management in order to speed up the rate of organisational change. In spite of this top-down agenda the complexity of the organisational structure and diffusion of power within the NHS does not necessarily ensure that policy is translated into local strategies. The role of those who lead change, whether they are in sponsorship or product champion roles, each play a crucial part in strategic change. Similarly, in a professionalised service such as the NHS, the role of clinicians particularly, is also central to the successful implementation of strategy, and the relationship between managers and clinicians a crucial aspect of any change agenda which impacts on the delivery of clinical services. The influence of organisational culture was also considered and its influence in creating barriers to change. Some of the limitations of change models based on programmatic techniques which attempt to fundamentally change working practices are also examined. Lastly, the risks associated with the diffusion of innovation are recognised, with the tensions between inclusive and exclusive positions, and the issues leaders need to consider when championing change.

5 Research Methodology

Introduction

This chapter describes the origins of the decision to research quality management in a district health authority, the choice of research location, previous work which informed the research aims, the choice of research methods and details of the research process. The chosen research strategy is discussed, examining the purpose of the research, followed by a discussion of the range of research methodologies available and those appropriate to the research aims, with an evaluation of the possible strengths and weaknesses of the chosen methods. The chapter then discusses the analysis of data and the techniques used to generate conceptual questions at the writing stage. Finally, the chapter discusses the validity of data in the context of qualitative research and considerations in writing up the case study in order to produce a accurate account of the events researched.

Why research TQM?

In the previous chapters we have seen that the introduction of TQM into the NHS was controversial. It was an approach to quality that made particular demands on the demonstration sites chosen by the DoH, because of its origins in the world of business management. Moreover, the particular environment of NHS organisations with their highly developed professional systems and methods of working made it difficult to transfer TQM effectively into these settings.

The decision to research TQM in the health service was based on 1) the researcher's interest in the management of change in public sector organisations 2) a former association in a non-executive role with the district health authority which was the location for the research, and 3) access to a number of senior managers and other staff who had participated in the TQM demonstration site. While not personally involved in the initiative, having left the district early in 1990 when changes to the appointment of non-executive members were introduced following the implementation of the *Working for Patients* (DoH, 1989) reforms, the researcher nevertheless had acquired considerable knowledge of the district during the period in the non-executive role.

In making the decision to embark on a study of the TQM demonstration site, the researcher's approach was shaped by his previous experience, both of the NHS and the potential choice of research methods that could be deployed. The researcher had a particular interest in the use of qualitative methods, particularly where this would provide the opportunity to undertake an in-depth investigation into the process of strategic change seen through the experience of a small number of key informants. The researcher had also used case study methods successfully in earlier research in the NHS (Scragg, 1986) and the current research was seen as an opportunity to develop a greater understanding of case study methods and further refine the skills developed at an earlier stage of the researcher's career.

In making early decisions about research strategies Yin (1994) identifies preunderstanding as an important factor, and the researcher's previous knowledge of the NHS as an employee and non-executive board member would be particularly valuable in this respect. The researcher's previous non-executive role and experience would also increase the potential to successfully access senior managers and professionals who had been involved in the TQM demonstration site. A further strength was the researcher's training and experience of interviewing which had been developed as a practitioner in the NHS and social services departments and later in contracted research projects.

Conceptual ideas which shaped the research focus

The researcher had a long-standing interest in a contextual approach to understanding change (Pettigrew et al, 1992), developed through earlier studies of strategic change in the NHS, and had used this model of change with managers in training and consultancy work. The opportunity to research strategic change in the NHS, using a contextual framework to analyse the change process, created the necessary motivation to pursue doctoral research.

In deciding to research the TQM demonstration site drawing on the work of Pettigrew, it is necessary to discuss the contextualist approach and the potential benefits it offers the management research student. In the words of Pettigrew 'there are remarkably few studies of change that actually allow the change process to reveal

itself in any kind of substantially temporal or contextualist manner' (1990: 268–9). This statement was the starting point for the research, in that much had been written about TQM in the health service, with lengthy accounts of its problematic implementation, but none had revealed in sufficient depth how the process of introducing and implementing TQM was managed, and the strategic intent of the DoH and the realities of local implementation (Pettigrew et al, 1988).

A conceptual framework offered by Pettigrew et al (1988) using the contextual model of change provided an opportunity to explore the TQM initiative, not as a discrete episode with a clear beginning and end, but rather as a strategic innovation which had its roots in the antecedent conditions created both in the external context of Government policy and the internal context of the district health authority. It was recognised that the TQM initiative would be shaped and moulded by these wider contextual factors which in turn would influence its potential for success. In researching strategic change in the district, it would be necessary to understand both the context and process of change and how these elements influenced each other. Pettigrew et al (1988) suggest that the demands on managers do not fit easily with simple notions of rationality and top down directives (particularly in services with a long history of professional autonomy), but require an understanding of the continuous interplay between the context, process and content of change and the skills of managing these different elements. It is insufficient just to have the 'correct' policies. An organisation's capacity to change is also necessary, as well as the ability to translate the change agenda into practice (Pettigrew et al, 1992).

In elaborating this approach to researching change, Pettigrew et al (1992) see the importance of a continuous interplay between ideas about the context of change. They distinguish between the inner context, referring to ongoing strategies, structures, culture and management processes through which change must proceed, and the outer context, referring to the political and social context of the district as well as policies and events at national and regional level in the NHS. The process of change refers to the actions, reactions and interactions of the those people involved in a proposal for change. Lastly, there is the content of change which refers to the particular area of transformation under study. The challenge, according to Pettigrew

et al (1992), is to make connections between the content, contexts and processes of change over time to explain the achievements of the change objectives.

A final aspect of the work of Pettigrew et al (1992) which influenced the approach taken in researching strategic change in the district, was the influence of the model of receptivity to innovation, and the metaphor of the receptive and non-receptive contexts for change. This model identified a series of 'signs and symptoms' of receptivity which were associated with more rapid change. In their original study of change in a range of DHAs, Pettigrew et al (1992) posed the question – why was the rate and pace of strategic change different across different DHAs?. The starting point for explaining the rate and pace of change was to be found in the interplay between the content, context and process of change, with the context the potential critical shaper of the process of change. They concluded that the management of change was likely to be contextually very sensitive and that there was no one way of securing change in such a pluralistic organisation as the NHS, particularly as general management itself was differently interpreted and effected in different DHAs.

In a later study concerned with the managerial response to HIV/AIDS, Bennett and Ferlie (1994) tested the original model of receptivity to innovation in order to confirm, develop or refute the model based on more recent evidence. Although this later study focused on the response to the emergence of the HIV/AIDS epidemic of the 1980s as opposed to the implementation of general management in the original research, Bennett and Ferlie nevertheless found that the original features of receptivity for change were present in their study, and suggested that the evidence from the managerial response to HIV/AIDS demonstrated that there were likely to be generic components to strategic change processes in the NHS.

Initial ideas that shaped the research strategy

Although the researcher did not start with an hypothesis about quality management and change in the NHS, some broad questions were formulated early in the research process which subsequently shaped the direction of the fieldwork. There was also a conscious attempt to allow some issues to remain vague and tentative until more insights were revealed from interviews and analysis of what appeared to be relevant

in terms of emerging concepts. The broad research questions were based on a review of previous research, and discursive conversations with two senior managers who had been directly involved in the TQM demonstration site which constituted the pilot stage of the research process. The information gained from the subsequent review of the literature sharpened the focus of the research and enabled a small number of statements to be formulated about TQM in the NHS which were used in focused interviews with informants. It was recognised that these would need to be modified and extended as the fieldwork evolved and issues emerged that warranted further exploration. What the researcher wished to avoid was developing too structured a stance, which would have meant a more selective approach to data collection, with the risks that a greater level of data reduction would take place. This in turn would rule out certain variables and relationships whilst focusing on others (Miles and Huberman, 1984).

Recognising these realities, the researcher kept the questions as broad-ranging as possible to avoid directing energy too far in a particular direction and consequently the risk of ignoring other variables and relationships, but at the same time keeping a realistic focus on what could reasonably be researched in the timescale available. With this framework established, a series of topics was identified, along with a set of questions which formed the starting point for the fieldwork, although these were modified during the fieldwork as new issues emerged.

Developing a coherent research strategy

In justifying the use of qualitative methods, Marshall and Rossman (1995) provide helpful guidance for the researcher in relating the purpose of the study, the research questions, the research strategy and forms of evidence collection. In an exploratory and descriptive research study (which the researcher categorises this study) the intention is to investigate a phenomenon, to document it and identify important variables, and in turn generate hypotheses for further research. This then leads to research questions which address the question – what is happening in this setting and what are the salient behaviours, events, beliefs, attitudes and processes occurring in the phenomena? These questions in turn lead to a case study research strategy and in-depth interviewing for purposes of evidence collection. This framework proved

invaluable to the researcher in providing the guiding principles on which the study was based.

Establishing the research questions

Following the review of literature it became increasingly clear that the focus for the research lay in revealing the multi-layered issues present in the district prior to and during the period of the TQM demonstration site, guided by a contextualist framework. Although the literature (Joss and Kogan, 1995; Nwabueze, 1995; Hart, 1995; Ovretveit, 1998) had identified a number of factors in the implementation of TQM in the NHS, they did not examine the detailed actions of those implementing change (Pettigrew et al, 1992). This then would be the starting point for identifying the broad definitions of the research problem, stated as empirical generalisations, which would guide the research process. In developing the research questions they were seen as contingent, and open to modification if they did not prove as useful as first envisaged (Remenyi et al, 1998). With the contextualist framework in mind, and so many potential factors influencing the implementation of TQM, there was the danger of too wide a research focus resulting in a study of little value. This was recognised at an early stage of the study as a main question and a small number of broad sub-questions were identified in order to avoid the trap of an unfocused study.

The starting point for identifying the research questions was to establish an overarching definition of the research problem which would be used to guide the research through all its stages. After many versions were discarded, it was decided that the main question – 'to reveal the process of managing strategic change in a district health authority through the implementation of a Total Quality Management initiative' would provide sufficient focus for the research. This was a broad overarching statement of the research problem that would in turn enable sub-questions to be identified (Remenyi et al, 1995). The set of sub-questions resulting from this statement were as follows:

- what were the antecedent conditions (prior to TQM) and how did these influence the decision to become a TQM demonstration site?

- how was TQM embedded into the district and what were the consequences for the service?

- what management processes were illuminated through the implementation of TQM?

- what was the impact of the wider NHS policies on the district during the period of the TQM demonstration site?

- what were the consequences of TQM through continuing quality activities?

Research design decisions

With the decision to research one TQM demonstration site in depth, and with the likelihood that the number of people interviewed would be relatively small, this pointed to a qualitative methodology within a case study approach, which would provide the framework for the research. The bounded nature of the study seemed to fit neatly within the idea of researching and learning what was important about the particular case within its own world (Yin, 1994), rather than the wider concerns and issues of quality management within the NHS generally. This approach also fitted well with the single case study of 'one population' (a group of managers and other staff associated with TQM) in one particular context (the district health authority) during a particular timeframe (1985–1993). The aim was to describe the case in sufficient depth so that the reader would gain an insight into the events that took place during TQM and could draw conclusions about the introduction of TQM into the NHS based on the tentative generalisations drawn from this study.

With the decision made to undertake a small-scale case study, and the unit of analysis identified, it was decided to focus on those managers and staff who were directly involved in the implementation of the TQM, recognising that this would be a relatively small number of senior managers, clinicians and training staff and each would offer their own particular perspective of the implementation. Similarly it was decided to make the period 1985 to 1993 the main time focus, with the understanding that events prior to TQM were likely to have been influential in the decision to bid

for funding and would need to be considered. It is likely that the particular changes in the district since 1985, when the influence of general management was introduced following the Griffiths report (DHSS, 1983), were a significant factor in the district's decision to bid for TQM funding. Similarly, although the project officially ended in 1993, the research would explore any subsequent changes that could be attributed to the TQM.

Decisions about methods

With the focus of the research decided, the next stage was to identify those research methods which would provide the most suitable tools for exploring the strategic change. The starting point for a discussion of methodology is the recognition that the choice of methods means that decisions will need to be made between those methods that attempt to achieve a high degree of rigour through the testing of hypotheses and theories, and those more naturalistic methods which attempt to describe the idiosyncrasies of the social world, and the use of 'soft' methodologies in order to understand that world (Hardy, 1985). This latter approach accorded with the development of a tentative conceptual framework, which acknowledged that social realities are complex, and warranted a loosely structured, emergent, inductively grounded approach to data gathering (Miles and Huberman, 1984). This approach also suggested that the most important research questions often only become clear as fieldwork progresses, and that the most meaningful settings and actors cannot be predicted prior to the fieldwork commencing. This appeared to be a useful way of working when exploring an under-studied phenomena or very complex social reality.

The decision to use qualitative methods was based on the assumption that to fully understand the reasons for becoming a TQM demonstration site, the management issues in introducing TQM into the organisation and the process of project development could be best understood using methods that would give the informants opportunities to 'talk' and describe their perceptions of TQM. In selecting the methods most appropriate to the research aims, Hardy's dictum resonated with the author's approach, 'when discussing the methods to use when researching complex issues, those that will provide meaningful insights by delving deeply into the social

and organisational life are necessary for the examination of the intangible aspects of process' (Hardy, 1985:115).

The decision to research TQM in depth also meant that qualitative methods would provide the flexibility and responsiveness necessary to elicit information about the complexity of implementing TQM and managing the strategic change process that was inherent in TQM (Joss and Kogan, 1995). It would mean refining the methods of data collection during actual fieldwork in order to explore ideas as they emerged from successive interviews with the managers and professionals. However, the objective would remain one of generating a rich picture to explain and understand the behaviour and actions of managers and staff during the period of the TQM implementation. Similarly, because the researcher had an opportunity to explore a number of sensitive issues, the quality of the research would depend on the relationship between the researcher and the informants, which could be achieved more effectively in a qualitative study (Remenyi et al, 1998).

Piloting research methods

When piloting research, where a separate study prior to main research is conducted to refine the research focus, Clarke and Causer (1991) suggest that piloting is not always appropriate in less formalised research studies. However they do advise that there is a need to be reflexive about the process of data collection and to ask oneself pilot-type questions of the data gathered, especially early on in the research process. This was the researcher's approach and, as stated above, 'conversations' took place with two senior managers who were central to TQM. Here it was possible to test out some of the issues that would be covered in later interviews and to begin refining a focused questionnaire for use with informants.

Taking the research beyond the published work

It is acknowledged that a considerable amount of research has already been published about TQM in the NHS (Joss and Kogan, 1995; Nwabueze, 1995; Hart, 1995; Ovretveit; 1998), but where the present research could add to that corpus of knowledge about TQM in the NHS was in a more inter-personal perspective on the process of implementing TQM in a district health authority. This is where the

researcher believes this research makes a further contribution to the understanding of the management of strategic change in the NHS and illuminates some of the issues that lie beneath the surface of the broad findings of earlier research through a more naturalistic and flexible approach to data collection.

In searching for a framework to meet the objective of a further contribution and understanding of TQM, the researcher was attracted to the work of Vaughan (1992) and her notion of theory elaboration. This is a 'process of refining a theory, model or concept in order to specify more carefully the circumstances in which it does or does not offer the potential for explanation' (p175). This recognises that theory will emerge during and after data collection as part of an inductive process. This approach is rooted in the work of Glaser and Strauss (1967) and is not involved in testing formal theory in the deductive positivist tradition, but in testing by comparison, with the data from a case study used to assess some stated theory. This seemed to offer a suitable framework for the research in that it would be starting from the theoretical propositions of Joss and Kogan (1995; Nwabueze (1995); Hart (1995) and Ovretveit (1998) about the TQM demonstration sites, with the current research exploring in depth one particular site in order to elaborate their theory. This would develop a bridge (Glaser and Strauss, 1967) between the macro level findings of Joss and Kogan (1995) and the micro level findings from one site. Another way of looking at this approach would be to see the large-scale evaluative research of Joss and Kogan (1995) as helpful in revealing differences between the TQM sites, with the current research illuminating the processes of TQM implementation that took place within one site utilising some of the strengths of the case study methods.

Strengths and weakness in case study methodology

A common question posed in case study research is 'what can be learned from a single case?'. The case study, with its emphasis on the study of phenomena in a real-life context, particularly where the boundaries between the phenomena (TQM implementation) and the context (NHS in a period of radical change) are not clearly stated (Yin, 1994) can provide sufficient justification. The use of a single case study is also supported by Remenyi et al (1998) who states that there is a growing acceptance that knowledge can be generated by research from one location, so long

as the researcher spends a considerable amount of time with informants and there is proof of careful triangulation of the evidence collected. Similarly, a single site is seen as adequate if case material is treated in a sufficiently generic fashion (Pettigrew, 1990). The researcher believes that this case study meets these requirements, with efforts made to ensure sufficient informants participated in the research and to ensure that multiple data sources were used.

Further support for the use of case study methods can be found where the researcher wishes to deliberately explore a contextual situation, avoiding focusing on a few selected variables, but dealing with the entangled situation between phenomena and context (Yin, 1994). The focus of this research concentrated on trying to understand the complexities of TQM implementation, starting with what was commonly known (from other studies of TQM initiatives in the NHS) and what was particular to the research location. An additional strength of the case study approach is the potential for the researcher to use many more data points and draw on multiple sources of evidence, with data converging in a triangulating fashion in what constitutes a comprehensive research strategy (Yin, 1994). This potentially rich source of data is ideally guided by the prior understanding of the theoretical propositions which provide a focus for data collection and analysis (management reforms; quality management techniques; a radical reform agenda and theories about organisational change).

In using case study methods the skills needed to be a good case study researcher are important. As Yin (1994) makes clear 'the demands of case study research can be greater than other research strategies as they make demands on both the intellect and emotions' with 'the continuous interaction between the theoretical issues being studied and the data being collected' (p55). During data collection unexpected opportunities arise which the researcher needs to take advantage of, rather than being trapped by them. This is much more likely where the researcher is using relatively informal data collection methods (for example a schedule of questions) and the parameters of the issues being studied are more fluid and open to comment and interpretation by respondents. This non-routinisation creates boundless possibilities

for the researcher and respondents to open up new lines of enquiry stimulated by statements or comments during the course of interviews.

Further guidance for the intending researcher which was found helpful in thinking through research tactics is suggested by Yin (1994). Firstly, the researcher should be able to ask 'good questions' and interpret the answers. This means knowing how to ask questions, using techniques common to many areas of practice where it is important to elicit information, particularly of the sensitive nature (qualitative sociology, counselling, social work, clinical case studies). Secondly, the researcher should be adaptive and flexible so that new situations are seen as opportunities rather than threats. Here the desire to learn as much about a situation as possible, without rushing to judgement is important in enabling the researcher to be flexible and responsive to encounters which suggest or generate new insights. Thirdly, a firm grasp of the issues being studied is essential, including a detailed understanding of the context of the issues and their relevance to the research, and at the same time avoiding over-involvement and 'going native' (Pettigrew, 1990).

Data collection issues

Gaining access is seen as the essential first step in the research process and a precondition to the research being conducted (Burgess, 1984). Although Gummerson (1991) considers access to be the researcher's number one problem, this was not found to be the case in this research. Access was straightforward as the researcher's former non-executive status facilitated access to senior managers and other staff involved in TQM. To some extent the DGM, although no longer having any managerial responsibility for many of the informants, nevertheless acted as an 'informal sponsor' of the research. He suggested names of managers who would be useful to interview and assisted in the retrieval of archival materials. Similarly when his name was mentioned to potential informants several volunteered to be interviewed as they felt a commitment to TQM and its aims with which he was personally identified.

Following perusal of archival and documentary material the researcher was able to identify a range of managers and other staff who had been involved in the TQM

demonstration site and these were approached initially by telephone and followed up by a letter that set out more formally the aims of the research. In approaching potential informants no pressure was placed on individuals to participate in the research. The researcher explained the purpose of the research (completion of a doctoral thesis) and made clear that the research was not sponsored by any organisation and was a result of the personal interest of the researcher to learn more about issues of strategic change and quality management in the NHS.

Although access proved relatively straightforward with most informants, this did not prove effective with all potential informants. In spite of a considerable number of telephone calls and correspondence over an 18 month period, the management consultant declined to be interviewed and would only deal with the researcher through a third person. The researcher believes this is a shortcoming in the research as it leaves a gap in the account of the TQM demonstration site in which the consultant played a brief, but significant role. This situation was ameliorated to some extent by the materials the consultant used in the district, a publication of his work with a former company on a quality improvement project, and information from another NHS site where he acted as consultant. These were made available to the researcher by an informant and enabled a reconstruction of the consultancy approach to be made. Similarly, informants who worked closely with the consultant were helpful in describing his work with the district and his influence on the direction of TQM. Three other potential informants, who were involved in project sites also declined to participate as they felt they were too distant from the events and had little to contribute, or had only a peripheral involvement with the demonstration site. One potential informant nevertheless suggested a colleague who had a greater involvement and this lead was followed up successfully.

Ethical considerations

In explaining the purposes of the research to potential informants the researcher was conscious of the need for confidentiality. All informants were assured of complete confidentiality with no identification of individuals in the thesis, and with an assurance that the taped interviews would not be used in a way that would identify individuals or be used by other researchers. Matters of confidentiality did create

constraints for the researcher as some managers had published accounts of their involvement in TQM in journals and newspapers. Similarly the DoH had published accounts of the progress of TQM demonstration sites which had illustrated the work undertaken in the district studied. Although this documentation was used as a data source it has not been possible to reference it in order to maintain confidentiality. The researcher was also provided with archival material (letters, memoranda and training materials) which were confidential to the district. In engaging in this research, it is recognised that the informants were investing the researcher with a high degree of trust when discussing their views of the TQM initiative and the research was undertaken in the spirit of a mutual commitment to confidentiality and respect for the views and interests of informants.

In spite of these pre-conditions for the conduct of the fieldwork, the issue of confidentiality was not raised as a major concern by informants, which may be accounted for by the time that lapsed since the TQM demonstration site came to an end, and the considerable transformation that has taken place in the NHS subsequently. A number of informants had left the service following the major reorganisation that had taken place in the service following the creation of NHS trusts. In fact, TQM was becoming less of a contemporary situation and any findings from the research would be used in a context that was distant from the original one (Adelman et al, 1984).

Sources of data

A variety of data sources was used, initially archive material held by the trusts which has superseded the district, including internal memoranda and minutes (some of which had been retained by informants privately), TQM training manuals and guides, and contemporary newsletters which contained information on the progress of TQM. Additional material in the form of evaluative reports, both external and internal were made available. The archival material was used initially to familiarise the researcher with the key events and the chronology of implementation. Another source of material in keeping with the 'grounded theory' approach (Glaser and Strauss, 1967) was the examination of contemporary journal and magazine articles which were perused and analysed to verify and supplement interview material, and suggest new

lines of questioning in subsequent interviews. The archival material retained by the district proved invaluable in suggesting areas of exploration about features of the TQM demonstration site.

Triangulation

To ensure the validity of the research, the researcher sought to triangulate the different data sources. Triangulation is a process of using multiple perceptions to clarify meanings and verify interpretations. It is acknowledged that no interpretation is perfectly repeatable, and that triangulation serves to clarify meaning by identifying different ways the phenomena is being seen (Stake, 1994). The main sources of data were interviews, supplemented by district archives and documentary materials. It is recognised that each of these data sources has its own strengths and weaknesses in relation to the research aims. A particular strength is the potential for seeing TQM in the NHS from different perspectives, and that those perspectives are used as a means of comparison and contrast and in turn lead to more rounded and complete research (Denscombe, 1998).

Focused interviews

The main sources of data collection was through focused interview with informants selected because they had been directly involved in managing or supporting some aspect of the demonstration site. Interviews were held with 23 informants, using a schedule of questions which formed the basis of an *aide memoire* used in interviews (see Appendix 2). The interview schedule was modified as interviews generated issues which merited greater exploration. For those staff directly involved in the implementation of TQM, the questions focused on their particular role and functions in the demonstration site. For senior managers, the questions focused on strategic issues and particularly the impact of change in the district and on key staff groups. In this way the focus of interviews shifted in response to the role and responsibilities of the informants, with each interview used as a building block to pursue particular issues as they emerged.

Each interview lasted on average from between 45 and 90 minutes and a tape recorder was used to record all interviews. Some informants were seen twice, others

were telephoned to check particular details or for clarification of issues raised in later interviews. The researcher was conscious that some informants had heavy commitments that inhibited the potential to explore some aspects of TQM in more depth. Consequently the researcher felt under pressure at times to focus the interviews as effectively as possible, whilst retaining the potential to explore issues tangential to the research focus which could lead to useful insights. This was a compromise that the researcher tried to overcome by using different data sources to verify issues raised in interviews, and by using subsequent interviews to clarify matters identified in earlier interviews.

None of the informants objected to the use of the tape recorder, although some informants asked for the tape to be turned off while they related a personal account or described the actions of an individual which they did not wish to be recorded. The researcher recognised that confidential statements required the tape recorder to be turned off when requested and assured the informants that these statements would not be recorded or used in the thesis. The researcher was also conscious of the need to maintain a commitment to safeguard the sources of evidence supplied based on ethical considerations of how research should be conducted (Remenyi et al, 1998). After each interview a letter or phone call of thanks was made, and this opportunity was used to confirm that the interviews would be transcribed and to request contact with the informant again to confirm details or explore a particular area in more depth if necessary.

Alongside archival data and interviews, a research diary was kept which was used for a series of jottings during the period of the research. The use of the diary was particularly helpful in combining notes made after supervision, useful insights from the literature, and observations made after interviews and visits to the service. This was also used in recording conversations from chance meetings with individuals who had knowledge of the TQM demonstration site and proffered their opinions (one of which turned out to be invaluable and led later to a full interview). Reflecting on the notes over a period of five years (the time taken to complete the research from registration to submission) this has provided a continuous record revealing the

different stages the research passed through, and the themes that arose at different points during the lifetime of the research.

Researcher's involvement with the research location

The researcher was conscious that his previous role in the district and contact with a number of senior managers and other staff had the potential for him to 'go native' and become too involved with the views of people he had worked with in the past and had respected for their views. The researcher kept Pettigrew's words in mind when interviewing informants, that 'researchers are in the perspective business' (1990:278). This meant actively seeking out different versions of reality, and being privileged to listen to all sides of the events being researched. The main concern of the researcher was to balance detachment and involvement and avoid over-identifying with any particular informant's interpretation or interest. The researcher recognised that in a large-scale research project, with for example a research team, different perspectives would be easier to achieve, whereas the lone researcher needs to be disciplined in their approach to achieve the ideal level of involvement and detachment.

Data analysis

After each interview the recording was reviewed several times to obtain a sense of the whole interview, including the main themes which seemed to be emerging. The researcher's aim was immersion in the data in order to become more fully aware of the world of the informants, and to enter the other person's frame of reference (Burnard, 1991). After this was completed the tapes were transcribed and read in detail. The purpose of this stage of analysis was to use the data to think with (Hammersley and Atkinson,1995) in order to identify interesting patterns and to ascertain whether anything surprising or puzzling emerged.

The analysis of transcripts followed the ideas of Glaser and Strauss (1967), and Strauss, (1987) with headings made of all aspects of the content. Such headings or 'categories' were freely generated. These categories were then reviewed and grouped under higher-order headings. At the second stage the intention was to reduce the number of categories by collapsing similar ones into broader categories. The

categories were then coded according to the list of headings, and all coded sections compared and grouped again in order to produce a final list of categories which would form the basis of the case study and the potential to relate findings to previous research on strategic change in the NHS. During this process the complete interviews were referred to and related to the wider context in which statements were made by informants (to avoid losing the sense of the interview and the informants statements). Throughout this stage of the data analysis the emphasis was on identifying issues, linking these with ideas from interviews, and relating them to previous research.

Validity of data

In adopting a qualitative approach the researcher was conscious of the argument that the 'scientific method' as a research strategy makes strong claims of reliability and generalisability, whereas qualitative methods can be regarded as inferior in this respect by those who adopt the traditional scientific approach (Remenyi et al, 1998). The qualitative approach on the other hand offers advantages as a research strategy where it is concerned with exploring the actions and behaviours of people in organisations. This can be difficult to discern in more traditional positivist approaches which do not capture the rich understanding of the behaviour being studied. In research that is primarily concerned with exploring organisational processes, qualitative methods can successfully reveal much more about how decisions are made, particularly where such approaches explore the meanings individuals attach to their actions. (Ferlie et al, 1998).

A further issue raised by the use of qualitative approaches concerns the accuracy of the information produced as a result of such methods. Researchers using such methods are vulnerable to the accusation that they can deliberately falsify information or at least be influenced by subconscious bias of their informants (Hardy, 1985). In order to overcome this potential weakness multiple methods were used. Interview transcripts were checked against documentary records (memoranda, reports and letters from files) and official publications (reports of the NHSME, Executive Letters to DHAs, publicity material produced by the DoH and the DHA). This triangulation of methods offered a number of advantages. It provided additional data as well as the opportunity to check the accuracy of statements made by informants, and also

provided contemporary information of the events, whereas interviews were conducted from a retrospective standpoint, although the intention was to recover some of the interests which produced different views at different points in time. Using this approach data collection and analysis were inextricably linked. The theory was grounded in the data emerging from it, rather than being imposed upon it (Glaser and Strauss, 1967). This approach has enabled a conceptual map of the territory, from a thematic analysis of field notes, to be constructed (Zuboff, 1988), with the intention that the final theoretical framework would emerge out of the data (Hardy, 1985).

Writing up the case study

In writing up the findings it was recognised that interpretation of data involves making judgements about what is significant and meaningful. At the same time there needs to be a clear relationship between the research questions and the findings. The intention was to retain the narrative where possible in order to identify the unique experiences of individuals involved, with minimal editing, except where this was necessary for purposes of clarity. Similarly it is recognised that differences in perceptions and opinions about events are important sources of data in themselves (Hardy, 1985). In order to capture the differing and conflicting viewpoints, quotations from interviews are used extensively in the case study chapters to illustrate the evidence collected (Denis et al, 2000).

One of the key issues at the writing stage is that of validity and the degree to which phenomenological research, which offers a glimpse of another person's world (Glaser and Strauss, 1967), is influenced by the researcher's bias and subjectivity when attempting to make sense of interview data (Burnard, 1991). In order to achieve a degree of verification of the evidence collected, the researcher checked the broad interpretation of the findings with two informants in order to ascertain whether the issues were understood and described correctly (Remenyi et al, 1998). This was a helpful process in that basic inaccuracies were eliminated and the findings presented a more faithful portrayal of events surrounding the introduction of general management and the implementation of TQM.

Conclusions

This chapter has set out the reasons for researching strategic change in the NHS, with a specific focus on the implementation of TQM in a district health authority. This was followed by a discussion of the conceptual ideas which influenced the research, particularly the importance of contextual factors and receptivity to change in studies of strategic management in the NHS. These ideas provided the framework which guided the research at an early stage, with a discussion of the decisions made in relation to research strategy, research questions and detailed design issues. The chapter then described the researcher's previous involvement with the DHA, and the potential this offered to access a group of senior managers and staff, and the opportunity for an in-depth investigation into the unfolding account of strategic change between 1985 and 1993. A justification for the choice of case study methods is made, with the recognition of the strengths and weaknesses of the chosen methods Lastly, the importance of rigour in the collection, analysis and writing up of the case study is discussed in order to achieve a faithful account of the implementation of TQM within a wider strategic change agenda.

Chapter 6 Antecedent Conditions: Under New Management

Introduction

This chapter, and the following two chapters, explore the events occuring in the district health authority from the introduction of general management through to the demise of the TQM demonstration site. Each chapter follows a similar format, with the first section outlining a series of themes which emerged from the data and which serve as a framework for an examination of the case study material. This is followed by the case study findings, and finally a return to the earlier themes, which are used to develop a dialogue between the empirical data and theory with the intention of revealing the complexity of organisational change

Themes and issues

This chapter explore the events occuring in the district prior to the introduction of the TQM demonstration site through a description and analysis of the antecedent conditions which have their starting point, for the purposes of this research, in the mid-1980s following the introduction of general management, including some of the key events which influence the district to bid for TQM funding. This chapter also includes information on the district health authority, highlighting some of the issues facing the service during the period researched.

The 1980s saw district health authorities operating in an environment where there was powerful and sustained top-down external pressure from Government on the service. These policies were designed to reshape the system of health care on more business-like lines at the same time as maintaining pressure on costs and resources, in what was perceived by Government as an inefficient and wasteful system of service delivery. These forces were in turn part of a wider historical movement that was questioning the very basis of public services themselves, leading to changes that subsequently came to be called the 'new public management' (Ferlie et al, 1996).

It is against this background that the events in the NHS unfolded as the service responded to these external pressures for change. The research location, like other DHAs at that time, was experiencing the consequences of the widening gap between

Government funding and increasing demand (Ham, 1999), and in spite of efficiency improvements, the financial crisis of 1987 exposed serious underfunding of the service (Ranade, 1994). These conditions offered a fertile ground for the introduction of general management, recommended in the Griffiths Report (DHSS, 1983) with newly appointed general managers who were expected to achieve greater efficiency through the vehicle of a more dynamic management approach which would motivate staff and facilitate organisational change (Ham, 1999).

Although general managers were appointed in a service where finance would be the main preoccupation, the limits of a crude value-for-money and efficiency gains approach (Ferlie et al, 1996) soon became apparent in the service. The early emphasis on cost efficiency would subsequently be seen as less important than value (Pettigrew et al, 1992) as a subtle, but important shift took place after the mid-1980s. This heralded the emergence of a human relations influenced approach to management, associated with the work of the 'excellence movement' (Peters and Waterman, 1982) which was apparent in the adoption of new management styles and which placed greater emphasis on culture as a means of pursuing innovation and change. For significant strategic change to take place, a cultural shift was seen as essential (Johnson, 1990). Evidence of change coexisted with older cultural and organisational forms in the research location, as the power of general management, legitimised by the Griffiths recommendations, was resented by some staff groups, contested by others, and ignored by the most powerful professional groups (Harrison and Pollitt, 1994).

Evidence from studies of this period of change in the service raised questions about how deep the changes had penetrated the service, with a number of studies suggesting that the degree of change was less significant than hoped by the new cadre of general managers. Change was not filtering down from the apex of the service to unit level (Ferlie et al, 1996). This highlighted the challenge of culture change which remained a complex issue in the research location, and less malleable in the pursuit of management ambitions that had been claimed by the more popular management writers (Meek, 1988). The culture being constructed by top managers did not necessarily replace existing cultures deeply embedded in the service, with their shared beliefs and assumptions (Johnson and Scholes,1999) that had developed over a long historical

timescale and were immune to managerial pressures, certainly under conditions that existed at that time. As Hardy (1994) makes clear, culture as a neutral tool that can be used to enhance organisational performance is essentially political and is not necessarily seen by all staff to be an advantage, and can limit attempts to manage the process of cultural change.

The aforementioned financial situation that threatened all DHAs in the late 1980s had its impact in the research location. National issues intensifed pressure on the district, and its particular pattern of demand placed heavy pressure on the service and kept financial matters at the forefront of management action. This situation, combined with a long-standing difference of interpretation between the district and the Regional Health Authority over the revenue budget and the redevelopment of an acute hospital site, affected relationships between the two authorities. This led to intense pressure on senior managers and their relationship with professionals, particularly clinicians as they managed the crisis. This situation raised issues of retrenchment and cutback management (Levine, 1979) and resulted in some of the early tests for the new general manager's attempts to influence the behaviour of clinicians who were the key resource allocators (Pettigrew et al, 1992). The financial crisis which increasingly impacted on the service in the late 1980s would set the stage for management–clinician relationships, as general managers more firmly grappled with the change agenda (Pettigrew et al, 1992).

In spite of the buffeting created by the financial resource problems in the service, managers can revitalise an organisation which is experiencing retrenchment. The evidence of strong top-down leadership using mission statements, explicit communications strategies and more intensive staff training programmes was evident in the service during this period, and demonstrates a move away from traditional administrative management to a much more active style of management which combines top-down and bottom-up elements (Ferlie et al, 1996). The DGM in the research location fitted the mould of the charismatic top-down leader who had a clear vision of the future. He was intent on shifting the focus from survival to excellence as part of an overarching goal that challenged interest groups who questioned change. This was done through the use of incentives, particularly the encouragement of bottom-up

initiatives around reputational management, that reframed retrenchment in a more positive light (Pettigrew et al, 1992) as part of a strategy of 'turnaround management'.

The search for excellence spawned increasing interest in quality, which had firmly arrived on the agenda of the service by the late 1980s. This occurred as a result of the Government seeking new ways of improving the effectiveness of the service following a period of squeezing the service financially which was beginning to have damaging consequences politically (Pollitt, 1993). The emergence of quality as an issue in the service, and new approaches transferred from the private sector converged in the DoH TQM demonstration sites introduced in 1989 in which managers, as opposed to professionals, would claim sovereignty over quality for the first time (Ovretveit, 1998). The availability of funding provided an opportunity for districts to bid to become demonstration sites, with the subsequent evaluation of the initiative suggesting that there were extremely diverse reasons for DHA's involvement with TQM. These reflected local preoccupations, but also limited understanding of the theories and concepts of TQM and the implications of introducing private sector models of quality into the NHS (Joss and Kogan, 1995). In the research location the invitation to bid for funding meant an opportunity to undertake further activity which would support the district's strategic change agenda, which in cultural terms still remained largely at the surface level, and had not penetrated the deeper recesses of the district's culture.

The District Health Authority

The district was established in 1982 following the *Patients First* (DHSS, 1979) reforms. It had a population of 240,000 and an annual revenue budget in 1985/6 of £90m. The district was in a coastal location with three large centres of population and a number of small towns and villages in its predominantly rural areas. The rural and suburban areas were relatively affluent in contrast to the declining coastal towns which contained a high percentage of older people and also small pockets of considerable deprivation, with associated housing and employment problems. The age structure of the district was weighted heavily towards older people, with 27% of the population aged 75 and above. This demographic structure meant that a significant part of the population were heavy users of health services. The district had a workforce of 4,500 staff, although it faced continuing problems throughout the

1980s due to recruitment problems, with high housing costs in parts of the district seen as a disincentive for staff to move to the area. According to internal documents, the district fell into the lowest 10% of staffing in ratio to patients served, both in indirect care and clinical staff, within the health region.

The district services included two general hospitals with over 800 beds and a small community hospital providing a further 110 continuing care beds for older people. In addition the district had two community hospitals with 54 beds, served mainly by general practitioners, and six health centres providing a range of primary care services, including general practice, community nursing and remedial therapies. The district also provided inpatient mental health and learning disability services, including day centres and community housing. The district was also the location for the management of the county ambulance service.

Throughout the 1980s the district was recognised to be one of the most underfunded in the region, in spite of the fact that it was treating more patients than the average for all districts, with a lower than average length of stay in hospital and cost per treatment (DHSS, 1988) – a situation aggravated by the slow implementation of the national funding formula introduced in the 1970s to reduce disparities in resources in different parts of the country (DHSS, 1975). Consequently the district was considered to be £17m below its target funding at the time of the TQM initiative in 1989. There was a difference in the perception of the funding crisis between the district and the RHA, which affected relationships between the two authorities for much of the 1980s and early 1990s. These financial pressures were exacerbated by a Government cost improvement scheme introduced in 1983 which required all districts to identify economies, and (later in the 1980s) the requirement to generate efficiency savings year-on-year as part of placing downward pressure on NHS spending.

The district also faced a number of major challenges from the early 1980s, including the need to provide services for people with mental health problems and learning disabilities who had largely been placed in services outside the district. The district was, as a consequence, under intense pressure to develop community-based accommodation for these neglected patient groups. The district had also been seeking to redevelop one of its

acute sector sites for over 15 years, and wished to reach an agreement with the RHA on this major capital development project. This would support improvements in the acute services which had become a victim of Government reluctance to fund capital development, and inertia on the part of the RHA across a number of areas relating to the financing of the service.

Implementing general management

The District General Manager appointed

Two years after the publication of the Griffiths Report (DHSS, 1983) the district appointed its Administrator as the District General Manager. He had joined the district coincidentally with the publication of the Griffiths Report, having moved from 'a much more high profile and dynamic district'. His appointment to the DGM post was evidence of the district and regional health authorities' confidence of his ability to lead the district, and the recognition that his appointment would mean a number of changes, including a more proactive style of leadership. He was seen as a manager who would motivate staff and create a more dynamic culture which would embrace the changes necessary to achieve the aims of general management.

> *He was seen as one of the lead general managers in the region. His strength was that he was very much a visionary type of leader. He was always good at seeing the long term. That was his great attraction to the people above. This was a man who knew where he wanted to take the district. That was his major strength.*
> (Health Authority Member)

> *There was regional pressure to bring in somebody from outside, who was high profile. He had been a national trainee, had a good grounding in management and certainly wanted to make his mark.*
> (Unit General Manager)

The DGM saw his new appointment as a confirmation of the district's confidence in him. He also saw his appointment as a signal of support for ideas which he had been incubating during his period as district administrator, and he now had the opportunity to introduce changes which he felt would raise the profile of the district and bring recognition to the service. This quickly led to the introduction of a more active management style which was intended to support the enthusiasm and commitment that he felt was latent in the district:

When I moved here I thought the district undersold itself. It was a very sleepy place, very staid, with people isolated from the rest of the world. They didn't see things changing around them. They didn't see the need for change. That was the mentality among doctors and nurses. It was a very parochial place. I felt on arrival in the district that I had joined an organisation which was doing good sound health care, although nothing was at the cutting edge. I thought that it needed some flag, some crusade, it needed something to ignite the enthusiasm that was latent in the district. The NMA (New Management Agenda) and later TQM was something they would responded to.
(District General Manager)

The decision to appoint the district administrator as general manager provided the necessary bridge between the old and new forms of management in the district. The authority had not resorted to a general manager from business or the armed forces (as happened in a small number of districts) and was evidence of the advantages of continuity and stability, with managers able 'to draw on the "memory" of the district's services, relationships and objectives', 'with no major disjuncture of approach or ambition'. (Pettigrew et al, 1992: 217).

A new cadre of senior managers

Following the DGM's appointment, the district quickly made the appointments of two unit general managers (UGM) and other key senior posts. These early senior appointments demonstrated the political skills of the DGM in avoiding on the one hand a potential schism with the nursing profession, and on the other currying favour with clinicians. Both groups of professionals had severe reservations about general management. Following the publication of Griffiths (DHSS, 1983) there had been a strong rejection by the Royal College of Nursing of the sidelining of nursing and the loss of the senior nurse representative at board level. The DGM skilfully avoided confrontation with nurses in the district by appointing the former Chief Nursing Officer as unit general manager for the priority care services. She was a popular and well respected senior manager and her appointment, also carrying the role of nursing adviser, meant the Griffiths changes did not generate hostility from nurses. She was also held in high esteem by the DGM and confirmed Strong and Robinson's (1990) view that some CNOs were powerful enough to be able to choose their roles in the new management arrangements and play an influential role in the development of the service.

The other area of tension following Griffiths was the relationship between the newly appointed general managers and doctors. Doctors quickly recognised the potential threat posed by Griffiths, particularly if their clinical freedom was questioned and challenged (Ham, 1999). Again the DGM sensed the importance of maintaining good relations across the clinical–managerial interface (Pettigrew et al, 1992), and following some evident persuasion was able to appoint a medical consultant to the post of unit general manager for the acute sector. In agreeing to the appointment the consultant nevertheless felt uneasy, and commented that he 'felt uncomfortable among colleagues for going over to the other side'. Nevertheless this appointment was a coup for the DGM in enabling the new team to have a respected clinician at board level and someone who would provide a conduit to clinicians in the future as the impact of general management increased and the perennially problematic acute sector ran into further difficulties.

A further strengthening of the District Management Board (DMB) took place with the appointment of a highly experienced and committed director of personnel. He brought a clear understanding to the district of the critical role human resource management would play in reshaping the workforce of the district, and supported the new initiatives which raised workforce morale. With the introduction of appraisal and performance management initiatives his role would prove invaluable to the district, and later as an enthusiastic advocate for quality management initiatives.

The final member of the DMB was the Director of Finance who had worked in the district for some years and pre-dated all the other senior managers. He was seen by colleagues as a 'steady and safe pair of hands' who had successfully steered the district through difficult times financially, particularly in his skilful management of the financial resources in an acknowledged underfunded district. His continuity of experience and understanding, particularly of the political issues around the relationship with the RHA, and the arguments for increased funding were invaluable to the district. He had also guided the district through the early phases of the Government's increased emphasis on financial control and the drive for efficiency gains. The increased importance of the financial function, with emphasis on cost and information systems, had in turn strengthened his position and would be further extended as the district responded to new Government-driven financial measures in the late 1980s.

The leadership team

The appointment of the respected district administrator to the DGM post put in place the key element that would drive the district forward in the restructuring that followed Griffiths. Similarly the appointment of two unit general managers would build a strong team of senior managers, supported by the skills of the personnel director and experienced finance director and was evidence that leadership of the district was not the responsibility of one man. Although the DGM was a high profile leader, demonstrating many of the attributes of the transformational leader (Kotter, 1990), he was creative in appointing a senior team that would be able to shoulder the challenges facing the district, in speeding up the rate of change. The senior team members were all seen to be committed to raising the profile of the district, but at the same time were perceived as aware of the need to balance development with skilful financial management in a chronically underfunded district.

Leadership style and the senior team

The construction of the senior team demonstrated the importance of the availability of key people in critical posts who were responsible for leading change (Pettigrew et al, 1992). Although the DGM was clearly in the transformational mode of leader (with his vision of the future for the district, a highly interactive style which avoided 'top down' pronouncements in favour of talking directly to staff, and the use of language and symbols to build the argument for strategic change (Kotter, 1990)), he nonetheless could not be described as the heroic or individualistic macho manager. The building of a strong senior team, with their continuity of experience in the district, and with unit general managers representing the two main professional groups, confirmed the potential strengths of the more subtle and pluralist leadership, drawing on complementary skills and valuing continuity of experience (Pettigrew et al, 1992).

A *'New Management Agenda'*

Where the DGM's approach to leadership was evident was in his authorship and promotion of a '*New Management Agenda*' *(NMA)* for the district. It was clear early on following his appointment that he wanted to set to work on the long haul of changing

the culture of the district. He had ideas about the sort of organisation he wanted to lead and the Griffiths mandate gave him that opportunity. He quickly began work after his appointment, with his senior team, to produce a short statement which would outline a new approach to management in the district. This document, which was later described as a 'slender nine pages which were decisive in laying down the approach that would underpin TQM', set out the new agenda for the district, including strategy, standards and style. The strategy element of the document referred to the District Strategic Plan which set out the service aims for the period 1985–1994, describing financial and personnel objectives and key service developments. The second element was concerned with standards, and referred to explicit statements of service standard for different parts of the service which the district would measure itself against in the future. The third element was concerned with management style, which was spelt out for the first time and which sought to clarify and reinforce the management of the service, both to existing managers and to those who sought management posts in the future.

The style of management that the *NMA* intended managers to adopt throughout the service included: high standards of personal management, regular contact with patients and actively seeking their views through regular visits to wards and clinical departments. This was to be underpinned with face-to-face communication with staff, including team briefing, question-time sessions and a greater emphasis on training and development. In the future managers would:

- demand high standards of themselves and others
- have regular patient contact
- make regular rounds of their service areas
- be visible to patients and staff
- work through their staff.

The second area was to improve staff conditions with emphasis on physical facilities, clothing and better equipment. The third area was concerned with rewarding staff and recognising that the financial situation in the DHA meant that improving morale would depend on non-financial recognition. Ways of rewarding staff efforts included publicising staff achievements, long service awards, study tours and prioritising

internal promotions. The final area was for managers to become more effective at managing change, concentrating on clear objectives and supporting staff who were experiencing change across a range of district activities. In meeting these new objectives individual managers were asked to declare their own priorities within the overall plan, setting their objectives with the DGM which would be used to establish a means of measuring management performance.

The *NMA*, of course, as described by a manager, had not 'come out of the blue'. It was part of a clearly orchestrated development on the part of the DoH, NHSME and Region to force the pace of change following Griffiths. Shortly after their appointments DGMs found a number of publications landing on their desks which promoted ideas of managerial effectiveness (for example: NHSTA, 1986). These publications placed particular stress on managers' responsibility for the quality of management development in the service and on the notion that they had the freedom to pursue approaches and priorities appropriate to the local circumstances. Examples of similar developments could be found in other district health authorities and followed a similar pattern of establishing a philosophical basis for the service, identifying the values and beliefs of the service and those measures that needed to be put in place to effect cultural change in the service.

Spreading the message

The publication of the *NMA* was not altogether a surprise to staff as the DGM had, soon after his appointment, begun to show his commitment by being visible, being willing to answer the difficult questions of staff and by participating in operational activities. His actions were in complete contrast to those of other managers in the district and rapidly raised his profile among staff.

> *I was prepared to go out front and talk about what I wished to create. It's risky, but I went to staff and said 'I believe in communication, training and good facilities'. We then had to show we would take the actions needed to deliver. I spent a lot of my personal time communicating. I held monthly question and answer sessions when I would go with other senior managers and talk to nurses on the wards, for instance, and discuss their problems face-to-face. Once a month I did a shift, as nursing assistant or whatever. It's seen as symbolic having a chief executive prepared to empty bed pans.*
> (District General Manager)

The *New Management Agenda* did not receive universal approval from all managers, particularly at a time when the problem of financial savings created by Government policy was having an increasing impact on the service and creating acute pressures for some managers.

> *When it was first published it was met with a great deal of derision by those on the ground floor. The vision portrayed was seen to be cloud cuckoo land. They didn't see it as having any relevance to the way they did their day-to-day job. We were in a situation where resources were scarce with shortages on the wards and here he was talking about something cosmetic rather than practical. Outside the boardroom people look around them and see things they haven't got and need in an ideal world. That was the main area of concern for staff.*
> (Support Services Manager)

> *There was a feeling of the little red book about it. It might have been inspirational stuff, but it was for the inner sanctum. There was quite an issue of managers versus professionals. It was about what was in it for managers.*
> (Manager, Biomedical Sciences)

In spite of the initial scepticism which greeted the *New Management Agenda* it was nevertheless recognised by some managers as the beginning of a change in the way the service would be managed. The former approach to management in the district was clearly no longer able to respond to the increasing pressures on the service. The publication was seen as the DGM beginning to stamp his new found authority on the service and spell out how he required his managers to manage the sort of service he intended to lead:

> *It was very much his vision, the sort of product one was beginning to expect from him at that time. It was all him. We didn't see it as a collective. It wasn't from any form of consensus. But more positively it acted as a focus when it was fully accepted, but it wasn't accepted very easily in my recollection and it took a long time to bed in. Things did begin to happen and attitudes did begin to change. Apart from the immediate impact, when you took time to analyse it you knew there was going to be a sea change in attitudes.*
> (Clinical Services Manager)

For other managers the guidance on the future style of the district was seen as helpful. It spelt out, albeit briefly, what was expected of managers, how their performance would be measured, both in their personal standards and in their relationships with patients and staff.

It might have been one man's vision to start with, but I saw it as a statement of intent, what we were all about. I was impressed by the vision that we could make a difference, we could put ourselves in patients' shoes and improve the service.
(Training Manager)

Although there was a mixed reaction to the *NMA* among non-clinicians, its message was not considered relevant to all parts of the service. Doctors were said to have taken little notice of it and considered it, like most management statements, to be of no concern to them. This was summed up by a senior doctor:

It was seen very much as a management paper. It was about how management was going to manage and deal with the externals and the superficial as far as we (doctors) were concerned. If he had promoted it too strongly among the doctors it would have rubbed them up the wrong way.
(Medical Consultant)

Different perspectives on the NMA

Reflecting on the impact of the NMA the DGM felt he had successfully begun raising the level of debate about management in the district, and early responses from those committed to change suggested that general management was beginning to have an impact on the district:

It was a surprise to me. Although it was a simple document [NMA] and made some very obvious statements it seemed to catch the imagination of people in the district. It seemed to go down well and was used more extensively than I thought it would be quite early on.

Another perspective on the *NMA* questioned its impact:

Everybody applauded the concept and signed up to it, but in reality its impact right through the system was fairly limited. It did have an impact at headquarters [of the DHA], but beyond that it didn't really hit the target. The managers and members had it drummed into them and understood exactly the direction the general manager was going, but I'm not sure everyone on the patch saw it that way. They might have said it was good stuff, but hang on, we've got a job to do and with funding dominating everything – where's the money coming from?
(Health Authority Member)

Implementing the *New Management Agenda*

Following the publication of the *NMA* a range of initiatives was introduced in 1986 including, monthly briefing sessions where managers were expected to meet with their staff teams and brief them on current developments impacting on the district.

The new demands placed on managers would inevitably mean that implementation would be a slow process as the perception held by managers of what constituted their role was challenged by the *NMA*:

> *Bits of it got implemented by quite a few managers reluctantly. The changes weren't natural for them to be out of the office more, being more visible and making regular contact with staff and patients. Some found good excuses for not doing it and hid behind the paperwork. You can always use that as an excuse. There were some managers who, and it's a sad reflection on the way we were, didn't relate to staff on the ground floor. They were old school managers and found it difficult.*
> (Support Services Manager)

Further developments included a newsletter informing staff of policy changes and other developments as well as promoting the vision of the district and celebrating staff achievements. At senior level a monthly question and answer session led by the DGM, UGMs and other board members took place in frontline service areas in order to respond to staff's concerns. Photographs of the DGM and the acute sector UGM, alongside staff in active service areas with jackets off and sleeves rolled up were widely publicised in district literature, and clearly intended to provide a role model for other managers, but also symbolically presented an image of the new post Griffiths management style that it was intended would be adopted throughout the district.

Management development

In implementing the *NMA* it was recognised that staff training would play an important role in supporting a change of culture, specifically focusing on the new management capabilities and skills (Pettigrew, 1987). A local higher education college was contracted to provide an annual management training programme as part of the commitment to increase the level of training contained in the *NMA* (the training budget increased from £90,000–£130,000 between 1985–1988). This programme was intended to support the new strategic goals of the district and to develop the next generation of managers who would be socialised through exposure to a culture based around commitment to more participative management, service quality and above all the concerns of the patients. To reinforce this message the DGM introduced each programme, reinforcing his personal commitment to the changes outlined in the *NMA*

and the importance of leadership at all levels of the service. The lecturer who led the management training courses had regular contact with the DGM and witnessed his commitment to developing the new management culture:

> *It was very much a philosophy. It was for all the staff, about making the district an integrated unit. His message was 'we're all here to serve patients'. He was passionate about it. He wanted to put the district on the map. He was really enthusiastic. He used to start each management programme personally spelling out how the service should be managed. It was hearts and minds stuff, beliefs, the mission for the service before it became popular in management. It was all about trying to build a high quality service for patients.*
> (Lecturer in Management)

Appointment of District Training Manager

The work begun on management development was subsequently reinforced when an opportunity to make a new appointment of a district training manager took place in 1988. The DGM was keen to establish a much closer relationship between training and the *NMA* and the district made the important appointment of a manager who brought a very different approach to training in the district, including an understanding of the need to relate the district's management strategy to the content of the annual training programme. In keeping with the emerging interest in the patient's voice (Ferlie et al, 1996), the programme began to place much greater emphasis on customer care courses and issues of consumerism which were growing in prominence at both regional and district level.

> *She was a new appointment and brought a different approach from her predecessor. She was less interested in technical training. She was a very positive and approachable person. She switched the ethos of training in a significant way. She had started doing work on customer care before TQM came along.*
> (Unit Manager)

This appointment was also significant as the district training manager would not only shift the focus of training to make the integration of the district's strategy with training and development much closer, but would subsequently play a key role in the quality management initiative and would later emerge as the 'product champion' (Bennett and Ferlie, 1994) responsible for driving the implementation of the TQM initiative.

Raising the profile of the district

Alongside the changes introduced in the *NMA*, the major drive from 1985 was on raising the profile of the district through participation in a number of local and national initiatives. This was in stark contrast to the period prior to general management when the district was described as 'a sleepy place' and 'where nothing of note occurred'. The intention was to raise the profile of the district and attract attention to its activities. This would in turn help to raise staff morale and introduce a culture of pride with staff feeling more confident in themselves, and would develop the district's self-esteem (Kanter, 1985).

Between 1986 and 1989 there was a flurry of submissions to national competitions with the district surprising itself on its success, including winning first place for its innovatory cataract treatment project for older people and similar success in a hip replacement project. This run of success was reinforced by the DGM being awarded 'Manager of the Year' in a local competition to find the best manager across the private or public sectors. A significant increase in the reputation of the district occurred in 1988 when it reached the finals in a competition organised by a broadsheet newspaper for the 'best health authority'. This competition invited districts to submit an entry which described the work they were doing. A group of unit managers and operational staff were convened and produced an entry which would lead to the district becoming runners-up in the final judging. This was seen as a positive exercise and would boost the image and morale of the district.

> *There was this competition the Best of Health. He (DGM) thought we're doing well in the district. A group of people from all over the District got together and produced a wonderful document and nearly won the competition. It was a positive exercise for the team and the district.*
> (Health Centre Manager)

The introduction of annual awards that recognised staff achievements was similarly given a high profile with the addition of travelling fellowships to enable staff to spend a short period abroad studying service developments. The profile of the district was further enhanced by the district inviting Sir Roy Griffiths to open a new learning disability facility and meet health authority members and staff. Alongside these

events the district developed a close relationship with the local press to feed 'success stories' to newspapers on a regular basis. Similarly public relations began to be taken seriously with regular press releases on service initiatives and changes.

The changes introduced by the *NMA* and its success in the national competition increased publicly the work of the district. This was beginning to create an environment that would be responsive to Government initiatives which supported and reinforced opportunities to change and build a new management culture in the district under the leadership of the District General Manager. In the wider context this was the time when the Department of Health was becoming attracted by the 'excellence' movement and would shortly develop the national TQM strategy for the NHS.

> *It was a fertile environment for TQM. We were aspiring to high standards, there was teamwork. Credit was due to him (DGM) he had the sort of style that involved you emotionally in his sort of approach. He was very much a hearts and minds person.*
> (Health Centre Manager)

Even senior managers who had been sceptical about some of the more publicity-orientated activities saw the benefits to the district of improving the visibility of the service, and were supportive of his colleagues' commitment:

> *We got into the health press and we gained a reputation for being in the forefront. I'm sure it was good for everyone.*
> (Director of Finance)

Funding crisis

The period of the early to mid-1980s was the era of the efficiency drive (Ferlie et al, 1996) with the Government's focus on value for money and efficiency gains in the public sector. For the NHS this era stretched into the late 1980s as Government put increasing pressure on districts at a time when the gap between funding and the level of demand was ever widening (Ham, 1999). The impact of cumulative underfunding became increasingly apparent from 1985 and grew in severity from 1987, although the roots of the problems went back many years with the district's funding problems which remained unresolved. The blame for this situation was laid at the door of the former administration of the district which the newly appointed DGM was unwilling

to accept the situation, and which would lead subsequently to the strained relationship between the district and the region:

> *The funding issue came to a head in 1985. The previous administration had never bothered to acknowledge the underfunding problem because they always coped. Their argument was, we're running the show, why is this new guy rocking the boat. He was right to rock the boat because the old guard didn't do anything. They coped alright, but they didn't run a whole host of services. The needs of elderly were recognised, the needs of the younger population were never acknowledged. He (DGM) actually harnessed all that and got the debate going.*
> (Health Authority Member)

The district had suffered ongoing financial problems throughout the 1980s as a result of historic funding patterns within the region. This was exacerbated with the introduction of the Government's cost containment scheme in 1983, and further intensified when annual efficiency savings were introduced in 1985. These cost pressures came to a head in 1987–88, when the district, in common with other areas of the country, experienced particular problems during the winter, when a cumulative shortfall in funding meant that it had to take urgent action to keep its expenditure within cash limits. Non-urgent admissions were cancelled and wards were closed on a temporary basis. This crisis was further exacerbated by the district's demography with its high percentage of older people, which made particularly heavy demands on the service at that time.

What the funding crisis of the late 1980s demonstrated was the dilemma faced by the District Management Board who were on one hand actively promoting development of the service following the implementation of the *NMA*, and on the other having to make decisions about which services to cut. This made maintaining staff morale difficult – particularly as it was increasingly under threat as concern grew about the future of the service.

This crisis was one of the first tests of the emerging culture, with the DGM's competence challenged in a way it had not been since his appointment. In the view of his senior colleagues, his work on developing a new way of managing the district and his own personal style proved helpful in the management of this crisis among the majority of staff.

It was his style to engage staff, try to develop good relations with staff and involve them in decisions, for example, when we had to make cuts in the service. When the impact of the cuts came we got away with it. He was sincere about it and they saw that.
(Director of Finance)

The District General Manager's skills in managing the crisis were acknowledged by health authority members who debated long and hard about the decision to close beds, but who recognised that the district was under intense pressure and that Government policy on the funding of the NHS was the root of the problem.

It was a difficult time, having to close beds when we knew demand was growing. Having to tell doctors to stop treating patients as that would increase the costs to the service, but it was well handled by him (DGM). We recognised there was no option, although it tarnished the image of the service he was trying to develop.
(Health Authority Member)

Managing service reduction

Where difficulties did arise was in discussions with clinicians, as the need to urgently reduce the level of service in order to manage the district's overspend meant that the DGM and UGMs (particularly in the acute sector) had to confront consultants and require them to limit their activities. This was particularly significant for the acute sector which was the main area where costs were difficult to contain and where clinical activity had the most impact financially on the district. The UGM with his clinical background proved invaluable at this time when management was viewed suspiciously by clinicians:

His (UGM) relationship with his clinicians was good. He'd become a manager, but he was still a doctor. Their view was here was a doctor doing business with us. It was a time when there were medical bodies and management. It was quite an uncomfortable relationship the whole time, and the DGM struggled – he never really had a relationship with them. He was a manager by profession and struggled to get the message through and get something done about it. There's more reality today. Clinicians have got far more awareness. Things have moved on and they understand you can't have everything you want.
(Health Authority member)

The pressures on managers and clinicians were an early warning of events that would be repeated as the district experienced further crises in 1989 and 1990. To some extent the district reduced the impact of the financial problems by shifting resources from the priority care services to support the acute sector, but it did begin to raise questions about the future of the service.

> *It was a difficult time for the district with the DGM having to tell the consultants to stop operating as it was pushing the district into the red. They didn't like being told what to do. What it did do was to open up the issues of how the acute unit operated and how it could manage its costs better. Could there be cheaper ways of treating patients?*
> (Unit Manager)

The winter funding crisis exposed issues of clinical–managerial relationships where the implementation of general management had placed particular responsibilities on DGMs and their senior teams to begin influencing the behaviour of clinicians as key resource allocators (Pettigrew et al, 1992). This was the first significant foray into the territory of doctors and would suggest that managers would have a difficult struggle to influence clinicians in what was seen as a 'no-go' area for managers.

Relations with the Regional Health Authority

What the funding crisis did was to intensify pressure on the Regional Health Authority, who were seen by the district as starving the authority of funding. The district's claim that it was chronically underfunded did not receive a sympathetic response from the Region, which was itself under pressure to reduce costs. However, the district's claim remained an area of high concern among health authority members and senior managers throughout the 1980s. The situation deteriorated in 1989 when a new Regional General Manager (RGM) was appointed and relationships between the district and the Region became more strained. The new RGM took a much harder line with the district and was uncomfortable with the pressure applied by the DGM concerning the underfunding.

> *He (DGM) had a reputation in the district of always arguing that there wasn't enough money and that didn't make him popular with the Region. He was also always banging the drum about what a good the district was. It created a difficult relationship and we were accused of whingeing by the region*
> (District Training Manager)

There was quite a lot of hostility from the Region. They said it (district) was an affluent place. Did we really need the money? There was tension with the new RGM.
(Director of Finance)

The DGM kept the pressure on the Region by the use of the media and other channels in the district to highlight the shortfall in funding which led to increasingly fraught relations with the Region. A health authority member who had connections with the Region summed up the feelings at that time:

I used to get comments from the Region – 'what's going on down there, why is this bloke always banging on about funding?'. It began to antagonise the powers above. It was creating publicity and the media pressure rebounded to London (Regional Health Authority headquarters) and they got irritated. Regions don't like that sort of thing.

Responding to the quality message

Although quality had been stressed at regional and district level following the appointment of the District General Manager (reflecting Griffiths's (DHSS,1983) concern that the service was not sufficiently responsive to users), from 1988 onwards it became evident that quality would be increasingly important in the service towards the end of the decade, and that managers would have a major role in leading these developments (Ovretveit, 1998; Sutherland & Dawson, 1998). In 1988 the Regional Health Authority published a strategy paper on quality which expected DGMs to provide leadership in this area, including, publishing statements of service principle, organisational goals and communicating and reinforcing the quality message throughout the district. It also required districts to establish a framework for quality, including a quality assurance steering group, with a medical consultant membership. The district was also expected to introduce training programmes to raise the awareness of quality among staff. This strategy paper mentioned total quality management for the first time, but was cautious about recommending that districts introduce TQM due to the 'vast changes that would be required in the organisation's culture'. The paper went on to describe the cultural revolution required as an exceptionally difficult feat, and suggested that the absence of doctors in the line management of districts would make it difficult to achieve consistency of message and accountability. Lastly the document described the NHS as a large ponderous

organisation that was unlikely to be amenable to the dynamism required of a total quality approach.

District Quality Strategy

In response to the regional demands, the district published its quality strategy in 1989. This established a quality assurance framework including a district quality assurance group (including audit groups for medical, nursing and professions allied to medicine) with additional groups covering acute, community and ambulance services. The intention was to move the district towards more customer-orientated services and in the words of the district strategy 'to create an environment in which 101 customer care initiatives can flourish'. The response to the Region was an opportunity to build on work, begun in 1986, on defining service standards which were seen to represent the DGM's interest in quality at that time and which had been stimulated by a study visit to Canada in 1985. The district's service standards focused on areas that would later become the target for improvement under TQM, including conditions in long-stay wards, the quality of outpatients departments, admission procedures for patients and the care received by patients on acute wards.

Reinforcing the quality message

The DGM attended the annual National Association of Health Authorities (NAHA) conference in June 1989 and was present during the address by the Chief Executive of the NHS Management Executive where he stated 'that quality should be high on the agenda of every health authority'. The Chief Executive advocated that authorities should set up quality schemes, and stressed improving services in the 'soft areas' such as waiting rooms and reception areas and improving appointments procedures (Nichol, 1989). This message was further reinforced by the Chairman of NAHA at the same conference who argued that districts should put greater stress on service quality, which meant improved appointment systems, prompt treatment, pleasant surroundings, smiling faces, good information, high standards of cleanliness and high calibre professionals and support staff (Long, 1989).

With keynote speakers promoting the role that quality should play in the service, management consultants (who would later play an important role in the TQM

demonstration centres) were promoting their solutions to districts keen to implement the new quality initiatives at the same conference. The consultant who would subsequently work with the district had designed a customer care campaign for a leading airline. He had also been responsible for the implementation of the quality strategy in this company, and was now promoting TQM as an approach to the management of quality in the NHS. The DGM was impressed by this presentation and discussed the district's interest in bidding for demonstration site status. The outcome of this meeting was the decision to employ the consultant to advise the district on its TQM strategy, should its bid to become a TQM site succeed.

Invitation to bid for a Total Quality Management Demonstration Site

Just prior to the NAHA conference, the district had received, in June 1989, an Executive Letter from the NHS Management Executive inviting districts to submit bids to become TQM demonstration sites (NHSME, 1989). This project was to be fully funded in the first year by the Department of Health and run for three years from 1990–1993. The district responded with enthusiasm to the invitation:

> *When the TQM bids were invited he (DGM) saw an opportunity to fulfil what he'd written in the NMA statement. He was keen to make the organisation as efficient and effective and customer sensitive as possible. This fitted with the TQM ethos about excellence and providing services for people. It happened because resources were on offer to do something different and the commitment and drive that came from the DGM and some of us. He made a good case, he was good at that, and in November we got money with no strings attached.*
> (District Training Manager)

> *We put together a case (for funding). There was no clear brief, so we looked to the Department (DoH) for guidance. There was a noticeable deficit there. The people from the Department came down and interviewed us. It wasn't a very memorable event. To my surprise we got the money. The question was now what is this TQM exactly about? We knew what we wanted to do, we've got to make it fit what they want.*
> (Unit Manager, Priority Care Services)

Some managers quickly saw the relationship between the *NMA* and the brief for the TQM demonstration sites, and the opportunity to draw on the experience of implementing the *NMA* in their department:

> *I think it was the natural successor the NMA. Without the amount of work that had been done before TQM came along we wouldn't have got TQM. It was a further*

opportunity to change the culture. That was what the NMA was about, but the change wasn't as strong as we had thought it was. It hadn't made that much impact by the time of TQM. This was another opportunity to make changes.
(Unit Manager)

The district submitted its bid in September 1989 with the proposal an 11-page document which described the work that had been undertaken following the publication of the *NMA*, setting out in a series of bullet points the achievements to date. These included a number of quality initiatives which were already in place, and demonstrated the work on improving standards in the district, and potential project sites for the first stage of the TQM implementation. The bid was successful, with the first tranche of funding for 1989/90 amounting to £69,000. This was to enable the district to establish its demonstration site and would mainly support the staffing (including the external consultant who would work with the district), the development of materials and initial training programmes to implement the first phase of the initiative, and a small 'pump priming budget' for project sites. The successful bid meant that the work on the *NMA* was seen as worthwhile and that external funding would provide the opportunity to support further work on strategic change in the service.

The label TQM was useful because it brought a pot of money. You had to use the words to tap into that pot of money. What I did have was a vision of the sort of organisation I wanted to run, the culture, the atmosphere, really the soft end of the business, the human resources end of the business, that interested me. I'd be fooling myself if I thought we had a vision of what TQM could do, but it did seem to go with the grain. It seemed a natural progression from the NMA.
(District General Manager)

The NMA was a demonstration of management style and was a fertile environment for TQM. We were aspiring to high standards and teamwork. This was the next step.
(Health Centre Manager)

Although there was a core of managers committed to the TQM bid, not everyone at Board level was so enthusiastic, and a hint of scepticism at the time of the successful bid would have consequences later in the life of the demonstration site:

It was his (DGM) bright idea. He got hooked on the whole idea of quality. It was from the private sector. He got more and more immersed in it. He dragged the rest of the organisation along with him.
(Director of Finance)

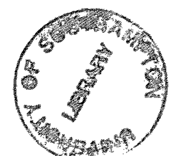
Case Study Analysis and Discussion

This section returns to the themes and issues identified earlier in the chapter and links with the grounded analysis of the case material, examining what can be learnt from the empirical data with the support of theoretical perspectives on the management of the NHS. There are four main themes, general management, reputational management, cutback management and the emergence of quality management.

General management

The first theme is that of general management which was introduced into all districts from 1985 and constituted at that time the most radical change in the management of the NHS since its inception. General management, it is argued, fundamentally changed the way the service was managed, with power vested in the general manager who became responsible for the direction of the service in a way that the earlier forms of administration had not (Pettigrew et al, 1992). This development was considered to have increased the power of general managers (including unit general managers and departmental managers whose appointments followed) in replacing the earlier consensus management with a single line management. The role of manager as 'diplomat' within a tripartite consensus arrangement (Harrison,1988) was no longer seen as an effective means of managing the service. Instead Griffiths recommended that responsibility would be 'drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance' (DHSS, 1983:11).

Evidence from the case study suggests that a break with the past had begun to take place soon after 1985, with the appointment of the general manager and unit general managers and the publication of the *NMA*, with its new strategy for the district and a shift towards a more active and engaged style of leadership which enhanced the role of managers in the district. These early changes could be seen as promoting the legitimacy of managers (Cox, 1991), increasing the expertise of existing and prospective managers through participation in the management development programme, and as using the *NMA* as part of the selection and subsequent socialisation of newly appointed managers. These were of course only beginnings, and would need persistence and continuity to translate the



mission and objectives into reality. But taken together they suggest that the proactive style of management recommended by Griffiths (DHSS, 1983) soon became evident after the introduction of general management, and that new ways of managing the service were beginning to take root.

Shift in values from practitioners to managers

Further evidence of the impact of general management is witnessed in the shift in values taking place in the service post-Griffiths. Prior to the implementation of general management the predominant values were those of practitioners, particularly doctors and to a lesser extent nurses and other professional groups (Packwood, 1997). Management's role at this time was to play a coordinating function with the emphasis on integrating different perspectives through persuasion and agreement. With the introduction of general management, consensus management was abolished and a more 'proactive, goal-setting approach was taken, that would promote service values and be directive in its nature' (Duncan et al, 1994). This shift in management arrangements would in turn influence the dominant values of the service, with movement towards managers emphasising service values over those of the earlier coordinative management functions which emphasised practitioner values (Packwood, 1997). This was most evident in the destruction of the nursing hierarchy in the district (although this was ameliorated to some extent by the promotion of the Chief Nursing Officer to a UGM post, and the appointment of nurses to nine out of ten unit manager posts, albeit with new identities and responsibilities) and the loss of influence of doctors at strategic level, with a single medical representative at district management board level replacing the former medical presence in the tripartite management of the service.

The role of power

In effecting the shift from practitioner to service values, power was a key element. In the pre-Griffiths era the role of administrator within a consensus management arrangement did not have access to the range of power levers necessary to introduce fundamental strategic change. What general management provided was the legitimisation of the use of power to achieve the goals of the service set by Government. According to Hardy (1994) power is essential to drive strategic change, with organisations consisting of competing and co-operative elements with actors operating from different perspectives,

or frames of reference, motivated by self-interest and collaborative activity to get work done.

How senior managers respond to these different elements is through the exercise of power. Hardy (1994) describes power in terms of the control of resources, the use of processes by dominant groups, defining change through the management of meanings to legitimise it, and the power that resides in the system which confers advantages on certain members over others. All these levers could be witnessed in action in the district. The creation of a single line management hierarchy gave the DGM and his senior team much greater control over resources and ultimately responsibility for managing them.

Secondly, organisational processes were used by managers to create new arenas which would increase opportunities for change, such as the devolution of financial responsibility to unit managers (thereby making staff more cost conscious and achievement orientated), the management development programme which was intended to institutionalise new behaviours, and the support for project groups identifying good practice which would be publicised and entered in national competitions. As Hardy (1994) makes clear, much of this activity places emphasis on new directions without the repeated application of resources. Thirdly, the management of meaning was clearly seen in the promotion of the *NMA*, where reality (the future of the district) was redefined so that change was perceived as legitimate and desirable. Communication played a key role in promoting change, with the DGM and the senior team using every opportunity and medium to press home the need for change.

Fourthly, the ascendancy of senior managers in the reformed service bestowed advantages on them that served their interests in supporting strategic change, although the unconscious acceptance of dominant values, traditions and culture (Hardy, 1994) remained contested territory. This was particularly so in areas of the organisation still beyond the reach of managers. For clinicians, the changes contained in the *NMA* were potentially threatening, but since they perceived it as essentially managerial in its thrust rather than concerned with changes in clinical activity, they tended to ignore it. In power terms this was understandable as there was no attempt to engage with them, particularly the senior consultants, who were seen as the most powerful actors in the district.

Management was able to use power to bring about change in the district, but there were limits, and this applied particularly to the one area that it is argued (Cox, 1991) was the subtext of the Griffiths Report (DHSS, 1983) – the managerial control of doctors. In spite of the new- found power in the general management system, it did not extend to this domain, and this confirms the view that this was a difficult area for general managers in view of clinicians' power and their views on management (Dopson, 1994).

Wider impact of general management?

What is less certain is how far general management influenced the wider service during the period researched. In Banyard's survey (1988) it is suggested that there was a downward gradient of enthusiasm for the Griffiths reforms the further one moved away from the centres of managerial power. In this survey, direct care staff did not see the changes benefiting patients, and morale among this group was poor. The relationship between the introduction of general management and the wider political and economic context meant that changes in the management of the service were associated with a range of mainly financial measures that had replaced the values of compassion and caring and in turn the motivation of direct care staff (Cousins, 1987).

What this suggests is that general management (at least in the centres of managerial power) was beginning to make an impact on the service, in developing new strategies and beginning the long process of culture change. However, in other parts of the service, particularly clinical areas, staff remained to be convinced of the benefits of general management. This confirms the argument (Johnson, 1990) that the strong adherence to the cultural norms of the past (where values and beliefs legitimise the denial of the need for fundamental change) meant general managers would in effect need to challenge the existing paradigm of the service if new service goals and processes were to be introduced. Here the case material suggests, particularly in relation to the *NMA*, that the strategic ambitions of senior managers were unwelcome to many staff at a time when they were experiencing resource constraints, and also when demands were growing on the service and creating a climate of uncertainty about the future of the service (Cousins, 1987).

Reputational management and a culture of pride

The second theme concerns the activities intended to raise the profile of the district which reached a significant level by 1989 and had transformed the way the district viewed itself (at least in the eyes of some health authority members, senior and middle managers and staff). The district could have been accurately described as one without substantive changes taking place and without significant service initiatives planned at the time of general management being introduced. It was clearly not a high change district (Pettigrew et al, 1992). From the evidence, two particular aspects support the view that there were some changes in the culture of the service through reputational management and the fostering of a culture of pride.

The identification of clinical and management activities which could attract national attention was a distinct break with past practice. The district was becoming much more outward facing, encouraging staff to enter competitions, using the press and public relations to influence the image of the district (both to the public, and importantly, in terms of building a new culture) and to the professionals and staff in the organisation (Ferlie at al, 1996).

The second area concerned the fostering of 'cultures of pride' (Kanter, 1985). Here the activities that had begun to be put in place following the publication of the *NMA* resonate with Kanter's argument that there is a clear link between fostering individual self-esteem and organisational self-esteem. Where organisations are promoting innovation it is argued that job satisfaction increases and there is less emphasis on hierarchical distinctions. Similarly, intangible aspects such as culture which promotes change and senior managers acting as opinion leaders are important in fostering a culture where it is appropriate to support innovation (Kanter, 1985). The extent to which the senior managers, and particularly the DGM promoted the 'message' of the *NMA* confirms Pettigrew et al (1992) that it is not possible to rely on the merit of the ideas or the loyal response of staff alone, 'but (they) had to actively communicate their intentions at every level and on every occasion' (p222). This was borne out by the multiple level activities (entry to competitions, award ceremonies, travelling fellowships) with each activity reinforcing the other and with the DGM and senior team actively promoting the district at each event.

Cutback management

The third theme is concerned with the management of the financial situation which occurred each winter from 1987 in the district and presented a major challenge to senior managers as they attempted to keep within prescribed cash limits and introduced a range of cost-saving measures, including bed and ward closures. This activity has been described by Levine (1979) as cutback management, and entails 'managing organisational change to lower levels of resource consumption and organisational activity', (p180).

The dilemma facing senior managers was how to support the drive for innovation and at the same time recognise that each winter the service would be faced with having to adopt new coping strategies to manage the recurring financial crisis. According to Flynn (1991) the absence of growth makes it more difficult to 'maintain consensus, promote innovation and reward enterprise, yet at the same time this is what managers are expected to do in a contracting organisation' (p217). According to Hardy (1994) managing decline is a zero-sum game where there is little to gain and much to lose. The case evidence suggested that this was certainly so in the district, and that the financial situation had the potential to derail the strategic and cultural change by breaking the fragile consensus that had begun to build in the district. Although that change was possible was evidenced through raised self-esteem and other reputational activities. Much of the success at keeping the spirit of innovation and change alive during these difficult years was put down to the commitment and personality of the DGM and the important role of the clinically trained UGM, as well as efforts in the years preceding the crisis of 1987–89 to pressure the RHA for increased funding. In this sense, the organisational memory (Pettigrew et al, 1992) worked in the favour of senior management who was recognised by staff to be committed to developing district services, even at a time when the Government and the RHA were taking an increasingly parsimonious approach to financing the service.

Although the recurring financial crises were clearly unwelcome in adding to an already stressed fiscal situation, they did provide an opportunity to explore issues of service costs and resource allocation. The negotiations with consultants about activity levels in the district mirrored similar discussions that took place in other districts

nationally at this time and provided general managers with a legitimate reason to undertake a detailed scrutiny of district services and associated costs in order to make decisions about future priorities (Flynn, 1991). Although there were risks associated with cutback management (particularly in terms of relationships with clinicians and concerns on the part of other staff about the future of the service), and in spite of protests and lengthy debates by the health authority, a consensus was achieved and the district weathered the crises which recurred each winter up to the time of the *Working for Patients* (DoH,1989) reforms. Evidence from the district suggested that these discussions were unpopular with clinicians, and supports the argument that medical power was being tentatively challenged for the first time by the DGM and the acute sector UGM. This confirms the view that retrenchment of services spurred on by the crisis of 1987 onwards increased the power of managers and enabled them to extend their influence over the medical profession (Flynn, 1991).

The emergence of managerial quality

The fourth and final theme is concerned with the emerging quality agenda which began increasingly to impact on all services from the mid-1980s and was reinforced by Government pronouncements, regional initiatives and responses by districts to this growing agenda. Most observers agree that the concerns expressed by Griffiths (DHSS, 1983) about the need to place greater focus on patients as consumers was an important milestone in the emergence of quality as an issue in the service. In addition, the establishment of district-wide quality posts, particularly for some senior nurses in districts nationally who had been displaced by the Griffiths reforms, was a further development. But probably the most important factor was the strengthening of management post-Griffiths, which saw managers taking a wider interest in quality (which had previously been the preserve of professionals (Ovretveit, 1998)) and seeing this as an area where it was legitimate for them to intervene.

Evidence from the district supports the perception that quality had 'taken hold' by the mid-1980s with the district undertaking early work on service standards, and subsequently responding to regional pressure with a more systematically developed quality strategy beginning to be implemented through multidisciplinary groups of

staff. Here the emphasis was on quality assurance and customer care programmes (Ovretveit,1998), reflecting developments nationally in a number of districts.

What had changed by 1989 was a 'more hard nosed and less naive' (Ovretveit, 1998:5) approach to quality. The shift was towards a more consumerist approach fuelled by the populist political strategy of the Government, that was at the same time seen as an attack on professionals. The rise of customer service quality was subsequently to become a major theme in the NHS, reinforced by the publication in the same year as *Working for Patients* (DoH, 1989). What these developments signalled was that quality was no longer the preserve of professionals and that it was legitimate for managers to discuss approaches to quality and take responsibility for quality initiatives, including challenging professionals. This later consumerist approach to quality resonated with the stream of activities in the district since 1985, with its emphasis on service standards, seeking the views of patients and building a culture which stressed a quality service through management action and the celebration of achievement in national competitions. This meant that when quality emerged as a key element in achieving an effective service the district had become a receptive context (Pettigrew et al, 1992) to bid for funding for the TQM demonstration site.

Conclusions

The analysis of case material from the introduction of general management to the point when the district became a TQM demonstration site illustrates the processual nature of change during this time period. As the pace of external pressures grew the district in turn responded to these changes internally with a more overtly managerialist approach legitimised under the development of general management. A senior team armed with new powers began the process of introducing large-scale change in the district. Key people in important senior posts, with their knowledge of the district, formed a team with complementary skills, which began to energise the system and create an agenda for change. Here the importance of both continuity and change was crucial in terms of credibility when it came to promoting the new strategic direction for the district.

Although the district had a history of financial problems it avoided a retrenchment-based approach to the management, with the financial situation used as a gear, rather than a brake, and problems 'talked up' to demonstrate what could be achieved even in straightened circumstances. This strategy had some risks as the gradually deteriorating relationship with the Region became more apparent, but the approach adopted was seen as defending the district, which won support among staff and health authority members. The district throughout this period combined short-term crisis management with a strategic change agenda that supported a more proactive approach to the management of the service and greater emphasis on service standards and patients' views.

The influences of the 'excellence movement' were apparent in much of the new management style adopted and in the management development programme introduced to support strategic change. Alongside this essentially human relations approach to the management of the service the process of change was incentivised with tactics that raised the morale of staff and created a more confident service, and the range of measures introduced clearly captured the imagination of sufficient staff to bring the district recognition nationally. Although there remained powerful inhibitors to change, there were sufficient staff enthusiastic enough to support change and act as facilitators of this process. These staff, mainly unit managers and training managers, allied themselves to the new regime and begun to confidently use action-orientated behaviour to develop their services and they would later become the 'torch bearers' for TQM.

At their core the changes introduced were concerned with supplanting existing values and beliefs with new cultural forms that would support the goals of the new regime. However, culture change remained a complex issue in the district, with the traditional public service ethic resisting the top-down pressure to embrace more business-like approaches to the management. The degree of change was less significant than hoped at the time of the bid for the TQM demonstration site funding, as this was an attempt to maintain the pressure for cultural change in a service where shared beliefs and assumptions had developed over a long historical timescale and were immune to external pressure. With the advent of TQM there was an opportunity to press home the district's strategic change agenda as this was seen to resonate closely with the *NMA* agenda, and particularly in view of the external funding that could be used to support

further work on change. Much would depend on the potential of TQM to achieve the changes envisioned by senior managers and their supporters. The next chapter will describe the implementation of the TQM and how far it fulfilled their hopes.

Chapter 7 Implementation: Lighting Small Fires of Enthusiasm

Introduction

This chapter focuses on the implementation of TQM through a description and analysis of the events during the period 1990–1992. This period saw the formation of the quality team led by the DGM and the DTM, the establishment of the TQM project sites and the promotion of TQM techniques through staff training programmes. This period also witnessed a number of setbacks, including the lack of success in engaging with clinicians, the loss of a key supporter of TQM, a crucial period when the DGM was abroad, financial problems in the acute unit and the initial impact of the *Working for Patients* reform agenda.

Themes and issues

For any significant strategic change to succeed in an organisation it requires key people in the critical posts leading that change (Pettigrew et al, 1992). To achieve long-term results Pettigrew et al argue that the leadership cadre should be both broad and deep thereby reducing the risks associated with one-dimensional heroism and individualism often associated with leadership. The leadership of a change process also requires people in a number of supporting roles, who together with the leader constitute the change strategists and implementors, with responsibility for convincing the recipients of the benefits of change (Garside, 1998). In the district the strategists and implementors consisted of a small group of committed staff constituting the driving force for change intent on moving the service through a transitional state as they attempted to change the organisational archetype from the current way of working to a desired future state (Denis et al, 1996). In sustaining the degree of change necessary to embed TQM into the district it would require the sustained and continuous commitment of this key staff group, with the movement or loss of key personnel posing threats to the change process (Pettigrew et al, 1992).

Once the district had received demonstration site approval it began the novel task of implementing TQM. The structures and processes put in place followed the pattern of implementation which reflected the 'improvement infrastructure' found in a number of commercial sites and recommended by TQM practitioners (Dale, 1999). These

included a steering committee, a quality coordinator and facilitators, quality management tools and techniques and staff training programmes. In common with other sites, the district drew on the experience of a management consultant to guide it though the process of implementation. This also accorded with Government belief in the benefits to the public sector of exposure to commercial models of quality improvement (Kirkpatrick and Martinez Lucio,1995), with consultants from a private sector background, bringing new ideas to the service and experience of working on TQM implementation elsewhere in business organisations. The implications of introducing TQM techniques based on the assumptions and values of the private sector would become apparent as the process of implementation unfolded.

In their evaluation of demonstration sites Joss and Kogan (1995) found that doctors played a peripheral role in TQM and resisted engagement with quality processes, or saw them as concerned with non-clinical activities in a number of sites. The involvement of clinicians was seen as an important objective in the district (as it was in other sites) particularly as the limits of environmental improvements were reached, and quality processes were felt to be important in influencing the operation of clinical services, if broader improvements in performance were to be achieved. A critical point in the implementation of TQM in the district occurred when the senior management team attempted to draw clinicians into active involvement in the demonstration site. The introduction of TQM into the district followed hard on the heels of a more assertive management style introduced by the Griffiths Report (DHSS, 1983) which had begun to challenge the professional values of clinicians (Hinings et al, 1991). This meant that clinicians would be wary of the consequences of further management intrusion into their territory and would take some convincing of the benefits of TQM.

For an innovation to diffuse throughout an organisation it requires those leading the change to be aware of the issues of boundary management (Bennett and Ferlie, 1994). For TQM to become firmly embedded in the district it would be necessary for it to diffuse from the initial four project sites across the district. The means of achieving this in the district was through staff training programmes where it was hoped that an increasing number of staff would participate and spread the message of TQM to all

corners of the district, thereby avoiding the risk of organisational dualism characteristic of many quality management initiatives (Hill, 1991).

How far TQM was effectively diffused was also dependent on support from managers who were in a position to facilitate its adoption in their departments and encourage staff to engage in training in TQM techniques. With employee involvement fundamental to TQM (Dale, 1999) both in terms of an educational process and direct involvement in quality issues, managers would be supporting staff's involvement with TQM processes which would have implications for the management of the service. The idea that all staff can contribute to quality requires a degree of participation in decision-making which means a major adjustment to the culture and style of managing an organisation. For managers in the district this would mean embracing more participative forms of management and relinquishing some of their power to teams who would constitute the driving force in quality improvement systems (Dale, 1999). Those most likely to be affected by TQM developments according to Schuler and Harris (1992) are middle managers and supervisors who are likely to be threatened by teams with responsibility for implementing improvements, and as a consequence are likely to resist the change process.

The final theme is concerned with the introduction of the *Working for Patients* (DoH, 1989) reforms which increasingly impacted on the district and the demonstration site from 1990. The implementation of *Working for Patients* affected all district health authorities and required them to begin restructuring their services in preparation for trust status. These initial changes led to boundaries being established between different units, which caused staffing and financial consequences as they gained greater autonomy from districts (Ham, 1992). Similarly the organisational change engendered by the reforms presented new job opportunities with the movement of key personnel as some districts moved more rapidly towards trust status. Throughout this period of growing turbulence the staff involved in the demonstration site maintained their commitment to TQM, although the movement of key staff (including the temporary absence of the DGM, and decisions about the priority accorded to TQM) would have significant consequences for the site and would lead to a reduction in activities. Subsequent attempts to revive the level of TQM activity

would ultimately be affected by changes at board level resulting directly from the *Working for Patients* reforms (Ferlie et al, 1996). In addition these activities would also take place against a background of continuing difficulties in the district's relationship with the regional health authority which further impeded the development of the demonstration site.

Leading the Demonstration Site

The introduction of strategic change in an organisation requires the pulling together of a leadership team with complementary skills (Pettigrew et al, 1992). In the case of the district a small group of people played a significant role in the development of the TQM demonstration site, with each contributing a particular area of expertise to the process of implementation. Initially three people played a significant role in the implementation of TQM in the district, the DGM, the District Training Manager and the external management consultant. They worked together on the development of initial ideas for the site, the focus of activities and the broad implementation plan for the project sites. The following sections describe the roles played by the three main actors and how their actions were perceived by staff who worked closely with them.

District General Manager

The introduction of TQM into an organisation ideally requires senior managers to become personally involved in both the early stages of implementation and the development of a quality process, and to demonstrate a visible commitment and confidence by leading and managing the service based on an understanding of continuous improvement (Dale, 1999). The DGM clearly fulfilled this role and his drive and commitment had seen the district successfully secure DoH funding and had recognised the potential of TQM to support the strategic transformation of the service originally envisaged in the *NMA*.

Following the decision of the DGM to commit the district to bidding to become a TQM demonstration site, he led the initiative from the front, sponsoring the process of implementation (Bryson, 1995). He used his power and authority to drive the initiative forward and played a key role in chairing the steering group which managed the demonstration site, identifying project site leaders and supporting the District Training

Manager and appointing Quality Facilitators who would work directly with project site teams. For many staff, TQM would not have happened without his unswerving commitment:

> *It was very much around one person. If it hadn't been for him TQM wouldn't have happened. I don't know how much the other senior managers would have supported it. Here was a chance to do something new and different and the commitment and drive came from him.*
> (District Training Manager)

> *He was the main player, the driving force. He had a passion for it and was always strong. I was very impressed with his approach. He said 'you can make a difference, putting yourself in the patient's shoes'.*
> (Unit Manager)

> *There was a strong top-down commitment from him. He was totally caught up in it and was the driving force. We couldn't have achieved it without his influence.*
> (Project Site Leader)

The DGM's commitment to TQM was important in maintaining the momentum of the demonstration site and in building a team around him of allies that constituted the 'critical mass' of staff who were committed to TQM and shared his vision about the changes he wished to introduce (Pettigrew et al, 1992). In playing the sponsor role the DGM nevertheless needed the support of a 'product champion' who would translate the ideas of quality management into action, initially in project sites and later through diffusion to the wider district. This would be the role played by the District Training Manager.

District Training Manager

The District Training Manager played an influential role in the TQM demonstration site and fulfilled the role of 'product champion' (Bennett and Ferlie, 1994) . Following her appointment in 1988 she had committed herself to raising the profile of the training department, supported by the Director of Personnel, who had board level responsibility for the district's training policy. Shortly after her appointment she quickly aligned the training programme with the *NMA*, adopting a more strategic approach to training in the district. Picking up on ideas from the Griffiths Report (DHSS, 1983) and later *Working for Patients* (DoH, 1989) which emphasised the patient as consumer, she had shifted the focus of frontline staff courses to include customer care aspects, in turn reflecting a

shared interest with the DGM in giving greater priority to patients' needs and concerns. Colleagues who had worked with her throughout the period of demonstration site described her impact:

> *She was a great ambassador, a great preacher of TQM. She quickly picked up the themes of the NMA and then the TQM approach in the district and took that message out in an evangelical way to everyone she had contact with. She was greatly respected by managers, people recognised that she set high standards and gathered some good people around her.*
> (District General Manager)

> *She was a brilliant leader for this project. She was very positive and approachable, a good role model. She was the real driver. She lived quality and demonstrated it in her approach to people and got a lot of champions on board. I don't think it would have been so successful without her. She was around long enough to put into place structures, in spite of her struggles with some managers and doctors.*
> (Training Manager)

Notwithstanding the District Training Manager's commitment to the TQM she was not able to influence all the staff she came into contact with:

> *Some staff didn't take her seriously. She spent time with the doctors, trying to find out what they wanted from the project, but in the end she focused on the more comfortable areas.*
> (Quality Facilitator)

> *She was less successful in integrating the TQM work with the mainstream medical work. She had been working with the project sites and tried to bring the doctors on board. It was like a coming together of hot and cold fronts.*
> (District General Manager)

What the demonstration site did provide for the District Training Manager was an opportunity to advance her career in an area that was becoming increasingly important as quality management initiatives spread rapidly through the NHS. In this sense she was a 'climber' (Downs, 1967) who was able to use the opportunity of leading the demonstration site to promote the district and her part in its success through publications, contact with civil servants at the DoH, and participation in national events:

> *It was sheer opportunism really. I was in the right place at the right time and it did something for my career. There was this strong commitment from the top and it gave a drive to training that I needed. Later I was seen as the person who got*

things done. I also had this fundamental belief that we could bring about significant change and improve the service we delivered.
(District Training Manager)

Management consultant

The third member of this small influential group was the external management consultant who played a significant role in the strategic direction of the initiative in the district. He had considerable experience of quality initiatives, including the authorship of a book on customer service written while he was working in the airline industry. He was also advising other demonstration sites which were using an almost identical approach to implementing TQM found in the district.

With TQM a novel concept to the district, senior managers and project site leaders relied on the consultant in charting the implementation process, with the result that his influence shaped much of the direction of the activities over the three year duration of the demonstration site. His influence began with guidance to the DGM at the outset of the project, later developing the training kit used in project sites, and subsequently leading training sessions with the District Training Manager and acting as a mentor to the DGM, DTM and project site leaders.

The DGM who had met the consultant at the NAHA conference in 1989 had been highly impressed by his presentation and relied on him to guide the district through the complex processes of implementing TQM:

I appointed him because he was familiar with TQM. He'd done training on TQM and worked on customer care in the airline industry. He was familiar with the language and techniques of TQM, and was able to bring with him some of his stories about how it had worked and the approach adopted. He had his own particular model which he touted around. He was very successful at putting it across, including to a wide range of health services staff. He was a good communicator, a good trainer and people liked him.
(District General Manager)

This view of the consultant was shared by the District Training Manager, particularly as she similarly recognised that they were entering new territory and would need his guidance:

He was very influential. He had done a presentation at the conference attended by the DGM and as a direct result of that he was asked to do a similar presentation to us. There was a recognition that this was a new journey for us and we needed someone who could give us a steer and help us develop and grow and he was brought in to do that. He could say, 'I've done that with other organisations'. We didn't have enough credibility in terms of the deliverables. I'm not sure what model he used. I think he drew on everybody's approach. This suited us down to the ground as we could contextualise it further it terms of what it could deliver for the organisation.

His knowledge and experience was similarly valued in the project sites and is summed up by one of the project site leaders:

He was very impressive and had an important training role with managers. He had no credibility problems and fitted in well with managers and the people on the Quality Forum. I got a lot of support from him. He was here regularly and felt part of the team. He was an evangelist and so positive. He got people enthusiastic about TQM.

Although the consultant was held in high regard by the DGM and staff involved directly in the demonstration site, his appointment was not viewed positively by all staff. He had very little contact with some board members who were sceptical about his appointment and did not respond to an offer of support. Similarly he had almost no contact with clinicians and a suggestion of his involvement with this group of staff resulted in a forthright rejection:

He offered support to some board members, but they didn't take it up. They were sceptical about him. They were disparaging about the district paying a consultant. Their line was – what were we paying for, extras or fripperies?
(Quality Coordinator)

When it was proposed that he work with them (doctors) they said 'what does he know, coming from an organisation that flies planes?'
(District Training Manager)

Although the consultant had proved critical in guiding the district through the early stages of implementation of TQM when he had spent a little more that a year in the district it was agreed that the quality team had by then gained sufficient experience to lead the initiative confidently without his direct support. Although he no longer had direct contact with the district he continued to support the quality team, particularly the

District Training Manager, acting as an informal adviser at the request of team members.

Phase One: Establishing the Demonstration Site

Following shortly on the successful bid for DoH funding, the DGM, District Training Manager and consultant agreed the activities which would constitute Phase One of the demonstration site, with the consultant developing the implementation framework and with the District Training Manager acting as the quality coordinator, supported by two operational staff appointed to roles as quality facilitators (constituting the quality team). A steering group, the Quality Forum, was established to manage the initiative, and publicise information on the four project sites (where the main activity of Phase One would take place). Further activities included the development of the staff training programmes and the production of a project kit, used initially to train project site leaders, and containing a detailed explanation of how they could use a range of quality improvement tools and techniques (for example, cause and effect analysis and process flow diagrams) with their project teams.

Further funding secured

With the successful establishment of the demonstration site by early 1990, the DoH invited districts to submit new bids for funding for a three year period (1990–1993). The formula for funding changed for new bids, with the DoH and the Regional Health Authorities providing matched funding. The bid for further funding was to be based on the progress made in establishing viable demonstration sites, with the district receiving £150,000. This immediately created difficulties for the district with its acrimonious relationship with the RHA causing a delay in the transfer of the Region's element of the funding for 12 months. According to the DTM there followed 'heated discussion with the Region over several months', the funding was subsequently released, and, together with the DoH element, enabled the district to develop a further two phases of the demonstration site.

Managers involved in the demonstration site saw this reluctance on the part of the Region to support the district as a direct result of the newly appointed Regional General Manager's attitude which had become more confrontational regarding the

disputed general funding of the district. The District Training Manager, who was involved in liaison with the Region in relation to quality management policies, summed up the feelings at that time:

> *They were no support, in fact they were obstructive. They fought for 12 months to avoid stumping up the money. TQM threw up the difficult relationship between the Region and the district. The DGM was still banging on about underfunding. They were playing a political game.*

This view was reinforced by a project site leader who felt the district was now getting increased publicity in national reports on the demonstration site produced by the DoH, which piqued the Region:

> *There was a lot of envy from the Region because we had got so much money from the DoH. The Department was also enthusiastic about what we were doing. We got involved in a lot of national activities. It definitely affected our relationship with the Region. It made us unpopular with the Region who had to take money out of other projects to give to us. That really went against the grain.*

The Quality Forum

The main mechanism for managing the TQM initiative was the Quality Forum, which was chaired by the DGM, and included the District Training Manager, the Quality Facilitators, the management consultant and Project Site Leaders. This group met for the first time early in 1990 to establish the objectives for Phase One of the TQM demonstration site:

- to make a difference to the way the health authority is run
- to ensure that it becomes customer-driven
- to develop a high standard of excellence in the targeted project areas.

In developing the key objectives for the demonstration site it was decided that the term TQM would be dropped and the *NMA* was updated and included in the a new statement – 'The Quality Way'. In the words of the DGM 'the intention was to send a message to the organisation that the new initiative was taking the *NMA* a stage further', but also revealed an anxiety about the use of TQM terminology.

We decided that we wouldn't call the initiative TQM, but would go for the 'The Quality Way'. This said to the rest of the organisation that we were building on what we already had. TQM with its origins in Japan and the USA, its language and techniques, and particularly its origins in manufacturing would have created problems for some staff.
(District Training Manager)

The Quality Forum was primarily involved in coordinating and steering the activities in the project sites, and later extended this remit to a district-wide focus as the range of activity increased in Phases Two and Three. The Quality Forum was seen by many managers as the important focus for TQM in the district:

It was the driving force. It was a good meeting to go to. You met people from other places and got to know about each others' projects. This really helped. We discussed things and got his help (consultant). We shared good practice and celebrated successes. It was quite a vibrant meeting!
(Project Site Leader)

The Quality Forum was where you heard about what other people were doing, the way they set up their projects. It avoided us becoming blinkered. We had a broader picture of other sites and what we could develop in our own patch..
(Project Site Leader)

But not all project site leaders felt the work in the Quality Forum was helpful and they felt that some project site leaders and members of the quality team tended to talk up the success of implementing TQM:

The biggest problem that I had with the Forum was when people were reporting on progress. I used to get the feeling that most people were saying 'everything wonderful and terrific'. I got the feeling that people were telling him what he (DGM) wanted to hear. I got a Christmas card from him one year saying 'thank you for always telling me the truth! I treasured it for years. I just got the feeling that he was not being fed the reality of the situation.
(Project Site Leader)

Project sites

The project sites were where the TQM would be initially tested. The reason for selecting particular project sites had been based on an assessment by the DGM, District Training Manager and consultant that these sites were led by unit managers who were sufficiently committed to change, and who would be willing to lead projects in their site and would support the implementation of TQM. The four sites were: an orthopaedic unit, the

portering service in the acute unit, a health centre and a community hospital. All were established by summer 1990 with the intention of achieving significant improvements in the project sites, which would in turn be followed by further sites throughout the district. It was asserted in the words of the original submission to the DoH 'that the high standards set in the project sites would quickly become the subject of curiosity and envy elsewhere'. The initial idea was to create a small base of activity and then extend these activities across the organisation, using project staff to promote interest among staff who would adopt the techniques used in the original project sites.

Identifying managers committed to change

A key to the success of the demonstration site was to identify managers who would be willing to lead project sites. A Project Site Leader described the selection of sites and the incentive to participate in TQM, particularly where there would be additional support from the Training Department, the consultant and access to a small budget for improvements:

> *The Quality Forum identified enthusiastic managers, positive people, the type of manager who wanted to run a good department and had good relations with staff. You know, forward looking people. We were asked to identify a TQM project. I thought what's this TQM? The DGM said there's money around. I always wanted to do some work on my unit, so we got picked.*

Orthopaedic ward

The first site chosen was an orthopaedic unit in the acute unit and was seen as a priority for development in view of the pressure on the unit due to the high volume of older people in the district and the extensive waiting list for operations. The Unit Manager who assumed the role of project site leader valued the support of the consultant and the District Training Manager in developing the project site. He described the focus of activity, particularly those areas that could be improved quickly:

> *We were expected to bring people together and get them to think of themselves as an improvement team. Most of the people in my project were very responsive, although the clinicians were less involved. One or two doctors came to meetings, but they were happy to let others get on with it. They saw the improvements were aimed at areas outside the clinical ones, but they were not against it. We concentrated on the soft areas, you know environmental things. Later we moved on to harder areas, like improving appointment times.*

Acute Sector Portering Service

The selection of the portering service was seen as important in terms of having a support service represented in the demonstration site, particularly in view of its central role in the service. The project site leader described his early work with staff:

> *Our task was to look specifically at the role of the portering service and how it could be improved. Like many ancillary services it had been neglected. The porters felt a cast-off entity. There was this undercurrent that the porters felt they were not valued anyway and the service they provided was not valued. We'd been trying to do some work to boost their view of themselves and give them some self-esteem back. This project was welcomed for that reason.*

This project site leader went on the describe how the TQM initiative also proved useful in examining services which would subsequently come under pressure with the introduction of the *Working for Patients* reforms (DoH, 1989) .

> *The project was important as we could see a few years down the road that things would have to change. There would need to be a more flexible approach in terms of the working arrangements and a concern that we should be providing a better service. With this project we could sell it as a different package, by saying we're not here to cut down your staff, or ask you to work harder for less money or change your rota system. We're here to explore what you do. We started to look at what didn't work, what got up their noses, to see if there was anything we could look at to make the Portering Service one of excellence, the best in the country.*

A Health Centre

A health centre was chosen because it was seen to be badly in need of improvement environmentally in a number of areas. Staff felt the centre had been neglected with the 'NHS letting it fall apart', with poor relationships between some of the professionals and support staff based in the centre. When it came to announcing that it had been designated as a project site things did not go initially as expected as described by the Project Site Leader:

> *I remember the famous first meeting. We told them (staff of the health centre) that we were to be a TQM project site. The room was full of nurses, GPs and reception staff. There was a remarkable level of hostility. It was all about, 'you must have chosen us because we are low quality now'. It was a difficult meeting to salvage. I'm surprised they didn't lynch me! They all agreed at the end to go away and think about the things we might want to improve.*

After the initial meeting, responsibility for the detailed work in the site was delegated to a respected nurse manager who took a practical approach to developing the project. Her skills were seen as crucial to the success of TQM and her work with staff identified improvements that were needed and which, if forthcoming, would reduce the antagonism directed towards TQM. Three weeks later a further meeting was held and the project site leader was surprised by the change in attitude of staff:

> *I walked into a room full of storyboards, full of ideas, it was amazing. In three weeks they had produced a wonderfully creative response. I put it all down to the manager who led the project. From the original, very negative meeting we had a very exciting project from that time onwards.*

A Community Hospital

The fourth site selected was a community hospital for older people with a number of severe problems. The recent appointment of the Unit Manager and her commitment to improve the service resulted in an enthusiastic response to the invitation to become the fourth project site. The service was under threat as result of increasing criticism nationally of hospitals for older people and provided the impetus for the project site. The hospital, in an old and poorly adapted building, was facing a visit from the Health Advisory Service, which it was anticipated would recommend closure. Designating it a TQM project site meant that the district would provide external consultancy expertise and financial resources to manage the closure programme and transition to a new service based on small community units. The unit manager who became the project site leader described her delight at being one of the demonstration sites:

> *They identified the sites they wanted to be involved in the project and we were one of them. After the meeting with the other chosen sites I went straight to my UGM and said this is just what I've been waiting for. It's the key to unlock the door. It will bring everything together and raise the profile of the service and provide a focus.*

Focusing on the soft side of TQM

Once the project sites were selected, the managers leading the sites received training led by the consultant and the quality team. This involved an introduction to TQM philosophy and methods and detailed instruction in the use of quality techniques. In spite of the emphasis placed on the development of the training kit and the instruction in its use, when it came to work with their staff, Project Site Leaders shied away from

using the prescribed procedures that represented the 'hard side' of TQM with its use of statistical process control and other quality management tools (Dale, 1999). Instead they concentrated on the 'soft side', emphasising staff involvement and commitment, as this was seen as more likely to create the conditions for a customer-driven service promoted by the quality team. The approach taken by all Project Site Leaders is summed up by the leader of the health clinic site:

> *We wanted to light small fires of enthusiasm. We wanted to switch people on, and when you switch a group on the last thing you want to say is, hang on a moment, have you done a pareto analysis on some resource issue? We had a motivational and empowering approach rather than looking at things in a scientific way. We concentrated on the hearts and minds stuff.*

The direction taken by project site leaders also resonated with the human relations approach promoted by the DGM, with emphasis placed on developing a well-trained and motivated workforce who would in turn be more committed to developing a successful service. This approach was also seen as avoiding the risk that project site staff would be less interested in TQM if they were required to focus on the hard, measurable aspects of costs and performance and working to prescribed procedures (Dale, 1999).

Progress in project sites

Progress in the project sites was rapid with a wide range of achievements reported by early 1991. These included, multi-disciplinary staff meetings, joint problem-solving sessions, environmental improvements, training in customer care, and patient satisfaction surveys. Each site had access to a budget of £5,000 to support small environmental improvements. These included, new furniture for wards, new staff uniforms, walkie-talkie phones and improved signposting. Although the initial emphasis on environmental improvements was seen as important, it was recognised that more effective teamwork would be the real gain and would be nearer to the principles of TQM. The project site leader for the health centre described the focus of the activity in this site:

> *We only had a small amount of money, so we concentrated at first on physical improvements, the soft systems stuff that made small, but significant improvements. The big win though was getting everybody*

working together. This site was successful in involving all staff and GPs from the outset, although the doctors were less involved overall.

Although the sites were able to produce an impressive list of achievements, when the second year of the project started it was recognised by the quality team that the sites needed to move forward and explore some of the processes using quality management tools that would influence the quality of services provided.

We made good progress in the pilot sites, although they were peripheral to the core of the business. In doing that, and having some success in those areas, those looking on would say OK that's jolly good, but its still not hitting the heart of the business which would involve the clinical areas. (District General Manager)

The Project Site Leader responsible for the portering service described the frustration as he attempted to move beyond the initial activities and engage with clinical staff:

When we had done some of the internal things in the service we needed to look more closely at our relationship with other departments. How they related to the portering service, for example, junior doctors and nurses. How we could improve the service we provided. They did things which impacted on porters and the way they worked. We tried to talk to the doctors' representative, but he said there was nothing he could do. Porters were just seen as lackeys and told what to do. This attitude wasn't just confined to medical staff.

Phase Two: The Cost of Quality Project

Phase Two, which ran from late 1990 to early 1992, involved continued activity in the project sites, but also a scaling up of the initiative in one of the acute hospitals. The main activity was a Cost of Quality Project which was an attempt to widen the scope of the demonstration site with a more structured and harder approach, that would attempt to measure poor quality. The site chosen was a 17-bed ward for older people in the acute unit and was designed to examine all systems and processes relating to the ward, including identifying areas of non-conformance and wastage. The intention was to reinforce a message that had been promoted in the training programme, and reports from project sites that there were costs associated with poor quality and that these could be reduced by improving overall systems.

The project examined four areas: the time spent establishing and monitoring nursing standards, monitoring stock and drug levels, the cost of repeat activity where errors occurred and external failure costs such as complaints handling. The Quality Facilitator who lead the project described the extensive preparatory work that was involved in establishing the basis of evaluating the cost of quality:

> *For three months we looked at all systems and processes and tried to identify non-conformance and wastage. I worked with a clinical nurse manager and a sister to brainstorm areas of problems and then listed tasks to examine. We looked at the way the ward worked on a day-to-day basis and broke down the systems and processes. We then met with ward staff to draw up a supplementary list of issues. We looked at the customer supply chain and how other departments interacted with the ward. We were trying to identify the weak links and develop ideas for improvement.*

The acute sector UGM supported the project, but recognised that the activities involved in examining processes in detail would be uncomfortable for some staff and would affect the potential success of the project:

> *It was always going to be hard work. She (Quality Coordinator) was working with some hardened people who would be resistant to what she was doing. She would be raising questions about aspects of the service which had not been examined before. That would have consequences.*

The Quality Facilitator completed her report on the project and immediately experienced opposition to her work from the Finance Department and recognised that the project had probably alienated some finance staff:

> *They didn't get involved and were scathing about what we were trying to do. The Director of Finance was sceptical and that was disappointing for me. He got a student attached to his Department to comment on our report. On reflection it would have been wise to have got them on board earlier. The activity was too self-contained.*

The Director of Finance who had an equivocal attitude to TQM had his views reinforced by the cost of quality project, where he believed the quality team had attempted to develop an understanding of the costs of care without the necessary expertise. His comments on this project were unpopular and made for uncomfortable relationships with the DGM:

It wasn't a convincing report. It needed a proper evaluation of the cost of quality by a university department. I upset him (DGM) with my criticisms. His reply was we've at least tried to do something.

The Cost of Quality Project demonstrated the difficulties facing the Quality Team who were engaging in worthwhile activities, but at the same time failing to network with other departments (Bennett and Ferlie, 1994) where they could begin to mobilise support for their activities. The work on the costs of quality was always likely to be difficult as it was known that the Director of Finance was lukewarm about TQM and unlikely to support an activity that had implications for his department:

It wasn't his (the Director of Finance's) scene. He was an accountant by background and his priority was the underfunding of the district, not TQM.
(Quality Coordinator)

An attempt to involve clinicians

The TQM demonstration site was introduced at a time when there was an evolving relationship between managers and doctors following the Griffiths Report (DHSS, 1983). The steadily growing influence of general management was beginning to impact on clinicians by raising issues about management excursions into territory formally the preserve of clinicians (Ovretveit, 1998). At first this situation did not arise as a decision was taken early in the implementation phase not to involve clinicians directly, except as part of clinical teams in project sites. It was argued by senior managers that they should wait to involve doctors until there were some demonstrable successes and then present the achievements to them in the hope that they would want to engage in further project activity:

I think it was lack of confidence on our part about the new techniques and the TQM approach. We went for much safer targets. We went for areas where we thought we could prove it worked, and we wanted to get those successes under our belt before trying to engage people more widely in the organisation. It avoided all the usual problems of persuading clinicians giving up time.
(District General Manager)

The District Training Manager held a similar view about the right timing for involving clinicians:

It was around the thing of credibility. We wanted to be able to say that the approach we've taken has achieved this. These are the outcomes. Isn't that a good thing?

Other board members reinforced this view, although the decision was made on purely pragmatic grounds:

We didn't involve the doctors early on. There was this policy, we're not going to win with the doctors, so let's do something else.
(Unit General Manager)

A medical consultant who had taken on a management role summed up the views of doctors about TQM:

It didn't attempt to tackle, and kept well away from any issues about clinical effectiveness. If health care is about anything it's about clinical effectiveness in delivering a high quality service. That's the bit you've got to get right. People have been pussyfooting around for years with this issue and this (TQM) was another example.
(Medical Consultant)

He added:

Let me bite the bullet! Doctors didn't buy it. Maybe there were some false expectations as far as managers were concerned. I never had that false expectation. I was very sceptical that they would ever get involved. It was dealing with the soft side. Some of these things it did a good job on. I think it actually achieved change, in the outpatients, appearance of buildings, how people approached patients, their manner with patients, timekeeping, appointments, Patients Charter type of stuff.

Another Board member similarly had concerns about the decision not to involve clinicians, although this perception appeared over-optimistic about the willingness of clinicians to engage with TQM:

The major weakness was avoiding clinical quality. At first this was understandable. To make initial progress it was not surprising that non-clinical areas were chosen. However as time went on this position was difficult to sustain. It's all very well to see improvements in patients' stationery or the colour of a ward, but what about the effectiveness of the medical interventions that were taking place? Due to this I think the initiative failed to win over the doctors.
(Director of Finance)

Although the Director of Finance felt that there should have been an attempt to involve clinicians earlier, comments made to him by a consultant suggested that any overture would be risky, particularly when the DGM's strong commitment to making services more sensitive to patients' needs and consulting them on their opinions of the service was raised:

> *I remember one consultant, who was usually supportive of the general manager, laughing out loud at his (the DGM's) vision of the future way patients would be treated here. I think there was a feeling of scepticism in that area among medical consultants.*
> (Director of Finance)

Although the decision not to involve clinicians was maintained for a period it became clear that the demonstration site would need to address wider issues than environmental improvements, which were well under way by the end of 1990. Consequently a presentation was made to a group of doctors in the postgraduate medical centre. This meeting involved the DGM, District Training Manager, UGMs and the management consultant. It was a tense and difficult meeting with TQM given 'a frosty reception by the consultants present'. Issues were raised by the consultants as to why they had been excluded from the initiative:

> *They said why, if you've been doing this for a year, are you only just talking to us?*
> (District Training Manager)

The District Training Manager felt they were in a no-win situation:

> *The clinicians complained about being ignored, but on the other hand saw TQM as another management fad, with something else coming fast on its heels that they would be asked to engage with. Some of them couldn't stand managers. The comment was – they (managers) dream up these things (TQM) to fill up their CVs and move on. Doctors are different. They make a commitment to the organisation and tend to stay. Managers in their view are 'CV fillers'. You can see we had a hard selling job trying to get them on board.*

The acute sector Unit General Manager (himself a doctor) remembered this meeting and the reaction of his clinician colleagues and some of the wider issues that were likely to influence their views of what was essentially a management-led initiative:

> *I remember the meeting well!. One or two (doctors) might have bought into it, but there was a lot of sarcastic criticism. I was wheeled in (as a doctor) to try and ease the way. I think there were some bigger issues around, which were about the*

whole question of management and the professions. There is a conflict with professional people. To me it's about control and the fact that the professions like to see themselves as autonomous and self-regulatory. Medicine is one of the strongest at playing that card. Management is fine so long as it is facilitating them, actually doing what they want to do. The moment it tries to organise them to do something different then management is no use to them.

From this clinical perspective it was clear that TQM was perceived as another attempt by managers to enlarge their sphere of influence and would raise questions among clinicians about attacks on their autonomous status:

In the end it (TQM) was seen as a management initiative and there were those (doctors) who were opposed at that time to any management initiative. If it had been left to run, and at the end of the day if you took quality seriously, it would start to impinge on their work, how they worked and ultimately questions about their competence to do the job. Then it would have become a threat.
(Unit General Manager)

In spite of the attempt to engage with clinicians the DGM recognised that they were unlikely to participate in TQM as this would have raised wider issues about control:

They hated it because they thought we would be telling them how they were going to work, and for 40 years they'd had total and complete autonomy. They thought the developments around at that time were all about managing doctors.
(District General Manager)

Spreading the TQM message

Staff training programmes

The main method used to generate a district-wide interest in TQM was through a staff training programme designed specifically for the demonstration site staff and other managers and professionals who it was hoped would develop a commitment to TQM and cascade it throughout the district. A series of three-day courses for middle managers and senior professionals focused on 'quality, leadership and change' (QLC), whilst a series of one-day quality workshops for professionals was provided to 'explain the concepts and benefits of TQM'. For frontline staff a series of one-day customer care workshops was offered. The district hoped in the words of the quality team that 'quality pioneers would use the training to identify the "can do" people who would promote TQM in their units and departments'. The intention was 'to create a critical mass of staff who would start thinking and acting in a quality way, with the "can do" people acting as catalysts for this process'.

A problem the quality team faced was the sheer size of the organisation and the extent to which sufficient staff could be introduced to TQM concepts and trained in quality methods. This was also compounded by limited financial resources available to support training and the unwillingness of managers to promote TQM training and a lack of staff motivation to attend training sessions. It was acknowledged that the staff training programmes did not effectively target staff who would be key to widening the implementation of TQM:

Not all managers and staff signed up for training. Lots of staff between the top of the service and the bottom didn't attend any training courses. There was a definite gap in the middle of the organisation. First line managers and supervisors didn't get tackled systematically. We did customer care training for frontline staff, but they didn't get the support at the next level up.
(District Training Manager)

The QLC programme aimed at middle managers was to have TQM sold to them, just to see if they were going to come on board. If they were not we recognised it would be a waste of time. It was fairly successful with quite a bit of commitment. There was some resistance, but we tended to target the areas that were enthusiastic. There were obviously areas that didn't want to know. They were left to do their own thing. That was probably a mistake in hindsight.
(Quality Facilitator)

The quality team also received feedback from some staff which suggested that in spite of apparent enthusiasm for TQM on training courses, once managers were back in the workplace their willingness to set time aside to instruct staff using the training aids was limited.

The training was intended to cascade TQM through the service. The idea was to share the work of the project sites with other people. We took them though the project kit, but it wasn't widely used in the workplace. People said 'my manager doesn't do this', even though we knew their manager had been on the training. Their attitude was 'we haven't got time for this', or 'how much did it cost to produce?'
(Quality Facilitator)

The quality team also encouraged clinicians to participate in the training courses, but with limited success, according to a Quality Coordinator:

We had two or three doctors on the courses, but they didn't want to be there. They said that the training was too long and took them away from their clinics. We had some doctors who attended but didn't say a word throughout the course.

Problems of language

In spite of replacing some of the terminology of TQM early in the development of the demonstration site in order to reduce resistance to the quality message, and to emphasise the 'soft' aspects of quality management, the language and concepts of TQM continued to cause resistance amongst some staff and their willingness to participate in training. Two Quality Facilitators summed up the difficulty they faced in overcoming resistance to the language of quality management:

> *The word 'management' in TQM caused more problems than anything else. The staff perceived it as being for managers and not something relevant to everybody in the organisation. From the staff who didn't come on board it was 'well that's TQM, we're not managers'.*

> *Although we got rid of some of the language of TQM it still went down like a lead balloon. It was full of jargon, strategy, flow charts, models, etc. The whole language of TQM alienated people.*

Staff concerns about the future of the service

A further factor which was felt to have limited staff interest in TQM training was the concerns about the problem of sufficient resources, with the consequences of Government spending policy on the NHS increasingly impacting on the front line of the service (Ham, 1999). This was further reinforced by the growing uncertainty among staff about the future of the service, as pronouncements from senior managers about the possible consequences of the *Working for Patients* (DoH, 1989) reforms on the district were interpreted as threats to jobs:

> *Staff were obsessed with shortages of money and the increased pressures at that time. It led to a blame culture that was around at that time which we never actually tackled.*
> (Training Manager)

> *Yes, it (Working for Patients) affected the progress of TQM. It was introduced at a time of great uncertainty and some people dug their heels in and stuck to the traditional boundaries. They were under pressure and with the changes that were coming didn't sign up to TQM.*
> (Project Site Leader)

An inclusive or exclusive approach?

A further barrier to the successful cascading of TQM throughout the district was the perception that TQM was the preserve of a specialist group of staff, whose approach to

the management of the initiative led staff to view the quality team as an 'elite group'. Issues of exclusive or inclusive approaches to the management of the demonstration site and the management of boundaries between the TQM core team and the wider district system (Bennett and Ferlie, 1994) raised questions in the minds of staff who felt they had the potential to support the wider adoption of TQM. The lecturer responsible for the management development programme was puzzled by the lack of integration between the TQM training programmes and the management development programme, and why the quality team did not support greater cross-fertilisation between the different training programmes, as this decision limited the potential to reach a far larger group of staff who were attending the management development and related programmes with the TQM message. He suspected that there was an issue of elitism surrounding the demonstration site activities and this led to a lack of work at the boundaries of the two training systems:

> *We continued to run the management training programme alongside the TQM training, but there was no attempt to integrate the two. You'd have thought that if they wanted to spread the word throughout the district that they would have integrated it into all the training programmes. The majority of staff were being trained on our programme and did not take part in the TQM training. In the end our programmes were marginalised and had no TQM input, in spite of the large number of staff attending the courses. I think the DTM and the consultant wanted to keep it to themselves. There was a lot of prestige being involved in the project and certainly an attempt to build a quality department, with training on the sidelines.*

The Impact of *Working for Patients*

The announcement of the successful bid for the TQM demonstration site coincided with the publication of the White Paper, *Working for Patients*, (DoH, 1989) with its radical reform agenda for the service. Although the first months of the demonstration site were relatively unaffected by this agenda, towards the end of 1990 managers begun to raise doubts about the future of the initiative as the demands of *Working for Patients* grew:

It began to adversely affect TQM. It distracted senior managers, who were more concerned with 'will I survive?'. We also saw that the emphasis in the reforms was on cost and volume as opposed to quality of service and that was a warning.
(Unit Manager)

Consequences of the temporary absence of the DGM

The introduction of *Working for Patients* had wider repercussions in the District and was thought to be a factor in the DGM's decision to apply for a travelling fellowship in mid-1990. In late 1990 he spent six months in the USA studying quality management in business and health care organisations (this would be the first of a number of overseas visits by senior managers and project site leaders, including further visits to the USA, Japan and Australia).

He saw this as supporting his continuing interest in quality management which had first been kindled by his visit to Canada in 1985 and his leadership of the TQM initiative. His interest in applying quality techniques in the NHS had led him to write a newspaper article about the potential of TQM, based on the personal experience of a member of his family in the health care system, which had convinced him that there should be improvements in the way patients were treated.

Despite the difficulties I saw the potential prize to be reaped from TQM to make it worth exploring. I felt it was a way of taking ideas forward and wanted to give it some time. It appeared very relevant to the NHS. I came back (from the USA) with continuing enthusiasm for it, although I was left slightly sceptical about the extent to which it had actually transformed some of the companies I saw. When I got back I saw we needed to go further, although achieving quality in health care using TQM techniques is going to be more elusive than in manufacturing.
(District General Manager)

Although there was no doubt about the DGM's commitment to TQM with his study tour to USA seen as a natural stage in his personal development, it was nevertheless viewed sceptically by a number of his colleagues, who felt the *Working for Patients* reform agenda was also a major factor in his decision to pursue his interest in TQM in the USA at this critical time:

He went to America. That tells you a lot doesn't it? You got the impression he tried to be positive about it (reform agenda), but it wasn't the type of NHS he supported and I think America came up at that time and off he went. I never thought he was particularly sold or keen to promote it (Working for Patients). *His idea was to*

provide a good service for everybody without problems of people getting into a two-tier service. I think that bothered him.
(Health Authority Member)

I don't think he was interested in trust status. It was a shrewd move on his part going to the USA. He used to say we'll be the last district in the country. They have to take us in kicking and screaming when it's down to level 4 (the final fourth wave trusts).
(District Training Manager)

Whatever lay behind the personal motivation of the DGM to undertake the study tour, it left a temporary vacuum in the leadership of the demonstration site, which was filled by the appointment of the Director of Finance as acting DGM. The loss of the DGM's high profile sponsorship role affected the small group of staff leading the demonstration site, particularly the District Training Manager, who lost her main support in her role as product champion. His absence also resulted in a loss of momentum in the demonstration site:

I had a close working relationship with him (DGM). He felt we could deliver this and he was heavily involved in the whole process. He chaired the Quality Forum as well as meetings between us to discuss what was going on and how we could move things forward. When the Director of Finance took over he only wanted an overview of things and the meetings stopped. He was really 'hands off'. You felt the brakes were on while he was in charge. He was less charismatic and started asking questions like... 'what are we getting for our investment?' It was a very functional approach. It lost impetus under him, definitely.
(District Training Manager)

The DGM had similar views about events during his absence:

It ticked over, it continued, but there were no big breakthroughs. The fire was smouldering, but it hadn't spread in the way I would have wished.

The Director of Finance who took over responsibility during the absence of the DGM had his own perspective on this period:

He (DGM) went to the States on the back of TQM. I thought he would leave or take on a national role on quality when he came back. I decided not to chair the Quality Forum as we needed to refocus the whole organisation. My assessment of the situation was that too much priority was being given by him (DGM) to TQM. Tough management was needed. We had a business plan to deliver with key objectives to meet. I washed my hands of the committee (Quality Forum). I felt the undercurrents – 'he's not interested'. I think some staff felt I was not fully

committed, which was not true. I just felt there needed to be a greater sense of balance. It was the bigger picture. We had to demonstrate to the Region that we knew what we were doing. We had to convince them that we were badly underfunded. My job was to plan and deliver that. I didn't want to spend my time in the detail of TQM. It (TQM) was a good thing. There was a buzz around the district and we got a reputation, but there were bigger things.

Loss of the Director of Personnel

The increasing pace of reforms also meant that new management structures were being created in those districts intent on making an early application for trust status. The Director of Personnel took up an appointment in another district and was seen by the quality team as a particular loss. He had been strongly committed to the TQM initiative from the outset and developed human resource policies to support the new ideas emerging from the demonstration site (for example, individual performance reviews, relating managers' performance to standards established in the demonstration site). He also had line management responsibility for the District Training Centre where the TQM initiative was located and supported the quality team, representing their interests at Board level. His replacement was equivocal about TQM and was unwilling to provide active support to staff involved in the demonstration site:

He (former Director of Personnel) was very bright, on the button. He was a good bridge between what was going on practically, and what was in line with TQM theory. I missed him once he'd gone. He was very supportive with the underpinning people process from the Personnel front. He'd been my boss with TQM, half under him and half under the general manager. His replacement was just not in the same league.
(District Training Manager)

The new Director of Personnel was a traditional industrial relations man. She (DTM) clashed with him. They didn't see eye-to-eye and his lack of support for TQM.made her unhappy. He didn't understand TQM, The concept was alien to him. He felt we had another agenda.
(Training Manager)

The loss of the Director of Personnel was an example of the importance of continuity in key people involved in change processes (Pettigrew et al, 1992) and the consequences for such processes of the loss of those people and their support for change. In the case of the TQM site, the loss of the Director of Personnel with his commitment to the change agenda, and the appointment of a less committed new director, had severe implications for TQM.

Financial Crisis in the Acute Unit

It was during the absence of the DGM in the USA that the acute unit suffered a major overspend of £500,000. This was part of the continuing financial problem that had hit the sector each year since 1987. But the depth of the crisis was much greater as a result of the separation of the acute and priority care sector budgets under the *Working for Patients* (DoH, 1989) reforms. This was also a period when there was increasing pressure on DHAs from regions to reduce their overspends in the run-up to the implementation of *Working for Patients* (Bennett and Ferlie, 1994). This pressure was compounded by the new Regional General Manager who was taking a tougher line with the district in view of the continuing tension around underfunding.

At district level the financial crisis was regarded as a consequence of the establishment of acute and priority care Directly Managed Units (DMUs), following the first stage of the implementation of *Working for Patients.* This meant that the budget for the district was ringfenced for the first time, with the tradition of using the priority care services budget to support the acute unit at times of crisis no longer an option with the separation of the two units (in effect cost centres with devolved budgets). As a consequence, the Director of Finance recommended that the demonstration site be put on hold, resulting in activities being suspended at district-wide level, although project sites were still able to continue their activities:

> *He (Director of Finance) called for it (TQM) to be stopped. It was a mistake. He didn't look at the missed opportunities. You had to recognise that at that time there was severe financial difficulties in the acute unit, so that anything to do with quality was seen as a fluffy extra and therefore not appropriate in times when the chips were down. There was a real slow-down because of the financial crisis, so that all the money for TQM was in limbo and got frozen. We were not able to do all the things we had planned at that time. It didn't get unlocked until after the DGM returned. The message this sent out was – quality's for the good times, that quality's disposable. Between December and March we did nothing, although at least the funding was ringfenced.*
> (District Training Manager)

Unit General Manager resigns

As the financial crisis in the acute sector deepened it ultimately had consequences for the UGM who was held responsible for the overspend and was forced to resign. This decision created tension between clinicians and the management of the district, although

it was recognised that the Region, with its tougher attitude to financial management, had strongly influenced the decision:

> *He was a casualty of the overspend and was moved on. He paid a heavy price for it. He had a good relationship with his clinicians. His going caused a lot of problems among the clinicians and they said to me 'you can't trust those people at headquarters.'*
> (Health Authority Manager)

Raising the profile of TQM

As a consequence of the decision of the Director of Finance to make TQM a lower priority and the resignation of the Director of Personnel, the District Training Manager decided that TQM would need to be protected and given a more strategic voice in the district if it was to continue:

> *We recognised there needed to be a senior manager responsible for driving it through because it wasn't endemic in the organisation. There weren't enough fires burning, enough people of the right skills engaged in it.*

In order to give the demonstration site board level representation, the District Training Manager wrote to the DGM while he was in the USA and put forward a proposal to make quality a directorate in its own right. On his return from the USA he quickly began work with the District Training Manager to establish quality as a directorate:

> *She wrote to me in America and said she wanted to head up Quality and Training as a directorate in its own right. When I returned we set it up.*
> (District General Manager)

> *When he returned from the States I said I was really unhappy working for the new Director of Personnel. He was very industrial relations focused. It didn't sit very comfortably with some of the quality things. I said I might have to look round for something else as I don't think I can work with this chap. He (DGM) came up with the proposal to take quality out of Personnel and making it its own directorate. We had about 18 or 19 on the Board at that time, it was quite unwieldy and it got through the Board because he (DGM) wanted it and it came into being in 1991.*
> (District Training Manager)

Although the District Training Manager was now a Director in her own right with a place on the Board, the attempt to raise the profile of TQM proved uncomfortable for the District Training Manager, and unpopular with some board members:

I felt unsupported. It was a big step up for me from being a head of department to a director. I wasn't given any guidelines or expectations. There was no role clarification. I just wrote my own job description. I had to start thinking strategically and corporately about how we could influence quality. My viewpoint was, we've got a few projects that you've got to manage, what's this organisation going to be like in 10 years time and how are we going to use quality to get us from where we are now to where we want to get to? It was a whole new area I hadn't been prepared for. I had to fight my corner at the Board. You had to do things in a certain way and it couldn't be seen that I was 'teacher's pet' (referring to the support of the DGM) because it wouldn't have done me any favours either. I had this feeling that I was a fish out of water, not prepared for it and had no backing. It was a complete baptism of fire.

A Unit General Manager reinforced this perception of the pressures on the Board at that time and that TQM was seen as marginal to the main challenges facing the District:

Yes, the Board meetings were dominated by other issues. The agenda wasn't being driven by a quality agenda. When the DGM came back from the States he brought her (DTM) on to the Board in an attempt to raise the profile of quality issues and push it up the agenda. I don't think it made much difference one way or another. There were bigger issues, plus the whole question about how much people were really buying into TQM.

The District General Manager acknowledged that establishing quality as a directorate to raise the profile of TQM had taken place at a time when major structural changes as part of the *Working for Patients* reforms were being implemented. The introduction of clinical directorates meant new faces on the board including clinicians with management responsibilities who brought with them a negative view of TQM. This had a significant impact on the District Training Manager as a board member:

It was a brave attempt that failed. It brought her into the front line of dealing with doctors who were extremely difficult at that time. It was a major challenge to all of us. It was breaking the mould of working with the doctors and she got caught up in the battle. She had a wonderful naive enthusiasm and just got stuck in. I don't think she recognised at the time the scale of change that we were trying to tackle and got caught up in the cross-fire and it broke her spirit.
(District General Manager)

Case Study Analysis and Discussion

We now turn to an analysis of the themes identified earlier and relate these to the issues emerging from a grounded approach to the empirical data, drawing on theoretical perspectives to illuminate the issues of implementing TQM in the demonstration site.

There are four main themes, key people leading change, the implementation of TQM, involving clinicians and the impact of the *Working for Patients* reforms.

Key people

Sponsoring TQM: the District General Manager

The DGM's commitment to TQM was seen as absolute and his sponsorship of the demonstration site was evident from the analysis of case study material. In this he met the requirements for the role of sponsor of strategic change, through his prestige, power and authority (Bryson, 1995). In playing this role the DGM fitted with Bryson's profile of the leader who is able to articulate the purpose and importance of the need for strategic change (TQM), relating it to the mission and competences of the service, likely changes in the environment, and the issues the service will face in the future. According to Bryson, without a powerful sponsor a strategic change initiative is likely to fail, and is particularly important in keeping the change process on track as it hits the inevitable 'rough spots'.

But his ability to sponsor TQM and his obvious commitment to the development of the demonstration site also contained risks. In describing the leadership of TQM, the DGM was charismatic, inspirational and staff-centred, with a strong commitment to the quality team and the project site leaders. This leadership style was well suited to the evangelical approach engendered by the early implementation of TQM, and generated loyalty among staff who worked closely with him and who played a crucial role in the demonstration site and supported it through its initial phase. However, this leadership approach became less secure as the impact of the *Working for Patients* (DoH, 1989) agenda began to bite. The increasingly powerful external pressure from the RHA to begin the restructuring of the district, exacerbated the budgetary pressures on the service as it moved towards trust status. This led to some managers questioning the priority given to TQM in the face of these pressures, particularly the Director of Finance and later, clinicians at board level. With the growing impact of the reform agenda, a more task-centred approach was emerging in the district and threatened the DGM's management style, and was probably a contributory factor in his sojourn in the USA.

The product champion: the District Training Manager

The District Training Manager with her 'evangelical' commitment to TQM, was clearly the key actor in the demonstration site. She had brought to the district a different approach to staff training and had promoted a more consumerist notion of health care prior to TQM. This, allied to an ability to build a team of staff committed to her approach to training and a wider appreciation among some of the adherents of the *NMA*, meant she was an obvious candidate for the role of product champion. With both vision (being clear about the potential of TQM to transform the district), and also having the capacity to drive the development forward ('I was seen as the person that got things done') she met Bennett and Ferlie's (1994) criteria as someone who embodied both vision and drive and had the single-mindedness of the entrepreneur. She sought not only to introduce TQM, but to bring about a new approach through the development of a radically different model of managing the service. With this degree of commitment to the TQM project, she visibly personified the product champion who is willing to work with a change strategy in the face of deeply rooted opposition – in her case from clinicians and many managers and staff in the district who resisted the overtures of the strategists and implementors of change (Garside, 1998).

The third key actor in the strategic management of the demonstration site was the external consultant. His role and influence will be discussed in the next section in the context of implementing TQM.

Implementing TQM

In their report on the evaluation of TQM demonstration sites, Joss and Kogan (1995) identified a number of factors which influenced the decision of DHAs to bid for TQM projects, with many sites experiencing difficulties as their original ambitions became impossible to achieve. In the case of the district, the reason for applying for funding was largely pragmatic. TQM offered an opportunity to access financial resources to support strategic change, and this was allied with the interests of the DGM and his commitment to implementing the *NMA* through the vehicle of TQM. These were both major influencing factors.

Preparedness for TQM?

Where this pragmatic approach turned out to be a weakness was in the lack of any prior assessment of the district's readiness to respond to the introduction of TQM. The idea of a prior assessment is seen by Joss and Kogan (1995) as essential in enabling a service to establish a common understanding of the definitions of quality and the requirement for continuous improvement required within the TQM model. The district, in common with other sites nationally, was keen to secure demonstration site status allied to urgency on the part of the DoH to establish TQM sites that led to the district developing an approach to TQM which made only limited progress in selected project sites.

The quality team adopted a predominantly top-down approach to implementation, led strongly by the DGM and the quality team, but was unable to secure the commitment of sufficient staff at operational levels beyond the project sites. Although there was some evidence of limited bottom-up initiatives by frontline staff in project sites, these appeared to remain isolated examples. In describing an approach to the implementation of TQM, Joss and Kogan (1995) see strengths in a 'top-led and bottom-fed' process in which the 'top' formulates its policies on quality after it has created a joint agenda with staff at the front line, with the development of more formal description of requirements, standards and conformity, once it has the support of operational levels of the service. The establishment of a joint agenda around TQM was absent in the district and resulted in a lack of support from sufficient managers and frontline staff that effectively limited the diffusion of quality management techniques in the district.

Evidence from the case study suggests that the district was heavily influenced by the management consultant, and adopted a model of TQM which bore a striking resemblance to the approach adopted in another district which employed the consultant based on a model of service quality he had developed in the business sector. The district obviously needed outside consultation as it was required to develop a TQM strategy that was intended by the DoH, 'to cause a change in culture, organisation and working practices' (Joss and Kogan, 1995: 38). What did not happen was any form of assessment of the potential of TQM to bring about transformational change through the mechanism of TQM. In this sense the demonstration site was over ambitious in view of the culture of the NHS at that time, and the likely constraints the quality team would face in an

organisation where the content of change would challenge autonomous professionals (Hinings et al, 1991).

The experience of implementation also raised questions about the compatibility of TQM techniques, and how far processes developed in other contexts were transferable to the NHS. Introducing a model of quality which had been successful in the business sector, in very different environmental conditions and a different management culture, reinforces the assertion that there are risks of 'an over-mechanistic transfer from the private sector with assumptions of similarity' (Ferlie et al, 1996: 226). This would question the use of a 'one size fits all' notion with universalistic approaches to TQM, 'seeing it as a fixed entity that can be utilised by any organisation in any circumstances' (Hill and Wilkinson, 1995: 12).

Although the consultant no longer worked with the district after 1991 his influence remained in the structure and processes introduced under his guidance, confirming Joss and Kogan's (1995) claim of the power of consultants in a number of demonstration sites evaluated. The dilemma facing the district at the outset of the initiative was the recognition of its lack of expertise and the need for external guidance, although this posed risks according to Dale (1999) where too great a reliance is placed on consultants, whose prescriptive approaches do not necessarily suit the particular culture of a service. These difficulties are compounded according to Joss and Kogan as TQM models are particularly difficult to operationalise when they consist mainly of exhortation, training and the use of simple diagnostic tools, yet at the same time are 'expected to bring about widespread organisational change' (p37).

Issues of diffusion and boundary management

How effectively an innovation diffuses within an organisation is related to issues of boundary management (Bennett and Ferlie, 1994). In opting for a project site model, the failure of TQM to diffuse reinforced the perception that the team leading the initiative were 'special' with notions of exclusiveness and elitism. This perception of the team raises fundamental questions about innovation and how groups leading change manage their relationships with the wider organisation. It is argued (Pettigrew, 1985) that teams who are at the forefront of innovation face dilemmas about the management of their

boundaries with the wider system. Teams, according to Pettigrew, can be characterised as exclusive or inclusive, dependent on their relations with a wider organisational system. A group adopting an exclusive approach would have limited permeability at its boundaries, adopt different values and beliefs and assumptions and make limited exchanges with the environment through a restricted network. On the other hand, the group adopting an inclusive stand would see the reverse of the above characteristics, with highly permeable boundaries, similar values and cultural assumptions and a highly developed network and linkages which allowed it to facilitate a broad range of transactions with the wider system.

Evidence from the case study suggests that there was some degree of movement between the two characteristic approaches to the management of the quality team's boundaries with the wider system, although there was a perception on the part of a number of staff that the quality team had adopted a primarily exclusive stance which alienated staff outside the team or the project sites. But as Bennett and Ferlie (1994) argue, teams are faced with difficult decisions. There is a need to be seen to be different enough to create an agenda for change, but at the same time there is also a need to avoid perceptions that they are so different that they are 'folk devils' (p114). This accords with the idea of innovators who push to awaken the organisation to new realities and attempt to disengage it from the past, (Kanter et al, 1992) and by necessity maintain a strong group identity in the face of inertia and resistance to change.

In the case of the district, a relatively small number of staff (the DGM, a handful of senior managers, the quality team and project site leaders) could be considered the 'special team' who had the complex task of managing their boundaries with the district and building bridges with those who had similar values and others who were likely to be less receptive to the message of TQM. The risk of this strategy according to Bennett and Ferlie (1994) is limited influence over the wider organisational system, whereas inclusiveness carries risks of absorption and co-option undermining the drive for change. The tension between these two positions and their management would challenge the demonstration site and limit the effective diffusion of ideas in the district.

TQM as a threat to managers

The other issue which emerged from the analysis of case material was the view that managers who participated in training did not adopt TQM techniques or support their staff following attendance at training courses. In attempting to understand the apparent resistance to adopting TQM, Hill and Wilkinson (1995) argue that introducing TQM means fundamental changes in an organisation's processes, and as a consequence barriers to the implementation of TQM will be erected by powerful groups who are intent on maintaining the status quo. They are critical of the prescriptive approaches taken in the TQM literature which ignores issues of organisational power and behaviour, and as a consequence lacks understanding of the problems of the reality of implementing TQM. This analysis sees TQM as a potential source of conflict between competing interest groups, rather than a force for unity, with managers shaping their interest in quality to secure or advance their careers. This analysis of some of the consequences of introducing TQM reveals some of the possible reasons for the reluctance of managers to give their wholehearted support to TQM, which impeded the spread of TQM activities in the district.

Clinicians' engagement with TQM

In their analysis of the evaluation of demonstration sites, Joss and Kogan (1995) argue that it is not possible to claim that an organisation is implementing TQM as long as a large and influential group of staff remain uninvolved. This was the case with clinicians in a majority of sites nationally as well as in the district researched. Joss and Kogan argue that it is essential to secure the cooperation of clinical staff at an early developmental stage, and especially before a site is launched, as the longer their involvement was left, the more difficult it would prove subsequently to involve them.

A factor that Joss and Kogan did find suggested greater potential for the involvement of clinicians was the need to secure trust status and the development of processes which would convince purchasers and GP fundholders that a service could meet quality standards. The district on the other hand made a decision that both the acute unit and the priority care services were likely to be third or fourth wave trusts, resulting in less pressures on the district, in contrast to the situation where districts intended to be in the early round of trust applications. This lack of pressure may have been a contributing

factor to the reluctance of clinicians to engage with the quality agenda which would later be a significant element in contracting. In other words, there was insufficient pressure for a state of forced transformational change (Johnson and Scholes, 1999) to exist, where the service had to respond to powerful external pressures if it was to survive.

Importantly, engaging with clinicians meant acknowledging an important factor in strategic change in the NHS – the issue of professional power. Change in professional organisations requires the commitment of key professional power holders, and is regarded as the significant factor in any proposed change agenda, involving a critical number of professionals who consent to, or ideally lead change (Hinings et al (1991). In their study of receptivity to change, Pettigrew et al (1992) identified the critical role of effective managerial–clinical relations, and the risks of clinicians exerting a powerful block on change if they were in opposition to the strategic leadership's intentions.

Although issues of trust status acted as incentives for clinicians in some districts, Joss and Kogan (1995) nevertheless found that the majority of clinicians, certainly at consultant level, had little involvement with TQM in the demonstration sites evaluated, which raises the wider issue of managing strategic change in professional organisations. Here the work of Denis et al (1996) provides a useful way of making sense of the difficulties the quality team faced when they attempted to involve the district's clinicians in the demonstration site. Denis et al argue that organisational archetypes consisting of a number of characteristics tend to cluster together to form an internally coherent pattern. Structural arrangements and decision-making processes are supported and legitimised by ideas, beliefs and values forming an organisation's 'interpretative scheme'. If radical change is to be successful it requires movement from one 'archetype' to another, in the process transforming both the interpretative scheme and the structural arrangements of the organisation.

In the case of the demonstration site there was evidence from the case material of the strength of resistance by clinicians and the rejection of quality management and the refusal to let it play any part in clinical activity. In this sense the clinicians' reaction supports Ferlie's (1999) analysis of the district, conforming to the traditional NHS

archetype, with dominant professionals (particularly elite professionals such as doctors), hyper-politicisation of decision-making, bureaucratic forms, and a distinctive public service culture and values deeply rooted in the district. Consequently the overtures of the quality team to clinicians challenged this traditional archetype, and was one where managers had no legitimacy in raising questions about quality issues outside their traditional areas of non-clinical activities (Ovretveit, 1996).

What the resistance of clinicians confirmed was Pettigrew et al's (1992) argument that the relationship between managers and clinicians is critical in change, and to gain the support of clinicians requires initiatives on the part of managers to engage with them, building a climate of trust and understanding which clinicians value in order to trade effectively with them as part of the management brief. There was no evidence of this in the district, certainly on a scale that caused comment from managers or clinicians. As far as TQM was concerned there had been little engagement with clinicians, except junior doctors and a small number of general practitioners who reluctantly participated initially in some multi-disciplinary meetings in project sites. There was certainly no evidence of work with senior consultants who would have been powerful opinion formers in the clinician community.

Other factors worth consideration were the rise of management as a new ideology (Strong and Robinson, 1990) in the service, and the legacy of cutback management, with senior managers' excursions onto 'doctors' turf' during the financial crisis which led to temporary bed closures and imposed restrictions on clinicians' workloads (Flynn, 1991). Potentially, these were all areas where managers were regarded suspiciously by some clinicians, and were likely to contribute to a reluctance to allow managers to further extend their influence over the service. Whatever the speculation for the rejection of TQM by clinicians, their action exerted a powerful block on change (Pettigrew et al, 1992) and limited the extent to which the demonstration site was able to move beyond environmental improvements and influence clinical processes.

The reaction of clinicians in the district TQM confirmed Hinings et al (1991) in their study of professionals in the context of strategic change, that the agenda associated with TQM meant that the commitment of professionals was essential if it was to have any

chance of success. In the end no clinicians allied themselves to the work of the demonstration site, and for those that did have some involvement, it was as detached observers, not directly obstructive, but not overtly supportive except where there were clear practical benefits, such as improvements in the GPs' working environment in the health centre. This was probably the extent of clinicians' engagement with TQM.

Impact of the *Working for Patients* reform agenda

The demands made on demonstration sites in setting up the structures and processes for implementing TQM need to be seen against the background of the service-wide organisational change, much of it incompatible with TQM (Joss and Kogan, 1995). In fact the powerful impact of *Working for Patients* (DoH, 1989) demonstrated how quickly the restructuring of the district was taking place as a result of the externally driven changes (Ferlie et al, 1996) emanating from a Government intent on establishing the market-driven system as rapidly as possible (Ham, 1999).

Early in the reforms the establishment of directly managed units, with their greater autonomy, including the transferring of functions that had previously been the responsibility of the district, resulted in a degree of fragmentation that was inimical to progress in the demonstration site. The key change here was the transfer of financial responsibility to the DMUs which precipitated the crisis in the acute unit leading to the resignation of the UGM who had been supportive of TQM (probably uniquely as a clinician). Although difficult to identify in the empirical data, the growing assertiveness of the Region (Ham, 1999), under a newly appointed and tougher-minded RGM, may have played a part in placing more pressure on the district and the call for the 'sacrificial head' of the UGM. A further key element of the reforms was the introduction of the clinical directorate model, where doctors appointed as clinical directors sat on the Board for the first time, with responsibility for a specific area of clinical responsibility based on a care group. It was ironically the introduction of clinical directors at board level which was seen as responsible for helping to further undermine TQM when the District Training Manager was given a directorate role and joined the board. The agenda at the board was dominated by the future restructuring of the district and the ever-present financial issues, with clinical directors testing their newly acquired powers to challenge managers across a range of issues. As Ferlie et al (1996) argue, doctors do not have a

high opinion of managers or management and negative stereotypes exist on both sides. The decision to give TQM representation at the board was always likely to lead to a strong reaction from those clinical directors who were sceptical about TQM and its value to the service, with an opportunity to weaken its influence further by marginalising the District Training Manager.

These changes exemplified the problems described by Garside (1998) where managers in the NHS are continually forced to focus on immediate solutions to problems and have little opportunity for developing longer-term change strategies, as one initiative submerges the previous one, and with each requiring management action. Although the implementation of policy is tempered at the periphery of the service by decisions made by managers and professionals (Ham, 1999), the difference with *Working for Patients* (DoH, 1989) reforms was the resolve of Government to impose change on the service that quickly overwhelmed previous policy initiatives. The demands made on managers in the NHS are seen by Pettigrew et al (1992) as part of the culture of the service which reflects the top-down and short-term pressures from politicians which are relayed through the NHSME, regions and ultimately down to district level. Pettigrew et al described a service where 'priorities' escalate in number till they lose all meaning, arguing that it is 'persistence and patience in the pursuit of objectives over a long time period that is likely to be associated with achieving strategic change' (p285). The consequences of *Working for Patients* (DoH, 1989) and the structural and processual consequences would quickly begin to undermine the demonstration site, confirming Ovretveit's (1994) view that TQM initiatives were undermined by policy changes and directives which demanded immediate management attention, turnover of management staff and restructuring of units, all combining to reduce the impact of TQM. Taken together, these various factors suggest that TQM fell into the category of the 'symbolic policy' where implementation was no longer a serious consideration (Korman and Glennerster, 1985) as a more urgent agenda unfolded.

The other important consequence of the reform agenda was the changes in leadership in the district. The temporary absence of the DGM while he studied the USA was critical in terms of continuity, and led to a loss of leadership at a critical time when other

supporters of TQM were lost to the district. The reasons for the period in the USA and timing of the fellowship remain controversial, and clearly led to a hiatus in the development of TQM in the district. Coinciding with the DGM's absence was the increasingly serious financial position of the acute unit, which had become exposed to the consequences of the district separating its services into DMUs, with the subsequent loss of the supportive UGM. These problems were further exacerbated by the loss of the Director of Personnel who had promoted TQM and whose replacement brought a much more sceptical approach and quickly led to the separation of the demonstration site from the Personnel Department in order to safeguard its future.

The loss of two key personnel and the temporary absence of the DGM combined to affect the stability of TQM and certainly drained energy and commitment from the demonstration site (Pettigrew et al, 1992). What is also exposed by the impact of these changes was the risks to the strategic change agenda when the leadership is too dependent on a small number of individuals. Although change requires key people in critical posts to lead change (Bennett and Ferlie, 1994), broadening and deepening the range of people who play leadership roles is seen as important. The district had not achieved this desired state and was too dependent on a small number of committed managers who were lost to the service, either temporarily or permanently, which threatened the survival of the demonstration site.

Conclusions

In spite of the early progress work on establishing the TQM demonstration site by a core of staff and the external consultant, with the establishment of the Quality Forum and rapid work in project sites on environmental improvements and the district-wide staff training programme, the level of activity began to falter by mid-1991. By late 1991 a range of implementation problems emerged which suggested that the demonstration site was clearly no longer able to sustain the original level of commitment. Individual project sites continued to introduce improvements, although these were not being adopted by new sites and the district-wide level of activity was undermined by decisions to make TQM a lower priority. An attempt to involve clinicians was unsuccessful and suggested that managers had miscalculated the degree of interest in TQM, not only among clinicians, but among a wider number of staff, as the district came under greater

pressure with the fragmentation of the service in response to the *Working for Patients* (DoH, 1989) reform agenda.

The impact of the reforms on the district, with the brief, but critical absence of the DGM, and the loss of key senior managers contributed to the difficulties experienced by the demonstration site. A subsequent attempt to give quality a more strategic voice occurred at a time when the district was facing a rapidly increasing change agenda along with the presence of sceptical clinicians at board-level, which combined to reduce the potential of this move by the DGM and DTM. These internal issues were proceeding against a background of an unsupportive Regional Health Authority which placed additional pressure on the district by withholding funding for the demonstration site. This combination of internal and external factors which beset the demonstration site were portents of further problems to come during the final phase of activity which are explored in the concluding chapter of the case study.

8 Demise: TQM Dies a Rapid Death

Introduction

This concluding case study chapter focuses on the final phase of the TQM demonstration site, with a description of events during 1992–1993 as the remaining project activity took place and funding for TQM came to an end. The project activity that constituted the focus of this final stage was marked by growing vocal criticism by clinicians, leading ultimately to the resignation of the DTM. The district was also increasingly preoocupied with managing the transition from a unified organisation to acute and priority care DMUs, with continuing difficulties in the acute unit. Finally, this period saw the implementation of the *Working for Patients* reforms (DoH, 1989) and the introduction of the *Patients Charter* (Cabinet Office, 1991) with declining support from the DoH which further undermined the TQM demonstration site.

Themes and issues

As the TQM demonstration site entered its final phase of activity in the district, it was now operating in a rapidly changing service environment with the DMUs established prior to creation of trusts. TQM activities, were as a result, increasingly undertaken separately within the acute and priority care DMUs, with each unit addressing issues of quality management in its own way. As far as the acute unit was concerned, the quality team took the opportunity in the last year of the demonstration site to develop a project across one of the acute hospital sites in an attempt to improve a range of mainly environmental problems. This activity was the final project of the demonstration site and drew criticism from a number of quarters, particularly clinicians, who persisted in their sceptical view of TQM.

The problems experienced by the quality team in the acute unit were symptomatic of the troubles facing the demonstration site as it drew increasing criticism from clinicians at unit and at executive board level. The advent of clinical directorates and the increasing influence of clinicians was seen as a factor in undermining the demonstration site as they became more vocal in their criticism. In contrast, the priority care unit was moving rapidly towards trust status with a newly appointed acting chief executive bringing an interest in quality management to the service and

supporting the continuation of some activities which would prove useful in helping the unit prepare for trust status.

The appointment of the CEO to the priority care unit was fortuitous in that any activity, following the ending of the demonstration sites, would be dependent on chief executive commitment and interest in TQM (Joss and Kogan, 1995). The priority care trust was also a more integrated organisation and better able to adopt some of the quality techniques from the demonstration site into the mainstream of its services. This was reinforced by its support for the continuation of a member of the quality team as a quality coordinator in the unit, and support from the Project Site Leaders who had moved into senior posts and gave their support to the maintenance of quality activities.

The acute unit on the other hand was beset by a series of problems with the loss of its UGM (as reported in the previous chapter), and tensions between the DGM and clinicians following in the wake of his decision to lead the unit as it prepared for trust status, and with his credibility questioned by clinicians (Fitzgerald and Ferlie, 2000). Tensions between clinicians and management intensified as the influence of management grew under the *Working for Patients* (DoH, 1989) implementation agenda and strengthened the power of managers over clinicians (Ranade, 1994).

The priority care unit avoided the conflict which took place in the acute unit between managers and clinicians, with no evidence of clinicians challenging the leadership of the unit or trying to undermine quality management activities. The priority care unit was also different in not adopting the clinical directorate model and in having a number of clinical areas led by nurses or psychologists. Furthermore it was not significantly affected by the *Patients Charter* (Cabinet Office, 1991) which had significant consequences for the acute unit.

In comparing the implementation of TQM in different units, the size, specialisation and structure of units was seen by Joss and Kogan (1995) to be a factor in the level and success of TQM activities, with the tribalism, stratification and competition of acute units leading to stronger professional boundaries which reinforced disciplinary

perspectives. The priority care unit in turn conformed to Joss and Kogan's classification of services which were smaller, had flatter structures and were often led by nurses and other non-medical professionals, but also with greater commonalities found between specialisms typical of community services. The priority care unit also moved towards trust status earlier than the troubled acute unit, and therefore had a vested interest in maintaining a commitment to quality systems as part of its work on developing its trust application.

A further impact on TQM was the introduction of the *Patients Charter* (Cabinet Office, 1991) with its externally driven processes. This was introduced into the district in 1992 and put particular pressure on the acute unit. That unit was now required to meet a series of quantitative performance standards and this process began to influence managerial priorities (Ferlie et al, 1996). It placed further demands on a unit that had already weathered a series of financial crises and was now subject to further external demands. As a consequence of these changes the impact on the TQM demonstration site was significant, with staffing resources diverted to meet the requirements of the *Charter* monitoring process. The introduction of the *Charter* had deeper consequences for TQM as it refocused activities from demonstration site processes concerned with the 'soft side' of TQM to ones concerned with meeting Government targets set for the service and exposing staff more directly to consumer demands. To this end the approach was at variance with TQM, and staff found it difficult to integrate the two approaches, based as they were on different assumptions of quality improvement (Joss and Kogan, 1995).

The penultimate theme is concerned with the intensification of the market-driven changes of *Working for Patients* (DoH, 1989) reform agenda which had, by the time the demonstration site was in its final phase, become ever more pressing on the service, and contributed significantly in slowing down the implementation of TQM in the district. The service was now being driven by a series of powerful external demands as the RHA placed pressure on services to prepare for trust status. The first step on this road had been the disaggregation of the former district into separate DMUs that brought with it changes in relationships between different parts of the service and witnessed the emergence of suspicion and defensiveness as the impact of

the market reforms took hold (Hunter, 1996). These changes undermined the district-wide activities and led to the break up of the Quality Forum and cancellation of the district training programme. At board level the increasing influence of clinical directors further marginalised TQM and led to the resignation of the District Training Manager. With her departure TQM representation was downgraded with no board level reappointment or senior manager to lead the initiative, coinciding with the increasing demands of the *Patients Charter* (Cabinet Office, 1991) requirements draining further resources from the demonstration site.

The final theme concerns the level of support for demonstration sites and the apparent loss of interest in TQM by the DoH. From the outset staff in the district had recognised that the DoH provided limited support to sites and that officials had little technical knowledge of TQM, and were to a great extent reliant on information provided by sites at a series of national seminars to disseminate good practice examples (Joss and Kogan, 1995). As the demonstration site activities came under increasing pressure from competing demands associated with the *Working for Patients* (DoH, 1989) and the *Patients Charter* (Cabinet Office, 1991) it was apparent that TQM was no longer seen as a priority by the DoH and had been overtaken by other initiatives which now preoccupied policy makers (Joss and Kogan, 1994). Towards the end of the demonstration site period staff directly involved in TQM recognised that the DoH no longer had a commitment to maintaining TQM activities and that the reform agenda had moved on. It is possible to understand this declining commitment by the DoH through an analysis of the political pressures on Government at that time, particularly the reaction of NHS staff (especially clinicians) to the internal market reforms (Ham, 2000) and subsequent decisions by senior politicians to soften the language of the market and associated private sector techniques in order to avoid derailing the Government's internal market reforms.

Final TQM activity

The final phase of the TQM demonstration site ran from mid-1992 until the project funding ended in mid-1993. Although some activities were maintained by project site leaders in the original sites, these had now reached the limits of their development.

Consequently the quality team attempted a final large-scale project, which following on the Cost of Quality project, made a further attempt to widen the scope of TQM with a whole site approach in an acute hospital. It was also apparent to the team that the final activity would need to focus on environmental improvements as earlier attempts at district-wide initiatives such as The Cost of Quality project and encouraging clinicians' involvement had proved unsuccessful.

Like many NHS sites the district had its share of run-down facilities, due to the cumulative effect of lack of capital development in the service and specific problems of underfunding in the district. The acute unit site was chosen because it had been involved in all the stages of TQM from its outset. In year one the orthopaedic ward and portering service had been selected as an original project site and in year two the cost of quality was tested in the hospital, and in the final year specific environmental aspects of the hospital were selected by the quality team for improvement. The Quality Facilitator who led the final phase of TQM activity described how the range of improvements were decided:

> *We got eight key members of staff who became the action group. They were all staff with a positive attitude. We used brainstorming to come up with ideas to start the ball rolling. We identified five areas – signposting and ward renaming, environmental improvements, patient information booklets and art works for the walls. We then split into subgroups to tackle each area and get more enthusiastic people involved.*

Although a number of badly needed environmental improvements were identified for this final phase of TQM, the changes introduced by the team did not meet with universal approval and soon came under fire from a range of staff. The improvements were heavily criticised by some clinicians who branded the changes as 'trivial'. The quality team increasingly saw their activities subject to a stream of negative comments as relationships in the acute unit came under increasing pressure with the loss of the UGM as a result of the recent overspend. The Quality Facilitator described the reaction of staff to the improvements made:

> *We came under a lot of criticism for spending £10,000 on signposting, but you only had to look at the poorly signposted site and the decrepit signs to realise the improvement. It was speaking the language of customer orientation and that was*

not seen as a priority at that time when the unit was going through financial difficulties.

A specific change which resulted in a barrage of criticism was the decision to rename the wards which had been identified by numbers and letters. A competition was held and staff were invited to make suggestions for new ward names. The winner was a member of the domestic staff who suggested that the wards be named after birds and trees:

> *There was a very negative reaction from doctors to renaming wards. They felt it was pointless and one consultant wrote and said 'what a load of rubbish – a stupid idea'. It felt like continually overcoming obstacles, but put together we felt the changes added up to something.*
> (Quality Facilitator)

The modest improvements in the acute unit site were the last visible example of demonstration site activity, as a range of external and internal factors, particularly associated with the *Working for Patients* (DoH, 1989) reforms and the introduction of the *Patients Charter*, (Cabinet Office, 1991) both reduced the potential to develop further projects, due to organisational turbulence and the severely reduced level of staffing available as members of the quality team focused on other activities. The quality team also suffered from comments that they were 'only about cosmetics' which sapped their morale and their commitment to further project activity. The team would now increasingly devote their time to *Patients Charter* activities as these took priority and TQM activities rapidly became a lower priority.

Tensions in the Acute Unit

The aftermath of the funding crisis in the acute unit, which had resulted in the resignation of the Unit General Manager coincided with the return of the DGM from the USA and the decision that he would move to the acute unit as acting Chief Executive to develop the unit's application for trust status. This was seen as an unpopular decision from the clinicians' perspective with the loss of the general manager, who as a fellow clinician was felt to share their views on the service and was well regarded due to his specialist knowledge of the service (Fitzgerald and Ferlie, 2000):

The UGM had been perceived by the clinicians as a good appointment and they rated him. Suddenly he's pushed out because of funding problems and they are saddled with the DGM who wasn't a clinician and was identified with the Griffiths changes and now in charge of their unit. It was stacked up against him when he arrived. The perception was – here's somebody from H.Q. coming down here telling us what to do. He was battling against that attitude right from the beginning.
(Health Authority Member)

The move by the DGM to the acute unit was undertaken at a time when senior clinicians were smarting from the loss of the UGM and coming under increasing pressure as the market reforms penetrated more deeply into clinical decision-making, resulting in a torrid time for the DGM turned Chief Executive. His main task according to his colleagues was 'sorting out the funding problems and related pressures on the unit'. A manager who worked closely with the DGM commented that this was 'the time when some consultants were particularly militant and met together socially at weekends to plot how they could disrupt the unit executive'. The DGM described how at this time he was fighting for his own survival in the face of a concerted attempt to undermine him as a result of the changes he had to introduce in the acute unit in response to the overspend and preparation for trust status which meant that he could no longer pursue his interest in TQM:

I couldn't maintain my level of commitment. I failed miserably to see it through. I was caught in the cross-fire, the middle of a very bloody battle. I was having late night discussions about whether I should resign or not around the difficulties I was having with medical staff. It seemed difficult to break the mould and get a working relationship with them that was tolerable. I had to step back from it (TQM). I was dealing with a very different organisation from the one I was managing in the pre-reform days. Then you worked with managers, administrators and nurses who related to you comfortably. Suddenly I was dealing with people who, if not explicitly, were implicitly trying to nobble anything you did and limit your influence. It was a power struggle that had to be fought out before you could gather yourself together and start introducing initiatives.

With the crowded management agenda as a result of conflicts with clinicians and preparing the application for trust status, the DGM's level of commitment to the demonstration site declined rapidly. He also recognised that some of the key staff who had led the demonstration site were no longer around to support him, and that his influence was reduced as the service split into separate units:

TQM became a lower priority and died a fairly rapid death. My attention had to turn to other things, not just from TQM. This coincided with the District Training Manager leaving. The Personnel Director had also left some time before, so that some of the movers and shakers I had worked with originally had gone. Areas outside the acute sector (priority care unit) who were working on quality were no longer my responsibility as I prepared to become the Chief Executive of the acute trust.

Problems of maintaining TQM activity

Although the Project Site Leaders in the acute unit remained enthusiastic about TQM and wished to integrate the concepts into the work of the future trust, they acknowledged the limitations of their influence, particularly in relation to the resistance of powerful professional groups such as clinicians. The Project Site Leaders recognised that it would be difficult maintaining TQM in their unit if it was opposed by key members of staff:

Of course we continued to get obstructions from senior clinicians. All organisations have elite groups of people, scarce staff who won't go along with initiatives like TQM, people who won't buy in to what they see as the latest craze. They're influential people who've got their status position. Why would they go along with something that would undermine that position? Very few of them are going to buy into it.

It was coming to an end and I had an expectation of continuing the approach through the management process. It strengthened my beliefs of what could be done in a large organisation – the strong commitment to working in teams to solve problems. The difficulty was the diverse group of people. It was more difficult than in a factory (referring to his visit to the USA and Japan where he had witnessed TQM activities in manufacturing companies). There you didn't have the autonomous professionals like the NHS. They are difficult to manage, to push through a standardised quality system.

An outpost of Quality activities

Although the impetus of the demonstration site was rapidly dissipating, Project Site Leaders felt that the experience gained in implementing TQM should not be lost. Any future activity would become the responsibility of the separate trusts and staff in the priority care unit which had participated in two project sites worked together to maintain some elements of the TQM activities. This was aided by the resignation of the Unit General Manager, who although popular with staff, did not prioritise TQM in the unit to the extent that demonstration site staff had hoped for. She was replaced by a Chief

Executive, appointed to lead the unit to trust status, who saw the value of incorporating some of the TQM techniques into the processes of the shadow trust. This gave those staff committed to TQM a lifeline and a higher profile in the emerging trust, although the activities were now more focused on establishing standards for all aspects of the service, rather than the focus of activities in the former project sites.

> *The UGM was popular with her staff because of her style, but TQM was seen as a luxury towards the end of her time. When restructuring took place prior to the new trust she took early retirement. The new Chief Executive came from a non-clinical background and brought a different view of the service with her and pushed the quality agenda forward after she arrived.*
>
> *She was well ahead of the game and there was more TQM-type stuff going on there than in the acute trust. She eventually had a whole department dedicated to quality in the run up to trust status. It was a much more inclusive organisation and a real contrast to the acute trust which was very political and full of problems.*
> (Health Authority Member)

Staff who had worked in the demonstration site saw the opportunity with the new CEO to maintain some of the demonstration site activities, particularly with the requirement to include quality systems as a part of the trust application:

> *When the UGM left things really changed. She (CEO) gave it priority. She attended some of the quality meetings and wanted action. We got things done after she attended! Later when TQM funding stopped the unit (priority care) took over and recognised the value of the work we were doing. We were in a shadow trust by then and the quality activities helped us with the change to a full trust.*
> (Quality Facilitator)

Staff in the priority care unit were also fortunate that the *Patients Charter* did not impact on their service significantly which bore out the view of Joss and Kogan (1995) that the Charter measures were primarily geared to acute services. Ironically the funding made available to the Priority Care unit to meet its *Charter* requirements provided badly needed resources to maintain their quality work:

> *The* Patients Charter *didn't affect us too badly. It affected the acute unit – out patients clinics and A&E, that sort of thing, but we largely escaped it. The funding and lack of pressure enabled us to continue working on quality. Ironically we were able to maintain more TQM activity as a result.*
> (Quality Facilitator)

A Service Director in the newly established trust, who had been a Project Site Leader in the demonstration site, was clear that the work that had gone on in TQM had a direct impact on the quality programme in the priority care unit and subsequent trust:

> *We developed our own approach to quality once TQM finished. We were conscious we wanted to carry on doing something. There was no longer any money from outside to help us. We established a quality department and it produced our own tools to help people work in a quality way throughout the organisation. The department also runs clinical audit, risk management and health and safety and other things associated with quality. Projects didn't formally end for us they just spawned some valuable processes that you could say were TQM by another name.*

This was confirmed by the Unit Manager who had been responsible for the community hospital that had subsequently closed and been replaced by a new unit:

> *We made quality more operational. When the new unit opened we introduced it there. It then became part of everyday life. We got away from the perception that staff were doing it because it was TQM. I later became involved in other community hospitals and we looked at some of the quality techniques there. It was no longer a project, it was what had to be done. It was very much about standards so you can prove you have procedures for work with patients.*
> (Unit Manager)

The structure of the priority care service was seen to be one of the factors that helped support the development of quality management in the unit after the end of the demonstration site. In contrasting the impact of TQM across the priority care and acute units the DGM identified the consequences of different attitudes towards management in the two units and the difficulties experienced in maintaining a commitment to TQM in the acute unit with its powerful professional interests and suspicion of management:

> *The priority care service had much smaller units with a simpler structure. I'm sure that it was much easier in priority care with its clear hierarchical management structure, which means you can be much more proactive as a manager. Its very different in a large general hospital site from a community service. Community trust staff would recognise that the Chief Executive is their boss, whereas key opinion makers here (acute unit) will introduce you as their boss, but they do it with a laugh. You know what that says about how they see you.*

The deepening impact of *Working for Patients*

The pressures of implementing *Working for Patients* (DoH, 1989) meant that the district was now responding to a major strategic change agenda which was rapidly submerging

TQM. This politically driven agenda meant that TQM became lower priority, both at board level and among managers and staff. By late 1992 the district had reconfigured its functions as the priority care DMU made a decision to apply for trust status in the third wave, with these structural changes having an immediate impact on the demonstration site. Project Site Leaders in the acute unit found it increasingly difficult to maintain the motivation for TQM as the destabilising affect of change impacted on staff:

> *The reforms began to dilute TQM because of the other pressures. It was being swallowed up by this. There was a competitiveness around. You could no longer get help from another unit. Everything was being costed. You couldn't even borrow equipment from another ward. It began to break down so many good relationships and we were all ending up with mini-businesses that didn't talk to each other. The idea of teambuilding and working together was being undermined.* (Project Site Leader)

Other staff who were involved in supporting project site activity were also finding it increasingly difficult to maintain a commitment to TQM with enforced changes in roles and relocation within the district as the DMU's prepared for trust status. The hostile environment generated by the reforms also begun to impact on a wider service and made staff much more defensive and less willing to expend energy on an activity which was no longer central to their survival. These concerns were mirrored by a lessening of support from the quality team as it lost personnel or became preoccupied with new initiatives such as the *Patients Charter*. A manager who had supported a particular project site was acutely aware of the rapidly changing climate in the district and found herself moved to a new location and no longer able to maintain the commitment she had built up since the introduction of TQM:

> *By the end of 1992 there was a sea change taking place in the district. We wanted to keep it (TQM) going but personnel were changing and I was required to move jobs. You had to concentrate on keeping your job then as some people were losing theirs. There was a culture of fear growing, with veiled threats and a more authoritarian management from some of the new people and everything becoming very political. It knocked us off course and felt as if it was all being pulled apart.* (Nurse Manager)

Demonstration site activities undermined

The separation of the two units increased the growing sense of competition in the district which was recognised by a Quality Facilitator and Project Site Leader who

acknowledged that competitiveness was undermining the earlier collective approach to TQM:

> *The demonstration site gradually began to fold. The view was, 'we're not going to share what we do in our unit, we're a business now'. We lost a good network. Information was not being shared anymore and it became more difficult to communicate across the units.*
> (Quality Facilitator)

> *The competitive edge had a really negative impact on TQM. It got much tougher and people resorted to traditional methods and began to cut back on activities. They lost heart as we became more and more separated. It worked better when we were together. It was hard work keeping the momentum up when you were working alone.*
> (Project Site Leader)

One of the first casualties of this new climate was the training programme. With the separation of the two units it left the majority of demonstration site staff in the acute unit, with no responsibility for staff training in the priority care unit which was by this time arranging its own activities:

> *The training courses went by the board first and we lost the strong training element which was necessary if we were to keep TQM going. It was less easy for us to work together on things like training. The units had to develop their own approaches and their own tools.*
> (Quality Facilitator)

The separation also made it more difficult to maintain the Quality Forum, with staff who had previously valued the steering group now believing that it no longer had a useful purpose as they became preoccupied with the development of their own units. A Project Site Leader from the priority care unit felt it was appropriate to withdraw from the Quality Forum, a move justified by the competitive nature of trust development:

> *The environment was wrong for us doing things like that together. We were in a market situation, a discrete organisation with commercial sensitivities. It was less easy for us to work together. In the end it was right that the Quality Forum went as we had to look after our own interest. It did not mean quality work ended, we no longer did it together.*

A Project Site Leader commenting on the visible impact of the reforms witnessed the growing importance of new areas of expertise that would play a more pivotal role in the reformed service:

> *The changes quickly began to adversely affect TQM. Other departments in the district were now growing in importance, particularly I.T., marketing and contracting. The emphasis began to shift towards cost and volume as opposed to quality of service, and there was no place for TQM.*

Resignation of the Product Champion

The impact of these changes had significant consequences for the District Training Manager who was unable to support all the project sites as the district structure fragmented. With the separation into DMUs she found herself located in the acute unit, with no influence over the staff in the priority care unit. A Project Site Leader described the difficulties she faced:

> *TQM was getting swallowed up and diluted by the other pressures. Then she lost her central influence to keep it all going as she worked for the acute unit. It contributed to the loss of momentum on a district-wide basis.*

A colleague in the quality team witnessed the impact of the growing isolation of the District Training Manager 'who was now getting a lot of stick' from the board. She realised that the departure of the DTM was inevitable, as the demonstration site activities began to fragment and came under the control of an unsympathetic Director of Personnel. The DTM also anticipated losing her place on the board with the changes to the membership in preparation for trust status:

> *She suffered doubts towards the end, particularly when she got a place on the Board and was exposed to some of the politics. There was a lot of infighting going on and it exposed her more. She was pushing the customer perspective and this didn't go down well and she became an easy target. She didn't say why she was leaving, except that the DGM had backed off and made it difficult for her and she felt isolated. She realised that she would lose her Board place and would have to go back to the Personnel Department and would have lost her status and had a manager (Director of Personnel) who wasn't interested in the concept of TQM.*
> (Training Manager)

As the DMUs moved towards introducing the new structures, the District Training Manager had become isolated at the board with few allies. This situation was exacerbated by the fact that the DGM had now assumed responsibility for the acute unit

and became the acting Chief Executive with the remit to prepare it for trust status at the fourth level, and had less time to devote to supporting the demonstration site. She also recognised that she would lose her place on the board as the number of members would be significantly reduced to reflect the forthcoming arrangements in trusts and that there would be no place for TQM at board level under the new structure. These changes culminated in her decision to leave the district:

> *There was a lot of scepticism about quality and I could see the end coming so I decided to leave. I also recognised that I would lose my place when the trust board came in so it (TQM) would no longer have the strategic impact of a person representing at executive level. Looking back I was very naive about what was happening in the district. Senior people were playing games and I felt like the sacrificial lamb as we progressed towards trust status. I felt very vulnerable and knew I couldn't do it by myself as his (DGM) enthusiasm dipped.*
> (District Training Manager)

A Project Site Leader and Health Authority member each identified issues which they felt made the District Training Manager unpopular with some Board members, and meant she was unable to secure the support from Board colleagues:

> *I think she was disliked by some directors. I think it was the message she was trying to get across. It was unpopular with some of them. They didn't like the language of quality. She was forceful and passionate about quality and some of them didn't like that. There was a vacuum when she left. It needed her on the Board to keep the initiative going.*
> (Project Site Leader)

> *I think the Board pulled the carpet from under her towards the end and her empire was taken away from her. There were a lot of people who weren't into quality issues. She became disillusioned as a result.*
> (Health Authority Member)

The resignation of the District Training Manager led to deep disappointment among her colleagues, who had lost a leader who was able to motivate her colleagues and maintain the commitment to TQM in spite of the setbacks that were rapidly undermining the demonstration site:

> *I felt cheated when she left. She lived quality and demonstrated it in her approach to people. After she left we were making it up as we went along. She had given it direction. We felt we hadn't got a proper job – nobody was asking us to do anything. You had to be very determined to keep going. I got some support from other people committed to TQM in my darkest hour and was helped to see the value of what I was doing.*
> (Quality Coordinator)

TQM loses its Board-level representation

Following the resignation of the District Training Manager a decision was made not to reappoint a TQM coordinator post at directorate level and it reverted to one of the functions within the Personnel Directorate. The Quality Facilitator who was given responsibility for the demonstration site saw this as an early sign that TQM was quickly becoming a lower priority:

> *When she left I was running quality without a boss. I was accountable to the Director of Personnel with no voice at the Board and nobody bashing the drum for TQM. I struggled on with some help from the training team and finished off the acute unit project, but then the* Patients Charter *came along and that became my main responsibility.*

With the DGM now preoccupied with developing the acute sector trust, the resignation of the District Training Manager with her product champion role, and the remnants of the quality team increasingly preoccupied with the demands of the *Patients Charter* the demonstration site rapidly ceased activity at least as a district-wide initiative .

Introduction of the *Patients Charter*

The *Patients Charter* was published in 1991 (Cabinet Office, 1991) which set out a range of rights and standards for patients. These were accompanied by performance tables which measured such areas as waiting times and cancelled operations. The implementation of the *Charter* increasingly jeopardised the operation of the TQM from 1992 as it was a statutory requirement. Those remaining demonstration site staff were now given new duties under the *Patients Charter*, including collecting data on patient throughput which in turn created further tensions around quality issues with clinicians. The responsibilities under the statutory requirements of the *Charter* meant that it was increasingly difficult for staff to maintain their commitment to TQM activities. Two Quality Facilitators described the problems the introduction of the *Patients Charter* posed for them:

> *It contradicted our fundamental approach. It was very uncomfortable marrying up the Charter with what we were trying to do in TQM. The tensions came in the*

philosophy that underpinned the two approaches. It was also difficult because the doctors hated it (Patients Charter). *We were telling them how they are going to work and that's after forty years when they've had total and complete autonomy. It seemed like another mechanism to manage doctors to them.*

It was a big dilemma working on TQM and the Patients Charter. *It was two different things and they did not meet. The Charter was all about timescales, getting people through the system as quickly as possible, whereas TQM was about providing a quality service. The* Patients Charter *and TQM – it was a culture clash. It was a big disaster!*

The top down approach of the *Charter* was contrasted with TQM. The emphasis placed on waiting lists and standards were seen almost universally in a negative light by two Project Site Leaders who had to respond to the *Charter* requirements:

We had to respond. It had to be done. It was top down with no consultation. They (DoH) were not interested in discussion. We had no say in the standards. Some were highly inappropriate. It could have worked with TQM if the standards had been better thought out. It was typical of the DoH. Different sections running different projects and not talking to each other.

We all felt that if you were asked to design something that was not about quality you would have developed the Patients Charter. *It should be about listening to customers. It's what customers say that help you identify the problems. But somebody up there said this is what you will achieve. We all thought it was TNQ – totally non-quality. It was hard to argue with John Major (architect of the* Patients Charter*) in principle on shorter waiting times, but it was somebody else saying this is the standard you will adopt. It wasn't your local quality group. It didn't help at all. It was like oil and water.*

Similar views were expressed by a Quality Facilitator whose work was increasingly concerned with responding to the monitoring of response times and waiting lists and less on facilitating TQM processes.

It was calamitous! It didn't help the quality cause. We had to do the Patients Charter *and were not doing quality work at all. It was a Government initiative, you must do this monitoring. It was supposed to be about providing a quality service, by that's rubbish. I ended up doing no more than monitoring. I wasn't able to do any quality improvement work. It was at the expense of everything else. When the TQM funding ended we had two people in post doing quality work, a* Patients Charter *Coordinator and a Quality Facilitator. Guess who got the chop?*

Finally a comment from a Unit Manager summed up the feelings of many managers, who had worked on TQM developments and valued the approach to quality promoted in

the demonstration site, about the differences in the two approaches that became clear once the *Charter* requirements were understood:

> *We thought for a while after the* Patients Charter *was introduced that TQM and the Charter were quite complementary. But they're not. Fundamentally the PC is about setting standards through a quality control type audit. You've got two ways of coming at it. One was to audit and constantly check – that's what the Charter does. The other way is to get inside the organisation and get everybody thinking quality – that's what TQM tried to do. I'm not sure that they are really compatible.* (Unit Manager)

Diminishing Support for the Demonstration Site

As the impact of the *Working for Patients* (DoH, 1989) reforms intensified the quality team looked to the DoH for support, but found little to reassure them, confirming the assertion that little expertise existed in the DoH as far as TQM was concerned (Joss and Kogan,1995). This had of course been evident early in the life of the initiative according to some managers, who felt that a junior group of civil servants at the DoH had been given responsibility for the demonstration sites and clearly lacked technical knowledge of quality management techniques. Managers increasingly believed the DoH had very limited expertise in TQM to offer the district and that they were dependent on other demonstration sites to provide ideas on implementation. As the project entered its final phase the DGM became increasingly sceptical about the DoH's commitment to the initiative:

> *Towards the end we tried to get some of the senior DoH people convinced that this was something important which they ought to be taking forward as it could deliver big savings. We didn't achieve that and so there was no grand spreading out of TQM across the NHS based on the work of demonstration sites. The Department produced glossy brochures, but they came from the basement department to justify what they were doing and that they hadn't wasted their money or our time. But they never came from the top. No one said yes the demonstration sites have proved their worth and we ought to spread it out. There was never anything really said about whether it was a success and should be implemented elsewhere or whether it was a total failure. You were left really not knowing.*

This view was supported by the District Training Manager who had participated in national events with other demonstration sites and saw evidence of the DoH's changing preferences as far as policy was concerned :

I was invited to participate in a project set up by Virginia Bottomley (Secretary of State for Health) to produce an 'A–Z of Quality' to be published by the DoH. I went up to Whitehall and worked with the civil servants on the project and had this feeling that it was the swan song for TQM. It was an attitude of, 'we've done it, done the project, done the evaluation. ticked the box, let's move on'. After the A–Z was published there didn't seem to be any interest left. It was on to other initiatives.

Following her resignation the District Training Manager moved to a post in the Cabinet Office working on quality initiatives in the public sector on the strength of her work in the DHA. This meant that she worked alongside some of the civil servants who had been responsible for the TQM initiative. As a result of this contact she began to understand more about the thinking behind the demonstration sites and confirmed her view (and that of other members of the quality team) that the DoH had no real commitment to supporting the quality management initiatives developed in the demonstration sites after the funding ended:

I realised it was very much NHS short-termism. I just got the sense that the civil servants looked around in 1989 and saw something written about TQM.and said let's give it a try. There seemed nothing more scientific about it than that. I just wonder if somebody had read an article about quality in the health sector in America and thought perhaps we should do a bit of research around that and convince somebody to put some money behind it. And there we were bidding for funding and the rest is history.

The feeling that the DoH had dallied with and then dropped TQM was a view held by a number of managers who had committed themselves to the demonstration site. In the DGM's view the scale and complexity of introducing TQM into the NHS was not matched by an understanding of the time it would take to embed quality management into the service or the level of resources needed to achieve the changes envisaged:

I don't think the DoH worked to a correct timescale. I think if they had said this is a ten year project, lets evaluate it in 1999 and see if its succeeded, that would have been realistic. If they had really wanted some new thinking and new approaches in an organisation of this size and complexity, you are only going to scratch the surface if you only get year on year funding. The sort of money they put in is not going to transform the whole organisation. It was a modest sum in those days. It wasn't a tremendous demonstration by the Department of their belief in TQM.

A Project Site Manager who had visited the USA and Japan to study TQM techniques acknowledged how vulnerable TQM had become with other pressures pushing it down

the agenda with the loss of interest by the DoH. He had witnessed highly developed quality management systems in companies in the USA and Japan and recognised that TQM was operating in a very different organisational context in the NHS which did not have the structures, processes or commitment in place which could have supported it when it came under pressure from competing interests:

> *It was associated with only part of the organisation and when the going got tough it wasn't strong enough to survive. It wasn't perceived as something that if it was developed throughout the organisation would make it more efficient and reduce costs. It was seen as a cost, which was right initially as it did cost money to set up. There's an investment that has to be made to get it going. My trips to the USA and Japan helped me understand that and strengthened my belief. We saw what could be done in a large organisation. TQM was a systemised approach, with data and measurement. It wasn't the just the soft stuff, although that is obviously important.*

The demonstration site officially closed in mid-1993 when the funding ended. By this time the priority care unit had achieved trust status and the acute unit was in the final stages of its application to become a trust. With the complete separation of the two services the priority care trust had now established it quality management systems as part of its day-to-day operational activities, whereas the acute unit had only recently resolved the conflict between managers and clinicians about the future of the service which had overshadowed work on TQM. In spite of the difficulties facing the acute unit the DGM saw the *Working for Patients* (DoH, 1989) reforms as potentially making it easier to support TQM:

> *The leadership role was now much clearer and it broke down the size of the organisation into separate trusts, rather than a big district. TQM could potentially have found its day in the reformed service. But the irony is that the reforms created a vast amount of new work that meant you could no longer afford to invest in TQM because it wasn't going to deliver in the short-term the sorts of gains you needed in the new trusts.*

The new demands placed on the emerging trusts brought with them a tougher style of management and changes in the relative power of managers and staff. The DGM, who had been seen as sceptical about the reforms, was clearly uncomfortable with some of the developments these new organisational forms were creating:

> *You were grappling with new concepts, the new language of the marketplace – market share, financial disciplines, trying to outdo your opponents. All that meant that the hard edged managers were coming to the fore. It was becoming a pretty*

> *ruthless organisation, attitudes and relationships with staff, attitudes to other organisations in the NHS were confrontational. I don't think it got that bad locally, but there was that sort of feeling around, that sort of presence in the air that meant that the TQM type approaches lost out.*

Aftermath

The establishment of trusts in the acute and priority care services coincided with the formal end of the TQM demonstration site and the abandonment of many of the former activities as the new trusts responded to the demands of the internal market. This brought in its wake further structural change, with the two trusts reconfiguring their services in response to subsequent ministerial interventions. At the time the fieldwork for this research was conducted many of the managers interviewed no longer worked in the service, either grateful recipients of redundancy packages or victims of further change within the service. Survival would depend increasingly on the individual's ability to respond quickly and with flexibility to the ever changing demands made on the service. In this climate it was no longer seen as sensible to promote the activities of the demonstration site and in the words of one manager ' you got the message about what was important and it wasn't TQM, quality didn't exist in our dialogue anymore'.

Case Study Analysis and Discussion

This section examines the themes identified at the beginning of the chapter and relates these themes to the grounded analysis of the case material in order to examine the empirical data with the help of theoretical perspectives on the final phase of the demonstration site. There are four main themes, the final TQM activity, acute unit problems, the *Patients Charter* and the lack of DoH support and the problems of policy implementation.

Contested Final TQM Activity

The quality team's work on environmental improvements in an acute unit site was the last visible sign of the demonstration site activity and drew criticism from clinicians who regarded the activities as trivial and of no consequence. In attracting this criticism the quality team were disturbed by the vehemence of the disapproval which had grown with each succeeding project. The team on the other hand saw their activities improving the quality of hotel services (e.g. attractiveness of facilities and information provided for patients) in the acute site contributing to the overall quality

of the service offered, and very much in keeping with the exhortations by Duncan Nichol, Chief Executive of the NHSME, who had called for better information for patients, improvement to public areas and reception arrangements among the range of provision which needed improvement (NHSME, 1989), and Martyn Long, Chairman of NAHA who similarly stressed the need for improving the 'soft areas' such creating more pleasant surroundings, providing better information for patients and higher standards in hospital facilities (Long, 1989) at the outset of the TQM initiative.

What this tension between some clinicians and members of the quality team emphasised was the difference between managerial and professional perceptions of quality (Ranade, 1994).This conflict was a superficial example of the more fundamental issue of who defines quality in health care and what constitutes quality in the service. The traditional view of professionals that they determined matters of quality was increasingly being challenged by managers and constituted what Pollitt (1992) referred to as the lack of agreement about definitions and concepts of quality and 'turf wars' between different groups in the service. More fundamentally what this struggle over turf represented was the failure to establish a shared view of what constituted quality in the service (Ranade, 1994) which was the original intention of the TQM demonstration sites.

Acute Unit Problems

Problems of Management Credibility

The difficulties facing the DGM as he took over responsibility for the acute unit illustrated the problems facing managers as the implementation of *Working for Patients* (DoH, 1989) strengthened the formal powers of managers over clinicians (Ranade, 1994). The need to ensure that the unit progressed smoothly to trust status meant that clinicians and managers had to work together as they prepared for the unknown consequences of the internal market and the need to convince purchasers that the service would be able to deliver high quality cost-effective services. The work undertaken by the DGM as he assumed the role of the Chief Executive and steered the unit towards trust status meant that he had increasing influence over clinicians reflecting the findings of Ferlie et al (1996) that *Working for Patients* (DoH, 1989) emphasised managerial perspectives. The reforms also saw a change in relationships between services, and

within services, as they moved from management by hierarchy to management by contract, and in turn increased the skills of management and the nature of relationships in the service.

The DGM's responsibilities in the acute unit also raised issues of credibility as he succeeded the clinically trained UGM. Fitzgerald and Ferlie (2000) argue that many doctors do not consider non-professionals qualified to manage medical services, as they do not have the specialist knowledge to make decisions about detailed issues of service delivery. They argue that there are advantages to employing professionals in management roles in that their specialist knowledge gives them credibility among their professional colleagues. In the case of the DGM he was following in the footsteps of the UGM who as a clinician, and in spite of professional scepticism about the role of management, was well-regarded by his colleagues. Whatever strengths the DGM brought to the new role of CEO of the acute unit, he was still seen as the 'enemy' (Fitzgerald and Ferlie, 2000) in the eyes of some senior clinicians which could account for some of the 'bloody battles' he reported on taking up the post in the unit.

Loss of the product champion

The resignation of the District Training Manager was a major blow to the demonstration site and resulted in reduction in status of TQM from board level representation to that of middle management, reflecting changes taking place across other demonstration sites as commitment to TQM waned (Joss and Kogan, 1994). It also resulted in a loss of morale among the remaining members of the quality team which had been motivated by the personal characteristics of the DTM whose drive and energy 'to the point of obsessionality' (Pettigrew et al, 1992:107) had kept TQM alive in the face of growing opposition.

Although the reasons for the DTM's resignation were complex, the analysis of the case material suggest that the increasingly crowded agenda driven by *Working for Patients* (DoH, 1989) meant that the DGM was no longer able to support TQM activities as he became embroiled in a power struggle with clinicians over the future leadership of the acute unit, and this lack of top management commitment opened up the opportunities of those opposed to TQM to deal it a fatal blow. This pressure was reinforced by the rapid

restructuring that took place as the district separated into two units, with the DTM no longer able to promote the work of the demonstration site across the former district and left with responsibility for an acute unit which was proving hard to convert to the TQM cause. Lastly, the arrival of clinical directors on the executive board with key decision-making roles on resource allocation (Fitzgerald and Ferlie, 2000) meant that their hostile views of TQM were now being aired at the apex of the service and effectively marginalising the DTM and her efforts to influence the board in extending TQM activities. This accords with Pettigrew et al's (1992) view that venture managers can experience resistance to change when dealing with other more conventional departments.

Impact of the Reform Agenda

A consequence of *Working for Patients* (DoH, 1989) was the need for the service to respond to the powerful top-down reform agenda driven by central government, with managers and senior clinicians experiencing the impact, although in keeping with clinicians' scepticism about the value of management, the DGM became the focus of their discontent. As Fitzgerald and Ferlie (2000) stress, when professionals perceive their position and freedoms are being eroded it is 'management' who frequently get the blame. This is particularly so when they are seen in the role as the agents of government ministers concerned with securing compliance to the latest initiative (Hunter, 2000).

As the structural changes associated with the internal market began to impact on professionals and support staff in the district, the demonstration site was having to adjust to rapidly changing circumstances, These included the destabilising effect of restructuring with staff 'concentration on survival as the primary aim' (James, 1994:83). This led to what Hunter (1996) has described as 'low trust relationships', with the uncertainty about the future of the service leaving frontline staff disempowered. A further consequence of the internal market reforms was the separation of the acute and priority care units and a fracturing of the previously informal and collegiate relationships (Ferlie, 1999) between staff of the two units.

Maintaining a Commitment to Quality Management

Analysis of the case material revealed that the priority care sector was able to maintain a number of quality initiatives in contrast to the acute sector which was consumed by internal political conflict, following an overspend and the loss of the UGM. This reinforces Ham's (1999) argument that *Working for Patients* (DoH, 1989) was primarily concerned with acute services, with the priority care unit benefiting, in quality terms, from a more unified structure, and without the history of major conflict between clinicians and other professional groups, or managers. The service had traditionally taken a more proactive approach to service quality well before the introduction of TQM, with early work in the mid-1980s in both mental health and learning disabilities services on quality systems and patient advocacy, influenced by reports on standards in long-stay hospitals and the development of the concept of normalisation (Wolfensberger, 1972).

This service was also one where teamwork was more developed than in the acute sector, with the concept of multidisciplinary teams well established at the time of the TQM. In services as wide-ranging as care of older people, mental health and learning disabilities, multidisciplinary teamwork was the norm. The fact that these teams existed should not be taken as a statement that there were no internal conflicts, but that the professionals relied much more on each other for the effective delivery of the service meant that working relationships were well developed. The conditions reported in the priority care unit are mirrored by the findings of Pettigrew et al (1992) where mental handicap services experiencing major strategic change had a culture which included 'harmonious and cooperative relationships' between doctors and managers and 'well-established team working amongst managers and professionals' (p213).

A further factor which influenced the priority care sector, was the decision not to adopt the clinical directorate model in managing the services, as this was seen as less appropriate in a community-based service (Ferlie et al, 1996) where there was a tradition of devolved management (invariably nurse-led) for particular care groups prior to the reforms. This meant that when the trust board came into operation it was led by a managerial group who represented a wide range of clinical and other roles, and critically included a Chief Executive and service director (and a former project site leader) who had a strong commitment to quality management techniques.

A final factor which supported the maintenance of quality management in the priority care unit and later trust was the relationship between the Chief Executive and the staff of the unit. This service did not have powerful clinicians contesting power with senior management. Although the priority care service had its quota of senior medical consultants (geriatricians and psychatrists) there was no evident conflict between managers and clinicians. In structural terms, the power of doctors to exclusively control their area of work was less well developed in community services, with competing definitions of health care and treatment by psychologists, nurses and social workers.

Demands of the *Patients Charter*

The introduction of the *Patients Charter* (Cabinet Office, 1991) was seen as a 'flagship for improved standards' (Farnham and Horton, 1996:272) and an opportunity to spur the NHS into being more responsive to its patients and establishing standards which patients could expect. In this sense it had the potential of reinforcing a concern for quality, dovetailing with the work on TQM, but staff were quickly disabused of this assumption when this externally driven process began to distort service priorities. This was because the process took control away from managers and professionals, and led to inappropriate targets which, while meeting *Charter* performance targets, actually reduced the quality of service to some patients (Ferlie et al, 1996). The weakness of the *Charter* standards was regarded as a consequence of their being devised in isolation from the service, which angered professionals and also caused dissatisfaction among patients as a result of the gap between expectations of a service and the patients' perception of it (Flynn, 1997). In the view of one of the managers interviewed 'nobody asked patients what should go into *Charters*. It was about what was easy to measure'.

A further consequence which quickly became apparent was the aim of the *Patients Charter* (Cabinet Office, 1991) to informatise the public sector which meant that services had to prepare quarterly performance returns with extensive lists of questions on aspects of service performance, requiring the provision of detailed data (Bellamy, 1996). This data heavy service had significant administrative costs for public services according to Bellamy, and in the case of the district researched diverted members of the quality team from the demonstration site to meet the mandatory requirements of the *Charter*. The comments of members of the quality team suggested that their duties

under the *Charter* led to a further tensions in their relationship with clinicians as a result of 'chasing doctors for information to be returned to the DoH'.

The tensions which existed as a result of the different approach to implementing the *Patients Charter* and TQM is borne out by Joss and Kogan's (1995) findings. They found that the *Charter* was centrally-driven, explicit in it's content and designed around centrally established objectives and timescales. Services subject to *Charter* standards were required to continuously monitor the implementation of specific key service standards. The tightly monitored quantitative approach of the *Charter* was in complete contrast to the approach taken by the DoH which gave demonstration sites considerable freedom to develop their own approaches to TQM and left it to the influence of external consultants to guide the districts. Joss and Kogan (1995) compared the support for the implementation of the *Patients Charter* with that provided for TQM sites and found that the DoH did little to support the design of TQM activities or to monitor ongoing activity, in contrast to the level of activity associated with the implementation of the *Patients Charter.*

Declining DoH support and changing political priorities

Joss and Kogan (1995) argue that the contrasting approach between the *Patients Charter* and TQM illustrate the thinking of the DoH at that time, with support for implementation of the *Charter* in complete contrast to that offered demonstration sites, which was borne out by the experience of managers interviewed who were critical of the Department's absence of support and guidance. An absence of technical assistance highlighted the DoH's lack of expertise in TQM leaving staff in demonstration sites reliant on self-development activities and short courses to develop their knowledge of TQM. If a similar level of support had been provided to demonstration sites Joss and Kogan (1995) believe it would have enhanced their potential in designing and monitoring TQM objectives and targets.

Alongside this lack of support from the DoH the demonstration site also recognised a decline in interest in TQM on the part of the DoH, particularly by year two of the initiative. How can this decline in interest be explained? A speculative, though plausible reason, for the declining interest in TQM on the part of the DoH can be found in an

analysis of the changing political agenda during the period of the demonstration site (Ham, 2000). The period between the introduction of general management and the publication of *Working for Patients* (DoH, 1989) was a time when government was committed to strengthening the management of the service, with the market-based reforms building on the earlier management changes. This was also a period when government was promoting a concentration on quality, articulated through the leadership of the NHSME (Nichol,1989) and NAHA (Long, 1989).

The commitment to improving quality as part of the wider management reforms was quickly overtaken by the deteriorating relationship between the government and the British Medical Association, resulting from the antagonistic attitude of the government to the professions, which had begun to damage the government's credibility and threaten its reform agenda. As a consequence a decision was made in 1990 to rebuild bridges with the BMA and other representative bodies, including, jettisoning the rhetoric of the market and other business language in order to placate the professionals who were critical to the implementation of the reforms, and in turn moving the agenda to one of issues of concern to doctors and nurses (Ham, 2000). This shift in policy meant that the promotion of private sector techniques was quickly overtaken by other initiatives which stressed professional concerns as politicians 'dampened down' reaction to the reform agenda. The upshot of this decision to soften the reform agenda meant that TQM, as a archetypal private sector idea, quickly lost its appeal in the DoH as political priorities were reshaped. Successive Secretaries of State for Health shifted the focus from one that trumpeted the benefits of the market, and market-based approaches such as TQM, to a more inclusive agenda, focusing on consumer and professional issues typified by the *Patients Charter* (Cabinet Office, 1991) and the *Health of the Nation* White Paper (DoH, 1992) with its strategies for health improvement.

Conclusions

The closing stage of TQM in the district witnessed an attempt to improve the environmental conditions of an acute unit site, which drew critical comment from some clinicians, in spite of useful improvements which had been seen as important at the outset of TQM. The negative comments exemplified the difficulties facing the quality team as they struggled against increasing scepticism which undermined their

commitment to TQM activities. These activities were also taking place against a background of increasing turbulence as the district, now separated into acute and priority care units, prepared for trust status. Tensions between the DGM, who had now assumed responsibility for the acute unit, and clinicians highlighted the power struggle that was taking place as the influence of management grew in the service as it drove through the restructuring that would be required to enable the service to survive in the coming internal market. The wider consequences of separation of the units saw the TQM training programme and Quality Forum come to an end, followed by the loss of the District Training Manager, leaving as she became increasingly isolated at the executive board and could no longer rely on the support of the DGM as he became embroiled in his own fight for survival.

The glimmer of hope, as far as TQM was concerned, was to be seen in the priority care unit which maintained some activities under a new CEO and committed project site staff working in a different organisational context which was more sympathetic to quality management techniques. On the other hand the problems of the acute unit were further intensified with the arrival of the *Patients Charter* which rapidly drained the remaining resources from the demonstration site as the unit responded to the mandatory requirements of the *Charter*. Finally, as the demonstration site closed, staff who had made a deep investment in TQM were disappointed and puzzled by the attitude of the DoH whose support had evaporated at a time when they were hoping to maintain some TQM activities. Little did they realise that TQM had become a victim of changing political priorities, as government shifted focus in order to achieve its wider reform agenda, with no place for private sector techniques such as TQM.

9 Concluding Discussion

Introduction

This concluding chapter begins with a review of the research questions which guided the study, integrating the findings from the case study with theories of strategic change in the NHS. The second section examines the extent to which the district provided an environment that was amenable to change, utilising the concept of 'receptivity', and confirming its value in revealing a series of factors that created implementation problems for the TQM initiative. The penultimate section moves to a broader level of analysis, locating the TQM initiative in the context of strategic change in the NHS during the period researched. The final section examines recent Government policy initiatives which are intended to improve quality systems, and speculates about this new agenda and the potential for strategic change, which provides a fruitful area of research in the future.

Review of the research questions

The purpose of this thesis, as stated in the main research question in Chapter 5 was 'to reveal the process of managing strategic change in a district health authority through the implementation of the Total Quality Management initiative', and this was used to guide the direction of the fieldwork throughout the period of the research. Subsumed within this broad main question was a series of more specific questions which were intended to reveal different aspects of the TQM process. Firstly, what were the antecedent conditions prior to TQM and how did these influence the decision to become a TQM demonstration site? Second, how was TQM embedded into the district and what were the consequences for the service? Third, what management processes were illuminated through the implementation of TQM? Fourth, what was the impact of wider NHS policies on the district during the period of the TQM demonstration site? Finally, what were the consequences of TQM through the continuation of quality activities? In addressing each of these questions in turn, the following section integrates the results of the fieldwork with theoretical concepts, thereby illuminating the main themes emerging from the case study.

The importance of antecedent conditions (for the inception of the demonstration site)
The case study findings confirm that the antecedent conditions prior to TQM were critically important for the decision of senior managers to respond to the DoH's invitation to become a demonstration site and to secure TQM funding. The research commenced with the introduction of general management (DHSS, 1983) and confirmed the beginnings of a distinct break with the past management practice, as the new general management team brought about a shift from an administered service where the manager was cast in the role of 'diplomat' to one where the newly appointed general managers were expected to adopt a more active management style and provide the strategic leadership absent prior to the Griffiths report (Harrison, 1988) in the belief that stronger management would solve the problems of the service.

The case study revealed the actions taken by senior managers to speed up the pace of strategic change in the district with the publication of the *New Management Agenda* strategy document, a series of reputational management initiatives and increased emphasis on management development, as part of this more proactive approach under the leadership of the DGM. This new approach to management of the district contained many of the elements found in discussion of the 'new public management' with a continuing commitment to the public sector ethos of the service, alongside the emergence of a number of techniques imported from private sector management. These included, a stronger managerial spine, standard setting and responsiveness to consumers, bringing professionals into management and the strengthening of the financial management role (Ferlie et al, 1996). These developments coincided with the Government's growing interest in quality management as part of its drive to increase the transfer of private sector techniques intended to improve the performance of the public sector (NHSME, 1989; Ham, 2000). The TQM initiative arrived conveniently at a time when senior managers were actively seeking the means of sustaining the strategic change begun with the *NMA* and to enhance the district's reputation through a national initiative which 'would put the district on the map'. That the earlier initiatives had not captured the imagination of staff beyond a small cadre of staff surrounding the DGM was evident, and supported the argument that enthusiasm for strategic change evaporated as one moved away from the centre of power.

A further important factor in the antecedent period revealed by the case study, and one that was to have an impact on the demonstration site, was the relationship with the RHA which had deteriorated following the appointment of the DGM, whose campaign to improve the district's financial situation had become increasingly more public to the dismay of the Region. The reasoning behind his decision to highlight the district's financial situation publicly was rooted in the decisions of the district prior to his appointment, and led to increased tension between the two organisations following the appointment of a new Regional General Manager. His arrival heralded a tougher line on the financial management in the region and increased pressure on the district at a time when it was struggling to meet its commitments and experiencing repeated winter crises. This tougher line was to have significant consequences for the district in the RHA's sluggish response to funding the TQM demonstration site and the pressure on the acute sector UGM following an overspend in his unit which led to his resignation.

What is evident from the analysis of the events between 1985 and 1989 is that without the introduction of general management and the subsequent efforts of the DGM and his senior team to speed up the pace of change, it is unlikely that the district would have been in a position to bid successfully for TQM. The events that took place during this period prepared the district for the TQM initiative, with a more proactive approach to the management, the promotion of a new management style, and the building of a wider coalition of managers who supported the DGM's commitment to change. All these actions were in keeping with the notion of revitalising a service in the pursuit of 'turnaround management' (Pettigrew et al, 1992). The evidence of these changes, however tentative at the time, was nevertheless considered to be the main factor in the DoH's decision to award TQM funding to the district, as stated in a DoH publication on the demonstration sites. In adopting this longer-term perspective it can be seen that the TQM bid was part of a continuous stream of activities emanating from the top-down approach of Government whose main goal of reforming the management of the service had begun with general management, continued with the emphasis on quality management, and would later be reinforced by the market-based reforms of *Working for Patients* (DoH, 1989). This evidence of the antecedent conditions confirms that change should not be seen as single event or a discrete episode separated from the immediate or distant antecedents that give the events form, meaning and substance. This contrasts

with the episodic view of change – where innovations are seen to have clear beginnings and ends – which fails to explain sufficiently the mechanisms and processes through which change is created (Pettigrew et al, 1992).

Embedding TQM into the district and the consequences for the service

In examining the process of embedding TQM into the district the case study demonstrates that this was undertaken primarily through a top-down process, influenced heavily by the external consultant who was using similar approaches in other districts, and aided by the DGM and DTM who contextualised the private sector ideas of the consultant to fit the ethos and culture of the district. As in other demonstration sites introducing TQM, the district relied heavily on the consultant, as the level of understanding and experience of TQM among NHS staff at that time was extremely limited (Joss and Kogan, 1995). As a result of this limited understanding of TQM on the part of the district's staff, the consultant's approach was particularly persuasive, as he guided the district through what has been described as a conventional approach to implementing TQM (Dale, 1999), but one more fitted to a commercial environment than a professional setting such as a DHA. In developing the model of TQM adopted by the district, the consultant drew heavily on his work in the private sector, using a model that he had developed in an industrial setting and promoted through his publications, with strong elements of a programmatic change approach. However, the problems that began to surface at the implementation stage suggested that the implementation had the hallmarks of an over-mechanistic transfer of ideas from the private sector (Ferlie et al, 1996) into a service dominated by professional groups, with their strong value base and a culture that was resistant to change.

The problem of embedding TQM in the district resulted from the Government's intention of transferring private sector techniques to a service that was poorly prepared for its consequences. The ethos and culture of the service, with its long tradition of professional power (Hinings et al, 1991) and growing anxiety on the part of many staff about the Government's intentions for the service (Hunter, 1996), meant that TQM was being introduced into a service that saw it as a foreign import, and as something that would threaten the autonomy of professionals, particularly senior clinicians. It was also associated in the minds of its critics with the interests of a small group of general

managers and training staff who had coalesced around the DGM at the time of the *New Management Agenda,* and who were viewed suspiciously by many staff in a conservative organisation still coming to terms with the management changes following the Griffiths report (DHSS, 1983).

The case study showed that TQM did not, in fact, became firmly embedded in the district. Clearly improvements took place which were badly needed, with some environmental changes in a service where the plant was often run-down and shabby due to lack of investment by successive governments. Some new equipment was purchased which improved the performance of support staff. Similarly, staff teams in the project sites were able to develop multi-disciplinary working methods in order to solve problems, albeit without the contribution of clinicians in most locations. Some of the work in the priority care unit subsequently enabled staff, who had built up experience of quality management techniques, to maintain quality activities, although these focused much more around work on service standards and as part of the development of the priority care trust. The maintenance of quality management techniques in this service was also related to the nature of the organisational arrangements where multi-disciplinary working was more secure and clinicians were not necessarily service leaders or so influential in terms of treatment techniques.

In contrast, the situation in the acute unit was seen to be much more difficult, with TQM contested, and strong opposition to project activity by clinicians and a low level of commitment by many staff. The power of clinicians and their ability to block change were the main factors (Hinings et al, 1991) and demonstrated how far they were able to use their power to challenge the growing managerial influence in the district. Similarly middle managers and staff in the acute unit were less engaged with TQM outside the project sites, confirming the argument that middle managers and supervisors were likely to be threatened by quality management techniques as frontline staff took on more responsibilities as part of quality management teamwork (Schuler and Harris, 1992). By the same token the major restructuring of the service meant staff were preoccupied with survival rather than engaging in innovative project activity (James, 1994) which further undermined commitment to TQM.

It can been seen from the responses of informants that throughout the life of the demonstration site the quality team struggled to introduce improvements in the acute unit. Their attempts at winning over clinicians were rejected, and project activities brought repeated criticism which undermined the morale of the team. The structure of the unit with its hierarchical and discrete work processes meant it was more difficult to introduce team-based activities into the unit, except those that operated within particular locations controlled by managers and which did depend on clinical involvement. In the end the initiative was limited to a small number of project sites which soon reached the limits of their potential to deepen and extend TQM.

Management processes illuminated by the study

In examining the implementation of TQM the case study has illuminated the management processes at work in the district during the period researched. Implementation was top-down, and led by the DGM in the mould of the charismatic leader who had committed himself to the process of culture change in the district. In turn, the detailed work of TQM was the responsibility of the quality team, headed by the DGM, whose high profile could be used to lend credibility to the demonstration site and who could legitimise activities and be the visible face of the initiative (Bryson, 1995). The other key figure in the management of TQM was the DTM who in the product champion role fitted the description of the tireless enthusiast working conscientiously on implementation issues with a wide range of staff (Bennett and Ferlie, 1994). Her dedication to TQM was seen as almost evangelical, and with the DGM she inspired considerable loyalty among members of the quality team and enabled them to maintain their commitment to TQM in spite of criticisms from clinicians and other staff.

As the level of activity diminished in the latter stages of the demonstration site, the single-minded approach of the DTM and the quality team highlighted a number of potential weaknesses around the process of introducing radical change. The top-down approach lacked any prior assessment of the service's readiness to adopt quality management techniques, or an assessment of the potential impact of these techniques on the service at a time when other major change agendas were being implemented. The management of TQM was undertaken by a small group of managers who were caught up with the perceived benefits of TQM one that was promoted by consultants with

extravagant claims of its potential to transform services (Huczynski, 1996). The appeal of TQM was apparent in comments of members of the quality team; many saw opportunities to drive through their goals of strategic change. However, in their enthusiasm for its apparent attractions, they failed to take into account the difficulties of introducing change into a service which conformed to the traditional archetype with (among other features) the dominant role of professionals and its public service culture and values (Ferlie, 1999). In addition TQM was also being introduced at a time when staff were increasingly concerned about the future of the service as the *Working for Patients* (DoH, 1989) reforms bit more deeply into the district.

What was also apparent from the approach taken by the quality team was the absence of an agenda shared with the district's staff concerning the quality processes. At that time, such an agenda was part of the professional's stock in trade, and that would need to be integrated with the broader approach taken by the quality team. Instead there is evidence that the quality team's promotion of TQM and its benefits antagonised many professionals and support staff. The analysis of the case study findings reinforces the argument that top-down strategies need to exist alongside minimum levels of readiness and capability at a local level, with links made between higher and lower levels in the organisation when strategic initiatives are introduced (Pettigrew et al, 1992). In adopting these particular management processes, the case study has revealed that the actions taken by the quality team lacked the sensitivity necessary in a service where professionals had traditionally assumed responsibility for quality (Ovretveit, 1998) and where there was suspicion of managers' intentions in this area.

A further management issue highlighted by the case study concerned the diffusion of TQM techniques within the district. As most activity remained the preserve of the quality team it was seen to be the exclusive domain of a small number of staff. This alienated the team and its work from the wider organisation, and confirmed the argument (Pettigrew et al, 1992) that 'pilot sites' or 'experiments' rarely spread to the wider organisation, and that the very nature of leading and developing innovatory activity can marginalise teams (Bennett and Ferlie, 1994) and lead to tensions and rejection by those not engaged in the change activity. Of course the quality team, like any group attempting to introduce innovation, trod a fine line between exclusivity and

inclusivity, but were unable to build a sufficiently wide coalition to support diffusion. This is demonstrated by the case study evidence, which supports the view that the quality team were perceived by staff as exclusive, thus further cutting them off from opportunities for wider adoption of TQM techniques.

The case study also highlighted the limited power of managers to achieve a wider adoption of TQM in the district. This was seen in the reaction of clinicians when an attempt was made to engage their interest, and (as noted earlier) of middle managers who saw TQM potentially undermining their power. Among the wider staff group many viewed it sceptically, briefly flirting with it but doing nothing to ensure its implementation, and seeing it as another management fad imported from the world of business. Alongside this resistance, there were other more powerful voices within the district, such as the finance director. He questioned the emphasis placed on TQM from the purely pragmatic standpoint that senior managers should be making the long-standing financial problems of the district their priority, and took the opportunity to make the demonstration site activities a lower priority when he was appointed acting DGM.

The impact of wider NHS policies on the district

The introduction of TQM coincided with the publication of *Working for Patients* (DoH, 1989) and as a consequence the reform agenda had a major impact on the demonstration site throughout its short life. The TQM initiative was one element in a stream of Government initiatives which had the objective of further strengthening the management of the service, extending the manager's sphere of influence and challenging the autonomy of professionals (Ovretveit, 1998). Paradoxically, the policy of extending the management influence in areas such as quality was undermined by other initiatives which eventually thwarted attempts to maintain the work of the demonstration site. Most notable were the progressive changes associated with the introduction of the internal market under the *Working for Patients* (DoH, 1989) agenda. These changes fragmented the district structure, separated the acute and priority care services, introduced market-mindedness and competition between staff, and split the quality team responsible for the demonstration site.

Although the Government commitment to introducing the internal market remained the main policy objective during the period of the demonstration site, a shift took place in the political priorities when the Government became concerned in 1990 that its reform agenda was creating potential electoral risks (Ham, 2000). With the change of emphasis in the Government's handling of the reform agenda, a stronger public sector orientation emerged, with the development of new initiatives concerned with raising standards in the service and developing a more consumerist orientation, such as the *Patients Charter* (Cabinet Office, 1991). This initiative contributed to weakening the work of the demonstration site, as the mandatory requirement of the *Charter* took priority over TQM activities and became the focus of quality activities in the service. From the recent accounts of Government ministers responsible for health policy at the time of the demonstration site (Ham, 2000), it is now possible to understand why the DoH's commitment to TQM quickly began to wane. Government was becoming increasingly concerned about the pressure from clinicians' leaders who were deeply opposed to *Working for Patients* (DoH, 1989), and the consequences of the business language of the reform agenda which was alienating staff. Concern about the political consequences of the reforms led to a shift of emphasis away from the promotion of private sector ideas to one concerned with 'dampening down' concern about the reforms and jettisoning the language of the marketplace (Ham, 2000). These events lend weight to the argument that TQM was a victim of this shift of emphasis. As the Government agenda moved on, private sector initiatives such as TQM were left without support at the centre. Further, the DoH rapidly lost interest in initiatives due to the shift in political priorities, and other quality initiatives became higher priority.

Consequences of TQM through continuing activity

From the informants' accounts of the work of the demonstration site it was difficult to discern any significant or long-lasting changes, with TQM appearing to leave little in its wake following its demise in 1993. By this time key staff involved in the demonstration site had either left the district or moved into new roles in the emerging trusts and the whole edifice of TQM was quickly dismantled and seemed to rapidly disappear from the memory of the service. The acute and priority care DMUs were now moving towards third and fourth wave trusts and these developments consumed the energies of managers and staff. The work in the acute DMU was heavily influenced by the major structural

changes that were taking place in that unit, with its powerful clinicians testing the limits of managerial power and control following the loss of the UGM, which led to criticism of succeeding TQM projects and the resignation of the DTM. Taken together these attacks on the management regime left TQM severely wounded in the acute unit. As a consequence of the loss of the UGM, the DGM was now in the Chief Executive role and no longer able to devote time to the demonstration site. This change also coincided with the resignation of the DTM, at a time when the remaining staff were increasingly caught up with the *Patients Charter* (Cabinet Office, 1991) and the restructuring which was taking place in readiness for the fourth wave trust bid.

In contrast the priority care unit, with its earlier move for trust status, saw advantages in uncoupling itself from the troubled acute unit. It was structurally a different service from the acute unit, with its well-established multi-disciplinary teams, a more pluralistic leadership, and an absence of clinicians willing to use their political power to challenge the leadership of the service. It was a service where quality issues had also long been a familiar feature, symbolised by its earlier work on standards for community services, particularly in the learning disability division (Wolfensberger, 1972). It was also a service that benefited from the appointment of a new chief executive who wished to sustain some quality activities that would meet the needs of the unit's trust application. This offered a lifeline to those staff who remained committed to TQM and were able to use their experience in developing the quality systems within the priority care trust, although the terminology and project activity of TQM was quickly dropped from the language of the new trust.

Review of the research questions: conclusions

In concluding the review of the research questions it has been revealed, through the case study evidence, that TQM was part of a stream of activities undertaken in the DHA during the period researched which were intended to bring about strategic change in the service. The questions posed by this research have revealed the extent of the difficulties the district faced in implementing TQM, as a result of a complex set of factors which created barriers to its adoption. What emerges most forcefully from the analysis of the case material is the extent of the resistance to change in the district, rooted in opposition to private sector techniques, and introduced in the face of suspicion by professionals and

scepticism by the wider staff group. This resistance is unsurprising since the introduction of TQM took place at a time when the service was seen to be replacing its traditional values of compassion and caring for those of business and finance, and was therefore likely to prove a formidable environment to introduce strategic change based on private sector methods.

The District Health Authority: a 'receptive' context for change?

In making the decision to research strategic change through the implementation of TQM in the DHA, the researcher found the model of 'receptivity' to innovation and the metaphor of the receptive and non-receptive context for change a helpful frame of reference in the analysis of the case study. In adopting this model of receptivity, the researcher wished to examine how far the district exhibited the 'signs and symptoms' of receptivity which were associated with more rapid change found in the earlier studies of Pettigrew et al (1992) and Bennett and Ferlie (1994), and which constituted generic change factors. Although these earlier studies were concerned with larger scale change, it was felt that the model of receptivity would nevertheless be helpful in revealing more of the process of strategic change in the district. In the following analysis only those factors relevant to the implementation of the TQM initiative are used, namely: the quality and coherence of policy, the availability of key people leading change, a supportive organisational culture, effective managerial–clinical relations, simplicity and clarity of goals and priorities and environmental pressure-intensity, scale and orchestration. These will be discussed in turn.

The quality and coherence of policy

The first factor is concerned with the quality and coherence of 'policy'. In terms of the concept of receptivity, 'policy' refers to activities at a local level, and centrally with the 'coherence between goals, feasibility, implementation requirements and the need for parallel strategies such as finance and human resources' (Bennett and Ferlie, 1994:165). It can be seen from the review of the literature that the emphasis on quality first emerged with Griffiths (DHSS, 1983) who recommended that the NHS take greater account of the concerns of patients and that districts should appoint managers with a responsibility for quality. Subsequently the district began to receive the message that quality was an important policy issue with the emergence of guidance from the RHA (SWTRHA,

1988) and the NHSME (NHSME, 1989), which subsequently coalesced into a clear policy direction by 1989 with the announcement of the first demonstration sites. This initiative epitomised the interests of the Government at that time who were keen to see private sector techniques introduced into the NHS (Ham, 2000). The initiative also sat comfortably within the stream of national and regional imperatives which encouraged districts to pay more attention to quality, and promoted the view that this was a legitimate arena for management action (Sutherland and Dawson, 1998). When it came to testing quality techniques through the TQM initiative, the district (along with other demonstration sites (Joss and Kogan, 1995)), lacked a clear conceptual understanding of TQM and its relationship to the service where it was being introduced. This situation was largely a result of the drive from the DoH to promote quality management in the service, and the purely pragmatic decision of the DHA to bid for funding with no prior opportunity to test its suitability as a vehicle for change in the district.

The difficulties for the district were compounded by the policy being steered by civil servants who had little experience of quality management techniques, and who relied on districts to develop their demonstration sites under the guidance of management consultants, whose experience and understanding of the NHS was limited. Relying on consultants from the business sector, with their programmatic change models, meant that the strategies adopted were likely to be insensitive to the traditions, culture and power relationships in the service. The difficulties experienced in implementing TQM are an example of taking a policy 'off the shelf', without any test of initial thoughts to ensure that the strategic framework would ensure a coherence between goals, and would complement the service strategy with the necessary functions of finance, human resources and communications (Pettigrew et al, 1992) in place.

In adopting TQM the district was signing up to a 'detailed blueprint' inherent in the programmatic change model promoted by the external consultant. This approach to policy development challenged the notion of policy as a broad, rather imprecise vision, much more likely to stimulate change than the detailed blueprint adopted (Bennett and Ferlie, 1994). This latter approach provides greater opportunity for commitment-building, and allows those interested to develop their ideas around the

change process through a combination of top-down pressures and bottom-up concerns. However, these processes were lacking in the demonstration site. An absence of a shared view about the implications of adopting TQM in the district (the decision to bid for funding being taken by a small group of managers without the time to test out ideas with staff) would eventually lead to its marginalisation and demise.

The availability of key people leading change

The second factor is concerned with the leadership of change, with the availability of key people in critical posts leading change being seen as a decisive element (Pettigrew et al, 1992; Bennett and Ferlie, 1994). The case study identified a small group of managers who were critical to the strategic change processes in the DHA, and were identified early in the case study as the 'enthusiasts' who coalesced around the DGM and provided support, and who were in turn supported him as they pursued the *New Management Agenda* and participated in the reputational management activities which preceded the demonstration site. These managers constituted the 'critical mass of enthusiasts' (Pettigrew et al, 1992) who shared a set of values about the service. It was from their ranks that the District Training Manager emerged, who adopted the role of 'product champion' and led the implementation of TQM 'from the front'. Alongside this small group of managers were other staff who, although not directly engaged with TQM, were positively disposed to the initiative and in a position to support its implementation. The Director of Personnel fell into this category, along with some unit managers and nurse managers, whose loss was felt when the *Working for Patients* (DoH, 1989) reforms led to changes that resulted in the movement of these key supporters.

It was in the movement of these supporters that the weaknesses in the leadership were exposed, when the pressures of the reform agenda began to take its toll. The loss of personnel, with new opportunities created by the reform agenda and the movement of staff as the boundaries between different services were established, led to a more fragile leadership cadre. This group were further depleted by the problems of the acute unit for the DGM and the loss of the DTM as TQM became more marginalised in the new executive board. In the end the leadership was reliant on too few individuals, and was unable to broaden and deepen its base sufficiently to overcome the pressures created by

Working for Patients (DoH, 1989) and the undercurrent of antipathy that existed towards TQM. The antipathy towards TQM was particularly strong among clinical leaders, and had serious consequences for the initiative. Throughout the period of the initiative the quality team was unable to gain the support of any senior clinicians, resulting in the absence of a key element of support in attempting to broaden the base of TQM by drawing other clinicians into the activities of the demonstration site. The antipathy to TQM was fuelled by the Director of Finance's reluctance to support its high profile, when the financial situation deteriorated in the acute unit during the absence of the DGM in the USA. His decision not to act in a sponsor role and to suspend activity sent out a powerful message that such activity that could no longer depend on support at board level.

It is also useful to extend the notion of the role of key people beyond the district, and examine whether the DoH and the RHA provided leadership during the period of the demonstration site. Although no interviews were conducted with regional staff or members of the DoH, it is possible to speculate about the reasons for the lack of responsiveness on the part of these organisations from the accounts of informants who had contact with staff from these organisations. In the case of the DoH, from the outset of the TQM initiative it was apparent to DHA staff that they were unlikely to receive a strong steer from civil servants, whose knowledge of TQM was clearly limited, although understandably so in terms of its business roots. As the work of the demonstration site progressed it became increasingly obvious that the DoH could offer only minimal guidance and relied increasingly on the sites to provide the expertise at periodic progress meetings. The rapid decline in interest in the work of the site coincided with changing political priorities and the abandonment of the 'policy' of quality management. In the case of the RHA, the lack of involvement with the work of the demonstration site can be accounted for by the difficult relationship between the Region and the district arising from the disagreement over funding and new developments. Although the Region had pressed the district to increase its quality management activities in 1988 (SWTRHA, 1988), in the view of informants the Region's resentment of the district's TQM activities and the publicity surrounding this work contributed to the holding back of its matched funding for the demonstration site.

A supportive organisational culture

The third factor used in the analysis of the TQM initiative was the relationship between organisational culture and the potential for change. It is argued that enormous energy is required to effect change in an organisational culture, which is seen as a consequence of the weight of history on a service, shaping its values and defining the norms within an organisation. (Pettigrew et al, 1992). This view of culture is reinforced by Bennett and Ferlie (1994: 162) who describe culture as the 'deep-seated assumptions and values far below the surface manifestations, officially espoused ideologies and even patterns of behaviour'. In analysing the culture of the district it was clear that it would not be easy to facilitate the introduction of quality management. This can be seen from the evidence of the introduction of general management in a traditional service that was experiencing the pressures of its particular demographic problems and chronic underfunding, with reported low morale and suspiciousness of the new forms of management introduced following Griffiths. This was also a district which had not developed links with universities or other research centres (its management development programme was one of the first initiatives which were developed in partnership with a higher education institution) and was not noted for any innovative projects at the time of introduction of general management. It was therefore unlikely that managers would be able to introduce significant change in the district where the culture of the service was so well entrenched.

The gap between the ambitions of the DoH who saw demonstration sites bringing about radical cultural change (Joss and Kogan, 1995), and the strength of the district's culture, exposed the difficulties facing the quality team. The culture of the district was a hurdle the quality team had to surmount if it was to achieve the aims of nothing less than a complete cultural change, which was seen as necessary if TQM was to be successfully implemented into an organisation, with all employees undergoing the same training and internalising the same values of customer orientation (Oakland,1989). It was evident that the introduction of TQM was never likely to achieve these over-ambitious goals in a service where professional and occupational groups closely preserved their professional autonomy and were unlikely to be convinced of the exaggerated claims made for TQM.

Although it can be seen from the case study that following the DGM's appointment he made a rapid start on introducing features said to be associated with a high rate of

change, there was an absence of such features as, flexible working across boundaries rather than formal hierarchies, an open and risk-taking approach, openness to research and evaluation, and a positive self-image and sense of past success (Pettigrew et al, 1992; Bennett and Ferlie, 1994). At the time TQM was being implemented some of these features were beginning to emerge, but the inertia that the DGM experienced around the strategic change agenda reinforced the view that the district's traditional culture (or more accurately cultures) was a key factor in inhibiting the transformation he sought, and that significant change would require a long time frame (Ferlie et al, 1996).

Effective managerial–clinical relations

The fourth factor considered was the relations between managers and clinicians. Studies of strategic change in the NHS have identified managerial–clinical relations as a critical factor in receptivity to change, arguing that where clinicians are opposed to change they can exert a powerful block on managers' intentions (Pettigrew et al, 1992; Bennett and Ferlie, 1994). In the district the introduction of general management brought with it a requirement for the DGM and his senior team to improve the performance of district and speed up the pace of change by closing the gap between Government policy and local implementation.

To achieve this it was necessary to begin the process of actively managing the performance of professionals (Ferlie et al, 1996), although this did not extend to doctors. Where the DGM did engage with the work of clinicians, concerned their activity levels during the winter funding crises. A further example was when the quality team led by the DGM and DTM attempted to engage clinicians in the activities of the demonstration site and were openly rebuffed. Later, when the DGM was appointed as Chief Executive of the acute unit following the resignation of the UGM, he once again found himself in conflict with senior clinicians who were unhappy with his appointment. Although there was no evidence of a breakdown in relationships between managers and clinicians, it was clear that wherever managers moved on to the 'turf' of clinicians it was likely to be viewed with suspicion at a time when managerialism was seen as slowly eroding the clinician's power base.

Up to the advent of *Working for Patients* (DoH, 1989) there was little evidence from the case study of clinicians taking a more managerial and strategic role in the district (with the exception of the medical representative on the DMB). However, with the introduction of clinical directors this began to change. The policy created further problems for TQM, with the recently appointed clinical directors exerting their new-found influence to undermine the demonstration site, with the criticism that the TQM activities were concerned with trivial changes at a time when the service was under severe resource pressure. The clear evidence of clinicians having 'gone into opposition' to block the development of the demonstration site reinforces the argument that strategic change is more difficult in organisations such as the NHS where professions have considerable discretion over practice which it is difficult for managers to challenge (Ferlie, 1999).

Simplicity and clarity of goals and priorities

The fifth factor examined was the ability of managers to establish a set of key priorities and insulate them from the constantly shifting short-term pressures common in the NHS. The issue of goals and priorities also has ramifications for the process of implementation which in turn is likely to be influenced by the degree of change involved and the extent to which there is consensus about the goals of change among the participants (Pettigrew et al, 1992). A further factor which had relevance for the TQM initiative is the extent to which there is the development of a sense of 'mission' by those closely involved in the process of innovation (Bennett and Ferlie, 1994). It is evident from the case study that there was an accumulating weight of initiatives which managers had to respond to, with priorities escalating rapidly after the publication of *Working for Patients* (DoH, 1989) and the introduction of the reform agenda. This external pressure on the district was increasingly felt as Government forced the pace of implementation, and later, following a shift of emphasis by Government (Ham, 2000), introduced the *Patients Charter* (Cabinet Office, 1991). The case study evidence clearly demonstrates the pressure managers were under during this period, and how the TQM initiative was quickly submerged by these competing demands.

A second aspect of this receptivity factor concerned the degree of consensus about the TQM initiative. Factors considered important here are the amount of change involved

and the degree of consensus about the change proposed. The case study evidence suggests that outside the quality team, and those staff who participated in the project sites, the degree of consensus was quite limited. A combination of resistance by staff (particularly professionals such as clinicians) and suspicion by other staff who questioned the roots of TQM and its relevance for the NHS imply that a consensus was not achieved. Where there was support for TQM it appeared much more instrumental in that units benefited from the injection of funding into resource-starved areas and environmental improvements took place or equipment was purchased which improved the particular service. It was in the priority care unit that a greater degree of consensus was achieved, with the visible improvements in long- stay wards and the health centre, whereas in the acute unit changes were much less visible and attempts to improve the environmental conditions were received with a greater degree of scepticism.

The third element, as evident in the study of HIV/AIDS (Bennett and Ferlie, 1994), found some of the managers and training staff associated with TQM had developed a deep sense of 'mission' about quality management, exhibiting what has been described as 'evangelical fervour' for the promotion of quality (Wilson, 1992). There were also those who committed themselves early on in the process of implementation and played champion roles, until events overtook them as the demonstration site activities contracted. There were also those staff who 'used' TQM to enable them to progress their career, either outside the organisation in the case of the DTM, or internally in the priority care trust. What was not in evidence were the 'managerial butterflies' who flitted in and out of the process (Bennett and Ferlie, 1994), with the members of the quality team remaining intact and deeply committed until the external and internal pressures began to undermine the initiative. What was evident from the case study was the difficulty the quality team had in insulating the demonstration site from waves of short-term pressures impacting on the service from 1990 as the Government pressed districts to move rapidly to trust status, through the establishment of DMUs and disaggregation of the service. The degree of change resulting from these top-down initiatives quickly sapped the energy of the quality team – in spite of their evident commitment – and rapidly reduced the activities of the demonstration site.

Environmental pressure – intensity, scale and orchestration

The final factor considered is that of long-term environmental pressure, with evidence from outside the NHS, suggesting that it can act as a trigger to radical change (Pettigrew, 1985). In the case of the NHS matters are somewhat more complex, with excessive pressure on the service potentially draining energy out of the system, or alternatively producing movement, dependent on how skillfully the pressure is orchestrated (Bennett and Ferlie, 1994).

Evidence of pressure on the district was apparent from the long series of exhortations about the need to give greater priority to the development of quality systems that began with the Griffiths Report (DHSS, 1983) and its recommendations that there should be a greater focus in patients as consumers, with the appointment of district-wide quality posts. A consequence was increased emphasis on the development of service standards and much greater concern to learn of the views of patients, which was evident in the statements contained in the *New Management Agenda*. This was followed in 1988 by Regional guidance to districts on the importance of quality, and requirements that districts put in place quality structures and systems (SWTRHA, 1988). This pressure intensified with the NHSME's (NHSME, 1989) letter to regions and districts, coinciding with the announcement of the first TQM demonstration sites, and statements at the NAHA conference (Nichol, 1989; Long, 1989). By 1989 this increasing stream of messages had reached a point where it was clear that responsibility for quality was now firmly part of the manager's domain (Sutherland and Dawson, 1998).

Where the case study testified to a second, and even greater environmental pressure, particularly in its scale and intensity, was in the requirement of the district to respond to the publication of the White Paper, *Working for Patients* (DoH, 1989). The subsequent reform agenda brought with it increasing pressure from the RHA on the district, both to speed up the pace of change to meet the Government's need to establish trusts and financial pressures on an already over-stretched district. This agenda ushered in radical change, seen in the dismantling of the DHA into separate acute and priority care DMUs and the increasing transparency of budgets which were separated and generated more pressure on the acute unit. The appearance of competitive behaviours was also evident, which quickly undermined the district-wide demonstration site, the voluntary and forced

movement of staff as new opportunities arose as restructuring took place or staff were required to move as part of the development of DMUs and eventually trusts, and the consequent submerging of TQM activities under the relentless pressures of the reforms.

Implications of the findings

The six factors used for the purpose of this analysis demonstrate the interconnectedness of receptivity factors and how in combination they played a critical role in both driving and inhibiting change in a district. Taken together these factors worked against the degree of strategic change senior managers sought through the introduction of TQM, and highlighted some of the key factors – poorly thought through policy formation and implementation, a proactive, but ultimately fragile leadership, a deeply entrenched organisational culture, growing tension between managers and clinicians, the insistent demands of the external reform agenda, with an escalating the number of priorities, and finally, the DoH's diminishing lack of commitment to the demonstration site as political priorities changed. These factors each played their part in undermining TQM and highlighting limited managerial power and influence on the one hand, and a top-down power driven change agenda on the other, each converging to limit the development of the manager's new found responsibility for quality.

The application of the concept of receptivity also confirmed its value in explaining the degree of change achieved in the district, and reinforced the argument that there are generic components to strategic change processes in the NHS. (Bennett and Ferlie, 1994). The analysis of the receptivity factors in turn raises fundamental questions about how effective the introduction of quality management techniques were as a vehicle for radical cultural change in the NHS (Joss and Kogan, 1995). This is particularly important in view of the over-simplistic adoption of a private sector technique, driven primarily by ideological rather than considered judgments, which was always likely to be controversial in a service that had suffered a decade of attrition and deprecation as a result of Government policies, and as such was unlikely to be a receptive context for change.

The TQM Initiative in Context

This penultimate section reflects on the consequences of the TQM initiative based on the evidence of the empirical chapters and set in the wider context of a series of change initiatives which impacted on the NHS during the period researched. Reflection on these events a decade later provides a greater understanding of the management of strategic change, with lessons for the future development of quality improvement initiatives in the NHS which will be discussed in the final section. The evidence from the case study has shown that the period between 1985 until 1993 the DHA witnessed a continuous series of top-down externally driven change strategies. These were intended to bring about a transformation of the service, in order to meet the Government's aim of a service which more closely reflected the world of business which was held up as the benchmark against which the NHS would be measured. The establishment of the TQM demonstration site was one element in this series of Government-inspired initiatives which were designed to bring about a change in the culture of the service which would be more attuned to the laws of the marketplace, and a service that was more responsive towards consumers and their preferences. Each initiative, would in turn, strengthen the influence of managers over the service and fulfill the original aims of the Griffiths report (DHSS, 1983) and provide the means by which they could reshape the service in the Government's image.

Although this series of policy initiatives did begin to impact on the district by introducing into the service elements of what became known as the 'new public management' (Ferlie et al, 1996), its managerialist influences increased the gap between the goals of managers and the staff of the service. Throughout the period researched the trust between Government and the staff of the service was tested as the radical reform agenda intensified the feelings of professionals – people who had been operating under increasing pressure as the gap between needs and resources became ever more acute. These feelings were further intensified by the end of the decade with increasing concern about the future direction of the service, fuelled by Government rhetoric which trumpeted the virtues of business and the market, resulting in fears of job losses, or at least enforced changes of role and relocation, as the internal market reforms dug deeply in to the service.

In spite of staff fears, the strategic transformation of the service continued as government sought to ensure its reform agenda was not hijacked by professionals. In the end, the gulf between Government and the professionals, particularly clinicians' representatives, increased the political temperature sufficiently to cause the politicians to 'dampen down' the reform agenda and begin to build bridges with the professions again (Ham, 2000). The consequences of these shifting political priorities resulted in the virtual abandonment of the TQM demonstration sites by the DoH as witnessed in the case study. Although the implementation of the market-based reforms continued, some of the Government's missionary zeal for transferring private sector techniques to the NHS had gone, with TQM an apparent victim, to the dismay of those staff who had championed this new technique which they believed could bring about the radical changes earlier initiatives had failed to deliver.

What this case study has reinforced is the assertion that achieving change in the NHS does not follow automatically from the assertions of managers that it is necessary (Butler and Wilson, 1990). The NHS is fundamentally a conservative organisation, heavily influenced by its history and harbours a reservoir of deeply held beliefs which constitute a powerful barrier to organisational change. Although there was certainly evidence of tactical behavioural compliance (Ferlie et al, 1996), in the face of power-led initiatives, these behaviours were not based on a belief in a unifying philosophy that the changes being forced on the service were improvements. Staff working at the front line remained largely hostile, or at least indifferent, to general management and the market-based reforms (Hunter, 1995) arising from the perceived threat to their jobs, or ignorance of what the changes were intended to achieve. The difficulty in grasping the end-view of the changes resulted in a deep resentment over what was perceived to be the destruction of the service.

Clearly the influence of general management was beginning to change the culture at the time of TQM, but the power of managers was still limited and had not expanded sufficiently to enable them to influence professionals and other staff and persuade them to adopt quality management techniques. Some of the limitations can be laid at the door of Government, whose campaign to vilify the public sector and reduce its role in society had made staff acutely aware that managerial changes in the service were fundamentally

concerned with downward pressure on resources and attempts to undermine established patterns of professional activities. In the context of this political and organisational landscape, it was unlikely that staff would embrace what was seen as another technique for increasing managerial control in the service. In spite of concerted attempts by managers to secure cultural and organisational change, it was realistically something that could take years to achieve and become apparent (Pettigrew et al, 1989).

The widespread adoption of quality techniques had become a central part of the plan to reform the organisation and management of the public sector. (Kirkpatrick and Lucio, 1995), holding out the hope of strengthening the influence of management and improving performance in the search for value for money and greater sensitivity to the consumer. These hopes for quality were nevertheless to be short-lived, as the consequences of the *Working for Patients* (DoH, 1989) reform agenda generated strong resistance by doctors, and was mistrusted by other staff groups. The growing tension between Government and the professions eventually resulted in a decision to jettison the language of the marketplace and the more overtly commercial activities (whilst still retaining the goal of an internal market). This occurred as successive secretaries of state for health shifted the focus from one concerned primarily with structural change to one concerned with professional interests and greater consumerism (Ham, 2000). It was this shift in the government's management of the reform agenda, which took place between 1989 and 1990, that sounded the death knell for TQM. Although TQM would continue through till 1993 when the funding for demonstration sites ended, it would no longer be seen as an initiative that the DoH supported, as would become increasingly apparent to the staff of the district health authority.

In spite of the weight of evidence suggesting TQM's limited impact and rapid demise, its activities were nevertheless important in that they formed part of a change agenda that had begun early in the mid-1980s as quality began to lose its exclusively clinical focus. With Government making quality a higher priority in public services, the definition of what constituted quality in health care was reframed, and managers found themselves expected to engage in the management of quality for the first time (Sutherland and Dawson, 1998). What the TQM activities revealed was the emergence of longer-term changes in the management of the service, assisted by the introduction of

the demonstration sites, along with other initiatives during the period researched. The TQM initiative enabled members of the quality team to develop new knowledge and skills about quality improvement systems which in retrospect can be seen as part of a stream of emergent activities – 'building on each other piece by piece and creating greater receptivity to change' (Ferlie et al, 1996: 230) on the part of those individuals involved (it was interesting to note that a number of staff who had been involved in the TQM initiative were now in clinical governance teams or managing other quality systems). The case study, in confirming the importance of antecedent conditions and the historic evolution of ideas (Pettigrew et al, 1992), strengthens the view that each initiative provides the potential to enhance the managerial skill base (Ferlie et al, 1996) and the willingness of individuals to engage with new approaches to service improvement.

Quality improvement and the NHS: the wheel turns full circle?

The lessons of the TQM initiative are clearer to see with the benefit of hindsight. For much of the early part of 1990s quality improvement matters stood still as the internal market was finely tuned. In spite of staff anxieties about the internal market, there were initial hopes among members of the quality team that the purchaser–provider separation would provide an opportunity to develop quality systems as part of the contracting process. The reality proved to be very different as quality was squeezed out of the equation and played a subservient role to that of finance, with chief executives judged on the financial bottom line, rather than having to ensure that they had systems in place to assure the quality of the service (Dewar and Hill, 2000). The marginalisation of quality meant that it remained within its separate clinical and managerial spheres of influence, and did not achieve the degree of synergy necessary for the development of a more comprehensive quality improvement system, which was the basis of TQM, and is now seen as essential in the new reforms. It was the neglect of this more comprehensive approach to quality improvement that had to wait until the election of the Labour Government to restore its importance in the service.

After the long period of neglect between the end of the TQM initiative and the recent policy initiatives of the Labour Government, with the announcement of the 'New NHS' and the introduction of clinical governance (DoH, 1997), the Government has declared

that 'the NHS will have quality at its heart'. Under the new arrangements for clinical governance chief executives of trusts are now accountable for the quality of the services provided and each trust has to establish a committee chaired by a senior clinician who will lead work on quality (Ham, 1999). Alongside the introduction of clinical governance is the increasing level of external regulation, signalling a further break with the past. These new initiatives are seen as largely a result of the failure of professionally controlled quality, that in the end warranted the introduction of a much greater degree of external regulation, with new bodies (NICE; CHI) established to address issues of clinical performance. The establishment of NICE and CHI are part of this new system of regulation which it is argued 'herald the beginning of a new era in medical accountability' (Ham, 1999: 169) and which may act to constrain the traditional clinical autonomy (Ferlie, 1999).

What has changed is the recognition that, although quality remains a contested concept dependent on the experiences, values and assumptions of different actors in the health care system, it is nevertheless multifaceted and means different things to different people (Sutherland and Dawson, 1998). What can be discerned from the latest stage of reform is that they are part of an historic shift in the role of quality in health care which began in the mid-1980s, firstly within the domain of clinicians and their control of clinical practice, then in the late 1980s extended to non-clinical areas such as waiting lists and hotel services, which were firmly part of the manager's domain. The current stage, witnessed in the introduction of new quality systems under Labour Government policies, is the integration of the clinical and non-clinical domains which are now the legitimate concerns of both clinicians and managers.

The new initiatives concerned with improving the quality of services, are seen as a move away from the past where emphasis was placed on imitating private sector models of quality, to one that recognises the importance of ownership and participation in clinical governance systems by professionals working in partnership with managers. There is now a more realistic approach to improving quality in the service, with the recognition by Government that strategic change will not take place overnight, and that it could take 10 years to achieve the standards of service now recognised as essential (DoH, 2001). What is different is that both the professional

and managerial landscape has changed since the TQM initiative, with the acceptance of much greater external regulation by the professions, and the requirement for clinicians and managers to work together in the pursuit of quality improvement.

The development of a new policy initiative on quality does not necessarily mean it will be implemented. The analysis of the TQM initiative demonstrated the hurdles a policy has to surmount to achieve its objectives, with the power of professionals remaining strong in a highly decentralised service, alongside staff, many of whom remain suspicious of government initiatives of any colour. Realistically, Ferlie (1999) predicts that these strategies may 'largely fail if the fundamental conditions of professional dominance are not removed'. In spite of growing performance management processes within the NHS, new policies are being introduced into an organisation where professionals still have considerable discretion over practice which is difficult to challenge. This raises continuing questions about the management of strategic change in professionalised organisations, where implementation processes are more complex than in other types of organisation (Ferlie, 1999). These latest developments in clinical governance provide new opportunities to research the implementation of quality systems which will require a much closer integration of clinical and managerial perspectives which foundered in the original TQM initiative and still present potential obstacles to change.

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List of Informants Interviewed

Appendix 1

Role	**Location**
Clinical Services Manager	Acute Unit
District General Manager	District
District Training Manager	District
Director of Finance	District
Health Authority Member	District
Health Centre Manager	Priority Care Unit
Lecturer in Management	College of Higher Education
Manager, Biomedical Sciences	Acute Unit
Medical Consultant	Acute Unit
Nurse Manager	Priority Care Unit
Project Site Leader (Orthopaedics)	Acute Unit
Project Site Leader (Portering Service)	Acute Unit
Project Site Leader (Community Hospital)	Priority Care Unit
Project Site Leader (Health Clinic)	Priority Care Unit
Quality Coordinator	District
Quality Facilitator	Acute Unit
Quality Facilitator	Priority Care Unit
Scientific Services Manager	Acute Unit
Support Services Manager	Acute Unit
Training Manger	District
Unit Manager	Acute Unit
Unit Manager	Priority Care Unit
Unit General Manager	Acute Unit

Interview Schedule: Themes and Questions **Appendix 2**

1. *Introduction of general management*

Questions:
- What was the impact on the district?
- What were the consequences of the appointment of the DGM?
- What was the purpose of the *New Management Agenda*?
- How was it implemented?
- How was it seen by different staff groups?
- How was the decision to raise the profile of the district received?
- What was the impact of the recurrent financial crises in the acute unit?

2. *Involvement with TQM*

Questions:
- What was your first contact with TQM?
- What were your specific responsibilities?
- How long were you involved with TQM?

2. *Decision to bid for TQM funding*

Questions:
- How was the decision made?
- What level of consultation took place?
- How would it benefit the district?
- Was it intended to support particular developments?
- What was the level of understanding of TQM among managers and staff?

3. *Key leadership roles*

Questions:
- Who were the main leaders of the initiative?
- What role did they play?
- How were they seen by staff who were implementing TQM?

4. *Project Sites*

Questions:
- How were sites identified?
- What were they expected to achieve?
- What staff were involved?
- What were the main changes that would be put in place?
- How did other staff outside project sites react to the chosen sites?

5. *Implementing TQM*

Questions:
- What was the implementation process?
- Who was involved?
- What roles did they play?
- What structures were set up?
- What were the main activities?
- Were these seen as successful?
- How were they seen by staff ?
- Did it lead to new working practices?

6. *Training programme*

Questions:
- What training was provided?
- Who led the training events?
- How was the training received by staff?
- Were specific training materials used?
- How were TQM concepts viewed by participants?
- What was the impact of the training programme?

7. *Impact on the management of the service*

Questions:
- How did it change the way that managers responded to quality issues?
- How did the activities of front line staff change as a result of exposure to TQM training?
- What was the influence of TQM on the relationship between managers and their staff?

8. *Involving clinicians*

Questions
- How far were clinicians involved in the TQM developments?
- How was TQM viewed by clinicians?
- What was their response to the demonstration site activities?
- What was the scope of their involvement across the district?
- Did TQM throw up issues of different approaches to quality?

9. *Working for Patients reforms*

Questions:
- What was the impact on the district?
- How did the development of DMUs affect the district?

- What were the consequences of the separation of units for TQM?
- How much were managers able to stay committed to TQM as the reforms rolled out?
- How did the reforms affect front line staff attitudes?
- What was the main impact on the Demonstration Site?

10. *DGM's fellowship in USA*

Questions: (Specific questions to DGM)
- What was the purpose of the fellowship?
- How did you feel it would help in the implementation of TQM?

11. *Financial crisis in acute unit*

Questions:
- What were the roots of this crisis?
- What impact did it have on the district?
- What were the consequences for TQM?
- What were the reasons for suspending TQM activity (question to Director of Finance)?

12. *DGM returns from USA*

Questions (Specific questions to DGM)
- Did the study tour influence your thinking about TQM?
- What were the consequences of your absence in the USA?
- What was the thinking behind quality becoming a directorate?
- What was the impact on the demonstration site?
- How was TQM seen by the new board?

13. *Tensions in the acute unit*

Questions:
- Describe relationships between managers and professionals in the unit?
- What were the consequences for the DGM?
- What impact did it have on TQM?
- What impact did it have on your support for TQM (question to DGM)?

14. *Patients Charter*

Questions:
- What was the impact of the Patients Charter on the district?
- How did it affect TQM?
- Was it an initiative that could be integrated with TQM?
- How was it seen by staff?

15. *External leadership, guidance and support*

Questions:
- What leadership did the DoH provide?
- Were they able to offer technical assistance?
- How did the DoH's involvement change during the life of the demonstration site?
- What leadership did the RHA provide?
- Did they provide technical assistance?
- What consequences did the district's campaign on funding have on TQM?

16. *TQM funding ends and consequent activity*

Questions:
- What level of TQM activity was maintained after the site officially closed?
- Are there any current quality posts and activities which had their origins in the demonstration site?
- Reflecting now on the TQM experiment, what should the DoH have done differently?
- What has been the lasting consequences of TQM?